Public Document Pack

Edinburgh Integration Joint Board

Notice of Meeting and Agenda

Edinburgh Integration Joint Board

2.00pm, Monday 24th August 2020

Virtual Meeting - via Microsoft Teams

This is a public meeting and members of the public are welcome to view the live webcast.

The law allows the Integration Joint Board to consider some issues in private. Any items under “Private Business” will not be published, although the decisions will be recorded in the minute.

Contacts

Email: rachel.gentleman@edinburgh.gov.uk / jake.montgomery@edinburgh.gov.uk

Tel: 0131 529 4107 / 0131 529 4010

NHS Lothian · EDINBVRGH · THE CITY OF EDINBURGH COUNCIL

Working together for a caring, healthier, safer Edinburgh

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 21 July 2020 – submitted for approval as a correct record	5 - 8

5. Forward Planning

5.1	Rolling Actions Log	9 - 18

6. Items of Strategy

6.1	West Edinburgh (Maybury) General Medical Services Provision – Report by the Chief Officer, Edinburgh Integration Joint Board	19 - 60

7. Items of Performance

7.1	Annual Performance Report – Report by the Chief Officer, Edinburgh Integration Joint Board	61 - 150
7.2	Evaluation of 2019/20 Winter Plan – Report by the Chief Officer, Edinburgh Integration Joint Board	151 - 222

8. Items of Governance

8.1	Finance Update – Report by the Chief Finance Officer, Edinburgh Integration Joint Board	223 - 232
8.2	Fair Work and the Living Wage in Adult Social Care – Report by the Chief Finance Officer, Edinburgh Integration Joint Board	233 - 238
8.3	Annual Review of Standing Orders – Report by the Chief Officer, Edinburgh Integration Joint Board	239 - 242

9. Proposals

9.1 None.

Board Members

Voting

Angus McCann (Chair), Councillor Ricky Henderson (Vice-Chair), Councillor Robert Aldridge, Councillor Phil Doggart, Councillor George Gordon, Martin Hill, Councillor Melanie Main, Peter Murray and Richard Williams.

Non-Voting

Eddie Balfour, Colin Beck, Carl Bickler, Andrew Coull, Christine Farquhar, Helen FitzGerald, Kirsten Hey, Jackie Irvine, Jacqui Macrae, Ian McKay, Moira Pringle, Judith Proctor and Ella Simpson.

Webcasting of Integration Joint Board meetings

Please note that that this meeting may be filmed for live or subsequent broadcast via the Council's internet site – at the start of the meeting the Chair will confirm if all or part of the meeting is being filmed.

The Integration Joint Board is a joint data controller with the City of Edinburgh Council and NHS Lothian under the General Data Protection Regulation and Data Protection Act 2018. This meeting will be broadcast to fulfil our public task obligation to enable members of the public to observe the democratic process. Data collected during this webcast will be retained in accordance with the Council's published policy.

If you have any queries regarding this and, in particular, if you believe that use and/or storage of any particular information would cause, or be likely to cause, substantial damage or distress to any individual, please contact Committee Services (committee.services@edinburgh.gov.uk).

Edinburgh Integration Joint Board

Minute

Edinburgh Integration Joint Board

10.00am, Tuesday 21 July 2020
Held remotely by video conference

Present:

Board Members:

Angus McCann (Chair), Councillor Ricky Henderson (Vice-Chair), Councillor Robert Aldridge, Mike Ash, Colin Beck, Carl Bickler, Andrew Coull, Councillor Phil Doggart, Christine Farquhar, Helen FitzGerald, Councillor George Gordon, Kirsten Hey, Martin Hill, Jackie Irvine, Jacqui Macrae, Councillor Melanie Main, Ian McKay, Peter Murray, Moira Pringle, Judith Proctor, Ella Simpson and Richard Williams.

Apologies: Mike Ash

Officers: Tom Cowan, Rachael Docking, Ann Duff, Tony Duncan, Rachel Gentleman, Lauren Howie, Linda Irvine Fitzpatrick, Jayne Kemp, Jenny McCann, Katie McWilliam, Jake Montgomery and Hazel Stewart.

1. Minutes

Decision

1) To approve the minute of the Edinburgh Integration Joint Board of 28 April 2020.

2) To approve the minute of the Edinburgh Integration Joint Board of 16 June 2020.

2. Rolling Actions Log

The Rolling Actions Log for July 2020 was presented.

Decision

1) To agree provide an update on the recruitment of carers and service user representatives and estimated timescales following the meeting.

2) To otherwise note the remaining outstanding actions.

(Reference – Rolling Actions Log, submitted.)

3. Edinburgh Integration Joint Board Governance Report

A report on some aspects of governance of the Board was submitted. Approval was sought to resume committee meetings which had been temporarily amended and proposed some amendments to the process for these meetings, the meetings schedule for the IJB for 2021 and the terms of reference for the five committees.

Decision

1) To agree to the resumption of committees to be held virtually until the end of 2020.

2) To note the Clinical and Care Governance Committee meeting had been rescheduled from 6 August to 27 August.

3) To agree the 2021 dates for the EIJB meetings and development sessions.

4) To agree the Terms of Reference for EIJB committees subject to a change in the number of non-voting members of Performance and Delivery Committee from two to four.

5) To clarify if the timescale for issuing committee meeting papers would be 5 days or 5 working days before meetings.

6) To note that the governance of development sessions would be discussed at a later date.

(Reference – report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

4. Return to Transformation

An update on the transformation programme set out the progress made to date, the impact of Covid-19 and the planning for return to transformation. The Board was asked to approve a two-phase approach to the delivery of the transformation.

Decision

1) To approve the two-phase approach to the delivery of transformation as set out in the report.

2) To emphasise the sustainability commitments within the strategic plan and to note that sustainability would be included in the review of the strategic plan by the SPG later in the year.

3) To note that a report on the wider sustainability considerations should be submitted to the Board at a later date.

(Reference – report by the Head of Strategic Planning, Edinburgh Integration Joint Board, submitted.)

5. Savings and Recovery Programme 2020/21

The Savings and Recovery Programme 2020/21 was presented. Approval was sought for Phase 1 of the programme set out in the report, which would allow the Board to set a balanced budget for the year.

Further details on Phase 2 of the programme and a three-year savings programme would be presented to the Board at a later date.

Decision

1) To agree Phase 1 of the Savings and Recovery Programme.
2) To note the content of Phase 2 of the Savings Programme and agree to receive more detailed plans about the proposals at a future meeting.
3) To agree to award the Carers contracts from 1 January 2021.
4) To note Phase 3 of the Savings Programme.
5) To agree that more details about the proposed three-year Savings Programme is brought back for consideration by the Edinburgh Integration Joint Board by the end of the year.

(Reference – report by the Chief Finance Officer, Edinburgh Integration Joint Board, submitted.)

Dissent

Christine Farquhar requested that her dissent to the above decision be recorded.

6. 2020/21 Financial Plan

Approval was sought of the 2020/21 financial plan. An update was also provided on the potential financial implications of Covid-19.

Decision

1) To agree the 2020/21 financial plan as presented in the report.
2) To note that, whilst financial balance could be achieved in year, this relied heavily on one off measures.
3) To agree to receive a first draft of the 2021/22 budget in line with our partners financial planning timescales;
4) To note that both partners have commissioned work to further understand the financial impact of COVID-19.

(Reference – report by the Chief Finance Officer, Edinburgh Integration Joint Board, submitted.)

7. Mental Health Services (including Substance Misuse): Quality Assurance – referral from the Clinical and Care Governance Committee

The Clinical and Care Governance Committee on 28 April 2020 considered a report by the Head of Operations on mental health services quality assurance.

The report had been referred to the Board for consideration and approval to support the HSCP joining the Royal College of Psychiatrists Accreditation Scheme for adult inpatient and community mental health teams.

Decision

To support the proposal that the Edinburgh Health and Social Care Partnership join the Royal College of Psychiatrists Accreditation Scheme for adult inpatient and community mental health teams.

(Reference – report by Head of Head of Operations, Edinburgh Health and Social Care Partnership; Clinical and Care Governance Committee, 28 April 2020)

8. Valedictory

The Chair informed the Board that Mike Ash had resigned as a member of the Edinburgh Integration Joint Board and thanked him for his input and work during his time as a member.

Edinburgh Integration Joint Board

Rolling Actions Log

August 2020

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
1	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	September 2020 ~~December 2019~~ ~~August 2019~~ ~~November 2019~~	**Recommended for closure** – information will be circulated prior to the meeting on 24 August
2	Primary Care Transformation Programme	24-05-19	1) To agree that a workshop would be arranged on the Primary Care Transformation Programme.	Chief Officer, Edinburgh Health and Social Care Partnership		**Closed –** Session on primary care took place on 24 February 2020.
			2) To agree that the next report to the Joint Board would include more details on how	Chief Officer, Edinburgh Health and	October Board	**Update**

Page 9

Agenda Item 5.1

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
			the Programme was being delivered and its impact on stakeholders	Social Care Partnership	~~December 2019~~ ~~October 2019~~	Scheduled for October Board.
3	Committee Terms of Reference and Good Governance Handbook	21-06-19	To agree that each committee would comment on the Terms of Reference at the end of the first cycle and this would be reported back to the Joint Board within two cycles.	Chief Officer, Edinburgh Health and Social Care Partnership	July 2020 ~~April 2020~~ ~~December 2019~~ ~~October 2019~~	**Recommended for closure** – TORs approved July 2020
4	Edinburgh's Joint Carers Strategy	20-08-19	To agree to develop a performance and evaluation framework around the Carers Strategy, which would be reported back to the Joint Board in two cycles.	Chief Officer, Edinburgh Health and Social Care Partnership	November 2020 ~~December 2019~~ ~~October 2019~~	**Update** A report is scheduled to come to next P&D in October and will be submitted to the Board in November. A situation report on the performance and evaluation framework for the Carers' Strategy was

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
						presented to the P&D committee on 20 November 2019 and the SPG on 22 November 2019. Direction was given to provide more time to complete the framework which will come forward to the SPG in due course.
6	Home First	22-10-19	1) To require a report on progress no later than April 2020.	Chief Officer, Edinburgh Health and Social Care Partnership	December ~~April 2020~~	**Update** This work will be progressed through the transformation programme and reported to SPG and EIJB in due course Home First Edinburgh is a key plank of the Partnership's response to Covid-

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
						19. The model will be reviewed to incorporate the learning from this with the update being presented to the SPG and then the IJB in due course.
			2) To agree that timescales would be added to the Direction.	Chief Officer, Edinburgh Health and Social Care Partnership		**Recommended for closure** – this will be completed prior to the meeting on 24 August
6	Adult Sensory Support	10-12-19	To agree that an update would be submitted in spring 2021.	Chief Officer, Edinburgh Health and Social Care Partnership	Spring 2021	Final tenders for the new contractual arrangements have been received and appraised. Officers are undertaking a review of next steps in the context of Covid.

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
7	Winter Plan 2019/20	10-12-19	To agree that a briefing note would be circulated, providing details of similar plans for general practice	Chief Officer, Edinburgh Health and Social Care Partnership	August 2020 ~~July 2020~~ ~~January 2020~~ ~~April 2020~~	**Recommended for closure** – information will be circulated prior to the meeting on 24 August
8	Ministerial Strategic Group and Audit Scotland Integration Reviews – Edinburgh Update	04-02-20	To agree to receive a further update report in December 2020.	Chief Officer, Edinburgh Health and Social Care Partnership	December 2020	
9	Enhancing Carer Representation on Integration Joint Boards – transferred from Strategic Planning Group	10-03-20	To agree that the Chief Finance Officer would examine the good practice outlined in the update report (Enhancing Carer Representation on Integration Joint Boards, SPG 17 August 2018) and provide an update to a future meeting of this Group on how it could applied with the Edinburgh IJB working practices. Referred to IJB to progress recruitment of Carer Representative.	Chief Officer, Edinburgh Health and Social Care Partnership	December 2020	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
	RAL – 10 March 2020					
10	2020/21 Financial Plan	28-04-20	1) To agree savings proposal 6 (external supported accommodation for older people) and to agree that a session would be arranged to allow members to fully scrutinise the proposal.	Chief Officer and Chief Finance Officer, Edinburgh Health and Social Care Partnership	July 2020	**Recommended for closure** – P&D held a workshop on 29 May to discuss the proposal.
			2) To agree that officers would further develop the other schemes in the proposed savings and recovery programme, including information on the risks and impact of additional costs, before being brought back to the IJB for approval prior to implementation.	Chief Officer and Chief Finance Officer, Edinburgh Health and Social Care Partnership	July 2020	**Recommended for closure** – Report on savings programme considered July 2020.
			3) To agree to receive an update on progress made towards balancing the financial plan at the next meeting.	Chief Officer and Chief Finance Officer, Edinburgh Health and	July 2020	**Recommended for closure** – Report on financial plan considered July 2020.

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
				Social Care Partnership		
			4) To note that the Chair would discuss the governance processes relating to financial planning with officers with a potential review of these in autumn 2020.	Chief Officer and Chief Finance Officer, Edinburgh Health and Social Care Partnership	October 2020	
11	Provision of General Medical Services – Edinburgh South	28-04-20	To request further information on how the renovation of the buildings could be carried out in line with the sustainability aims of the City Plan 2030.	Chief Officer, Edinburgh Health and Social Care Partnership	October 2020	**Update** Briefing note will come forward by October 2020.
12	Carer and Service User Representatives (agreed under RAL item)	21-07-20	To agree provide an update on the recruitment of carers and service user representatives and estimated timescales following the meeting.	Chief Officer, Edinburgh Health and Social Care Partnership	October 2020	Attempts to recruit carer and service user representatives continues. Issue covered in recent meeting with EIJB Chair and Head of Strategy.

No	Subject	Date	Action		Action Owner	Expected completion date	Comments
13	EIJB Governance Report	21-07-20	1)	To clarify if the timescale for issuing committee meeting papers would be 5 days or 5 working days before meetings.	Chief Officer, Edinburgh Health and Social Care Partnership		**Recommended for closure** – confirmed 5 working days before meetings
			2)	To note that the governance of development sessions would be discussed at a later date.	Chief Officer, Edinburgh Health and Social Care Partnership		
14	Return to Transformation	21-07-20	1)	To emphasise the sustainability commitments within the strategic plan and to note that sustainability would be included in the review of the strategic plan by the SPG later in the year.	Head of Strategic Planning, EHSCP	October 2020	This matter will be considered at the next SPG on 15 September as part of the review of the Strategic Plan.
			2)	To note that a report on the wider sustainability considerations should be submitted to the Board at a later date.	Head of Strategic Planning, EHSCP	October 2020	As above. Sustainability/environment will be part of the wider review of the Strategic Plan and subsequent report.

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
15	Savings and Recovery Programme 2020/21	21-07-20	1) To note the content of Phase 2 of the Savings Programme and agree to receive more detailed plans about the proposals at a future meeting.	Chief Finance Officer, EHSCP	October 2020	This will come back to the board in October
			2) To agree that more details about the proposed three-year Savings Programme is brought back for consideration by the Edinburgh Integration Joint Board by the end of the year.	Chief Finance Officer, EHSCP	March 2021	This will come back to the board as part of the financial plan for 21/22 in March 2021.
16	2020/21 Financial Plan	21-07-20	To agree to receive a first draft of the 2021/22 budget in line with our partners financial planning timescales;	Chief Finance Officer, EHSCP	October 2020	First iteration of financial plan will be presented to the board in October

This page is intentionally left blank

Edinburgh Integration Joint Board

REPORT

West Edinburgh (Maybury) General Medical Services Provision

Edinburgh Integration Joint Board

24 August 2020

Executive Summary	The purpose of this report is to provide the Edinburgh Integration Joint Board with the Initial Agreement for the Provision of General Medical Services in West Edinburgh (Maybury). The proposal seeks capital funding from NHS Lothian and the Initial Agreement has been prepared in line with the guidance contained in the Scottish Capital Investments Manual.

Recommendations	It is recommended that the Edinburgh Integration Joint Board 1. Agree the proposal to provide General Medical Services in West Edinburgh 2. 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 2020-21 Capital Prioritisation Process. 3. Approve the proposal and agree the presentation of the Initial Agreement to NHS Lothian's Finance and Resources Committee.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations		✓
	No direction required	✓
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Main Report

1. The population of Edinburgh has increased by some 65,000 people over the last 10 years and will continue to grow at a rate c5,000-6000 per annum, until at least 2026. This trend is expected to continue further in the next Local Development Plan known as City Plan 2030.
2. Greenfield space (site HSG19) (Initial Agreement appendix 2)adjacent to Maybury and between Turnhouse Road and the main rail link to Fife, has been released for housing development through the City of Edinburgh (CEC) Local Development Plan 2016 – 2026. It is proposed that the site will accommodate 1750 housing units, of which 25% will be affordable housing split over three development sites and equating to 3,675 additional population based on a standard planning minimum of 2.1 people per housing unit. As the provision of a primary school is included within the site, it is likely that the development will comprise predominantly family housing which is likely to increase the number of occupants per unit. As this is currently a greenbelt site on the outskirts of Edinburgh there is no existing GMS provision for any of the proposed housing, and GP practices nearby are at capacity or zoned for separate developments.
3. The adjacent area of South Gyle and Edinburgh Park has already expanded with an increase of 778 houses equating to 1634 additional population minimum. Much of this area was green belt or a business development area and has therefore had no previous requirement or provision for GP services.
4. Proposals for further housing and commercial developments in the area have been included in City Plan 2030 at several sites in the surrounding area (Edinburgh Park and South Gyle, Edinburgh International Business Gateway and Crosswinds). As City Plan 2030 also proposes the development of the West Edinburgh transport corridor, improving transport links on the west side of the city, there is an increased likelihood of this area being selected for future development. It was anticipated that a City Plan 2030 would be submitted to elected members in August 2020, following completion of the consultation period. This is now likely to be delayed till later in the year due to Covid-19. The report will also specifically consider the impact of the pandemic.

