Governance, Risk and Best Value Committee

10am, Tuesday 5 June 2018,

Immediate Pressures and Longer Term Sustainability – Health and Social Care

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Executive Summary

This report sets out short-term actions that are underway, together with longer-term intentions, for the alleviation of pressures on services and budgets, and the service design changes necessary to support sustainability of health and social care in Edinburgh. The plan, attached as Appendix 1, was approved by the Edinburgh Integration Joint Board on 18 May.

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Report

Immediate Pressures and Longer Term Sustainability – Health and Social Care

1. Recommendations

It is recommended that that Governance, Risk and Best Value Committee:

1.1 note the short-term actions underway, and the medium and longer-term actions set out in the plan at Appendix 1.

2. Background

2.1 Over the past two years, the Health and Social Care Partnership in Edinburgh has struggled with a range of pressures that have impeded the progress aspired to by the Integration Joint Board (IJB), the City of Edinburgh Council and NHS Lothian. These challenges relate to resources, performance and the requirement for organisational integration of staff groups from two separate organisations. Many of the challenges are articulated in the Care Inspectorate/Healthcare Improvement Scotland report of the inspection of older people's services, published in May 2017.

2.2 Much work is being done to address the specific recommendations in the inspection report, which is subject to a comprehensive programme management approach, and reported regularly to the IJB and the inspectors.

2.3 In addition, the Partnership, in collaboration with Council and NHS Lothian colleagues, has developed a plan to both alleviate short-term pressures and create the environment that will allow longer term, sustainable change.

3. Main report

3.1 The plan at Appendix 1 sets out first the key areas of development and change required. These cover: prevention; culture; demand management; service redesign; workforce development; business and IT support; and professional/clinical governance issues. The next section of the plan sets out short-term actions underway, which should be achieved in 2018/19, followed by the medium-term actions underway or planned for 2019/20; and finally, the longer-term changes necessary, which the Partnership aims to achieve by 2012.

3.2 There are 3 annexes. The first sets out the current position regarding people delayed in hospital; the second shows the governance arrangements established to monitor progress against the improvements agreed; and the third provides the financial context for the work.

4. Measures of success

4.1 The plan sets out a strategic direction and activities that will ensure a sustained focus on improvement in a number of areas such as; the number of people delayed in an acute setting, length of stay in an acute setting, and admission and readmission to an acute setting. Given many of the pressures on the Health and Social Care Partnership's current performance relates to capacity in the care market other key measures of success will include the development of capacity and models to meet demand.

4.2 Following approval at the IJB meeting on the 18 May 2018 it was agreed that the Chief Officer will now lead work to develop further the plan, key milestones and trajectories. These will be reported to the IJB at a future meeting.

4.3 The IJB is also responsible for reporting progress against a number of key measures and these will relate to measures of success in relation to this plan. They include; the 9 National Health and Wellbeing Indicators, the draft Ministerial Strategic Group measures and the developing IJB performance framework.

5. Financial impact

5.1 The precise financial requirements to deliver sufficient services to meet the long-term needs of the people of Edinburgh to an acceptable standard are difficult to determine when performance and capacity are not in balance. In the short-term, additional resources have been specified to assist in getting the Partnership into a steadier state (see Annex 3 of the plan). Thereafter, the long-term financial commitment required will be determined and reported to the IJB.

6. Risk, policy, compliance and governance impact

6.1 There is a danger that a singular and exclusive focus on addressing immediate, short-term pressures will not create the conditions necessary for long-term, sustainable change. Achieving this change successfully is the only way to avoid repeated financial crises, year on year.

6.2 Conversely, energy and attention focused solely on the longer-term changes require will leave people at risk now. The Partnership, IJB, Council and NHS Lothian must manage improvements across both these dimensions.

7. Equalities impact

7.1 An Integrated Impact Assessment would be undertaken in respect any proposed changes that require it.

8. Sustainability impact

8.1 A sustainability impact assessment would be undertaken in respect of any proposed changes that require it.

9. Consultation and engagement

9.1 A draft of the plan was commented on by several Partnership and IJB stakeholders, including the Council and NHS Lothian. Engagement and consultation will be a key characteristic of any service or policy changes that might be proposed as part of the implementation of the plan.

10. Background reading/external references

10.1 None.

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11. Appendices

Appendix 1 – Edinburgh Health and Social Care Partnership – Plan to alleviate immediate pressures and establish the environment for longer term sustainability

Edinburgh Health and Social Care Partnership – Plan to alleviate immediate pressures and establish the environment for longer term sustainability

Introduction

The Edinburgh Health and Social Care Partnership (the Partnership) is subject to significant pressures across many dimensions, including: operational delivery; performance against targets, standards and quality; strategic planning; financial constraints; market shaping and capacity. In addition, the Partnership needs organisational development support to assist in the cultural changes required in bringing two historic agencies together, and business support to assist in the establishment of robust operational processes to ensure effective service delivery.

The Statement of Intent and Improvement Plan produced by the Partnership in the autumn of 2017 categorise the individual actions required to address a range of improvements across these dimensions. This document sets these actions in a wider context of the transformation necessary to get the Partnership from its current crisis position to a steady state, with resources and performance in balance, and with the capacity to meet the needs of adults for health and social care in ways that reflect their wishes; that are sustainable in the face of long-term demographics and budget constraints; and to a standard that meets the expectations of the city and the regulatory bodies.

The Edinburgh Integration Joint Board (IJB) was legally established in June 2015. It agreed its first Strategic Plan in March 2016 and took on full responsibilities and powers in April 2016.

Following the formal establishment of the IJB, attention focused on the integration of staff groups from the two partner organisations (the City of Edinburgh Council and NHS Lothian), and the associated restructuring, organisational review and meeting of agreed savings targets. Although this activity was necessary and legitimate, it detracted from the operational delivery improvements that were required.

Although the range of IJB and Partnership responsibilities is extensive, much of the attention to date has focused on the critical, but relatively narrow area of people in acute hospitals whose discharge home or to more appropriate settings is delayed. The disproportionate negative impact on people's health and well-being of remaining in hospital when there is no clinical need to be there, coupled with the high cost of this inappropriate care and the damaging impact on other parts of the health and care system, is the reason for this understandable attention. Addressing it effectively will have much wider positive outcomes for the whole system, creating as it should the capacity and resources to support a higher volume of people in need.

Despite the inevitable emphasis on people delayed in hospital, the Partnership and IJB are aware of the needs of a much higher number of people living at home who also depend heavily on support. The improvements set out in this paper are intended to benefit *all* the citizens of Edinburgh who need health and social care services, support and protection.

The extreme pressures on the whole system and the urgency with which these need to be tackled led to two positive decisions. First, the acknowledgement from the IJB, the Council and NHS Lothian that additional financial resources are required; and second, that concerted, shared effort and non-financial resources are also needed over the short- to medium-term. These resources and commitment must be coordinated and targeted effectively if they are to have a lasting, positive impact. Whilst an immediate relief of the pressure on the system is required, more sustainable, long-term relief depends on a different use of resources, and the former should not jeopardise the latter if we are to avoid a vicious cycle of recurring crises.

The IJB has agreed outline strategic commissioning plans for: older people; mental health; primary care; and disabilities. During 2018, these will be developed into full strategic commissioning plans, which will provide the detail and the financial implications of many of the issues set out in this paper.

Set out below are **eight** key categories across each of which sustained change is required to achieve the ambitions of the IJB and the Partnership. Each section includes a brief explanation of the key issues. This is followed by proposals for the use of additional resources in support of the short-term **(2018)** relief of immediate pressures, and the medium-term **(2019)** actions required to ensure the right context for the change the partners are seeking. It then sets out the Partnership's long-term vision **(2021)**, and the activity that depends on a sustained commitment to ensure these changes make a permanent difference, given the known demographics of need and likely future resource constraints.

1. **Prevention** – we need a sustained and meaningful shift of attention and resources towards preventative and early intervention activity that will reduce dependency on acute services and crisis support. This activity must range from universal/life-style support in early years, to secondary and tertiary prevention at each life-stage and dependency state. At the secondary/tertiary end of this spectrum, there needs to be an expansion of our support to carers, respite, etc., which will lead to a reduction in presentations and admissions to hospital, as well as improvements in general well-being and independence. Without such a shift, the care and support system as we know it will be unsustainable in the near future, overwhelmed by higher and higher levels of acute need.