5. In addition, approval has recently been given for 1350 houses in Phase 1 of Edinburgh Garden District development, which equates to 2835 additional population minimum. The Garden District site is the south west corner, where the bypass meets the A8 westbound, next to the Gogar roundabout. The effects on population growth as a result of this potential expansion will be subject to separate consideration but are likely to be significant as the overall development proposed could be up to circa 3,000 units.

6. Parkgrove Medical Practice has benefited from small scheme funding and has been altered to enable an increase the capacity of the practice list allow them to register most of the new population anticipated from the Cammo development (HSG20) and to accommodate the development of a Community Treatment and Care Centre (CTAC). Cramond Medical Practice received a capital contribution from their Landlord, augmented by NHS Lothian, linked to lease renewal which will allow them to reconfigure their consulting space. This work, delayed by Covid 19, is due to start in summer 2020. This should allow them to accommodate the remaining population unable to register with Parkgrove.

7. East Craigs Medical Practice has also benefited from small scheme funding to create additional space to enable them to expand their practice list and are willing to grow, however this will still not provide sufficient capacity to accommodate all of the increased population.

8. Additionally, the introduction of the new GMS Contract (Scotland) on 1st April 2018 requires boards to provide alternative delivery of certain services to enable implementation of the contract. These changes such as Mental Health Hubs will impact on the accommodation requirements to support the current and future population of the area.

9. The EHSCP Population Growth and Primary Care Assessment 2016-2026, is the comprehensive strategic assessment of the primary care pressures and needs across the city. It reflects the extensive housing developments set out in the City of

Edinburgh Council (CEC) Local Development Plan (LDP) 2016-2026 and the consequent capital investment required to meet this need and that of re-provision schemes to deliver sustainable primary care in Edinburgh. This assessment was formally endorsed by Edinburgh Integration Joint Board in September 2017 and by NHS Lothian Capital Investment Group in March 2018.

10. The preferred option is for NHSL, in collaboration with CEC, to consider a joint development of a new GP practice for c10,000 and a primary school, built on a site which has been identified with sufficient space and is suitable for both facilities. The building will be built to Passivhaus standards or similar and will enjoy the benefits of shared space, reducing the overall footprint and meeting the 2030 carbon neutral standards required by CEC and NHS. Following the impact of Covid 19, CEC has reviewed and revised their programme with an anticipated completion date of May 2023. There may be design considerations for primary care premises resulting from the Covid 19 experience. There will be an opportunity to articulate these at business case development.

11. EHSCP and NHS Lothian have worked with CEC Children and Families to develop the proposal for the joint development which optimises design and shares common space within the available footprint.

Implications for Edinburgh Integration Joint Board

Financial

12. The resource implication at this stage is a capital investment of c£4million (including VAT). It is anticipated that the procurement of the project will be led by CEC supported by Edinburgh Health and Social Care Partnership and NHSL.

13. It is proposed that NHSL will provide a Capital Grant to CEC for the constructions costs and then lease the completed facility from CEC.

14. Recurring revenue costs in relation to facilities will be funded directly by the practice. Premises costs, including lease costs, will be fully funded via GMS payments.

Legal / risk implications

15. Uncertainty of timescale requirements and pressures on practices as a result of the impact of Covid 19 on the anticipated programme of housing developments.
16. Additional local population unable to register with a GP resulting in increased assignments and greater presentations through emergency provision.
17. The constraints of inadequate GP premises are an identified list in EHSCP's section of NHS Lothian's Risk Register.
18. No direction is required at this stage because it is covered by EIJB-22/10/2019-9 which has been issued to NHS Lothian in November 2019

Equality and integrated impact assessment

19. The project will allow local people to be registered and cared for in accommodation which is functionally suitable and accessible for people with impaired mobility and other disabilities. An Impact Assessment will be scheduled as the project progresses.

Environment and sustainability impacts

20. 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.
21. This will include consideration of the use of energy efficient building material for construction as well maintaining a low impact on the environment for the full life-cycle of the premises.

Quality of care

22. The project will provide premises which deliver General Medical Services safely, with optimal clinical functionality and which are compliant with statutory legislation.

Consultation

23. Whilst there has been initial engagement through the Community Council, it is difficult to engage with the general public since the delivery of the new practice is in response

to the population expansion which is yet to be in situ. The EHSCP Patient Involvement Worker will support engagement with the future population when appropriate.

Report Author

Judith Proctor

Chief Officer, Edinburgh Integration Joint Board

Contact for further information:

Name: David White
Email: david.white@nhslothian.scot.nhs.uk Telephone: 07974 185419

Appendices

Appendix 1	Initial Agreement West Edinburgh (Maybury) General Medical Services Provision

West Edinburgh (Maybury) General Medical Services Provision

NHS Lothian

Initial Agreement

Project Owner: *Fiona Cowan*

Project Sponsor: *David White*

Date: *28/07/2020*

Version: *1.9*

Version History

Version	Date	Author(s)	Comments
1.0	27/02/2020	Fiona Cowan	First Draft
1.1	04/03/2020	Fiona Cowan	Review and update of IA
1.2	02/04/2020	Fiona Cowan	Review and update of IA
1.3	27/04/2020	Fiona Cowan	Review and update of IA
1.4.	05/05/2020	Fiona Cowan	Review and update of IA
1.5	24/06/2020	Fiona Cowan	Review and update of IA
1.6	01/07/2020	Laura Smith	Update template & Financial/Economic cases
1.7	8/07/20	Fiona Cowan	Final Version
1.8	20/07/20	Fiona Cowan	Final Review for Edinburgh Integrated Joint Board and Finance and Resource Committee
1.9	28/07/2020	Immy Tricker	Minor updates to financial/ economic cases

Contents

1 Executive Summary 5
1.1 Purpose 5
1.2 Background and Strategic Context 5
1.3 Need for Change 6
1.4 Investment Objectives 7
1.5 The Preferred Option(s) 7
1.6 Readiness to proceed 7
1.7 Conclusion 8
2 The Strategic Case 9
2.1 Existing Arrangements 9
2.2 Drivers for Change 10
2.3 Investment Objectives 15
2.4 Benefits 15
2.5 Strategic Risks 16
2.6 Constraints and Dependencies 16
3 Economic Case 17
3.1 Do nothing/baseline 17
3.2 Engagement with Stakeholders 18
3.3 Long-listed Options 18
3.4 Shortlisted Options and Preferred Way Forward 20
3.5 Design Quality Objectives 23
4 The Commercial Case 24
4.1 Procurement Strategy 24
4.2 Timetable 24
5 The Financial Case 25
5.1 Capital Affordability 25
5.2 Revenue Affordability 25
5.3 Overall Affordability 26
6 The Management Case 28
6.1 Readiness to proceed 28
6.2 Governance support for the proposal 28
6.3 Project Management 29

7 Conclusion 30
Appendix 1: Strategic Assessment 31
Appendix 2: Site Maps 32
Appendix 3: Benefits Register 33
Appendix 4: Risk Register 34
Appendix 5: Non-Financial benefits Assessment 35

1 Executive Summary

1.1 Purpose

1.1.1 The purpose of the Initial Agreement is to seek approval for the proposal from Edinburgh Health and Social Care Partnership (EHSCP) / Edinburgh Joint Integration Board (EIJB) to consider the provision of General Medical Services (GMS) in West Edinburgh.

1.1.2 The proposal is to develop sufficient accommodation to deliver the additional capacity required as a result of housing developments being built in the area.

1.2 Background and Strategic Context

1.2.1 Greenfield space (site HSG19), adjacent to the Maybury and between Turnhouse Road and the main rail link to Fife, has been released for housing development through the City of Edinburgh (CEC) Local Development Plan 2016 – 2026. It is proposed that the site will accommodate 1750 housing units of which 25% will be affordable housing split over three development sites and equating to 3,675 additional population based on a standard planning minimum of 2.1 people per housing unit. As the provision of a primary school is included within the site, it is likely that the development will comprise predominantly family housing which will significantly increase the number of occupants per unit. As this is currently a greenbelt site on the outskirts of Edinburgh there is no GMS provision for any of the proposed housing, and only a limited number of GP practices nearby.

1.2.2 The adjacent area of South Gyle and Edinburgh Park has already expanded with an increase of 778 houses equating to 1634 additional population, based on a minimum of 2.1 people per housing unit. Much of this area was green belt or a business development area previously and as such has had no requirement or provision for GP services in the past.

1.2.3 Proposals for further housing and commercial developments in the area have been included in City Plan 2030 at several sites in the surrounding area (Edinburgh Park and South Gyle, Edinburgh International Business Gateway and Crosswinds). As City Plan 2030 also proposes the development of the West Edinburgh transport corridor, improving transport links on the west side of the city, there is an increased likelihood of this area being selected for future development. It was anticipated that a report would be submitted to elected members in August 2020, following completion of the consultation period. The report has been postponed due to Covid-19 and will also specifically consider the impact of the pandemic.

1.2.4 In addition, approval has recently been given for 1350 houses in Phase 1 of Edinburgh Garden District development. The potential expansion of this site up to circa 3000 houses will be subject to separate consideration but is likely to be significant as the overall development proposed could be up to circa 3,000.

1.2.5 The increased population will have a direct impact on Barclay East Craigs Medical Practice and Parkgrove Medical Practice and to a lesser extent on Cramond Medical Practice. Inevitably this will have a ripple effect on other practices, such as Ladywell Medical Practices, further into Edinburgh as the population expands.

1.2.6 **Barclay Medical Practice East Craigs** (list size 8,569, April 2020)

The practice is located in purpose built premises owned by NHS Lothian which are functionally suitable for the delivery of primary care. The practice is willing to grow but does not have sufficient capacity to accommodate the population expected as a result of development HSG19. The practice catchment area includes part of the West Edinburgh development sites and the practice will be in a position to accommodate some of the early population increase but the overall volume will ultimately necessitate the development of an additional new practice.

1.2.7 **Parkgrove Medical Practice** (list size 3,190, April 2020)

Parkgrove Medical Practice is a salaried practice in premises leased by NHS Lothian, which remain in reasonable condition and which are functionally suitable for delivery of primary care. Space within Parkgrove has been altered to enable most of the new population in Cammo to be able to register with the practice and to facilitate the development of one of Primary Care's Community Treatment and Care Centres (CTAC) which will open later in 2020. The lease for the building has recently been negotiated for a further 20 years.

1.2.8 **Cramond Medical Practice** (list size 8,864, April 2020)

Independent practice in GP leased premises which are in reasonable condition and suitable for the delivery of primary care. The practice received a capital contribution from the landlord, which, with additional capital support from NHS Lothian, will enable them to adjust the internal design of the building to have all consulting space accessible on the ground floor. The practice boundary was reduced recently but continues to include the development at Cammo and will be able to accommodate the remaining population unable to register with Parkgrove.

1.2.9 The extent of the planned new housing is such that the existing arrangements are insufficient to address the capacity required to ensure that all the new population will be able to access General Medical Services (GMS).

1.2.10 Additionally the introduction of the new GMS Contract (Scotland) on 1st April 2018 requires boards to provide alternative delivery of certain service to enable implementation of the contract. These changes such as Mental Health Hubs will impact on the accommodation requirements to support the current and future population of the area.

1.3 Need for Change

1.3.1 While there is some capacity in existing practices as detailed above, it is insufficient to manage the anticipated increase. There is currently no GMS provision for any of the proposed housing since it is presently a greenbelt site.

1.3.2 The Integration Joint Board previously approved the EHSCP Population Growth and Primary Care Premises Assessment 2016-26, and the subsequent high prioritisation of this area need through the NHS Lothian Capital Prioritisation Programme which invited the submission of the Initial Agreement. The Strategic Assessment (SA) identified that existing practices, due to a mixture of limitations of workforce and physical capacity, are unable to provide GMS to the significant additional population generated by the new housing

1.3.3 The population of Edinburgh has increased by some 65,000 people over the last ten years and will continue to grow at a rate of c 5,000 per annum until at least 2026. This trend is expected to continue with the subsequent implementation of City Plan 2030 which will ultimately supersede

the current development plan. Most of the growth has been absorbed into existing primary care provision without commensurate development of additional physical capacity.

1.3.4 City of Edinburgh (CEC) Local Development Plan 2016 – 2026 details the planned housing developments across the city. The West Edinburgh site which is shown in Appendix 2: Site Maps comprises a significant area of land within the plan where extensive housing is programmed. .

1.3.5 Although the house building programming extends over several years, the Housing Land Audit (HLA) 2019 details the expected completions rate of circa 200 houses per annum in the Maybury area. If developers are confident of house sales, that rate may be increased however the economic impact on the build rate as a result of the Covid-19 pandemic is yet to be assessed and may result in a decrease in the annual completion rate. HLA 2020 has been delayed due to Covid-19 however it is anticipated that a draft will be available later this year with an indication of future building programmes.

1.3.6 In addition to the above, Edinburgh Garden District, which was originally recommended not to be approved by CEC and was subsequently referred to the Scottish Government Reporters, had the decision overturned in April 2020 and approval given for the development of Phase 1 which includes 1350 houses, equating to 2835 additional population minimum.

1.4 Investment Objectives

1.4.1 The investment objectives the project seeks to achieve are

- To improve service capacity to enable everyone to access GMS
- The development of additional General Medical Practice
- To enable delivery of the Primary Care Improvement Plan as required for implementation of the new GMS contract

1.5 The Preferred Option(s)

1.5.1 The preferred option is for NHSL, in collaboration with CEC, to consider a joint development of a new GP practice and a primary school, built on a site which has been identified with sufficient space and is suitable for both facilities. The building will be built to meet the 2030 carbon neutral standards required by CEC and NHS and will enjoy the benefits of shared space and reducing the overall footprint.

1.5.2 The resource implication is a capital investment of c£4million (including VAT) based on construction commencing in 2021.

1.6 Readiness to proceed

1.6.1 The preferred option will be delivered in partnership with CEC. CEC will lead the procurement with NHSL providing a Capital Grant to CEC. CEC will be supported by NHS Lothian and Edinburgh Health and Social Care Partnership.

1.6.2 A benefits register has been included in Appendix 3 and a high level risk register in Appendix 4. A full risk register will be developed for the project at the Standard Business Case stage.

1.6.3 Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

1.6.4 NHS Lothian and Edinburgh Health and Social Care Partnership are ready to proceed with this proposal. Section 6.3 details the project management arrangements. Section 6.2 outlines the governance support and reporting structure for the proposal.

1.6.5 Engagement with stakeholders is outlined in the Economic Case. Members of the Project Management Group have been involved in its developments to date and will continue to support it.

1.7 Conclusion

1.7.1 The strategic assessment for this proposal (included in Appendix 1: Strategic Assessment) scored 21 (weighted score) out of a possible maximum score of 25.

1.7.2 The proposal has been prioritised by the relevant governance groups and identified as a priority for NHS Lothian as part of the NHS Capital Prioritisation Process 2020/21.

2 The Strategic Case

2.1 Existing Arrangements

2.1.1 Greenfield space (site HSG19) adjacent to Maybury and between Turnhouse Road and the main rail link to Fife, has been released for housing development through the City of Edinburgh (CEC) Local Development Plan 2016 – 2026. It is proposed that the site will accommodate 1750 housing units of which 25% will be affordable housing split over three development sites and equating to 3,675 additional population based on a standard planning minimum of 2.1 people per housing unit. As the provision of a primary school is included within the site, it is likely that the development will comprise predominantly family housing which will significantly increase the number of occupants per unit. As this is currently a greenbelt site on the outskirts of Edinburgh there is no GMS provision for any of the proposed housing, and only a limited number of GP practices nearby.

2.1.2 Whilst not included in this proposal, Cammo development is located immediately to the north of HSG19 where an additional 655 dwelling places are scheduled to be built starting in 2019. GMS provision for the additional population from Cammo can be accommodated in Parkgrove Medical Practice and Cramond Medical Practice.

A map showing development site HSG19 is attached as Appendix 2: Site Map

2.1.3 Within the past three years the adjacent area of South Gyle and Edinburgh Park has expanded with an increase of 778 houses which equates to 1634 additional population, based on a minimum of 2.1 occupants per unit. Much of this area was green belt or a business development area and as such has had no requirement or provision for GP services in the past.

2.1.4 Proposals for further housing and commercial developments in the area have been included in City Plan 2030 at several sites in the surrounding area (Edinburgh Park and South Gyle, Edinburgh International Business Gateway and Crosswinds) and are being deliberated as part of the consultation process. It was anticipated that a report would be submitted to elected members in August 2020, following completion of the consultation period. The report has been postponed due to Covid-19 and will also specifically consider the impact of the pandemic.

2.1.5 In addition, approval has recently been given for 1350 houses in Phase 1 of Edinburgh Garden District development. The effects on population growth as a result of this potential expansion will be subject to separate consideration but are likely to be significant as the overall development proposed is circa 3,000.

2.1.6 Additionally, City Plan 2030 proposes the development of the West Edinburgh transport corridor, improving transport links on the west side of the city and thus increasing the likelihood of this area being selected for future development.

2.1.7 The increased population will have a direct impact on Barclay East Craigs Medical Practice and Parkgrove Medical Practice and to a lesser extent on Cramond Medical Practice. Inevitably this will have a ripple effect on other practices, such as Ladywell Medical Practices, further into Edinburgh as the population expands.

2.1.8 **Barclay Medical Practice East Craigs** (list size 8,569 April 2020)

East Craigs Medical Practice has been managed by the Barclay Medical Practice Group since 2017. The practice is located in purpose built premises circa30 years old which were bought by NHS Lothian 2017 and have since benefitted from a small scheme to create an additional consulting room which has enabled them to increase the practice list. The practice is willing to grow but does not have sufficient capacity to accommodate the population expected as a result of development HSG19. The practice catchment area includes part of the West Edinburgh development sites and the practice will be in a position to accommodate some of the early population increase but the overall volume will ultimately necessitate the development of an additional new practice.

2.1.9 **Parkgrove Medical Practice** (list size 3,190 April 2020)

Parkgrove Medical Practice is a salaried practice in premises leased by NHS Lothian, which remain in reasonable condition and which are functionally suitable for delivery of primary care. The premises received support for a small scheme in 2019 enabling them to increase the capacity of the practice list. Space within Parkgrove has been altered to enable most of the new population in Cammo to be able to register with the practice and to facilitate the development of one of Primary Care's Community Treatment and Care Centres (CTAC) which will open later in 2020. The lease for the building has recently been negotiated for a further 20 years.

The lists for these two practices show that an average of 6.92% patients are over 75 years old while 8.91% of the practice are in the lowest deprivation quintile.

2.1.10 **Cramond Medical Practice** (list size 8,864 April 2020)

Independent practice in GP leased premises which are in reasonable condition and suitable for the delivery of primary care. The practice received a capital contribution, from the landlord, linked to lease renewal towards dilapidations and upgrading the premises in 2019, which, with additional capital support from NHS Lothian, will enable them to adjust the internal design of the building to have all consulting space accessible on the ground floor. The practice boundary was reduced recently but continues to include the development at Cammo and will be able to accommodate the remaining population unable to register with Parkgrove. Cramond has one of the highest ratios of elderly within Edinburgh; 13.53% are over 75 years of age compared to an average of 7.06% for Edinburgh. Only 0.84% of the entire practice is within the highest deprivation quintile.

2.1.11 The extent of the planned new housing is such that the existing arrangements are insufficient to address the capacity required to ensure that all the new population will be able to access General Medical Services (GMS).

2.1.12 Additionally the introduction of the new GMS Contract (Scotland) on 1st April 2018 requires boards to provide alternative delivery of certain service to enable implementation of the contract. These changes such as Mental Health Hubs will impact on the accommodation requirements to support the current and future population of the area.

2.2 Drivers for Change

The following section expands on the need for change as identified in the Strategic Assessment (included in Appendix 1) and describes the anticipated impact if nothing is done to address these needs and why action should be taken now through this proposal.

2.2.1 This Initial Agreement (IA) proposes that an additional General Medical Practice for circa 10k patients be built in West Edinburgh to accommodate the planned population due to the development of housing within West Edinburgh. While there is some capacity in existing practices as detailed above, it is insufficient to manage the anticipated increase. There is currently no GMS provision for any of the proposed housing since it is currently a greenbelt site; there is however an option for provision of a GP Practice of approximate list size 10k included within the site plans.

2.2.2 The Integration Joint Board previously approved the EHSCP Population Growth and Primary Care Premises Assessment 2016-26, and the subsequent high prioritisation of this area need through the NHS Lothian Capital Prioritisation Programme which invited the submission of the Initial Agreement.

2.2.3 The Strategic Assessment (SA) identified that existing practices, due to a mixture of limitations of workforce and physical capacity, are unable to provide GMS to the significant additional population generated by the new housing

2.2.4 The population of Edinburgh has increased by some 65,000 people over the last ten years and will continue to grow at a rate of c 5,000 per annum until at least 2026. This trend is expected to continue with the subsequent implementation of City Plan 2030 which will ultimately supersede the current development plan. Most of the growth has been absorbed into existing primary care provision without commensurate development of additional physical capacity.

2.2.5 City of Edinburgh (CEC) Local Development Plan 2016 – 2026 details the planned housing developments across the city. The West Edinburgh site which is shown in Appendix 2: Site Maps comprises a significant area of land within the plan where extensive housing is programmed.

2.2.6 Although the house building programming extends over several years, the Housing Land Audit (HLA) 2019 details the expected completions rate of circa 200 houses per annum in the Maybury area. If developers are confident of house sales, that rate may be increased however the economic impact on the build rate as a result of the Covid-19 pandemic is yet to be assessed and may result in a decrease in the annual completion rate. HLA 2020 has been delayed due to Covid-19 however it is anticipated that a draft will be available later this year with an indication of future building programmes. The known planned developments are illustrated in **Table 1**.

2.2.7 The table below, covering the period 2019 – 2026 and the longer term, is a snapshot of the City of Edinburgh Council Housing Land Audit (HLA) 2019 (provisional), showing housing sites that are under construction, sites with planning consent, sites in the Local Development Plan and constrained sites which have not yet been programmed.

Table 1: Planned Developments

Area	Number of Housing Unit	Population*
Anticipated increase in population which cannot be accommodated within existing GMS facilities and which therefore requires additional provision		
Edinburgh Park/South Gyle	778	1,633
Maybury Central	1,400	2,940
Maybury East	220	462
Maybury West	130	273
Total	2,528	5,308
Increase in population anticipated to be absorbed by Parkgrove Practice and Cramond Practice		
Cammo	655	1376

* Population projections have been calculated by multiplying the planned number of units to be built by the average household size for Edinburgh, source National Records Scotland (NRS). The average household size of 2.1 has been used in these calculations, although it is expected to decrease over time. Given the predominance of family housing to be built within all developments, it is likely that the population figure could be significantly higher and the numbers illustrated are the **minimum**.

2.2.8 In addition to the above, Edinburgh Garden District, which was originally recommended not to be approved by CEC and was subsequently referred to the Scottish Government Reporters, had the decision overturned in April 2020 and approval given for the development of Phase 1 which includes 1350 houses, equating to 2835 additional population. Again, this housing development will primarily be family dwelling places and it is therefore likely that the numbers estimated using the average household size will be greater than stated. The overall development proposed could be up to circa 3,000 houses.

2.2.9 Early discussions with the landlord's agent for site HSG19 considered the need for provision of GMS services to serve the population resulting from the housing development. Consequently a suitable location on the site has been safeguarded, without legal commitment, for the development of a GP practice of approximate list size 10k. This would be purpose built, developer leased, ground floor accommodation, with dwelling places above.

2.2.10 Simultaneously, the need to provide additional educational facilities within the locality has provided an opportunity for NHSL to collaborate with CEC to consider a joint development of new health premises and primary school with shared amenities. A proposal is being developed with CEC for a GP practice combined with the new school to be built on a site which has been identified with sufficient space and is suitable for both facilities. The building will enjoy the benefits of shared space reducing the overall footprint and meeting the 2030 carbon neutral standards required by CEC and NHS.

2.2.11 Whilst there are significant advantages to a collaborative approach to this provision, the projected timescales of requirement vary. CEC is required to provide the new school when the first houses are completed in 2023. In other circumstances, EHSCP would normally aim for completion of new medical premises when the potential population would reach a minimum list size of 2000. In this scenario, completion would be required around 2024/25.

2.2.12 The comparator to the joint development is a separate stand alone, developer led building. While all CEC and NHS new builds will be built to Passivhaus standards or similar and will meet the 2030 carbon neutral targets, it is likely that it will be more challenging to meet the environmental consideration in a developer led construction.

2.2.13 As a result of the Covid-19 pandemic, the construction industry is experiencing delays and disruption at all stages of development. Whilst completion dates noted above are as stated in the Housing Land Audit, a number of factors, including government guidance on lockdown, restricted movement in the housing market and availability of materials, will impact the ability to meet these timescales. It is therefore likely that the timescales may be delayed, resulting in a later completion date being required.

2.2.14 Recent developments of GP premises within NHS Lothian have followed a relatively standard schedule of accommodation and building layout. As a result of experiences during Covid 19 which altered the modus operandi within GP practices, it is anticipated that the design and requirements of future health premises will be altered to embrace new ways of working and meet stringent infection control requirements. This is may cause further delays whilst standards are in development stages.

2.2.15 Edinburgh Health and Social Care Partnership (EHSCP) and NHS Lothian Primary Care Contracts Organisation (PCCO) will develop the proposal to create a new practice partnership and invite business case submission from interested parties to deliver it. It is anticipated this could replicate previous models whereby an existing partnership, supported by investment, will seed the new practice by taking on additional patients, in its current premises, to an agreed list size – although other options are possible. Subsequently that patient cohort will form the nucleus of the new practice which the parent practice will have the opportunity to continue to manage as a branch practice, or can choose to relinquish it whereupon it can be advertised as a new partnership.

Table 2 below summarises the need for change, the impact it is having on present service delivery and why action is required now.

Table 2: 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?	Why action now?
Significant planned population increases in areas with little or no General Medical Services (GMS) provision	Pressures on existing practices to provide GMS provision to expanding population	Existing services under strain by additional capacity required to address this
Potential for the West Edinburgh developments to increase further in future Local Development Plan	Existing service arrangements unable to cope with future projected levels of population growth	City of Edinburgh Council Local Development Plan details the housing developments programmed for the area with additional 4000 population expected within 5years and an increase of 1700 planned beyond 2026. Release of more land for development will result in further population pressures.
Existing local practices do not have the physical capacity to absorb the additional population nor the desire to expand so significantly	Additional population unable to register for GMS provision	The timescales and practical issues relating to introducing new GMS services to an area are such that early actions are required to ensure practice list availability when the population growth reaches approximately 2000
Planned developments will generate sufficient population to offer a sustainable business model for new practices and provide development opportunity to existing practices through the new contract	Alteration to existing practices maximised to accommodate population growth, additional practice required to meet population needs and GMS contract implementation	New GMS contract came into effect on 1st April 2018, with time limited implementation for delivery of the Primary Care Improvement Plan to deliver the contract requirements
Opportunities to address and accommodate workforce uncertainty to meet new contract and locality needs.	Ability to recruit workforce is affected by condition of premises. Development of new premises for a new practice will have a positive impact on recruitment.	Time implications of setting up new practice / management support may be challenging and onerous. Early planned intervention will enable best solution to practice development

2.3 Investment Objectives

The assessment of the existing situation and the drivers for change have been used to identify what has to be achieved to deliver the changes required. These are defined as the investment objectives and are summarised in the table below:

Table 3: Investment Objectives

Effect of the need for change on the organisation	What has to be achieved to deliver the necessary change? (Investment Objectives)
Existing service arrangements unable to cope with future projected levels of population growth	Improve service capacity to enable everyone to access GMS
Additional pressures on existing practices nearby to provide GMS provision to expanding population	Development of additional General Medical Practice
Transformation of primary care services to meet the requirements of the new GMS contract	Enable delivery of the Primary Care Improvement Plan as required for implementation of the new GMS contract

2.4 Benefits

2.4.1 A Strategic Assessment (SA) was completed identifying the need for change, benefits of addressing these needs and their link to the Scottish Government (SG) five Strategic Investment Priorities below:

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

2.4.2 The above investment objectives and the Strategic Assessment (see Appendix 1: Strategic Assessment) have informed the development of a Benefits Register (see Appendix 3: Benefits Register). As per the draft 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 SBC stage.

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

- Ensure everyone has access to GMS through provision of adequate capacity
- Ensure that people who use health and social care services have positive experiences and their dignity respected
- Support the attainment of HEAT targets
- Provides safe and easy access to GP services. Premises are DDA compliant
- Delivery functionally suitable and sustainable healthcare estate
- Optimise financial and resource usage through an efficient estate and a stable health care system

2.5 Strategic Risks

2.5.1 The table below highlights key strategic risks that may undermine the realisation of benefits and the achievement of the investment objectives. These are described thematically and potential safeguards and actions in place to prevent these:

Table 4: Strategic Risks

Theme	Risk	Safeguard
Business	Failure to acquire suitable site or premises for development	Work with partners and developers to identify opportunities
	Proposed development not well received by patients and public	Clear communication and engagement plan at an early stage
Workforce	Insufficient workforce to meet the required capacity provision	Joint working by EHSCP and practices to facilitate required recruitment
Funding	Capital or revenue funding to deliver the project is unaffordable	Optimise resource usage Value engineering Cost certainty for business case
Scope	Scope of the project exceeds deliverability	Clarity on scope from outset Reduction of scope
Capacity	Future developments exceed capacity of practice	Monitor Housing Land Audit for changes
External	Earlier / later impact and timing than projected of population growth	Monitor anticipated growth and projected timing

A register of strategic risks is included in Appendix 4: Risk Register. A full risk register will be developed for the project at the Standard Business Case stage.

2.6 Constraints and Dependencies

2.6.1 The key constraints to be considered are:

- Availability of either capital or revenue funding may limit the ability to deliver the preferred solution

2.6.2 The key dependencies to be considered are:

- Availability of suitable sites and solutions which can be secured within appropriate timescales for partner agencies
- Agreement with practices to capacity increase to address growth

3 Economic Case

3.1 Do nothing/baseline

3.1.1 There is no existing provision as outlined in Section 2.1 and 'Do Nothing' is not feasible as it does not address any of the strategic drivers for change and has the potential to cause existing practice instability. A 'Do Minimum' option is therefore included as the baseline (as required by the Scottish Capital Investment Manual guidelines) against which other options are assessed. This will only address the strategic drivers in part and will result in capacity constraints which fail to provide for the population growth in the area. The table below defines the 'Do Minimum' option including the requirements to implement this option.

Table 5: Do Minimum

Strategic Scope of Option	Do Minimum
Service provision	Continue with existing
Service arrangements	Existing GP practices with support for some capacity increase where possible
Service provider and workforce arrangements	Existing GMS provision with additional workforce to address any increase
Supporting assets	Limited physical alteration to premises to increase capacity if feasible
Public & service user expectations	Public and service users will expect full access to GMS and require the ability to register with a GP in the local area

3.2 Engagement with Stakeholders

3.2.1 The table below summarises the stakeholders impacted by this proposal and the details of the engagement that has taken place with them to date and notes their support for this proposal.

Table 6: Engagement with Stakeholders

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
General public	Initial engagement has been through the Corstorphine Community Council	Representative from the community council has confirmed support for GMS development in the area
Key stakeholders: Barclay East Craigs, Parkgrove and Cramond Medical Practices Cardross, Site Agents	 Early discussions have taken place with all practices to keep them abreast of proposals Early discussions about space and location requirements for a GP practice	 Support confirmed Proposal supported and potential site safeguarded within development
Partners: City of Edinburgh Council	Discussions to develop a collaborative project	CEC have indicated a desire to undertake a joint project

3.2.2 Whilst there has been initial engagement through the Community council, it is difficult to engage with the general public since the delivery of the new practice is in response to the population expansion which has yet to be in situ. The EHSCP Patient Involvement Worker will support engagement with the future population when appropriate.

3.2.3 Until there is an agreed solution to the development of the practice it is not known how this may affect staff, however local practices will engage with their own staff as the project progresses.

3.3 Long-listed Options

3.3.1 The strategic scope of each option – that is the service provision, arrangements, provider and workforce – is the same for each option, namely GMS provision delivered by the independent contractor model.

3.3.2 The key outcome of this project is to ensure that sufficient capacity is provided to accommodate the planned growth in the local area. Existing practices have already indicated that they do not wish to increase their practice population by the quantity generated by the housing developments. It is therefore essential that a new practice is developed within the vicinity.

3.3.3 The options identified are outlined below

Option 1: Do Minimum - minor refurbishment in existing practices to increase capacity to accommodate some of the increased population due to the housing expansion

Option 2: New build for a new practice in a joint development with City of Edinburgh Council Education Department

Option 3: NHS leased premises in a new build for a new practice on a standalone site

The table below summarises the long list of options identified:

Table 7: Long-listed options

Strategic Scope of Option	Option 1 Do minimum	Option 2 New build in partnership with CEC	Option 3 NHS Leased premises
Service provision	As current arrangements	Increases GMS capacity	Increases GMS capacity
Service arrangements	Continue with existing	New practice with high risk of failure and significant revenue implications until practice stable	New practice with high risk of failure and significant revenue implications until practice stable
Service provider and workforce arrangements	Existing GMS provision – will provide additional workforce to address any increases	Will require additional workforce to staff the practice. Will address recruitment difficulties impacted by premise conditions	Will require additional workforce to staff the practice. Will address recruitment difficulties impacted by premise conditions
Supporting assets	Minor refurbishment to accommodate some of the population increase due to housing expansion	Purpose built premises designed with sufficient and appropriate space to accommodate the new population.	Purpose built premises designed with sufficient and appropriate space to accommodate the new population.
Public & service user expectations	Insufficient capacity to manage growth of the population who will expect full access to GMS and require ability to register with a GP in the area.	Will provide full access to GMS and opportunity to register with a GP in the local area from	Will provide full access to GMS and opportunity to register with a GP in the local area.

3.3.4 Initial Assessment of Options

Each of the long- listed options have been assessed for their advantages and disadvantages, and the extent to which they meet the investment objectives (as outlined in the Strategic Case) to identify the preferred solution(s).