2. **Wider cultural change** – our traditional model of health and social care support is based on expectations that formal care will be provided largely by public services, as part of a long-standing social contract, based on taxation contributions in exchange for universal benefits. Whereas the public funding envelope has reduced significantly in recent years, public expectations regarding the level and standard of provision have not reduced to the same extent. We need to begin a 'big conversation' with stakeholders about what it is realistic to expect in terms of public service support, and what might be a reasonable contribution to people's care from individuals, their relatives, their neighbours and their communities. Self-directed support is intended to assist in this cultural shift. It seeks to replace our current model of **deficit-based** assessment ('what is wrong and what can public services offer to fix the problem'), with a **strength-based** approach ('what are all the things you can do, either independently or with informal family/community supports, and what is the residual gap, if any, for which public services are required'). There is evidence that formal care is over-prescribed in Edinburgh, and that the tolerance to risk is lower than in other areas. For example, at 16.58 hours per person, Edinburgh has the third highest average hours per person in Scotland. In comparison, Aberdeen provides an average of 12.70 hours per person and Glasgow 9.30 hours per person.[1] These characteristics are impacting on the Partnership's capacity to meet expectations. There is a difficult balance to achieve here. It will require open and honest debate regarding the relative risks to people waiting without support for services they may never receive, against changing expectations to assume more personal/family/community contribution to self-care and support.

   Full and effective integration also requires significant cultural change for staff. The organisational development work on which this depends needs to be formalised and resourced.

[1] http://www.gov.scot/Publications/2017/12/3849

3. A **Reduction** is required in the volume of demand and expectation that is generated from initial requests for assistance. At present, all requests for health and social care are screened, however, most still progress to a waiting list for an assessment. Following assessment, most then result in a wait for allocation of a formal service. This results in long waits at each stage; unmanageable pressure on capacity; high levels of dissatisfaction; and often unnecessary expenditure. We need to redesign the system to create opportunities at each stage in the process for people to receive the right information or support at the right time. A new system would need to include:

    i. accurate web- and telephone-based information about: eligibility levels for formal services and realistic waiting times, alternative community supports, information about self-care/self-help and private providers of domestic services and care and support, benefits advice, charging, etc.
    ii. opportunities for self-assessment and direct access to equipment

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

5. This change of landscape must be complemented by a **redesign** of some of the Partnership's internal, high cost, direct care services. These include **Hospital at Home, Reablement, Intermediate Care, and other similar intensive support**, including emergency responses. At the time of the Partnership's organisational review, these relatively small individual services were disaggregated to the localities. It is not clear whether this was the best option, and the Partnership, together with NHS Lothian and the Scottish Government, is exploring options for redesigning a more substantive, specialist service, focused on alternatives to admission to hospital and facilitating early discharge. This will need to complement an **increase in effective, bed-based intermediate care**. Effective intermediate care can reduce dependency by up to 35%[2], and the Partnership must develop this form of care as a major contributor to prevention and demand management. This redesign must include faster and more effective matching of provision to individual need.

6. **Workforce development**: effective integration requires a focus on organisational development, leadership and support for staff groups who are being asked to work in a new environment. The factors driving the choices we need to make to deliver sustainable services cannot be limited to counterbalancing the impact of demand growth and budget reductions through prevention and a shift in the balance of care and/or a reduction in overall entitlement. In addition, the Partnership needs to consider the shape, size and skill mix of the workforce it will require to operate effectively in the landscape we are trying to mould. The Partnership must also shape a 'market' that will provide a skilled and sustainable workforce, from which we can commission the services described in our strategic plans. We need to consider how we support the costs of the Fair Work Convention and the Living Wage; and how the policy intentions of self-directed support,

[2] National Audit of Intermediate Care – Summary Report England, November 2017, NHS Benchmarking Network Document Reference NAIC2017

integration, prevention and self-care are accommodated. Health and social care job demand is projected to rise; however, similar growth is forecast in the retail and hospitality sectors, and competition for the low paid workforce between sectors is likely to become fiercer. Edinburgh is already carrying significant recruitment and retention challenges in respect of adult social care. Alongside this, the necessity to invest in and grow the low paid/low skilled early years workforce to deliver on the Scottish Government's commitment over the next 18 months will undoubtedly be to the detriment of the local adult social care workforce, and will add to the pressures to meet demand through the current models of care.

This added depth to the picture gives us an imperative for change. Without radical renegotiation and redesign, we will not have the people to deliver the type and level of care that citizens expect. The fact that the status quo is unsustainable on this very tangible level is an opportunity to unite and increase our risk appetite for: investing in prevention; a radically different model of care at home; increased volunteering; and support for carers. It also points to a need for a more proactive approach to empowering and supporting self-management, realistic care and a continued move towards self-directed support and active demand management.

7. The Partnership's ability to focus on these critical and transformational priorities is dependent not only on financial resources and a timetabled, monitored action plan, but also requires **adequate business support, processes and IT infrastructure**. The organisational review, which began integration and structural change in 2016, was not completed, and was not supported by sufficient consideration of the need for organisational development, information technology, business processes and communication. The move to localities requires further work and support if the anticipated benefits are to be realised in full. The effective implementation of improvement plans needs to be adequately resourced with project management, organisational development and business support. In addition, further, smaller scale service reviews remain outstanding, leaving staff uncertain, improvements at risk, and savings/efficiency targets unmet. Examples of required reviews include strategic planning, commissioning and contracting; primary care support; service access (Social Care Direct); telecare/ community equipment services; and intermediate care/reablement/Hospital at Home.

8. **Professional/clinical governance and quality** – the integration of staff groups with different employers, terms and conditions and professional backgrounds, requires careful consideration of a range of HR issues and governance arrangements. Each professional group is subject to the registration requirements of a different governing body and to that body's code of conduct. Notwithstanding these different expectations, the principles of integration require the seamless delivery of coherent, coordinated services. The Partnership is seeking to integrate the management of services and governance and quality assurance systems, whilst maintaining clarity regarding different lines of professional and clinical accountability. Further work is required in this area to provide all stakeholders with the necessary assurances.

ACTION

Short Term – 2018

Addressing the critical pressures on the system caused by people delayed in hospital and people awaiting assessment in the community is the immediate priority for the Partnership. Improvements achieved in learning disabilities and mental health services provide an example of how a strategic approach to transformation and capacity-building should support the changes needed in older people's services. **Annex 1** sets out the current position regarding

delays in hospital, together with the key contributory factors. Short-term improvement actions centre on addressing these factors and are summarised below.

- A project has been established to clear the waiting list for assessments. Funded on a temporary basis, a team of assessors has been appointed and trained. The project aims to clear all assessment waits by the end of July 2018. The project manager is seconded from one of the localities, and will now also manage the agreed review of high cost transport for people with learning disabilities, which aims to align the meeting of assessed need with the promotion of independence and a reduction in costs. **Underway**

- The implementation of self-directed support is being refreshed to ensure a meaningful shift to this new way of assessing need and brokering appropriate levels and type of support. The intention is to meet people's expectations quicker and more effectively, and make better use of individual strengths and family/community resources and assets, both maximising and prolonging independence. A Support Planning and Brokerage pilot in North East is progressing this work. The project is seeking to effect major culture change, providing flexible and safe support, focused on "good conversations" about what is important to people. The project will involve widescale reviews of existing packages of care, identifying creative and more cost-effective alternatives to traditional services wherever possible. Rather than await its conclusion, this will now be accelerated to allow the anticipated benefits to apply across the city at a faster pace. The staff training schedule has been extended between April and December 2018, so that a cohort of staff from all localities and some hospital staff will be able to adopt the new approach. The training programme includes provision for 'training the trainers', which will allow Partnership staff to deliver the training on an ongoing, sustainable basis. **Underway**

- This training will support the related action to redesign the assessment process, which will apply a strength-based approach and emphasise self-directed support. The underlying principles are that informal supports should be explored to support individual strengths, and formal care will only be required where residual needs cannot be met in this way. This will begin to change the culture of assumed dependency, and free up capacity. The new assessment will be closely aligned to the redesigned carers' assessment, which has been co-produced with carers, in readiness for the introduction on 1 April 2018 of the new carers' legislation. **Underway**

- A programme to design the optimal model for the provision of community-based services to support people to live at home in Edinburgh is underway. This will consider the sustainability and affordability of meeting the current and future demand. The programme is aligned to the Edinburgh Health and Social Care Partnership's early intervention and prevention activity to manage demand and build individual and community capacity and resilience. The programme will take account of the changing nature of care and support needs, including increasing people's choice and control through self-directed support. The work will consider options to develop a market fit to meet future needs in collaboration with providers, service users, carers, care workers, representative bodies and trade unions to coproduce the new specification. This will include plans for the commissioning and re-procurement of the Care at Home contract to replace the current contract due to expire in 2019. The programme will also address the longer-term focus for internally delivered services within the overall strategy to meet the demand for both mainstream and specialist support. This dedicated programme of work is being established to respond to current capacity challenges and to design the future model. The key elements are set out below.