Table 8: Assessment of options against investment objectives

	Option 1 **Do minimum**	**Option 2** **New build in partnership with CEC**	**Option 3** **NHS leased premises**
Advantages (Strengths & Opportunities)		Addresses capacity and access needs Functionally suitable premises Long term provision of sustainable practice	Addresses capacity and access needs Functionally suitable premises Long term provision of sustainable practice
Disadvantages (Weaknesses & Threats)	Insufficient capacity to address population growth	Required timescales for completion differ for partners	Environmental targets more challenging to meet
	Does it meet the Investment Objectives (Fully, Partially, No, n/a):		
Investment Objective 1	No	Yes	Yes
Investment Objective 2	No	Yes	Yes
Investment Objective 3	No	Yes	Yes
	Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)		
Affordability			
Preferred/Possible/ Rejected	Reject	Preferred	Possible

3.4 Shortlisted Options and Preferred Way Forward

3.4.1 Shortlisted options

From the initial assessment above the following short-listed options have been identified:

Table 9: Short Listed Options

Option	Description
Option 1	Do Minimum
Option 2	New build in partnership with City of Edinburgh Council (CEC)
Option 3	NHS leased premises in a new build for a new practice on a standalone site

3.4.2 Non-financial benefits assessment

Each of the shortlisted options was assessed against the benefits included in the benefits register

. Each of the identified benefits was weighted and following this each of the shortlisted options was scored against its ability to deliver the required benefits. The full assessment is contained in Appendix 5: Non-Financial benefits Assessment.

The results of the benefits assessment are summarised below:

Table 10: Results of Non-Financial Benefits Assessment

#	Benefit	Weight (%)	Option 1 Do minimum	Option 2 New build in partnership with CEC	Option 3 NHS leased premises
1	Everyone has access to a GP	25%	0	10	10
2	Ensure that people who use health and social care services have positive experiences and their dignity respected	15%	2	10	10
3	Support the attainment of HEAT targets *Reduces the rate of emergency inpatient bed days for people aged 75 *Reduces the rate of attendance at A&E *Supports early cancer detection	15%	2	8	8
4	Provides safe and easy access to GP services	20%	2	9	9
5	Ensure the functional suitability of the healthcare estate	15%	7	10	10
6	Optimise financial and resource usage through an efficient estate	10%	7	10	9
	Total Weighted Benefits Points		**275**	**950**	**940**

From the table above it is noted that the options that will deliver the most benefits is Option 2.

3.4.3 Indicative costs

The table below details the indicative whole life costs associated with each of the shortlisted options. For further detail around the determination of the costs see the Financial Case.

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 projects, on the basis of other similar type leased projects
- The base date for the proposal is October 2022.
- Phasing of the costs reflects the useful life and the programme of works as identified in the Commercial Case.

Table 11: Indicative Costs of Shortlisted Options

Cost (£m)	Option 1 Do Minimum	Option 2 New build in partnership with CEC	Option 3 NHS leased premises
Whole life capital costs	0	3,249	4,643
Whole life operating costs	0	759	759
Estimated Net Present Value (NPV) of Costs	0	4,008	5,402

3.4.4 Overall assessment and preferred way forward

The table below show the weighted benefit points for each shortlisted option, the NPV of costs and the calculated cost per benefit point. This calculated cost per benefit point has been used to rank the options and identified the preferred way forward.

Table 12: Economic Assessment Summary

Option Appraisal	Option 1 Do minimum	Option 2 New build in partnership with CEC	Option 3 NHS leased premises
Weighted benefits points	275	950	940
NPV of Costs (£k)	0	4,008	5,402
Cost per benefits point (£k)	0	4.22	5.75
Rank	**3**	**1**	**2**

3.4.5 The preferred solution was identified as Option 2 – New build with partnership with CEC. This was identified as the preferred option because it meets all the investment criteria identified in the Initial Agreement. Do minimum has been ranked last due to the inability to deliver any of the investment criteria.

It is recommended that NHS Lothian proceeds with this option to Standard Business Case stage where the implementation of the solution(s) shall 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 AEDET (Achieving Excellence Design Evaluation Toolkit) workshop will be undertaken as the project progresses to Standard Business Case.

4 The Commercial Case

4.1 Procurement Strategy

4.1.1 The total indicative costs for the preferred option at this stage are £4.006m including VAT. It is anticipated that the procurement of the project will be led by CEC supported by Edinburgh Health and Social Care Partnership and NHSL

4.1.2 It is proposed that NHSL will provide a Capital Grant to CEC for the construction costs and then lease the completed facility from CEC.

4.1.2 The project will be delivered in accordance with NHS Scotland construction procurement policy and it is anticipated that HubCo will be the best option.

4.2 Timetable

4.2.1 A detailed Project Plan will be produced for the SBC. At this stage the table below shows the proposed timetable for the progression of the business case and project delivery milestones:

Table 13: Project Timetable

Key Milestone	Date
Initial Agreement approved	August 2020
Standard Business Case approved	May 2021
Lease signed for the property	June 2021
HubCo Stage 2 Submission/Approval	October 2021
Construction starts	November 2021
Construction complete and handover begins	June 2023
Service commences	July 2023

4.2.2 The timescales outlined above are fully dependant on the development timescales. Any delays in the commercial/school developments will result in slippage in this programme,

5 The Financial Case

5.1 Capital Affordability

5.1.1 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. Option 1 does not require capital work therefore has not been included in the table below.

Table 14: Capital Costs

Capital Cost (£k)	Option 2: New Build in Partnership with CEC	Option 3: Fit out of Leased Premises
Construction	2,115	2,953
Professional Fees	378	680
Furniture, Fittings & Equipment	80	80
IT & Telephony	64	64
Inflation	89	123
Construction Risk	177	246
Optimism Bias	435	622
Total Cost (excl VAT)	**3,338**	**4,768**
VAT	668	954
Total Capital Cost	**4,006**	**5,722**

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

- Optimism bias has been calculated in line with SCIM guidance and is included at 15% of all costs
- Preliminaries are included within the total construction cost.
- An inflation allowance of 4% has been included using a base date of October 2022 and the construction timeline detailed in the Commercial Case
- VAT has been included at 20% on all costs. No VAT recovery has been assumed. VAT recovery will be further assessed in the SBC.
- Capital costs and programme will be reviewed as the project progresses

5.2 Revenue Affordability

5.2.1 The estimated recurring revenue costs associated with each of the short listed options are detailed in the table below. These represent the additional revenue costs when compared to the

'Do Nothing' option. There is no incremental increase for this project as there is no existing service provision.

Table 15: Annual Revenue Costs

Incremental Revenue Cost/year (£m)	Option 1 Do Minimum	Option 2 New build in partnership with CEDC	Option 3 NHS leased premises
Facilities	0	102	102
Premises Costs	0	18	18
Total Annual Revenue Cost	**0**	**120**	**120**

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

- Premises related costs have been estimated using a square metre rate from a similar type project, and is inclusive of rates, water and clinical waste.
- Facilities costs have been applied on the basis of annual costs of maintenance domestic services, and energy. These have been calculated on the basis of £39, £30 and £58 per sqm respectively, based on costs for similar type GP premises.
- In both options there will be a lease in place, either with CEC or commercial developer. At this stage no costs have been included for the lease and this will be assessed further at the SBC stage. For the purpose of comparison within the IA it is assumed that the lease cost would be the same in both options and would be fully funded by GMS in either option. It therefore does not affect the assessment of options

5.2.3 Staffing costs have not been included at this stage as they have not yet been fully assessed and it is anticipated these will be will be funded through GMS. There may also be a requirement for financial support in the establishment of a new practice. Both staffing and support requirements will be assess at SBC stage as well as the funding sources for these costs.

5.2.4 Recurring revenue costs in relation to facilities will be funded directly by the practices, subject to discussion and adjustment for any short term occupation considerations. Premises costs, including lease costs, will be fully funded via GMS payments.

All revenue costs detailed above will continue to be refined through the SBC process.

5.3 Overall Affordability

5.3.1 The capital costs detailed above are expected to be funded through traditional capital funding. This project has been prioritised by NHS Lothian and Edinburgh Health and Social Care Partnership. Availability of capital funding remains a key risk to the project. A high level of risk is included in the construction cost as the project is at a very early stage in the design process. Further work is scheduled to refine the cost estimates detailed above as part of the SBC process.

5.3.2 As the requirement for this project is driven primarily by population growth a specific capital allocation will be requested from the Scottish Government in order to fund the project

5.3.3 It is proposed that NHSL will provide a Capital Grant to CEC for the construction cost and then lease the completed facility from CEC.

5.3.4 Funding has been assumed for additional revenue costs from GMS and the practice itself, this will be refined in the SBC process and will then be reviewed and agreed by the relevant parties.

5.3.5 All costs will continue to be refined through the SBC process.

6 The Management Case

6.1 Readiness to proceed

6.1.1 A benefits register and initial high level risk register for the project are included in Appendix 3: Benefits Register and Appendix 4: Risk Register, respectively.

6.1.2 Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case

6.1.3 NHS Lothian and Edinburgh Health and Social Care Partnership are ready to proceed with this proposal and are committed to ensure the necessary resources are in place to manage it. Section 286.3 below details the project management arrangements. Section 6.2 outlines the governance support and reporting structure for the proposal.

6.2 Governance support for the proposal

6.2.1 Engagement with Stakeholder is detailed in the Strategic Case and includes information on how members of the proposal's governance arrangements have been involved in its development to date and will continue to support it.

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

6.3 Project Management

6.3.1 The table below notes the project board that will be responsible for taking the project forward including details of the capabilities and previous experience.

6.3.2 Legal advice for the project (if required) will be obtained from the Central Legal Office.

Table 16: Project Management Structure

Role	Individual	Capability and Experience
Project Sponsor	David White, Strategy Planning & Quality Manger, primary Care and Public Health	Previous experience as Project Sponsor in primary care capital projects
Project Owner	Fiona Cowan	Previous experience of NHS capital projects
Project Manager	Campbell Kerr	Senior Project Manager in NHSL Capital Planning with extensive experience and responsibility for primary care projects
Capital Finance Support	Laura Smith	Experience supporting capital investment projects including similar primary care provisions
EHSCP Chief Finance Officer	Moira Pringle	Previous experience at Senior Manager level in similar projects, formerly Head of Capital Finance NHSL
NW Locality Lead	To be confirmed	Dependant on appointee
Clinical Lead	To be confirmed	Dependant on appointee
Communication Rep	To be confirmed	Dependant on appointee

7 Conclusion

7.1.1 The strategic assessment for this proposal (included in Appendix 1 Strategic Assessment) scored 21 (weighted score) out of a possible maximum score of 25.

7.1.2 The proposal has been prioritised by the relevant governance groups and identified as a priority for NHS Lothian as part of the NHS Capital Prioritisation Process 2020/21.

Appendix 1: Strategic Assessment

PROJECT:

New practice West Edinburgh

What are the Current Arrangements: City of Edinburgh Council Local Development Plan identifies West Edinburgh for significant planned housing development for c 8,000 people where currently there is little or no General Medical Services (GMS) provision; West Edinburgh also has the potential for further significant increases in future plans

What is the need for change?

- Significant planned population increases from CEC Local Development Plan in areas currently with little or no General Medical Services (GMS) provision
- Potential for the West Edinburgh developments to increase further in future Local Development Plan
- The extent of the growth poses a threat to the stability of existing local practices which do not have the physical capacity to absorb the additional population, nor the desire to expand so significantly
- Planned developments will generate sufficient population to offer a sustainable business model for new practices and provide development opportunity to existing practices through the new contract
- Opportunity to address and accommodate workforce uncertainty to meet new contract and locality needs

Identify Links

What benefits will be gained from addressing these needs?

- Ensure everyone has access to GMS through provision of adequate capacity
- Shift the balance of care by increasing the proportion of patients receiving care in community settings;
- Reduce emergency admissions to hospital and rate of attendance at A/E; optimise delivery of additional services and use of third sector resource
- Ensure that people who use health and social care services have positive experiences and their dignity respected.
- Support the attainment of HEAT targets e.g early cancer detection, antenatal access, early years vaccinations
- Deliver functionally suitable and sustainable healthcare estate
- Optimise financial and resource usage through an efficient estate and a stable health and social care system

Identify Links

How do these benefits link to NHSScotland's Strategic Investment Priorities?

	Prioritisation Score
Person Centred	5
Safe	4
Effective Quality of Care	4
Health of Population	4
Value & Sustainability	4
TOTAL SCORE	21

What solution is being considered

Service Scope / Size

Provision of sustainable GMS services in areas with little or no practice provision

Service Arrangement

Increase capacity through development of new practices & contract

Service Providers

EHSCP, GMS contractors, NHS Lothian, City of Edinburgh Council, Third sector, partners, private

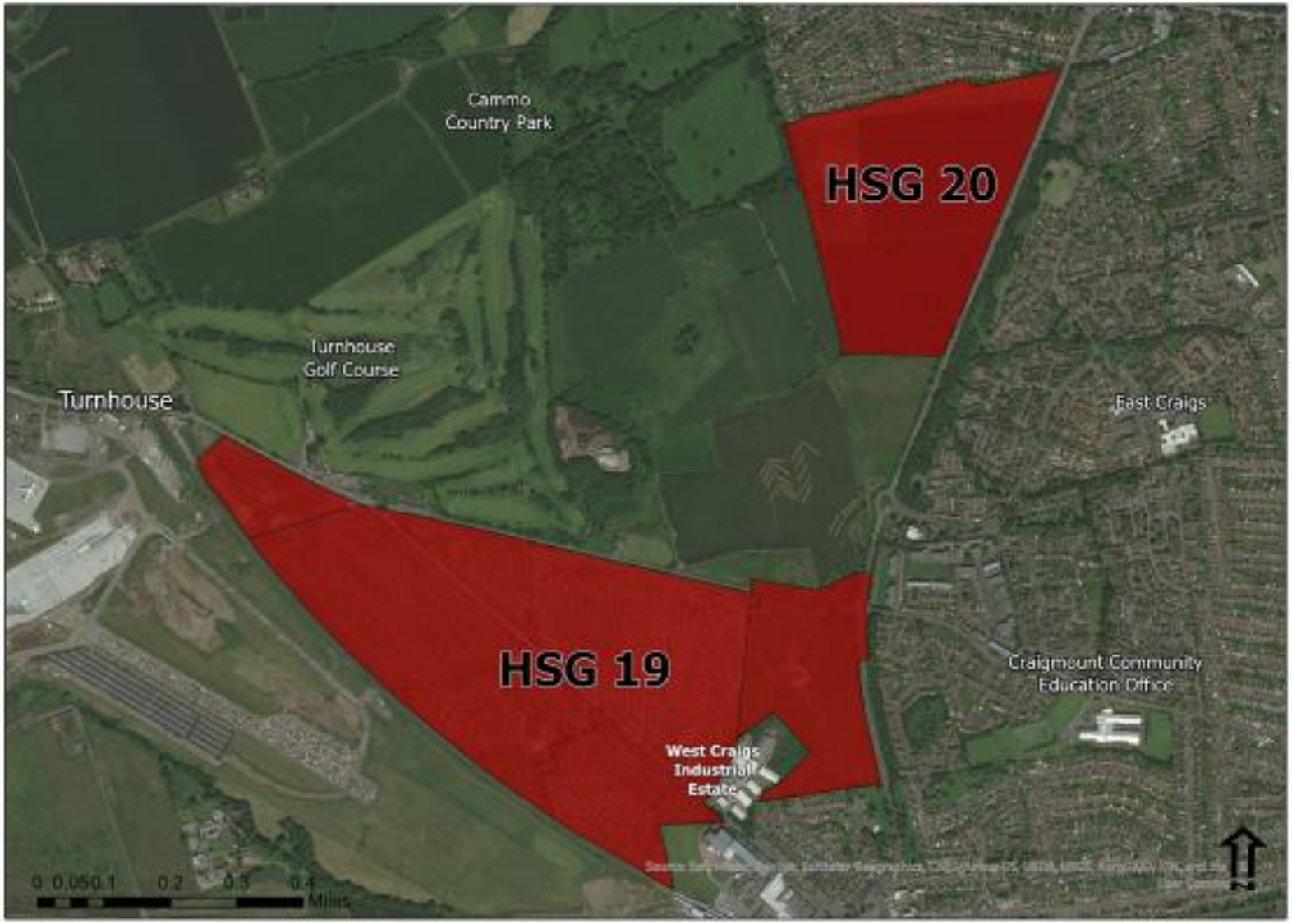
Impact on Assets

Potential new premises or refurbishment of existing assets - own or partners

Value & Procurement

New build will use the Hub Framework, other procurement to be confirmed in Initial Agreement

Appendix 2: Site Maps



Appendix 3: Benefits Register

Step 1: Identify desired benefits and include in the project benefits register

Project Name: West Edinburgh Primary Care Provision

1. Benefits Register						*2. Prioritisation*	*3. Realisation*					
Ref No.	**Benefit**	**Assessment**	**As measured by**	**Baseline Value**	**Target Value**	**Relative Importance**	**Who Benefits?**	**Who is responsible?**	**Investment Objective**	**Dependencies**	**Support Needed**	**Date of Realisation**
Guidance	*Describe Benefit*	*Select from dropdown*	*How are you going to measure this?*	*Where you are now on this (baseline)*	*Where you want to get to*	*Select from dropdown*	*e.g. Public, patients, staff?*	*e.g. service manager*	*Which investment objective does this link to?*	*Does achieving this depend on anything else other than the project?*	*Is there any other support (not this project) required to achieve this?*	*When will you measure the realisation of this benefit (usually after 12 month of operation)*
1	Ensure everyone has access to GMS through provision of adequate capacity	Quantitatively	Capacity increase, restricted lists, patient assisgnments	No of patients resident assigned	No restricted lists, patients assigned	5 - Vital	Patients, GP Practices	GP/EHSCP/ NHSL	Improve service capacity to enable everyone to access GMS. Enable delivery of the Primary Care Improvement Plan as required for the implementation of the new GMS contract			24 months post project
2	Ensure that people who use health and social care services have positive experiences and their dignity respected	Qualitatively	Patient experience of GP practice, patient experience of Health and Social Care services	New practice - no current information	Results of post completion questionnaire	4 - Important	Patients	EHSCP/ NHSL	Improve service capacity to enable everyone to access GMS. Enable delivery of the Primary Care Improvement Plan as required for the implementation of the new GMS contract			24 months post project
3	Provides safe and easy access to GP services. Premises are DDA compliant	Qualitatively	Patients experience of travel options questionnaire	New practice - no current information	Results of post completion questionnaire and full DDA compliance achieved	4 - Important	Patients	EHSCP	Improve service capacity to enable everyone to access GMS. Enable delivery of the Primary Care Improvement Plan as required for the implementation of the new GMS contract			
4	Improve the functional suitability and sustainability of the healthcare estate	Quantitatively	Proportion of the estate categorised as either A or B for the functional suitability facet	New practice - no current information	A	4 - Important	EHSCP		Development of additional General Medical Practice			
5	Optimise financial and resource usage through an efficiant estate and a stable health and social care system	Quantitatively	Annual statutory appraisal	New practice - no current information	A	3 - Moderately important	Population / EHSCP / NHSL	EHSCP	Development of additional General Medical Practice			24 months post project

Appendix 4:
Risk Register

PROJECT TITLE **West Edinburgh (Maybury) Development**

PROJECT RISK REGISTER

Risk No.	Date Raised	Description of Project Risk	Potential Failure / Cause	Direct Consequence	Severity (1 - 5)	Probability (1 - 5)	Risk Factor	Risk Allowance £k	Comments	Trigger	Mitigation Response	Risk Controller	By when
1	07/07/2020	Delay in negotiations with CEC.	Failure to agree commercial terms (lease, construction, service charges) for the development with CEC.	Cost / Time	4	2	8	0.00	NHSL/HSCP sign off required on design, costs and operational agreements. These are still outstanding.		Capital Planning involvement with design to date including details of construction cost.	Capital Planning / Project Board	Ongoing
2	07/07/2020	NHSL Capital budget exceeded	NHS element of the costs exceed expectations due to higher than anticipated inflation/tender prices.	Cost	4	2	8	0.00	Costings included in the IA are based on the current information available from CEC.		Costs will be reviewed during the design process will be cinfirmed in the SBC.	Capital Planning	Ongoing
3	07/07/2020	Revenue costs exceeded and unaffordable	Revenue costs may exceed estimates in IA	Cost	4	2	8	0.00	Revenue costs (including those for setting up a new GP Practice) will be reviewed for the SBC.			Finance	Ongoing
4	07/07/2020	Passivhaus design not compatible with NHS design guidance	NHSL has yet to use the Passivhaus model, this will need to be checked throughout the design process.	Time	3	1	3	0.00			Capital Planning involvement with design to date.	Capital Planning	Ongoing
5	07/07/2020	Revenue/Running Costs not agreed with new GP Practices	New Practice unable to sign up to recurring running costs	Time	3	3	9	0.00	Requirement for practice to agree revenue costs prior to SBC submission.		SLA cost to be shared with practice when they are selected.	Project Board	Ongoing
6	07/07/2020	IT / Telecom costs	Issues with E Health briefing and initial costing information	Cost	3	2	6	0.00			E - Health to be include in the early design stages.	Capital Planning	Ongoing
7	07/07/2020	Design changes /variations following design freeze	Final brief/design not agreed by all parties. Changes to user group or working practices during detailed design and/or construction stages.	Cost / Time	4	2	8	0.00			Final SOA and layouts etc to be signed off by users and Project Board.	Capital Planning	Ongoing
8	07/07/2020	Delays/Difficulties with Statutory Approvals	Planning Permission/Building Warrant difficult to obtain causing delays	Cost / Time	3	1	3	0.00				Capital Planning / CEC	Ongoing
9	07/07/2020	Unforeseen building condition issues	Survey work incomplete or insufficient. Unknown issues discovered during construction stage.	Cost / Time	3	1	3	0.00				CEC	Ongoing
10	07/07/2020	Exceptional weather during construction	Adverse weather may affect programme.	Time	2	2	4	0.00				Capital Planning	Ongoing
11	07/07/2020	Communications/public engagement	Adverse publicity, failure to communicate with local community	Reputational	2	2	4	0.00				Project Board	Ongoing
TOTAL RECOMMENDED CONTINGENCY ALLOWANCE													

Key

Severity scored 1 Minor to 5 Severe.
Probability scored 1 very unlikely to 5 very likely.

0 to 5	**GREEN**
6 to 11	**AMBER**
12 & over	**RED**

Appendix 5: Non-Financial benefits Assessment

#	Benefit	Weighting (%)	Option 1 Do Minimum	Option 2 CEC	Option 3 Refurbishment of available property
1	Everyone has access to a GP	25%	0	10	10
2	Ensure that people who use health and social care services have positive experiences and their dignity respected	15%	2	10	10
3	Support the attainment of HEAT targets *Reduces the rate of emergency inpatient bed days for people aged 75 *Reduces the rate of attendance at A&E *Supports early cancer detection	15%	2	8	8
5	Provides safe and easy access to GP services	20%	2	9	9
5	Ensure the functional suitability of the healthcare estate	15%	7	10	10
6	Optimise financial and resource usage through an efficient estate	10%	7	10	9
	Total Weighted Benefits Points		**275**	**950**	**940**

Maximum possible benefits points -

This page is intentionally left blank

Edinburgh Integration Joint Board

REPORT

Annual Performance Report

Edinburgh Integration Joint Board

24 August 2020

Executive Summary	
	1. Integrated Joint Boards are required by legislation to produce an Annual Performance Report (APR) by 31 July each year covering performance over the previous financial year (FY). 2. Due to the impact of the COVID-19 pandemic, most of the data presented in this APR is based on the 2019 calendar year. This approach has been sanctioned nationally. 3. The option to extend the publication date beyond 31 July if required has also been sanctioned nationally. It is proposed to publish the APR on Monday 31 August 2020. 4. Feedback from the Scottish Government on last year's APR has been fully considered in the production of this APR. 5. Our overall performance this year has remained for the most part in line with national averages, with encouraging signs of improvement in many areas.

Recommendations	
	It is recommended that the Edinburgh Integration Joint Board: 1. Approves the DRAFT APR. 2. Agrees a publication date of Monday 31 August 2020. 3. Refers the APR to the next Performance and Delivery Committee.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations		
	No direction required	✓
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Main Report

Background

1. Integrated Joint Boards are required by legislation to produce an APR by 31 July each year covering performance over the previous FY. In previous years a DRAFT APR has been published by 31 July and then ratified at the next available EIJB, normally in August. This process is driven by the need to await in year data, not available until mid-July each year, to complete the APR. This anomaly is well understood by health and social care partnerships. A change to the publishing date of 31 July would require a change in legislation and is an issue that will be taken up through the Chief Officers Operational Group and the EIJB Chairs Group.

2. Due to the impact of the COVID-19 pandemic, a range of data sets covering the previous FY, will not be available for several months yet. In response, it has been agreed nationally to use the data available for the previous calendar year (2019) in compiling APRs.

3. There has also been approval given to delay the publication of APRs beyond 31 July if required, up to a period of no more than three months. To that end and taking account of planned committee and EIJB core boards, it is proposed that the APR be published on Monday 31 August having gained EIJB approval. It is then proposed that the APR be referred to the next Performance and Delivery Committee to further consider the implications of the data.

4. Throughout the period of the pandemic, EHSCP has continued to compile case studies and analyse the available data to compile the APR 2019-20 at best effort based on the previous calendar year. The APR **narrative** does in parts, reflect more recent activity conducted in the early part of 2020.

6. Last year's APR was well received by the Scottish Government with the only comments for improvement aimed at information on finance and locality performance. This feedback has been fully considered in the production of this year's APR.

5. As required by the legislation and related guidance, the report considers and details performance in the following areas:

    a. Delivery of the nine National Health and Wellbeing Outcomes and related key priorities on the Integration Joint Board.
    b. Finance and best value.
    c. Moving to a locality-based model of planning and delivering services.

6. This year's APR provides context and updates on the initial roll out of Home First Edinburgh, Three Conversations, the Edinburgh Pact and Transformation. It then considers our performance framed around the EIJB six strategic priorities from the 2019-22 Strategic Plan:

    a. Prevention and early intervention.
    b. Tackling inequalities.
    c. Person-centred care.
    d. Managing our resources effectively.
    e. Making the best use of capacity across the whole system.
    f. Right care, right place, right time.

7. Our overall performance remains broadly in line with national averages. Edinburgh is performing well in respect of national indicator 12 - rate of emergency admissions - ranking third across Scotland. Edinburgh's rate of emergency admissions has been consistently lower than the Scottish average since 2013/14. Likewise, we have seen strong performance against the measure of rate of emergency bed days for adults (national indicator 13). Edinburgh is currently ranked ninth and has seen significant improvement in this area since 2015/16. However, we are not performing as strongly as we would like in the rate of emergency readmissions to hospital within 28 days of discharge.

8. Progress in relation to performance will continue to be monitored throughout the year by the Edinburgh Health and Social Care Partnership (EHSCP) Executive Management Team, the Performance and Delivery sub-committee and the EIJB.

Implications for EIJB

Financial

9. Financial details in relation to performance are included within the report.

Legal / risk implications

10. There are no legal implications arising from the report.

11. Risks are highlighted within the report. Performance should be monitored throughout the year to escalate risk and improve service delivery.

12. There are no new implications for Directions. As work is produced through the transformation programme, associated Directions can be expected.

Equality and integrated impact assessment

13. The final draft of the APR 2019-20 has been formatted to be accessible and can be available in an easy read format.

14. Other equalities implications are contained within the report.

Environment and sustainability impacts

15. There is reference to environmental considerations within the report.

16. It is recognised that all future models of care and delivery must take due cognisance of the impacts on the environment and in respect of climate change targets, including those associated with the Edinburgh 2030 programme.

Quality of Care

17. The report seeks to demonstrate our continued effort to improve the quality of care and experience for the citizens of Edinburgh and where applicable across Lothian.

Consultation

18. This APR has been produced with the involvement of data analysts from the City of Edinburgh Council and NHS Lothian and key stakeholders.

19. It summarises the achievements of locality teams with assistance from third sector organisations and wider teams in health and social care through case studies and feedback data.

Report Author

Judith Proctor
Chief Officer, Edinburgh Integration Joint Board

Contact for further information:

Name: Julie Tickle, Strategic Planning and Commissioning Officer, EHSCP
Email: Julie.Tickle@edinburgh.gov.uk Telephone: 0131 529 3244

Background Reports

1. Strategic Plan 2019-22 – EIJB report August 2019
2. Guidance for Health and Social Care Integration Partnership Performance Reports

Appendices

Appendix 1 DRAFT EIJB Annual Performance Report 2019/20

Edinburgh Integration Joint Board

Annual Performance Report 2019-2020

Edinburgh **Health and Social Care** Partnership

Thank you to everyone who helped us produce this Annual Performance Report, particularly the people and organisations who shared case studies with us. Your input, help and contributions are much appreciated.

Contents

Foreword	4
Introduction	6
Overview and transformation priorities	10
Performance summary	15
Locality profiles	25
Priority 1: Prevention and early intervention	30
Priority 2: Tackling inequalities	40
Priority 3: Person-centred care	47
Priority 4: Managing our resources effectively	59
Priority 5: Making the best use of the capacity across the system	67
Priority 6: Right care, right place, right place, right time	75
Looking ahead to 2020-21	83

Foreword

The Annual Performance Report for 2019/20 captures areas of progress that the Edinburgh Integration Joint Board (EIJB) and the Edinburgh Health and Social Care Partnership (EHSCP) have made over the last year. The report, as in previous years, measures our performance against the six strategic priorities set out in the EIJB Strategic Plan and against national indicators.

Due to the impact of the COVID-19 pandemic, the publication of the Heath and Care Experience Survey results has been delayed, as have some other data sets which we need to complete the annual performance report over the previous financial year. As a result, the performance data represented in this report, is mostly based on 2019 calendar year data. This approach has been approved nationally.

The EIJB approved its Strategic Plan for 2019-2022 in August 2019. At its heart, the new Strategic Plan sets out an ambitious transformation programme for the city over a three-year planning cycle, setting the conditions for longer term, sustainable change. Despite the impact of the COVID-19 pandemic, our preparations for the transformation programme are well advanced and we have made steady progress in the roll out of the Three Conversations approach in the city and in testing the concept of our Home First Edinburgh model.

We will continue to find ways to improve outcomes for people in Edinburgh and be innovative in our approaches against a challenging backdrop of a rising population, changing patterns of health and care need and ongoing financial pressures. Against this backdrop, our overall performance this year has remained for the most part in line with national averages, with encouraging signs of improvement in many areas.

Edinburgh is performing well in respect of national indicator 12 - rate of emergency admissions - ranking third across Scotland. Edinburgh's rate of emergency admissions has been consistently lower than the Scottish average since 2013/14. Likewise, we have seen strong performance against the measure of rate of emergency bed days for adults (national indicator 13). Edinburgh is currently ranked ninth and has seen significant improvement in this area since 2015/16. We are not performing as strongly as we would like in the rate of emergency readmissions to hospital within 28 days of discharge. We will focus on this alongside our continuing work to reduce the number of days people spend in hospital when they are ready to be discharged. The recent success of the Home First Edinburgh model during the COVID-19 pandemic has tested and proven the concept.

We would like to take this opportunity to thank our dedicated staff for their professionalism and fortitude and the many unpaid carers that provide vital care and support to the most vulnerable in our society. The EIJB and EHSCP are determined to enhance our performance further in the year ahead and beyond to bring about real and sustainable change for health and social care in Edinburgh.

Angus McCann, Chair
Edinburgh Integration Joint Board

Judith Proctor, Chief Officer
Edinburgh Health and Social Care

Introduction

Background and context

The Edinburgh Health and Social Care Partnership (EHSCP) is responsible for the operational delivery, providing integrated services and delivery of the strategic plan. Its workforce is made up of staff employed by both the City of Edinburgh Council and NHS Lothian under the leadership of a Chief Officer and executive management team. The EIJB's Chief Officer is accountable to the Chief Executives of both the City of Edinburgh Council and NHS Lothian.

You can read the EIJB's current Strategic Plan 2019-22. This performance report sets out the EIJB's progress against the strategic priorities and transformation plans within the Strategic Plan.

COVID-19 impact and response

The emergence of a new coronavirus, COVID-19, declaration of a pandemic and resulting restrictions has had a significant impact on our operational service delivery. The EHSCP has had to respond swiftly to protect and find new ways of delivering services to our most vulnerable citizens within a rapidly-changing landscape.

For example, as part the COVID-19 response, the EHSCP developed a mobilisation plan setting out the wide range of actions we were putting in place in response to the pandemic to ensure the health and care system was prepared for the impact of the virus. Our main focus was on creating and maintaining acute hospital bed capacity for the anticipated increase of admissions to hospital, and on supporting those people delayed in hospital back home or to a homely setting. The mobilisation plan was approved by the EIJB and by Scottish Government and operated across the pandemic. We have set out our renewal and recovery work to return to the 'new normal' of providing health and social care as we react to the Scottish Government route map through and out of the pandemic and in the EHSCP's contribution to NHS Lothian's Remobilisation Plan.

At the time of writing this report, services have had to adapt with many having to change their focus to meet emerging frontline needs and priorities. This has impacted on the availability of data in some service areas, with evaluations being delayed or resources shifted to support the frontline. This report presents the best data available, acknowledging there may be some gaps. Likewise, the full impact of the COVID-19 pandemic on finance and resources is not yet known.

Performance data and narrative

In this report we are following the recommendations made by Public Health Scotland (PHS), and using the most recent reporting period available, which is calendar year 2019. This ensures that these indicators are based on the most complete and robust data currently

available. We do not expect these numbers to differ greatly to 2019/20 financial year figures, once available, and so should not affect any conclusions that have been drawn.

There are nine national health and wellbeing outcomes which have been set by the Scottish Government. Each Integration Joint Board (IJB) uses these outcomes to set their local priorities. Underneath the nine wellbeing outcomes sits a core suite of integration indicators, which all HSCPs report their performance against. These national indicators underpin the nine wellbeing outcome measures and have been developed from national data sources to ensure consistency in measurement. We have presented performance from financial year 2013/14, to the most recent year available, with comparisons made to the Scottish average.

We have included performance summary information under a separate section; which includes trend data and Edinburgh's ranking against the Scottish average. You can find more detail on individual indicators, including locality information where available, under individual priorities. In addition, PHS published annual rates for the core suite of integration indicators for each integration authority area and Scotland in July 2020. This is the first time this information has been released in a single publication which you can find on the ISD Scotland site.

The **narrative content** in this report (case studies, project updates, updates on transformation priorities, financial information) covers the financial year April 2019 to March 2020 unless otherwise shown. We have changed all names and removed any identifying details in our case studies to protect anonymity.

Performance against national indicators

National indicators NI-1 to NI-9 are reported in the Scottish Health and Care Experience Survey (HACE) commissioned by the Scottish Government. Data relating to these indicators for 2019/20 was originally due to be published in April 2020, but due to staff redeployment during the COVID-19 pandemic, the publication was delayed and so the most recent survey results were not available for inclusion within this report. The latest data available is from the 2017/18 survey. We have made comparisons to the 2015/16 survey. This survey is sent randomly to around 5% of the Scottish population every two years. In 2017/18, the survey was sent to 47,949 people in Edinburgh with 10,327 responses which shows a response rate of 22%. The response rate across Scotland was also 22%.