- Opportunities to manage demand more effectively and reduce costs based on analysis of the capacity required. This will take account of the shift to a more asset-based approach, drawing upon individuals' and community resources and strengths. The Support Planning and Brokerage approach encourages innovation in service development by empowering people to transition from being passive recipients of limited services to active, self-directing consumers of a full spectrum of local support and care solutions.
- Opportunities to improve or change the current Care at Home contract to increase capacity and make more effective use of external provision for delivery of mainstream care.
- Redesign of internally delivered Reablement, Intermediate Care and Homecare to optimise value for money and effectiveness will be within the scope of this work.
- Identifying preferred option/s for an alternative delivery model to blend external and internal delivery of mainstream and specialist services. **Underway**

- Purchase of additional care home beds has been under negotiation between the Partnership and the independent sector since the proposal was approved by the IJB in December 2017. This capacity will begin to come on stream at the beginning of April 2018. In addition to relieving some delayed discharge pressure, it will also allow for consideration of the shape and type of residential, respite, nursing and intermediate care beds required in the longer-term. This intention is reflection in the outline strategic commissioning plan for older people, and will developed in detail in the full strategic commissioning plan for older people, which will be produced by December 2018. **Underway**

- The process of matching assessed need to supply of formal care must be accelerated. A pilot has been agreed with a private company specialising in matching. The pilot is at no cost to the Partnership. The model mirrors that used by online companies for hotel or travel bookings. The pilot will run for 6 months and then be reviewed by the Partnership. If successful, it will contribute to reduced delays and improved satisfaction rates. It will also free up current Partnership matching resources to be applied in support of other improvement projects. **Underway**

- Hospital at Home is operating in the South-West and South-East localities, and was funded through additional Scottish Government resources for winter planning to operate in the North-East until the end of March 2018. There is no provision in the North-West. This service has the potential to make a far more significant contribution to reducing admissions to hospital, shortening length of stay and accelerating discharges. Formal evaluation of the cost benefits is required, together with consideration of how other specialist in-house domiciliary services could be reorganised to complement Hospital at Home. This would include reablement, intermediate care and rapid response services. The 2016 organisational review disaggregated these services across the four localities. A review is required to confirm whether this is the correct deployment of these resources or whether an alternative might improve responsiveness, coordination and access. A workshop for Partnership, NHS Lothian, Council and Scottish Government colleagues took place on 1 May and began to scope the options to deploy these resources more effectively. This is a significant opportunity to help reduce admissions to hospital, shorten stays, and accelerate discharge, whilst also making much better use of the Partnership's highest cost domiciliary services. **Planned (requires project management capacity)**

- A data cleansing and business process improvement project was agreed to assist with finalisation of the move to localities, which had not been achieved within the original planned timescale. This is timetabled to conclude by the end of March 2019.

Underway

Medium Term – 2019

Increased support to carers will contribute significantly to reducing the need for formal care, and to the avoidance of admissions to hospital. Preparation for the new carers' legislation is on track, and the intention to increase the availability of respite beds, as part of the older people's strategic commissioning plan, will supplement this.

In addition, the Partnership supports voluntary organisations in Edinburgh through grant funding of approximately c£4.5m. A review of how these resources are targeted to drive forward our agreed priorities of tackling inequalities, and enhancing prevention and early intervention has begun. As with support for carers, the intention is to help reduce the demand for formal care. **Underway**

Benchmarking data (see footnote 3 above) suggests that there is an over prescription of formal care in Edinburgh, and figures indicate that the average support allocation for higher dependency is some 5 hours per week above the national average. The Partnership's performance for reviews is poor, with over 5000 reviews outstanding. A programme of prioritisation has been developed, focusing on the highest cost packages and those where it is considered that appropriate reductions could be made, freeing up capacity to meet the needs of people waiting for a service. **Planned**

Making significant inroads in this area will require changes on different levels, from the new assessment/review procedure to a change in culture of expectation, and tackling a long-standing, if anecdotal, history in the city of risk aversion. Developing a culture of realistic care, akin to the Scottish Government's realistic medicine initiative, will require engagement of all Partnership staff, acute clinical/nursing colleagues, local and national politicians, regulatory bodies, partner organisations and most importantly, service users and their families/carers. The principle that should underpin our approach to assessment is that an acute setting is the wrong place to consider a person's short- or long-term support needs. The assumption should be that a person who does not need to acute medical care should return home or be discharged to an intermediate care service for their needs to be assessed. **To be planned (requires project management capacity)**

The move to localities reflects the intention to bring service planning, performance and quality closer to local communities. In the implementation of this new model, consideration needs to be given to whether the current single point of access to services for the whole city remains the most effective process, or whether it creates duplication, delays and the danger of risks and vulnerabilities being missed. An options appraisal for access is under development and will be considered by the Partnership in May, followed by a report to the IJB, for an anticipated implementation during 2018/19. Irrespective of the outcome of this options appraisal, there is a need to consider the business support requirements for the localities to function as envisaged. These requirements will be reviewed as part of this work stream. **Planned**

At present, a significant proportion of requests for support are routed to the Partnership and join a queue for an assessment. This creates pressure on the system, delays in response times, and potentially increases risk and vulnerability. We need to develop a service offer that includes the opportunity for self-assessment and signposting for direct access to equipment and informal supports; and clearer communication regarding eligibility. Directing people to more appropriate assistance or resources at their first point of contact controls expectations and reduces demand on formal services. This would bring into better balance the demand for professional assessment and the staffing resources to complete these within our agreed standards. A more varied and responsive community-based landscape of informal supports is

consistent with our ambitions to prolong independence. **To be planned (requires project management capacity)**

Longer Term (2021)

Without undermining or underestimating the critical priority to address the immediate pressures facing the Partnership, the deployment of resources and energy needs to support the achievement of the IJB's longer-term vision, the main characteristics of which are summarised below.

- A profound shift in whole system culture will have been achieved in three years, with a clearly understood emphasis on supporting higher numbers of older people, people with disabilities and people with mental health problems to live in the community for as long as possible. The profile, particularly of older people living the community, will have changed markedly. They will be frailer and with higher levels of need than at present.

- Significantly more efficient use will be being made of the acute system. The Partnership's anticipatory care activity will reduce the need for attendance at hospital, and only those people with genuinely acute medical needs will be occupying hospital beds.

- Where people are being supported in the community by formal services, they will experience a more joined up and coordinated input from Partnership staff, irrespective of professional role. These formal services will complement a wide and varied range of community supports, which will form the mainstay of a preventative and person-centred approach to health and social care in the city.

- There will be more effective co-ordination between Partnership and acute staff and systems. The Partnership will be operating in a steady state regarding delays. The focus will have turned to the front door of hospitals and the joint activity needed in relation to unscheduled care. This will bring significant changes in pathways, processes, staff and clinical roles and responsibilities, and how resources are deployed across the whole system.

- Fewer older people with non-medical needs, such as loneliness, will present to their GP, but will instead be more connected to the community supports we will have helped to build across the city. This will assist us to make the best possible use of GP time and resource, particularly as clinical activity is shifted away from the acute system.

- There will be an even greater emphasis on family and carer support, building on the significant progress made in preparing for the requirements of the new carers' legislation. Families generally want to maintain their caring role in the community for as long as possible. The Partnership will help many more families achieve this, reducing demand for paid support.

- There will be a greater and more effective application of technology to help sustain both the carers' role and community living. This will combine the use of technology-enabled care for people with higher level needs who require support from the Partnership, with generally available technology that individuals and their families may choose to purchase from the open market to provide reassurance at the early stages of frailty.

- There will be closer and more effective partnership working with the housing sector in the city to help maintain tenants in their home for longer.

- The care home sector will look different. The resident population will have much higher levels of dependency and the average length of stay will be shorter, as people are supported for longer in their own home. This will present challenges to both the independent sector and the Partnership's own provision, in terms of staff skills mix and specialist clinical support for GPs, if we are to avoid revolving door admissions to hospital.

- The Partnership's collaboration with the third sector in the city will have matured further, building on the activity of recent years. The third sector has a key role in supporting and enabling the city's residents and mitigating against their premature presentation to the health and social care system.