The primary source of data for national indicators NI-11 to NI-20 are Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. In accordance with recommendations made by PHS and communicated to all HSCPs, the most recent reporting period available is calendar year 2019; this ensures that these indicators are based on the most complete and robust data currently available. We do not expect these numbers will differ greatly to 2019/20 financial year figures, once available, and so should not affect any conclusions that have been drawn.

Ministerial Strategic Group for Health and Community Care and Audit Scotland Integration reviews

The EIJB reports a range of performance indicators to the Scottish Government through the Ministerial Strategic Group for Health and Community Care (MSG). These performance

indicators give a view of how HSCPs are progressing against a range of whole system level measures.

Partnerships were asked to set objectives, targets and trajectories for each performance indicator to provide management information on the progress in the integration of health and social care systems. The performance indicators are largely based on hospital sector data due to routine availability of national data. A summary of the MSG measures and targets for the EHSCP in 2019/20 is shown in the table below.

Indicator	Baseline Year	Baseline Total	2019/20 Target Change	2019/20 Target Figure	2019/20 Achieved Figure *	Performance
A&E Attendances	2017/18	103,986	1.5% increase	105,546	107,289	🟡
Unplanned Admissions+	2017/18	35,597	1% decrease	32,241	39,196 +*	🔴
Emergency Occupied Bed Days:						
Acute	2017/18	330,759	3% decrease	320,836	312,416 *	🟢
Mental Health	2017/18	122,841	7% decrease	114,242	125,840 *	🔴
Geriatric Long Stay	2017/18	22,324	7% decrease	20,761	14,935 *	🟢
Delayed Discharges	2017/18	76,933	5% decrease	73,086	62,120	🟢
Last 6 months of life spent in a community setting	2017/18	85.7%	1.1% increase	86.8%	86.6% *	🟢
Balance of Care	2017/18	95.6%	0.2% increase	95.8%	95.7% *	🟢

*Data for unplanned admissions, emergency occupied bed days and last six months of life are shown for calendar year 2019. Data for the balance of care indicator is shown for financial year 2018/19. Please note that this data is provisional. There are also SMR data completeness issues for geriatric long stay unscheduled occupied bed days.

+The increase in the number of unplanned admissions is due to a service change at the Royal Infirmary in Edinburgh from April 2019. Some patients who have attended A&E have been admitted as an emergency inpatient to the Acute Assessment Unit. This has increased the number of emergency admissions in 2019. Most of these patients are discharged on the same day as admission to the Acute Assessment Unit.

Red, Amber and Green (RAG) Key for Edinburgh Performance

- 🔴 Performance fell by 5% or more
- 🟡 Performance fell but within 1% and 4.99%
- 🟢 Target met or performance is within threshold

The EIJB received an update on progress towards the recommendations arising from both the Ministerial Strategic Group and Audit Scotland reviews of integration at its meeting held in February 2020.

Care Inspectorate gradings

You will see a summary of the Care Inspectorate reviews of EHSCP and the City of Edinburgh Council services which took place during financial year 2019/20 in the section on 'person-centred care'. The data for NI-17 comes from the Care Inspectorate and covers all registered services, not just those run by the City of Edinburgh Council on behalf of the EHSCP.

Overview and transformation priorities

About Edinburgh – key facts and figures

Population

Edinburgh is home to 524,930 residents (as of June 2019). This is an increase of 1.2% from 518,500 in 2018. In the ten years to 2018 Edinburgh's population grew by 13.1% from 459,000 to 519,000 people. In the same time period, Scotland's population grew by 4.5%. Edinburgh's population growth from 2008 to 2018 was almost five times higher than past decade population changes.

Edinburgh is home to 79,335 residents aged over 65. Population projections show the number of over 75s in Edinburgh is expected to increase by 76% from 2018 to 2041.

Employment and the economy

Edinburgh has a higher percentage (77.8%) of the working age population in employment than any other major UK city. The large student population in the city accounts for 31.7% of the economically inactive population within the city.

Around 50,000 people in Edinburgh are employed in the health sector. This industry sector makes up 15% of all jobs in Edinburgh (Edinburgh by Numbers 2019).

Tourism is a key part of Edinburgh's economy. According to Visit Scotland there were around 16.9 million visitor nights in Edinburgh in 2018.

Poverty and inequalities

Poverty rates in Edinburgh vary considerably between different areas of the city, from as low as 5% in some areas to as high as 27% in others. Every locality has at least one area of significant poverty.

The Scottish Index of Multiple Deprivation 2020 indicated that of the 20% most deprived data zones in Scotland, 5.0% (70 data zones) are in Edinburgh. The most deprived data zone in Edinburgh is in Leith ward/North East locality.

Our achievements and challenges

The vision to deliver 'a caring, healthier and safer Edinburgh' underpins the EIJB and EHSCP.

The EIJB has set out an ambitious transformation programme within the Strategic Plan for 2019-22. This details our priorities for delivering sustainable, person-centred, flexible and quality services. The four key elements of our approach are:

- further development of the Three Conversations approach
- embedding the Home First model

- developing the Edinburgh Pact
- a wide-ranging transformation programme.

Here is a summary of progress in each of these areas.

Three Conversations

Three Conversations is a strength-based partnership approach developed by Partners4Change (P4C) which recognises that people are the experts in understanding their own circumstances and needs. It replaces the traditional model of 'assessment for services', avoiding a process-driven service that results in people on waiting lists and unnecessary bureaucracy.

Three Conversations is structured around three tiers or levels of intervention.

- Conversation 1: listen and connect.

  Listening to and understanding what people need and finding ways to build upon their strengths and connect them to family, community and others.

- Conversation 2: work intensively with people in crisis.

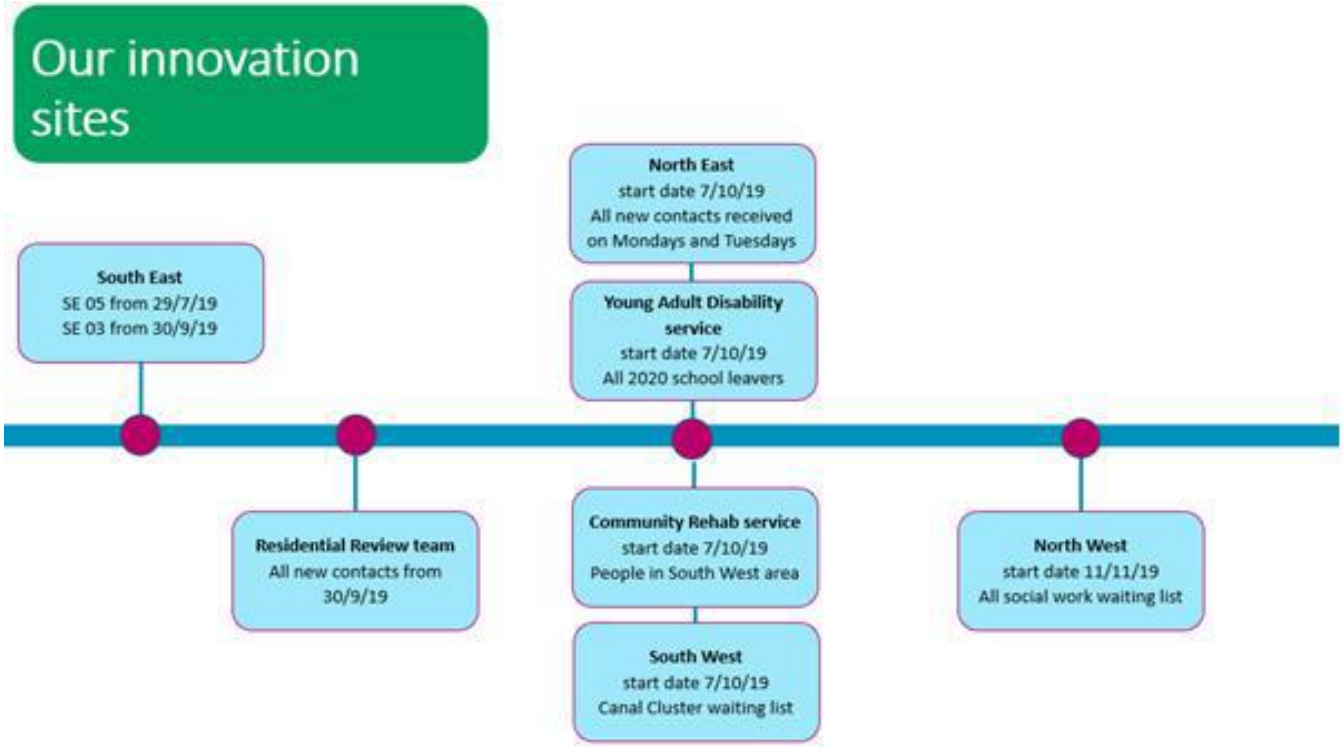
  Working out what is needed to help someone to regain control of their life or reach a point of stability and then ensuring that the emergency plan is delivered.

- Conversation 3: build a good life.

  This focuses on long-term planning.

Edinburgh is the first partnership in Scotland to adopt this new approach. During 2019/20 the programme focused on establishing innovation sites across the city and across service areas to test the approach and evaluate the lessons learned from phase one.

We now have seven innovation sites active in the city.



As part of the evaluation of the innovation sites, we collected data between July 2019 and March 2020 on the number of conversations completed, the type of conversations, how long it took for people to be connected with a worker, and the need for long-term paid for support as a result. Where possible, we compared data against approximate baseline figures from outwith the innovation sites.

The evaluation of phase one has shown:

- We held a total 1,609 conversations across the seven innovation sites, and we worked with 853 people.
- The majority of all conversations were conversation 1. Most people were supported at that point and did not need to have a further conversation. Only a minority of people required long-term support.
- We were able to respond to people's requests for support much more quickly. Prior to introducing the Three Conversations approach, the average waiting time for an assessment was 40 days, excluding the time from contact to screening and the time following allocation to a worker and start of the assessment. Within the innovation sites, the average wait to see a worker has dropped to 3.8 days.

The next stage of the Three Conversations approach will focus on scaling up and rolling out the approach. A challenge will be embedding the key principles in all areas of practice in EHSCP, as large-scale culture change of this type takes time.

Case study – Three Conversations

Agnes is a 94-year-old woman who lived with her daughter but wanted to return to her own home after a period of being unwell. Initially a package of care support was requested to help Agnes with meal preparation and dressing. However, through discussion, we found that Agnes felt she would be able to manage with some aids and adaptations to her home which support independent living. The care worker was able to link quickly with occupational therapy and got the equipment in swiftly and supported Agnes in its use. Agnes is now back in her own home, managing well and does not need any ongoing formal care or support. Both she and her family know to contact the service again should the situation change.

The Transformation programme

The EIJB ringfenced £2 million to support transformation in February 2019. The EIJB Strategic Plan 2019-22 sets out the detail of the two-year programme design, scope and intent.

The transformation programme is structured around the Three Conversations themes (listen and connect, work intensively with people in crisis, and build a good life) as well as focusing on cross-cutting enablers such as digital transformation and infrastructure.

Additional specialist staff with key project management skills were recruited during late 2019 and early 2020 and the programme was formally launched in February 2020. Work has already started on some transformational workstreams including Three Conversations, Home First Edinburgh, re-designing how people access our services and a bed-base review.

Home First Edinburgh

The Home First Edinburgh approach is critical to our ability to tackle delayed discharge and ensure that people are cared for in the right place at the right time. Home First supports people who are ready to return home after a hospital stay but need short term health and social care services to manage their discharge safely. Home First Edinburgh was initially tested in the Western General Hospital, with a further test at the Royal Infirmary of Edinburgh in late February and is being gradually expanded across other acute hospital sites.

Key to the delivery of Home First Edinburgh is Discharge to Assess and the creation of Home First community navigator posts. Discharge to Assess will have 16 therapists to deliver 80-100 discharges from hospital by supporting assessment at home. As of February 2020, a team of 8 therapists covering the north of the city have supported over 200 discharges over 16 weeks. Discharge to Assess has now been successfully rolled-out to south Edinburgh and increased the number of people supported to leave hospital.

The potential of Home First Edinburgh has already had a positive impact on the whole system with an overall improvement in both delayed discharge numbers and occupied bed days between April 2018 and December 2019. This facilitated the EIJB's decommissioning of 26 beds (ward 71) in the Western General Hospital by the end of October 2019. We also decommissioned ward 120 by the end of March 2020. The decommissioning of these acute wards supports a transfer of resource toward community models of care and also created an additional 15 intermediate care beds in the community within the same timescale. It is also worth noting that we completed the roll out of Edinburgh's Hospital at Home service across the city in December 2019 and will the service will undergo further review as part of the transformation programme.

As well as facilitating timely discharge, another objective of Home First Edinburgh is to prevent unnecessary hospital admission. As part of winter planning, there was investment in the flow centre to support care as an alternative to admission. Early data suggests that as a result of the work of the winter prevention team and Home First navigator, 48 people have been prevented from being admitted to hospital. This represents a saving of 388 bed days over 16 weeks. You can find more information about Home First Edinburgh in the EIJB report from 22 October 2019.

The Edinburgh Pact

The Edinburgh Pact will set out a new relationship between service providers and citizens. We will engage and collaborate to understand people's views of how statutory services should support people with health and social care needs. We have started the initial planning as part of the transformation programme and will develop the Pact over the next two years. As part of the Pact, we will carry out quantitative and qualitative research in the early stages involving senior leaders, staff and the public. It will also form a continuing dialogue between the EIJB and the public from the second half of 2020 and beyond.

Improving governance

During 2019/20, the EIJB has focused on strengthening its governance arrangements. The Good Governance Institute (GGI) carried out a review of governance in 2018 and the EIJB has now implemented most of the recommendations arising from this review. As part of this, we established a new committee structure including Strategic Planning Group, Performance and Delivery, Audit and Assurance, Clinical Care Governance, and Futures.

The EIJB approved a new Directions Policy in August 2019. The policy was developed to address the risk of non-delivery of directions by NHS Lothian and the City of Edinburgh Council which had been highlighted as a significant risk for the EIJB. The policy follows Scottish Government best practice guidance and increases transparency and accountability between the EIJB and its partner organisations; NHS Lothian and the City of Edinburgh Council. We plan to keep our Directions Policy under constant review and will monitor, review and amend the policy to meet Scottish Government guidance and approved best practise.

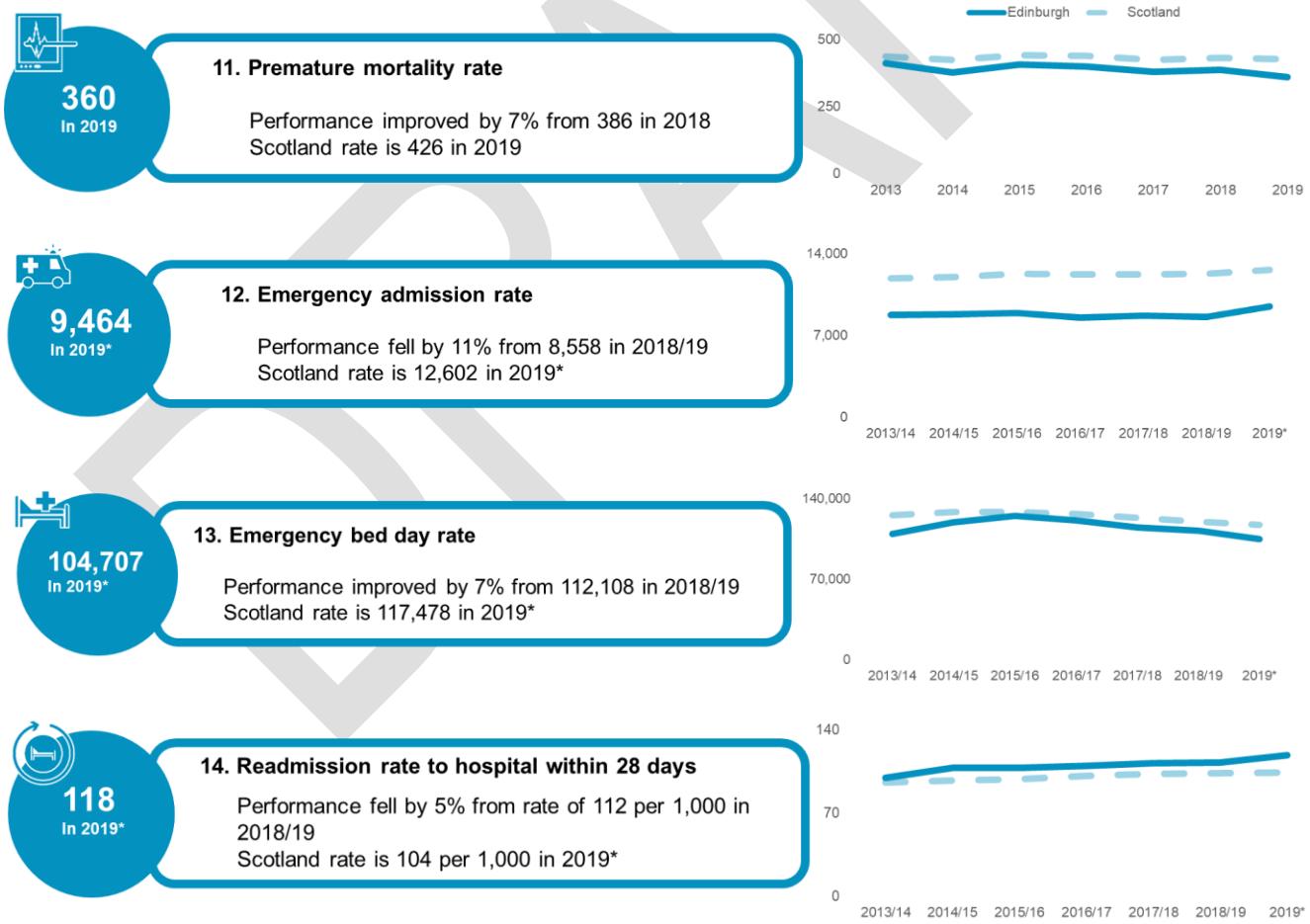
Initially, the EIJB developed and approved nine directions linked to the Strategic Plan in October 2019. The EIJB has since developed and approved more directions in-year to account for service change and redesign. We have also conducted an annual review of directions.