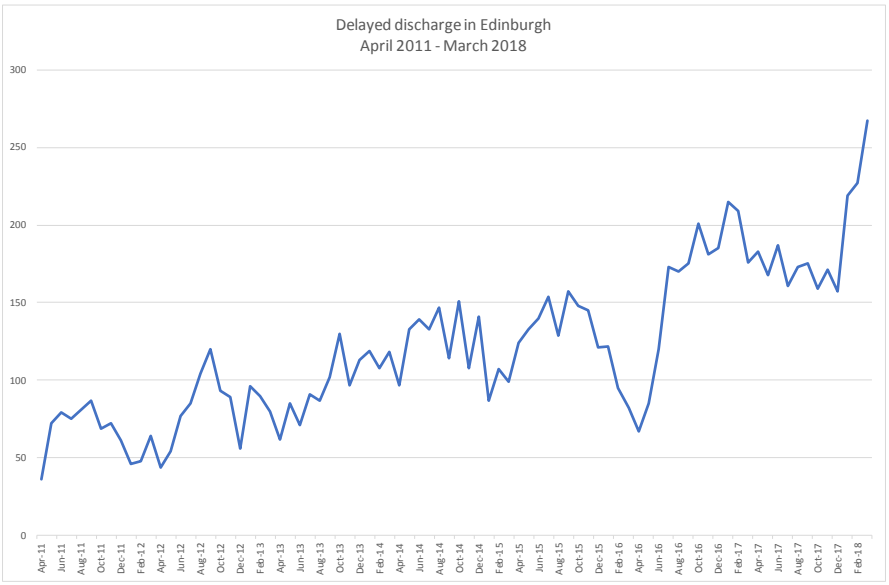
Annex 2 sets out the current arrangements for the governance of the plans set out here.
Annex 3 sets out the financial planning for achieving the actions articulated above (investment and disinvestment); and shows the planned trajectory for the impact of increased capacity.

Michelle Miller
May 2018

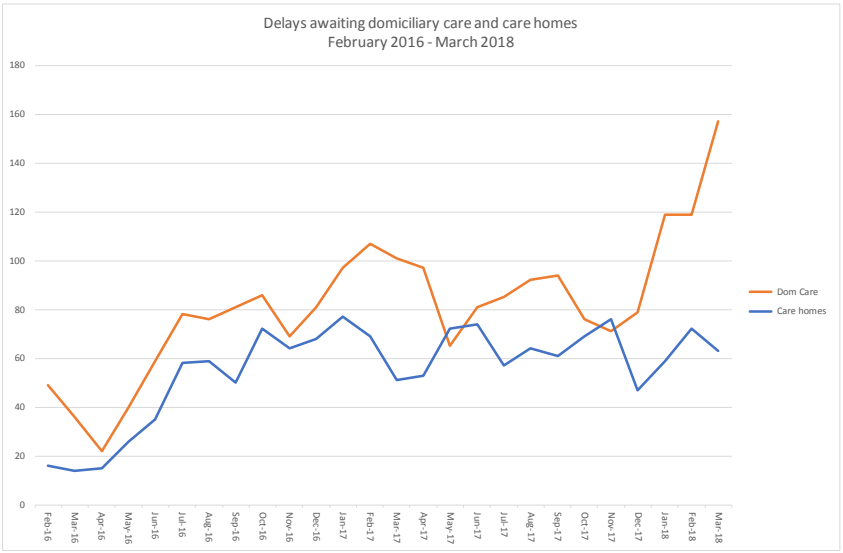
Annex 1

Delayed Discharges from Acute Hospital

1. Delays have been rising since April 2016. Any slight downward trend during 2017 was not sustained, and in March 2018 these remain critically high.



2. The main reason for delay generally continues to be people waiting to go home. This has increased noticeably in recent months. The graph below shows the number of people waiting for a care home place and those waiting for a package of care for the last two years. Prior to April 2015, the reason for delay was generally waiting for a care home place.



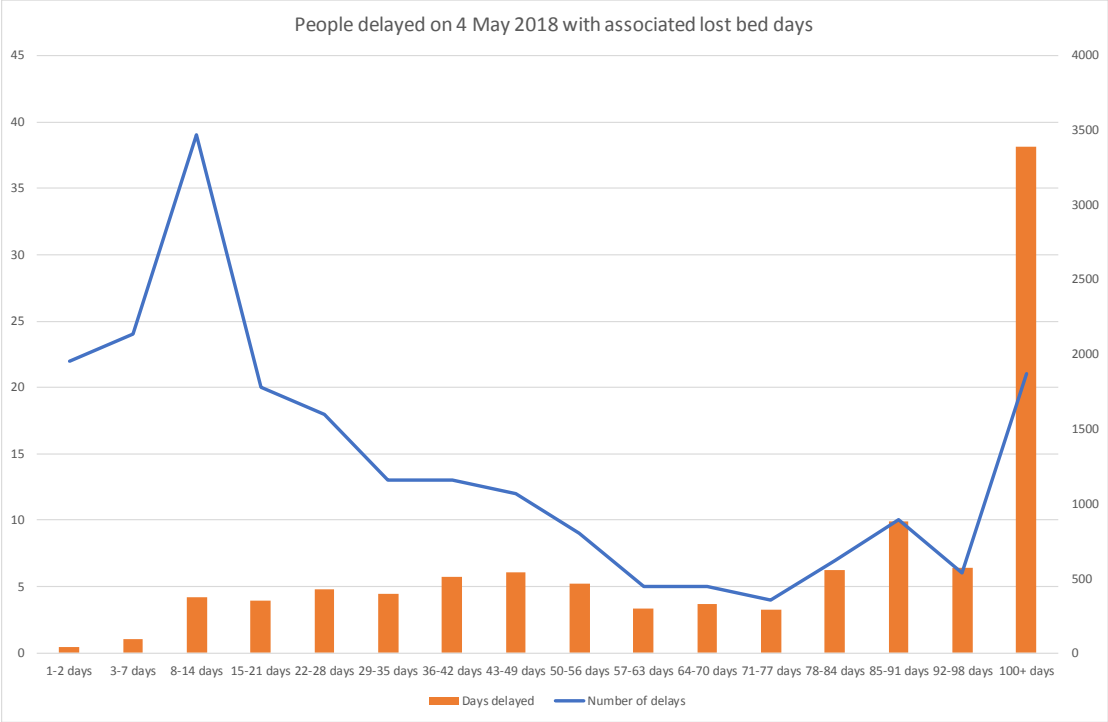
3. At the February 2018 census, there were 7,025 bed days lost associated with delays for Edinburgh residents (compared with 8,525 in May 2015). Although this is an improvement, Edinburgh compares poorly to other partnerships across Scotland. In addition, in January 2018, Edinburgh had

the third highest number of delays due to people with incapacity for whom court processes are required to allow decisions to be made on their behalf.

4. Overall, delays are spread almost equally throughout the city, slightly fewer in North East, explained by the lower older population in that locality and South East, however complex delays are concentrated in South East. The number of complex delays in South East, has been reducing in recent weeks. The two western localities are both similar in terms of reportable, complex and overall delays. The early-May figures indicate the following number of delays by locality:

	Reportable	Complex	Total
North East	49	1	50
North West	72	2	74
South East	41	8	49
South West	60	0	60

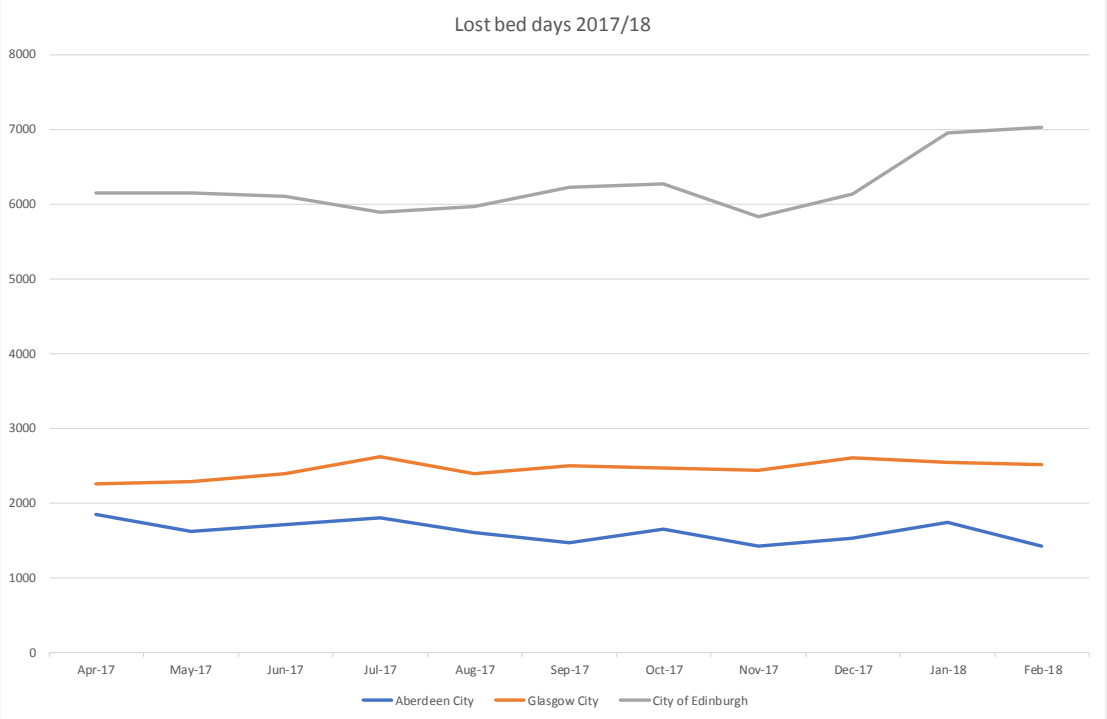
5. The number of people delayed for reportable reasons by delay length, and the associated lost bed days, are shown in the graph below. Over half the people delayed are delayed for less than one month with a fifth delayed for less than a week. There is a spike in people delayed for 13 weeks and for 15 weeks or more.



6. Although the number of lost bed days was relatively stable in Edinburgh during 2017, the number of lost bed days has increased since November. The number of lost bed days in Glasgow were substantially lower and more comparable with Aberdeen, despite the difference in population size. One reason for lost bed days being lower in Glasgow is the 90

Intermediate Care beds available as step-down and step-up. Glasgow commissioned these beds to reduce delayed discharges by providing a more appropriate setting for assessment, matching and rehabilitation.

7. Note that the lost bed day figures for Edinburgh, and other authorities where the delayed patient was in an NHS Lothian hospital, have recently been revised for the five months from September 2017 to January 2018. This is due to a coding error that has been identified for patients whose delay ended between census date and the day that the file was submitted to ISD.



8. Set out below are some of the key factors contributing to this performance.

    a. Too many older people are admitted to hospital when there could/should be safe and effective alternatives; and too many people remain in hospital because there is a perceived risk in discharging them. This risk averse culture does not take account of the risk to people of remaining in hospital when they no longer need to be there.

    b. There is a lack of intermediate care provision, either home- or bed-based. Intermediate care provides a far more appropriate setting in which people's needs can be assessed accurately. In addition, research shows that effective intermediate care can reduce dependency by up to 35%, impacting positively not only on outcomes for people, but on cost and system capacity. Sufficient volume of intermediate care will be a core contributor to significant

reductions in people delayed in acute settings.

c. The Partnership's specialist 'in-house' provision is piecemeal, high-cost and not coordinated effectively. This constrains capacity and efficiency, producing both gaps and duplication.

d. Assessment and authorisation processes are cumbersome and bureaucratic, as is service matching, and there is a culture of assumption that all need must be met by formal services.

e. There is a shortage of care home capacity at the National Care Home Contract rate; and a shortage of care at home capacity at the current contract price or at the standard required by the contract.

f. This lack of capacity is compounded by a tendency to over-prescribe care (as compared with other partnership areas), and by poor performance in reviewing provision.

9. The actions set out in the main document, in the Statement of Intent and in the Improvement plan are all intended to address these issues.

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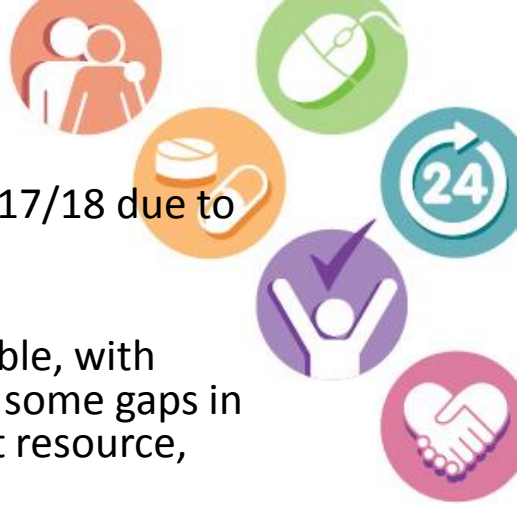
Annex 2

Edinburgh Health and Social Care Improvement Programme 2018/19

Delivery Approach and Resourcing

March 2018

Summary



- Key workstreams failed to deliver all the anticipated benefits in 2017/18 due to a lack of dedicated resource to drive progress.

- The scope of the 2018/19 programme needs to be more manageable, with appropriate resources allocated to support delivery. There are still some gaps in terms of both Senior Responsible Officer and project management resource, and these need to be resolved as a matter of urgency.

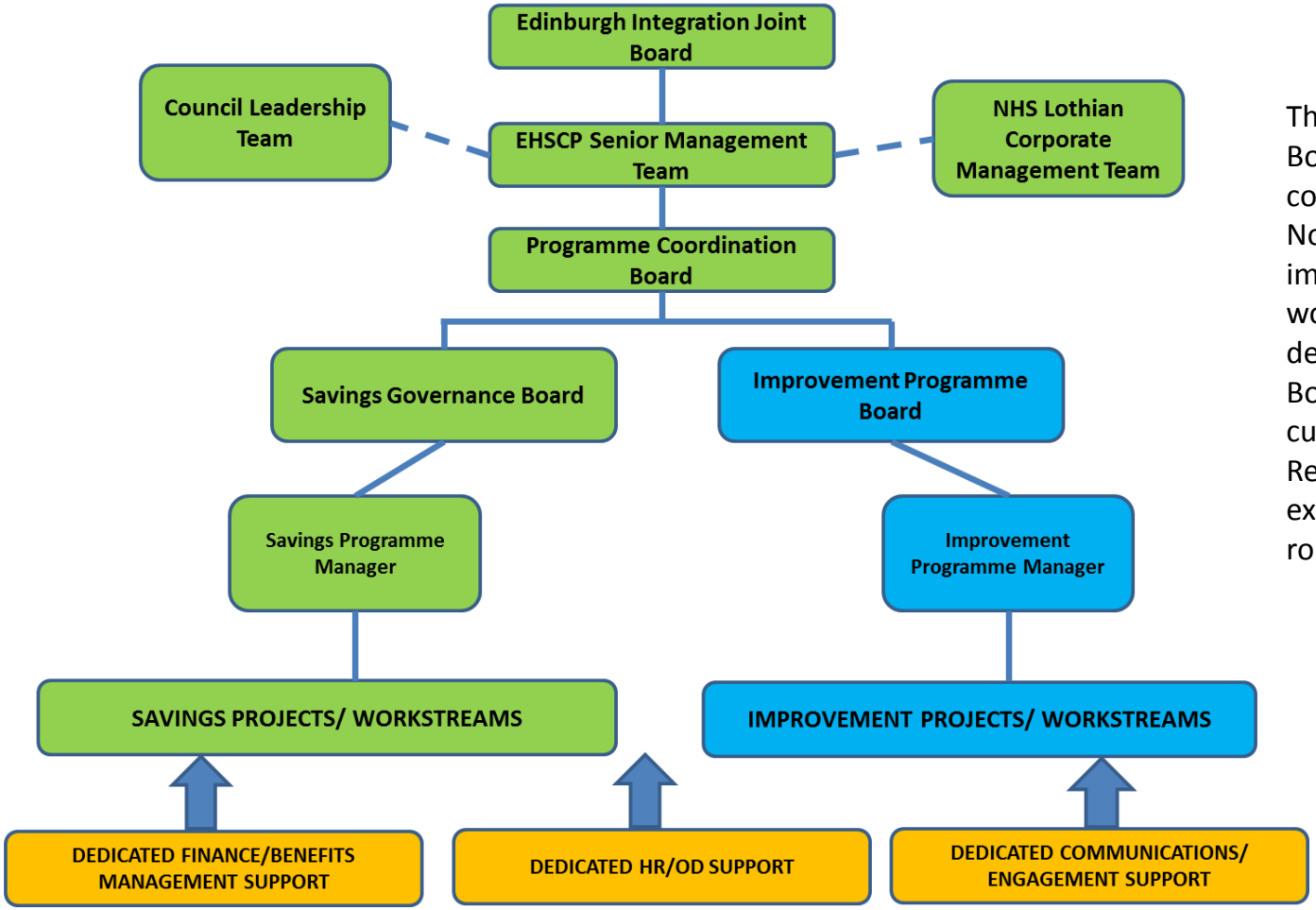
- There will be 2 distinct programmes, with clear lines of governance – one to oversee the Savings Programme and one to oversee the Improvement Programme. Regular reporting to the Council's Corporate Leadership Team and Change Board and to the Integration Joint Board will form part of the governance arrangements.