Performance summary

Performance at a Glance

The infographic below summarises EHSCP's progress against National Indicators 11-20 as new data is available for these indicators following from the 2018/19 report. The Scottish average has been included for benchmarking purposes. The infographic shows the following information:

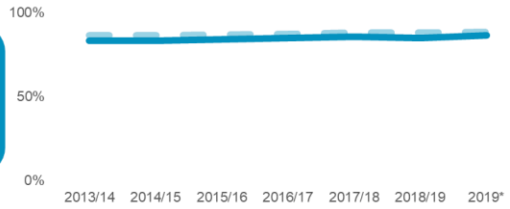
- The latest available figure for each indicator is shown in a circle on the left hand side of the infographic.
- A brief narrative on Edinburgh's performance over the last two years, along with the latest Scottish average is shown in the middle text box.
- The charts on the right hand side show time trends for both Edinburgh and Scotland for the past seven years.



87%
In 2019*

15. Of the last 6 months of life is spent at home or in a community setting

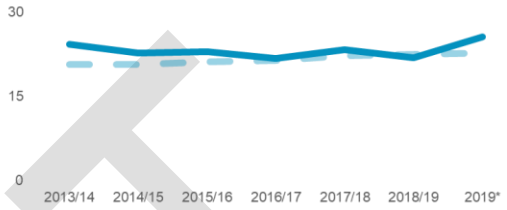
Performance improved by 2% from 85% in 2018/19
Scotland rate is 89% in 2019*



26
In 2019*

16. Falls rate (65+) per 1,000 population

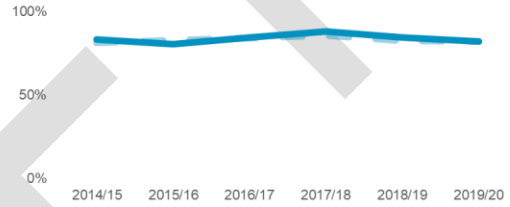
Performance fell by 18% from 22 falls per 1,000 population in 2018/19
Scotland rate is 23 in 2019*



82%
In 2019/20

17. Care services graded GOOD (4) or better in Care Inspectorate inspections

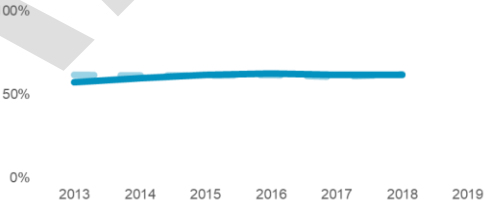
Performance fell by 2% from 84% in 2018/19
Scotland rate is 82% in 2019/20



62%
In 2018

18. Adults with intensive care needs are receiving care at home

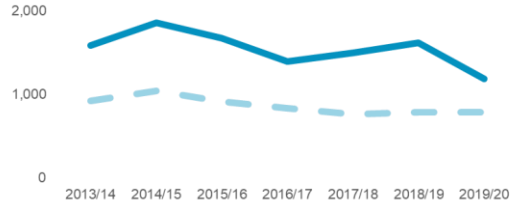
Performance remained at 62% in 2017
Scotland rate is 62% in 2018



1,191
In 2019/20

19. The number of days people aged 75+ spend in hospital when they are ready to be discharged

Performance improved by 27% from 1,621 rate in 2018/19
Scotland rate is 793 in 2019/20



23%
In 2019*

20. Health and care resource spent on hospital stays where patient was admitted as an emergency

The percentage fell by 1% from 24% in 2018/19
Scotland rate is 23% in 2019*

The table below compares the results for Edinburgh and Scotland from the last two Health and Care Surveys, which were published in 2015/16 and 2017/18. Please note that no data has been published for 2019/20 as the Scottish Government delayed the publication of the latest survey due to the pandemic.

1. Adults are able to look after their health very well or quite well

	15/16	16/17	17/18	18/19	19/20
Edinburgh	96%	N/A	94%	N/A	N/A
Scotland	95%	N/A	93%	N/A	N/A

2. Adults supported at home agreed that they are supported to live as independently as possible

	15/16	16/17	17/18	18/19	19/20
Edinburgh	81%	N/A	79%	N/A	N/A
Scotland	83%	N/A	81%	N/A	N/A

3. Adults supported at home agreed they had a say in how their help, care or support was provided

	15/16	16/17	17/18	18/19	19/20
Edinburgh	77%	N/A	74%	N/A	N/A
Scotland	79%	N/A	76%	N/A	N/A

4. Adults supported at home agreed that their health and social care services seemed to be well coordinated

	15/16	16/17	17/18	18/19	19/20
Edinburgh	71%	N/A	67%	N/A	N/A
Scotland	75%	N/A	74%	N/A	N/A

5. Adults receiving any care or support rated it as excellent or good

	15/16	16/17	17/18	18/19	19/20
Edinburgh	78%	N/A	80%	N/A	N/A
Scotland	81%	N/A	80%	N/A	N/A

6. Adults had a positive experience of the care provided by their GP practice

	15/16	16/17	17/18	18/19	19/20
Edinburgh	87%	N/A	84%	N/A	N/A
Scotland	85%	N/A	83%	N/A	N/A

7. Adults supported at home agreed their services and support had an impact on improving or maintaining their quality of life

	15/16	16/17	17/18	18/19	19/20
Edinburgh	83%	N/A	79%	N/A	N/A
Scotland	83%	N/A	80%	N/A	N/A

8. Carers feel supported to continue in their caring role

	15/16	16/17	17/18	18/19	19/20
Edinburgh	37%	N/A	35%	N/A	N/A
Scotland	40%	N/A	37%	N/A	N/A

9. Adults supported at home agreed they felt safe

	15/16	16/17	17/18	18/19	19/20
Edinburgh	82%	N/A	77%	N/A	N/A
Scotland	83%	N/A	83%	N/A	N/A

Performance against national indicators

The summary table below gives details of Edinburgh's performance against the national indicators over the last two years of the most recent available data (see the introduction section for more detail as COVID-19 has delayed the HACE 2019/20 survey results). Edinburgh's performance has been benchmarked against the Scottish average for national indicators 11 through to 20. We have shown the result as a RAG status in the final column. Green indicates that Edinburgh's performance, compared to last year, has improved. Amber signifies that Edinburgh's performance has decreased but is not behind the Scottish average. Red denotes that Edinburgh's performance has decreased and is also behind the Scottish average.

Indicator		2015/16		2017/18		2019/20	
Number	Description	Edinburgh	Scotland	Edinburgh	Scotland	Edinburgh	Scotland
NI - 1	Percentage of adults able to look after their health very well or quite well	**96%**	*95%*	**94%**	*93%*	**N/A**	*N/A*
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**81%**	*83%*	**79%**	*81%*	**N/A**	*N/A*
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	**77%**	*79%*	**74%**	*76%*	**N/A**	*N/A*
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**71%**	*75%*	**67%**	*74%*	**N/A**	*N/A*

NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	**78%**	*81%*	**80%**	*80%*	**N/A**	*N/A*
NI - 6	Percentage or people with positive experience of the care provided by their GP	**87%**	*85%*	**84%**	*83%*	**N/A**	*N/A*
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**83%**	*83%*	**79%**	*80%*	**N/A**	*N/A*
NI - 8	Total combined % of carers who feel supported to continue in their caring role	**37%**	*40%*	**35%**	*37%*	**N/A**	*N/A*
NI - 9	Percentage of adults supported at home who agreed they felt safe	**82%**	*83%*	**77%**	*83%*	**N/A**	*N/A*

Indicator		2018/19		2019*		How Edinburgh compared against Scotland^
Number	Description	Edinburgh	Scotland	Edinburgh	Scotland	
NI-11	Premature mortality rate per 100,000 persons (calendar year)	**386 *(2018)***	*432 (2018)*	**360 *(2019)***	*426 (2019)*	🟢
NI-12	Rate of emergency admissions for adults (per 100,000 population)	**8,558**	*12,275*	**9,464**	*12,602*	🟡
NI-13	Rate of emergency bed days for adults (per 100,000 population)	**112,108**	*120,177*	**104,707**	*117,478*	🟢
NI-14	Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)	**112**	*103*	**118**	*104*	🔴
NI-15	Proportion of last 6 months of life spent at home or in a community setting	**85%**	*88%*	**87%**	*89%*	🟢
NI-16	Falls rate per 1,000 population aged 65+	**21. 9**	*22. 5*	**25. 5**	*22. 7*	🔴
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	**84%**	*82%*	**82% (2019/20)**	*82% (2019/20)*	🟡

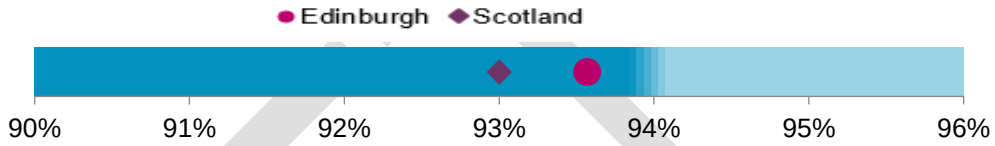
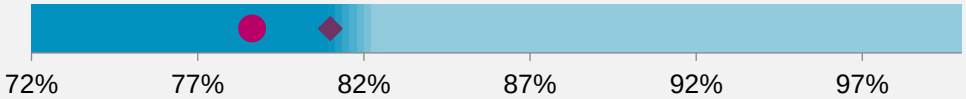
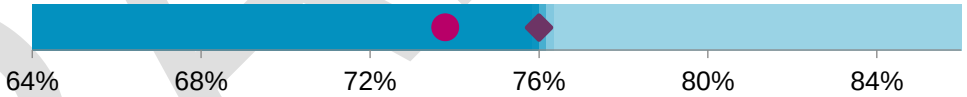
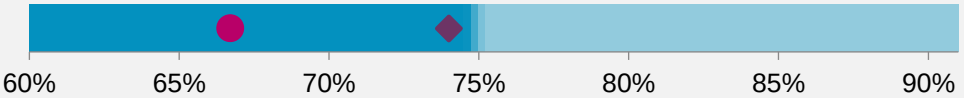
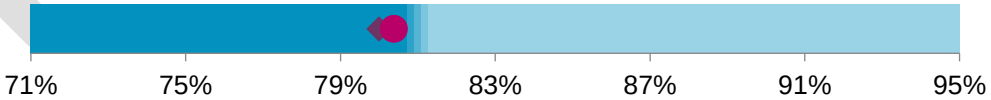
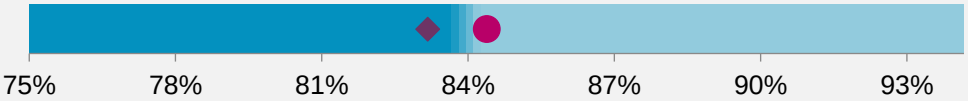
NI-18	Percentage of adults with intensive care needs receiving care at home (Calendar Year)	**62% (2018)**	*62% (2018)*	**N/A**	*N/A*	*N/A*
NI-19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**1,621**	*793*	**1,191 (2019/20)**	*793 (2019/20)*	●
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**24%**	*24%*	**23%**	*23%*	●

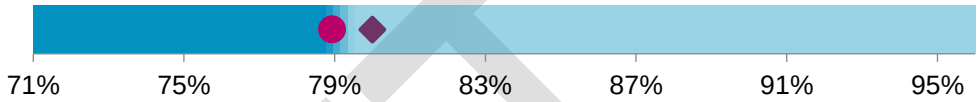
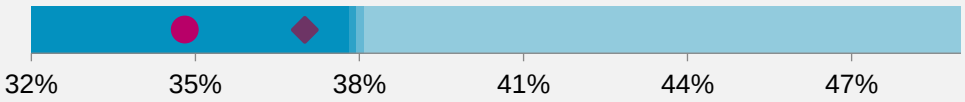
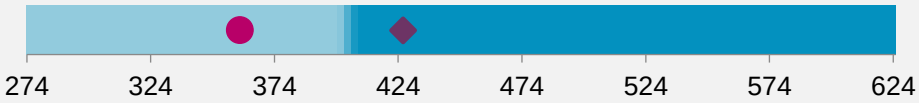
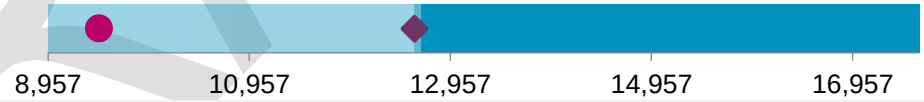
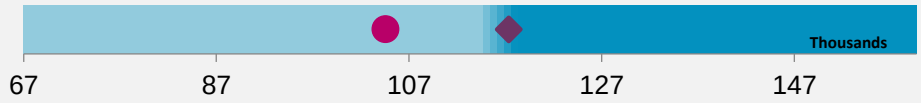
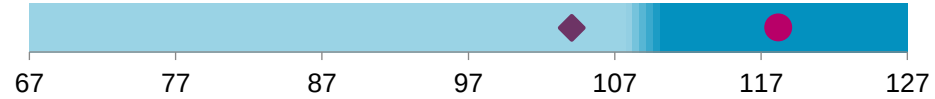
* The most recent reporting period available is calendar year 2019

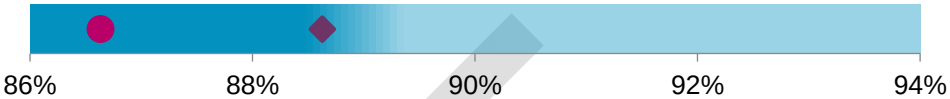
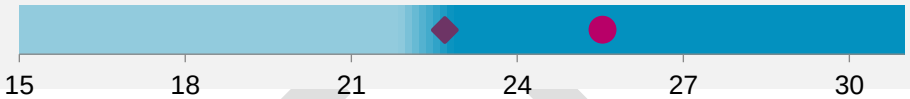
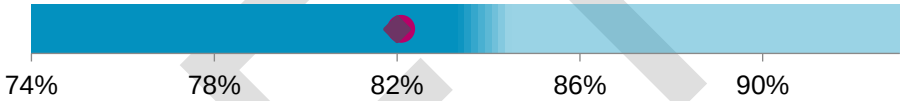
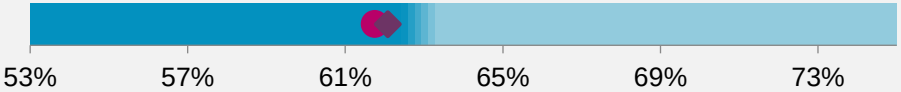
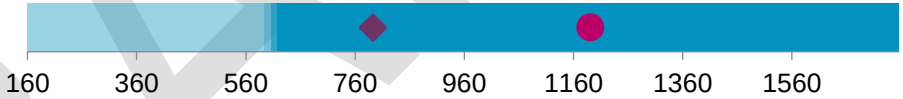
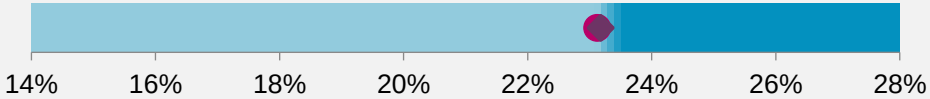
^ RAG Key

● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

Edinburgh's ranking against Scotland

Indicator Number	Indicator Description	Edinburgh City Current Rank (Scotland-wide comparison) Rank	
NI-1	Percentage of adults able to look after their health very well or quite well	16th	
NI-2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	26th	
NI-3	Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	22nd	
NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	28th	
NI-5	Total % of adults receiving any care or support who rated it as excellent or good	19th	
NI-6	Percentage or people with positive experience of the care provided by their GP	15th	

		Rank	Edinburgh ◆Scotland
NI-7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**19th**	
NI-8	Total combined % of carers who feel supported to continue in their caring role	**25th**	
NI-9	Percentage of adults supported at home who agreed they felt safe	**30th**	
NI-11	Premature mortality rate per 100,000 persons	**11th^**	
NI-12	Rate of emergency admissions for adults (per 100,000 population)	**3rd^**	
NI-13	Rate of emergency bed days for adults (per 100,000 population)	**9th^**	
NI-14	Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)	**28th^**	

NI-15	Proportion of last 6 months of life spent at home or in a community setting	**28th**	
NI-16	Falls rate per 1,000 population aged 65+	**26th^**	
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	**22nd**	
NI-18	Percentage of adults with intensive care needs receiving care at home	**20th**	
NI-19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**27th^**	
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**17th^**	

- *Latest data available is used for each indicator: 2017/18 – NI-1 to NI-9; 2018 – NI-18; 2019 – NI-11 to NI-16 and NI-20; 2019/20 for NI-17 and NI-19.*
- *The ranking charts displays a visual of Edinburgh's position relative to the Scottish average. The minimum and maximum value in each chart is a proximate value of the lowest and highest quartile. The gradient of the colour within each bar changes where the value lies.*
- *The light blue colour indicates good performance (equal to or above the middle ranking partnership) and the dark blue colour indicates lower performance below the middle ranking partnership. Some rates show good performance for a higher rate, whilst others show good performance as a lower rate.*
- *^ This symbol indicates where a low rate equates to good performance.*