- Smaller or less complex "business as usual" savings do not need to be subject to the same programme rigour and governance. These should be removed from the formal savings programme and delivered as business as usual, with delivery monitored by Finance and through normal line management arrangements.

- There is confusion and duplication between work streams involved in reviewing packages of care. The telecare expansion programme will be subsumed into the Support Planning and Brokerage programme, with one single implementation plan developed to drive delivery.

Revised Programme Governance Structure

The scale of the overall Improvement Programme for the Partnership is significant. There is a gap in programme and project management resource to drive day-to-day delivery on the ground. Two separate, but linked programmes have been created – one to manage those work streams delivering financial savings and one to manage improvement work streams. This governance structure will establish separate programme managers and programme boards to drive delivery. Additional delivery resource will also be provided by Ernst & Young to supplement the in-house resources in the savings programme. .



The Savings Governance Board as currently constituted will continue. Non-savings related improvement programme work will be overseen by a dedicated Improvement Board. The remit of the current Assessment and Review Board will be expanded to take on this role.

Council Delegated Services – Financial Plan 2018-19

The table below sets out the proposed details of the savings plan for Council delegated services for 2018/19. This plan will form the basis of the agreed savings governance programme for the coming financial year. The smaller savings are not included in the formal programme, but dealt with as part of business as usual. Details of the proposed formal savings governance programme are outlined in the next slide.

Savings Initiative / Additional Funding	£m	Accountable Officer
Disability Services (Interim Review)	£0.7m	Mark Grierson
Legal Services	£0.2m	Colin Beck
Discretionary Spend	£0.2m	Pat Wynne
Disability Services Review	£0.5m	Mark Grierson
Review of Sleepover / Night-time Services	£0.4m	Mark Grierson
Review of Transport	£0.2m	Sylvia Latona
Review of Charges	£0.4m	Wendy Dale
Review of Grants	£0.4m	Wendy Dale
Transformation - Telecare and Support Planning / Brokerage	£3.0m *	Katie McWilliam / Angela Lindsay
Workforce Management (including Agency Expenditure)	£1.1m	Pat Wynne
Service Transformation (Self Directed Support)	£1.0m	Michelle Miller
Homecare and Reablement – Efficiency and Productivity Improvement	£1.0m *	Mike Massaro-Malinson
	£9.1m	

* Assumes £4m estimated savings are "non-cash" and are achieved through release of capacity through Telecare, Support Planning and Brokerage and Homecare / Reablement productivity initiatives.

NHS Lothian Delegated Services – Pressures and Savings/ Additional Funding 2018/19

Pressures 2018/2019	£m	Accountable Officer
Baseline Overspend - Prescribing	£3.5m	Locality Managers
Baseline Overspend - Services	£2.3m	CMT
Pay Awards	£1.9m	N/A
Non Pay	£1.1m	Locality Managers
Service Pressures – Community Equipment Store	£0.2m	Locality Managers
Hospital Drugs	£0.2m	Sheena Muir
Prescribing Growth	£3.8m	Locality Managers
Strategic Investment – agreed Business Cases	£0.2m	
	£13.2m	

Savings Initiative / Additional Funding	£m	Accountable Officer
Baseline Uplift - Pay	£1.9m	
Non Recurring Resources - Prescribing	£4.4m	
Efficiencies – Clinical Productivity	£0.1m	Sheena Muir
Efficiencies – Prescribing Quality Initiatives	£0.2m	Locality Managers
Efficiencies - Workforce	£0.6m	Pat Wynne
Total Savings / Funding	**£7.2m**	
Residual Financial Gap	**£6.0m**	

NHS Delegated Services – SMT Financial Plan 2018-19 – Potential Savings

Savings Initiative / Additional Funding	£m	Accountable Officer
Efficiencies – Clinical Productivity	£0.5m	Moira Pringle
Efficiencies – Prescribing Quality Initiatives FYE / Roll Out	£0.4m	Locality Managers
Efficiencies - Workforce	£0.2m	Pat Wynne
Locality Prescribing Efficiencies	£2.3m	Locality Managers
Locality Service Efficiencies	£1.4m	Locality Managers
Hospital and Hosted Efficiencies	£0.4m	Sheena Muir
Strategic / Corporate Efficiencies	£0.2m	tbc
GMS Efficiencies	£0.6m	David White
	£6.0m	

Scope of Savings Programme

PROPOSED PROGRAMME WORK STREAMS

Review of High Cost Transport Packages	Support Planning and Brokerage (including Telecare Expansion)	Home Care and Reablement Optimisation	Workforce Management and Agency Control	Night time/Sleepover Review
Service Transformation – Self Directed Support	Council Disability Services Review	* Assessment Backlog	NHS Lothian Efficiency Workforce	NHS Lothian Efficiency Prescribing Efficiencies

Assessment Backlog project does not deliver savings, but will be managed as part of this programme due to the synergies with the Support Planning work stream.

PROPOSED BUSINESS AS USUAL WORK STREAMS

Council Grants Review	Council Discretionary Spend	Council Legal Services Saving	Council Charging Review	
NHS Lothian BAU efficiency - Localities	NHS Lothian BAU efficiency – Hospital & Hosted	NHS Lothian BAU efficiency – Central Services	NHS Lothian BAU efficiency – Strategic Services	NHS Lothian BAU efficiency - GMS

Approach to Delivery

CO-ORDINATION OF REVIEWING ACTIVITY

Telecare Expansion, Support Planning and Brokerage and the Transport Review savings all require a coordinated approach to the review of packages of care. There is a risk of duplication of effort. Progress has been hampered by resourcing issues (both project management resource and practitioner resource in locality teams) and problems with data quality.

Reviewing/reducing traditional packages of care through the use of asset-based approaches is key to releasing additional capacity to deal with unmet demand. Greater focus and discipline are needed to drive delivery. There is a need for better coordination of reviewing activity and this needs to be closely aligned with the data cleansing work to ensure practitioners have access to up-to-date records on existing service users.

The following action has been agreed:

- Establish one single work stream for reviewing activity, with one overall implementation plan driving the completion of reviews by locality teams.
- Central programme management to oversee the scheduling and tracking of activity and work closely with locality teams to drive the pace of delivery. Current programme manager to take a more hands on role in this.
- Telecare expansion reviewing becomes subsumed in the Support Planning and Brokerage implementation plan. Holistic reviews will be completed, with the potential for telecare solutions being considered as part of a broader, asset-based approach.
- This requires a resetting of the implementation plan, but NOT a departure from the agreed, approved business case assumptions.

Approach to Delivery

CO-ORDINATION OF ASSESSMENT ACTIVITY, DATA CLEANSING AND COMPLIANCE

In addition to the reviewing based work streams, a temporary project has been established to address the backlog of assessments. This project will not release savings, however, due to the synergies with the reviewing work streams, this work is also aligned as part of this programme and subject to the same programme management arrangements.

The temporary data compliance team is a key enabler of the assessment and reviewing work streams. Better forward planning of review activity will allow data cleansing work to be completed in advance, significantly improving the both the quality of data available and the timescales within which reviews/assessments can be completed.

The data compliance team reports through the Assessment and Review Board, but links with the savings work streams will be strengthened, and a representative from the team will attend Savings Governance meetings going forward.

BUSINESS AS USUAL SAVINGS

Some savings are required as part of the financial plan, which can be dealt with as business as usual, and which do not require a project/programme approach, due to their size and relative lack of complexity. These will be removed from the formal programme to ensure resources are targeted on the most significant work streams. Delivery of non-programme savings will be monitored by Finance and through normal line management arrangements.

PROGRAMME RESOURCING GAPS

PROJECT/ WORK STREAM	SRO	RESOURCE CURRENTLY IN PLACE	RESOURCE GAP	COMMENTS
CEC Savings programme manager	**MOIA PRINGLE**	**Jessica Brown**	N/A	The Partnership may wish to consider recruitment of second PM to manage NHS Lothian side of savings programme.
CEC Improvement programme manager	**MICHELLE MILLER**	**PROG MANAGER VACANT**	1 FTE programme manager	Additional resource required to manage non-savings related elements of improvement programme. Full programme for 2018/19 needs to be scoped.
Support Planning and Brokerage	**ANGELA LINDSAY**	**PROJECT MANAGER VACANT**	1 FTE project manager	Additional dedicated delivery resource to be provided by EY.
Telecare Expansion	**KATIE MCWILLIAM**	**PROJECT MANAGER VACANT**	N/A	Assuming telecare and Support Planning and Brokerage work streams are combined, PM role could be merged.
Assessment backlog	**MICHELLE MILLER**	**PROJECT MANAGER - Sylvia Latona**	N/A	Temporary team now largely in place.
Home Care and Reablement Efficiency	**MIKE MASSARO-MALLINSON**	**PROJECT MANAGER - Julie McNairn**	N/A	Locality engagement needed to support implementation of efficiencies.
Workforce Management	**PAT WYNNE**	**PROJECT MANAGER – VACANT**	1 FTE project manager	SMT approved recruitment of temporary PM for 12 months. Recruitment underway.
Night time/sleepover review	**MARK GRIERSON**	**PROJECT MANAGER – VACANT**	1.0 FTE project manager	PM required to work with SRO over 12 month period to ensure delivery of savings. Could also support disability service review if board decides that additional PM rigour required.
Disability Services Review	**MARK GRIERSON**	**N/A**	N/A	SRO advises no need for additional PM resource – managers in the service will lead the review.
Service Transformation – self directed support	**VACANT**	**PROJECT MANAGER -**	**TBC**	Work stream urgently needs to be scoped and appropriate resource identified.

Annex 3

Investment and Disinvestment

There are 4 separate, but linked, elements to the investment plan:

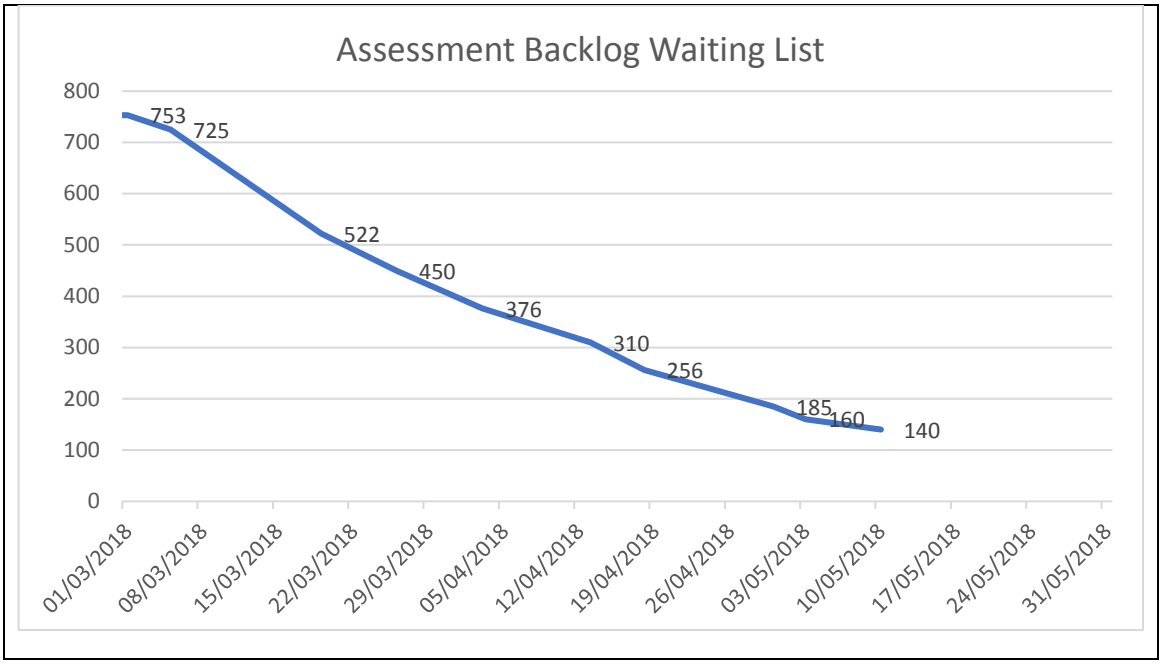
Short-term improvement funding	Financial plan investment	IJB provisions	Existing bed-based investments
•£4.5m	•£4.8m	•£2.3m innovation funding •£1.5m for older people	•£23.6m

These are discussed in turn in the sections below.

a. Short-term improvement funding

In December 2017, the IJB agreed a range of short-term measures to facilitate a minimum level of recovery from the current position. This required an injection of one-off additional resource to relieve the most urgent pressures focused on the following 3 priorities:

Priority 1 – reducing the backlog of assessment and reviews
Assessments to ensure adequate consideration of risk to vulnerable people who are not known to services, but who have expressed a need for support; and reviews to ensure appropriate levels of service continue to be provided, with potential identification of opportunities for increasing capacity or reducing costs. In November 2017, 1,913 people were waiting for an assessment. On 3 May 2018, this number had reduced to 1486; over the same period, the number of people waiting for an assessment reduced from 5,534 to 4809. To complete the backlog assessments over a 7-month period, whilst continuing to address new workload as this arises, was anticipated to cost in the region of £498k. This investment will support the assessments/reviews to take place; but did not cover the provision of a service, if required.
Progress
The team became operational on 7 March, although it is not yet up to full establishment. The immediate focus is on those assessments with the longest waits, and reviewing service users with packages of care with a high transport component. 725 outstanding assessments have been transferred to the team in the first instance, and this has reduced steadily, as shown in the table below. The team has a target date of 30 June to complete the full complement of assessments. Data is being collated on the outcome of the assessments.



Priority 2 – reducing the number of people whose discharge from hospital is delayed
To take immediate, one-off action to alleviate urgent pressures on acute health services and allow longer term work in support of a sustainable strategic shift, £3m was earmarked to purchase capacity in care homes above National Care Home Contract rates on a strictly one-off basis. This would also respond to the highest levels of need waiting in the community
Progress
Following an invitation to all providers to submit proposals, agreements are being concluded that will deliver an additional 67 beds across the city. 26 of these are already in place, with the others coming on-stream in the coming months. The use of these beds is discussed in more detail in **section d** of this annex.

Priority 3 – establishing efficient and consistent business processes

To be realised effectively, the vision to operate a model that brings service delivery and accountability closer to local communities needs to be supported by efficient and robust operating procedures. This requirement was not fully implemented as part of Health and Social Care's transformation programme during 2016/2017, and this is hampering progress in terms of both performance and budgetary control. A short-life team will facilitate effective and accountable budget monitoring; streamlined work flow; speedier response times; and meaningful data management. A temporary project team to address this weakness will cost £313k over a period of 16 months.

Progress

The team has been established and work is progressing.

- The business support administrators are focusing on the out-of-date reviews. 1,200 records cleansed to date. Problems identified are primarily inaccurate details recorded on SWIFT. This data cleanse is almost complete. The next stage is to work with locality teams to re-schedule out of date reviews. Liaison with EY to coordinate. 4,700 out of date review on SWIFT.
- The system and process management meetings are underway. These are chaired independently by the Council's Strategy and Insight service.
- Working closely with assessment and review project to assist with updating records accurately. Agreed process in place.
- Detailed progress reports prepared fortnightly for Senior Management Team.

Contingency

Although not explicit in the IJB paper, this left a contingency of £689k out of the total funding set aside of £4,500k.

Progress

A dedicated programme of work is being established to design the optimal model for the provision of community-based services to support people to live at home in Edinburgh. This will consider the sustainability and affordability of meeting the current and future demand.

EY will be commissioned to deliver this programme, which will align to the Partnership's earlier intervention and prevention strategy to manage demand and build individual and community capacity and resilience. Specifically, it will take account of the changing nature of care and support needs, including increasing service user choice and control through self-directed support. The

work will consider options to develop a 'market' (both internal and external) fit to meet future needs in collaboration with providers, service users, carers, care workers, representative bodies and trade unions to coproduce the new specification. This will include plans for the commissioning and re-procurement of the care at home contract to replace the current contract due to expire in 2019. The programme will also address the longer-term focus for internally delivered services within the overall strategy to meet the demand for both mainstream and specialist support.

The cost of this work will be funded from the contingency with the balance used to resource the Partnership's challenging improvement programme.

b. Financial plan investment

The 3 partner bodies (the Council, IJB and NHS Lothian) share the common goal of reducing the number of people waiting either at home or in hospital for assessment and services. They are working closely to identify and implement a range of solutions to address both the short- and longer-term impacts, as set out elsewhere in this paper. To this end, the partners have recognised the associated financial impact through their respective financial planning processes.

The Council's element of the Partnership's financial plan is summarised in the table below and incorporates the following investments:

- the full-year impact of current expenditure trends, including deferred staff savings
- anticipated inflationary pressures (pay awards and contract inflation)
- implementation of government policy and legislation (Carers Act)
- projected demographic pressures (in Learning Disability services and the continuing growth in care at home for older people); and
- provision to increase care at home capacity to address the long-standing delays for service (see further details below).

These investments are offset by funding sources, including additional Council funding, the full share of the £66m included in the local government settlement and delivery of savings.

Despite this, the plan remains out of balance by £10,300k. To address this:

- the Council has provided £4,000k in its budget agreed in February 2018
- NHS Lothian has indicated its intention to make provision in its financial plan to set aside an additional equivalent sum for the IJB during 2018/19; release of the funding will follow agreement of the associated trajectories for improvement; and
- the IJB is considering a proposal to allocate £1,800k on a non-recurring basis against the £2,300k and is committed to identifying the balance of £500k.

The recurrence of the NHS Lothian and IJB contributions will be reviewed during 2018/19.

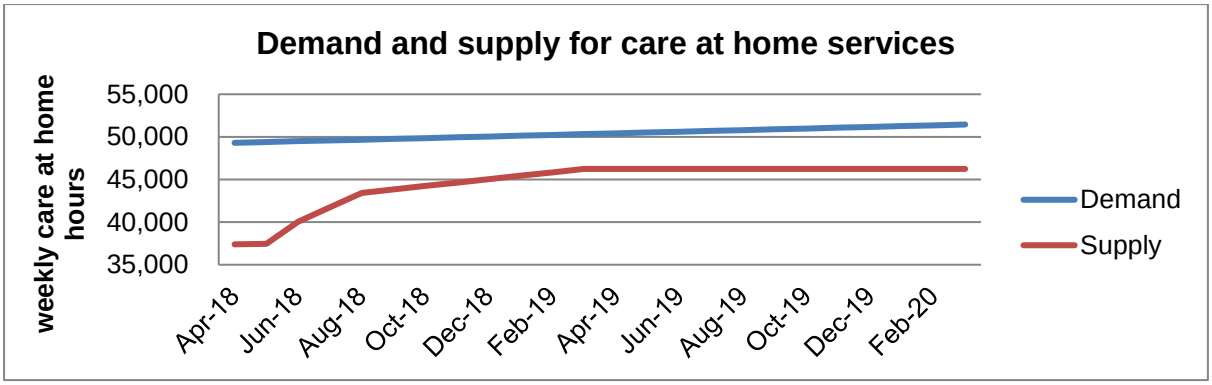
	Cash £k	Non- cash £k
Investments		
Baseline overspend	7,100	
FYE of 17/18 growth	2,000	
Deferral of staff savings	1,100	
Pay awards and inflation	6,007	
Carers (Scotland) Act 2016	1,200	
Demography – disabilities	2,000	
Increase in care at home capacity	4,800	4,000
Other	230	
Increase in costs	**24,437**	**4,000**
Funded by		
Savings	5,100	4,000
Baseline uplift in Council offer	3,000	
Local government finance settlement (share of £66m)	5,537	
Social care fund (disabilities)	500	
	14,137	**4,000**

As can be seen in the table, incorporated in the plan is provision to increase care at home capacity to the value of £8,800k. This increase in capacity will be partly generated internally by reducing average package sizes through: the use of support planning techniques; by substituting technological solutions for traditional care provision; and by increasing the productivity of the in-house home care and reablement teams. These initiatives are targeting a reduction in cost of £4,000k, releasing nearly 3,700 hours and supporting service delivery to an estimated 300 people annually. This in turn leaves an additional £4,800k of “cash” investment.

At the average package size of 12.2 hours and average hourly rate of £17.92 for purchased services, this would provide services for an additional 422 people a year, giving a total reduction of 724 people who are currently waiting for a service.

In addition, we know that demand for services is growing at around 3% each year, in line with demographic changes in the population.

Modelling has been undertaken based on these 2 factors (the existing waiting list and the impact of demographic growth). This demonstrates that whilst the investment initially addresses the gap between “demand for” and “supply of” of services, the impact of growth means that this position is not sustainable. Even with this level of investment, the number of people waiting never reduces to zero over the next 2 years. The lowest point is at March 2019, where 553 people would be waiting and the impact of growth increases this to 705 by the end of March 2020. This is demonstrated in the graph below:



These numbers are estimates, and being based on a range of assumptions, will not mirror the actual position precisely. However, they do illustrate that without further action, even with additional investment, the system will remain "out of balance".

The "Sustainable Community Support" work stream will address this, both in the short- and longer-term. Part of the work will explore sustainable models for the service, as well as a range of short-term initiatives to increase available capacity across both the internally provided and externally purchased services. This work will be co-produced with a range of stakeholders.

c. IJB provisions

Innovation funding

Edinburgh's share of the Integrated Care Fund was £8,900k, around 50% of which was used to underpin core services. Following a review in January 2017, the IJB agreed to ring-fence £2,300k as a fund to support innovation. Detailed plans have not yet been developed and in 2017/18, this money was used as a contribution to the £4,500k discussed above.

Colleagues from Healthcare Improvement Scotland (HIS) have introduced us to the concept of "community-led support", based on work undertaken elsewhere to expand community capacity and reduce demand for formal services. This approach, aligned with the ongoing grants review focused on primary prevention, will form a key plank of our strategy to improve health and wellbeing and manage future demand.

The grants review is due to report to the IJB in May 2018 and the next step in terms of community-led support is to bring together colleagues from HIS, the national development team for inclusion (who are sponsoring community-led support) and key Partnership officers to develop an outline proposal by the end of June 2018.

Investment in older people's services

The Scottish Government established the Social Care Fund in 2016/17 to support the sustainability of social care services and to provide funding to implement a range of government policies. The IJB, cognisant of the pressures facing services for older people, agreed to invest £1,500k in this area, pending the development of detailed plans.

In early 2018, the IJB published 5 outline strategic commissioning plans, one of which was for older people. This plan sits alongside the initiatives set out in this paper.

d. Existing bed based investments

The outline strategic commissioning plan for older people sets out the vision for the development of services in Edinburgh. It highlights that significant resources are tied up in

inappropriate bed-based facilities in the city and states the IJB's medium-term intention to invest this money differently. A high-level estimate assesses these costs at £24,607k, broken down as follows:

	£k
Oaklands Care Home	1,499
Interim facilities (Gylemuir House/Liberton Hospital)	6,397
Hospital-based complex clinical care (HBCCC)	9,900
Acute beds	6,811
Total	**24,607**

Whilst work to develop the proposals set out in the outline plan and to produce the associated business cases is ongoing, the current assumption is that these monies would be supplemented by the £1,500k IJB provision discussed above. This investment would be applied over a 5-year period to deliver a net, additional 100 beds across the city, in a combination of care homes and alternative care settings. The £3,000k short-term improvement money will be used to buy places on an interim basis until the longer-term plans are in place.

Over the 5-year period, the outline plan is not balanced, with a current shortfall of £3,087k. This will be refined as the programme is developed further, and will ultimately have to be reduced to zero by the end of the 5-year period. A summary is included in the table below:

	# beds	£k
Care homes	61	2,795
Care villages	480	26,400
Total cost	**541**	**29,195**
Funding released	442	24,607
IJB investment		1,500
Difference	**99**	**3,087**

Bed provision would change over the 5-year period as follows:

	18/19	19/20	20/21	21/22	22/23
Care homes	72	102	76	61	61
Jardine	57	57	57	57	0
Care village	0	0	0	240	480
Oaklands	(29)	(29)	(29)	(29)	(29)
Liberton	(62)	(62)	(62)	(62)	(62)
Gylemuir	0	0	0	(36)	(36)
HBCCC	0	0	0	(60)	(180)
Acute	0	(15)	(15)	(105)	(135)
Net bed changes	**38**	**53**	**27**	**66**	**99**

With the associated financial implications:

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	18/19 £k	19/20 £k	20/21 £k	21/22 £k	22/23 £k
Care homes	2,860	4,733	2,990	2,795	2,795
Jardine	1,665	3,329	3,329	3,329	0
Care village	0	0	0	13,200	26,400
Oaklands	(749)	(1,499)	(1,499)	(1,499)	(1,499)
Liberton	(1,415)	(2,829)	(2,829)	(2,829)	(2,829)
Gylemuir	(1,000)	(1,000)	(1,000)	(3,569)	(3,569)
HBCCC	0	0	0	(3,300)	(9,900)
Acute	0	(757)	(757)	(5,297)	(6,811)
Net cost	**1,361**	**1,977**	**234**	**2,830**	**4,587**
Funded by					
Improvement funding	1,200	1,800			
IJB provision				1,500	1,500
Net cost	**161**	**177**	**234**	**1,330**	**3,087**