Locality profiles

Localities working

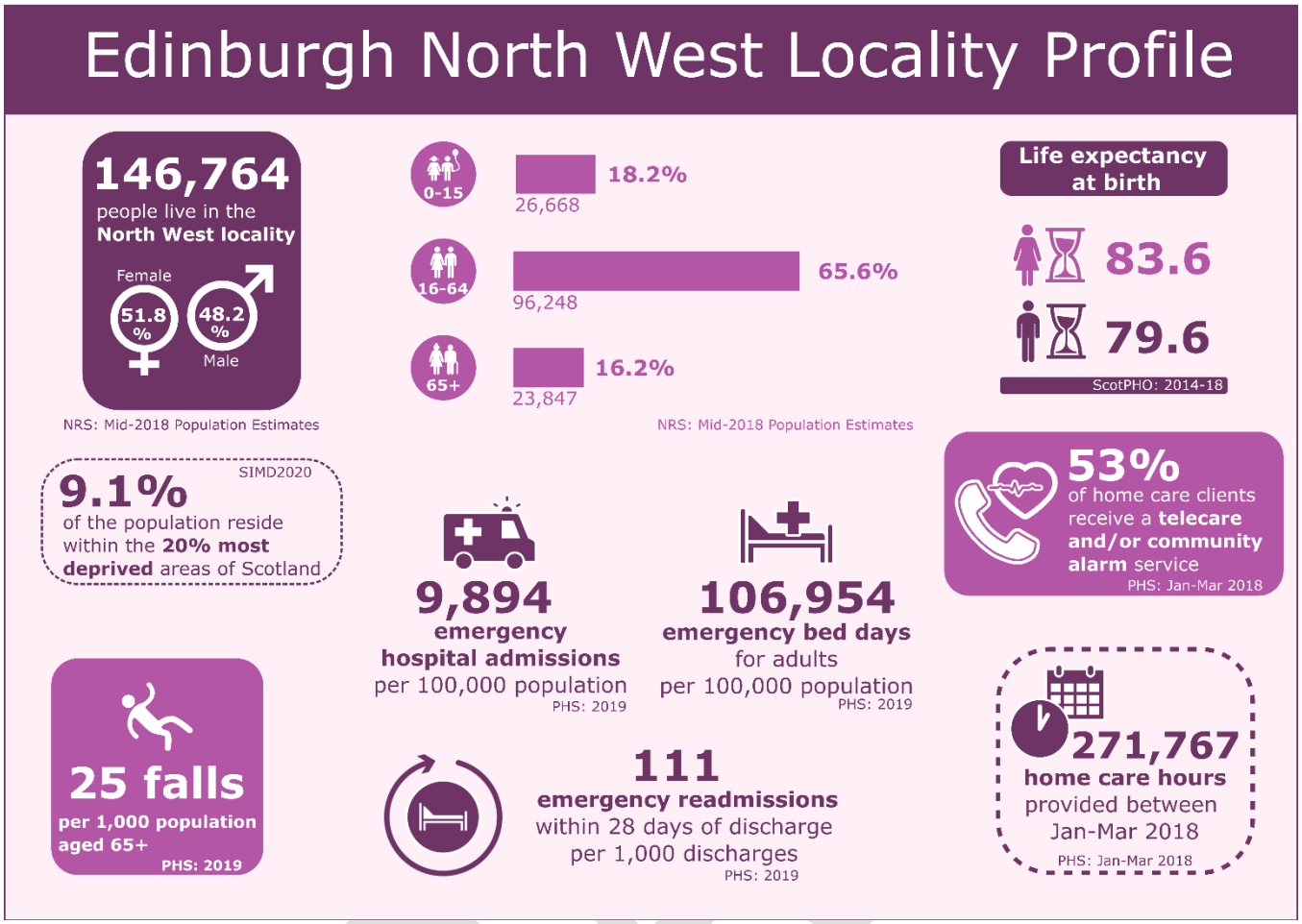
We organise our community health and social care services in Edinburgh around four localities where the management of most community health and social care services, including assessment and care management, home care, day centres for older people and care homes in Edinburgh is carried out. The four localities are grouped under: South East, South West, North East and North West. This allows us to plan and tailor services to the communities we are supporting. Each locality has a hub team that responds to new and urgent work and two cluster care management teams that arrange and review ongoing support. There is also a mental health and substance misuse team in each locality. A number of specialist services are managed on a city-wide basis.

Much has already been done to ensure that key services are organised and delivered locally. There remains more to do to embed the localities approach, to listen and respond effectively to the needs of communities and to ensure that strategic vision drives developments within localities. Key to this will be developing locality operational plans which support and implement the EIJB Strategic Plan. To help in developing this 'golden thread' of strategy, to plans, to implementation, we have established a Partnership Strategy and Operations Planning Forum.

You will see a summary of health and social care data for each locality in our four infographics. There is a lot of variation across, and within, the four localities with areas of high and low deprivation found in each. The North West is the largest locality and has the highest proportion of young people and older people. It also has the highest life expectancy at birth for both females and males. The North East is the locality with the highest proportion of the population living in the most deprived areas of the country and has the lowest rate of emergency bed days (the number of bed days occupied when the patient is admitted as an emergency). The South East has the lowest rate of emergency hospital admissions and the lowest rate of falls for older people is in the South West.

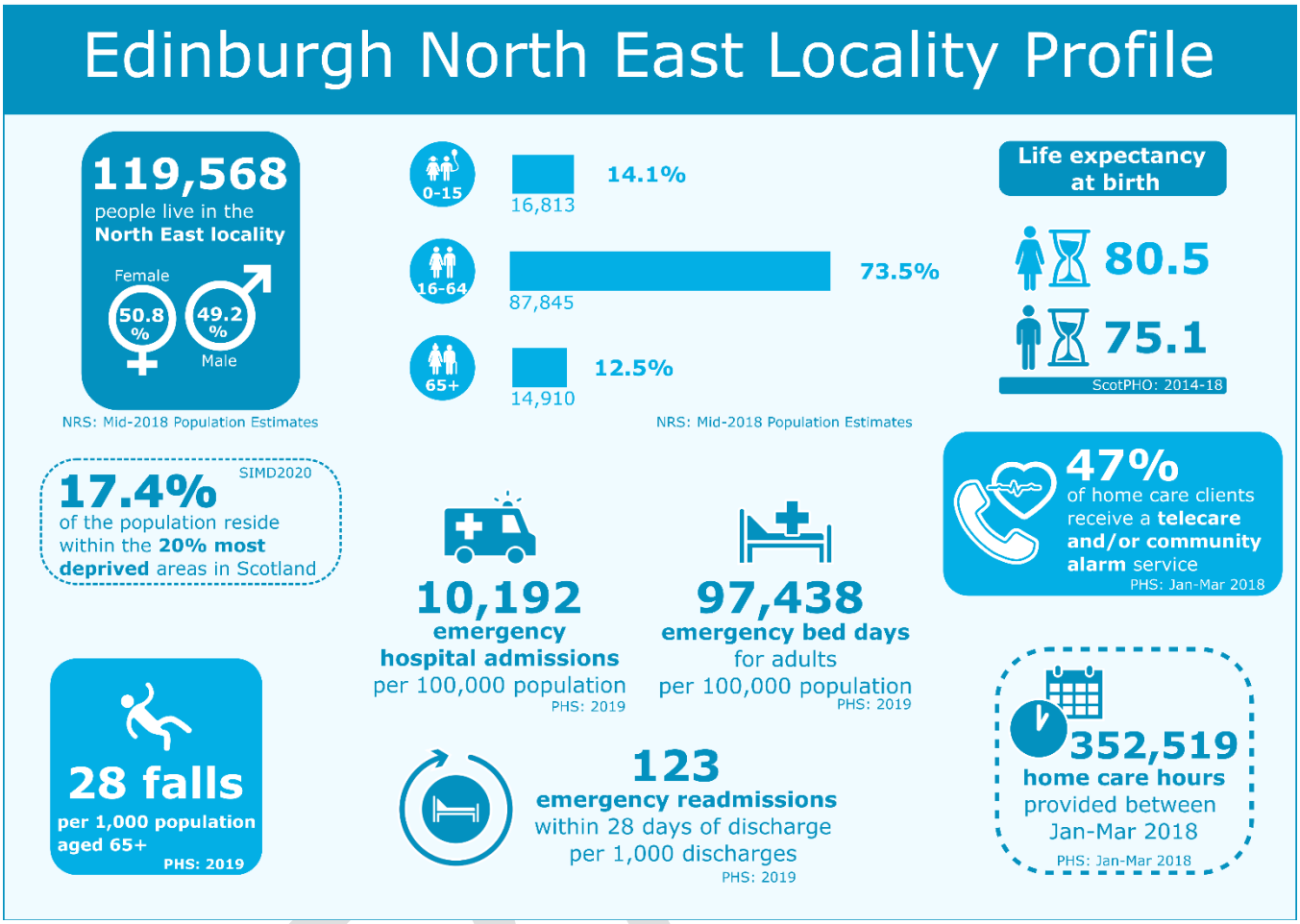
Sources:

- National Records of Scotland, City of Edinburgh Council area profile
- Edinburgh by numbers 2019, the City of Edinburgh Council
- Scottish Index of Multiple Deprivation 2020, Scottish Government
- Edinburgh Poverty Commission



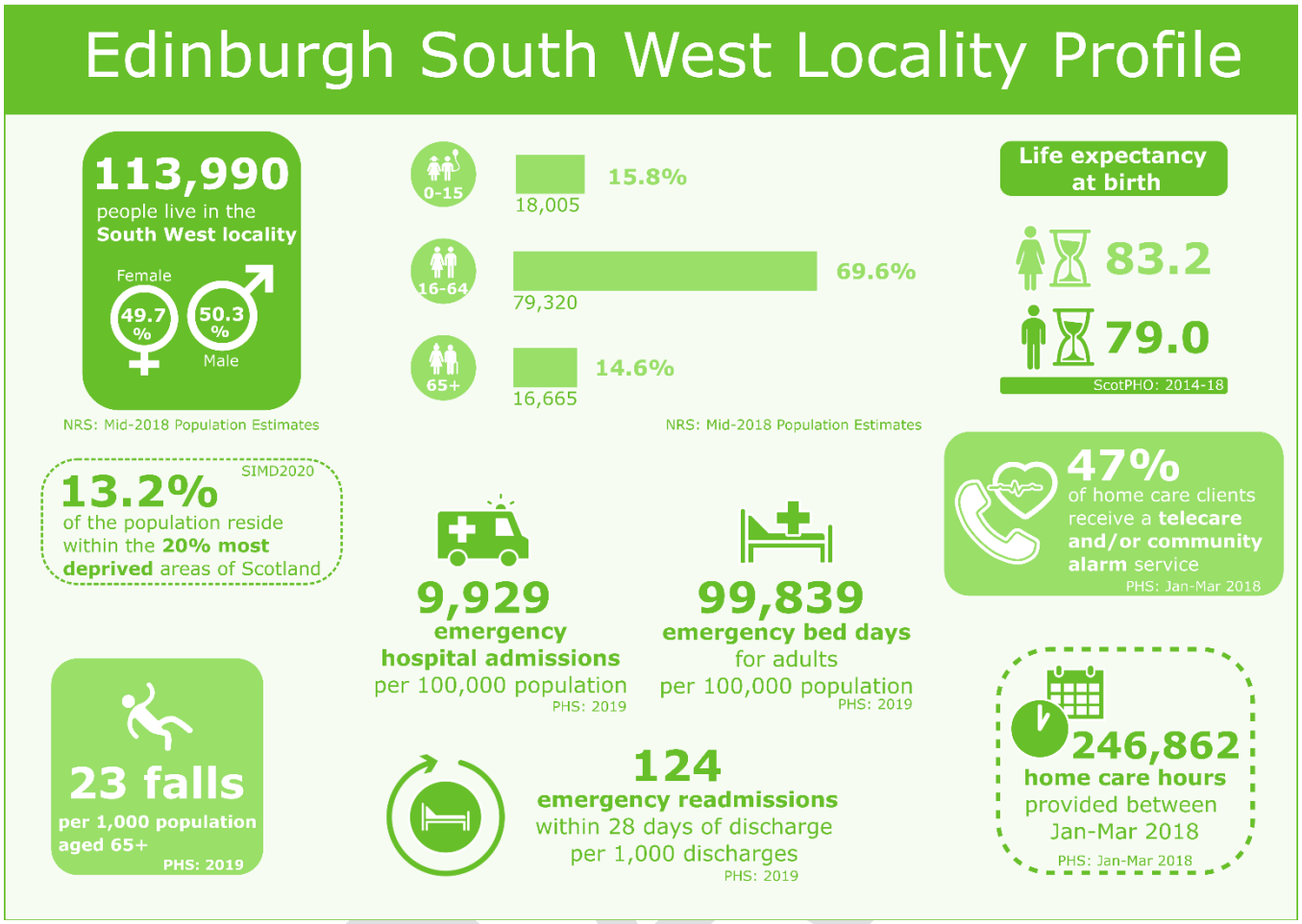
Key demographic information:

- 146,764 people live in the North West locality
- 51.8% are female and 48.2% are male
- 18.2% are aged under 16 and 16.2% are over 65
- 9.1% of the population reside within the 20% most deprived areas of Scotland
- life expectancy at birth is 83.6 years for women and 79.6 for men.



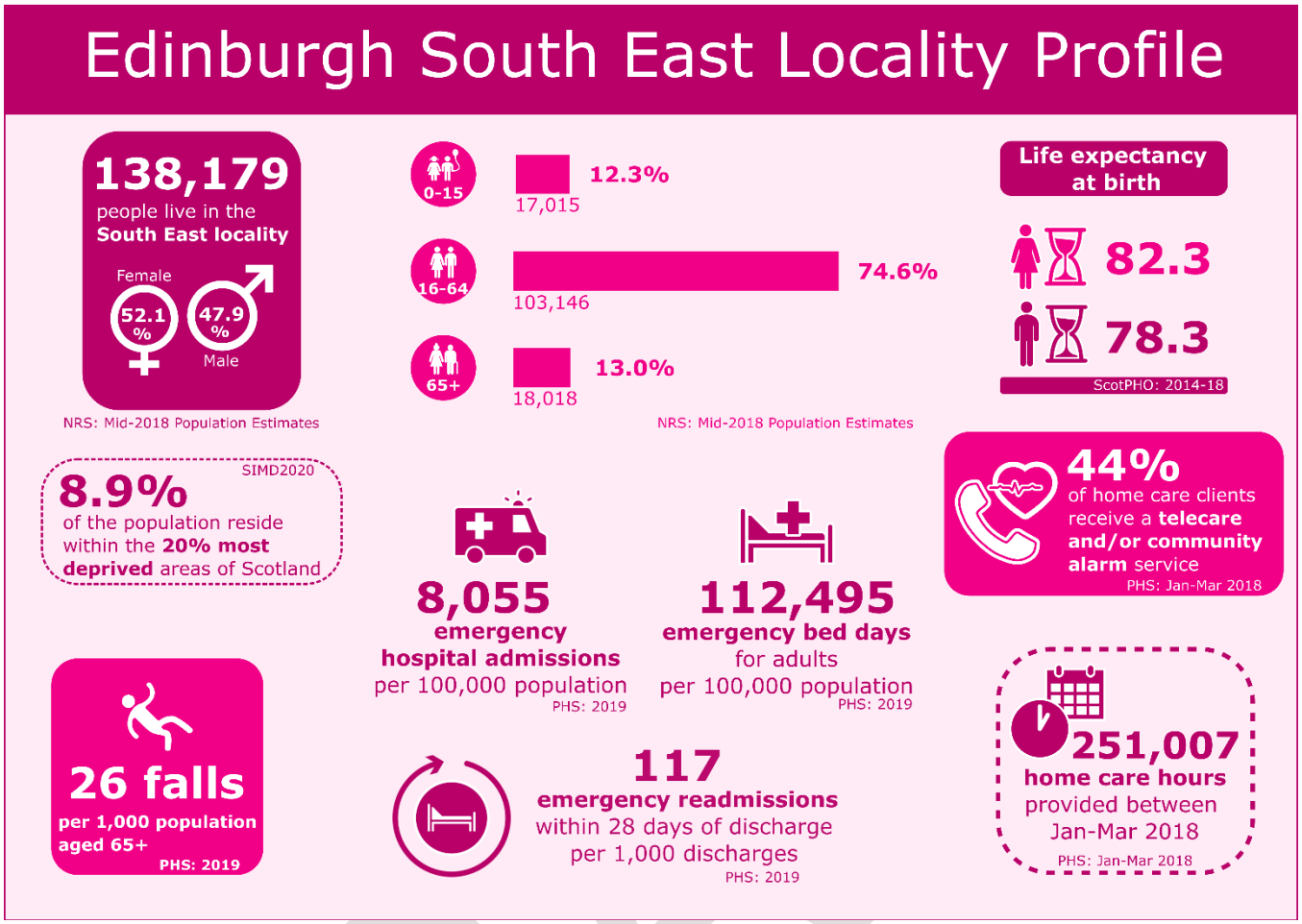
Key demographic information:

- 119,568 people live in the North East locality
- 50.8% are female and 49.2% are male
- 14.1% are aged under 16 and 12.5% are over 65
- 17.4% of the population reside within the 20% most deprived areas of Scotland
- life expectancy at birth is 80.5 years for women and 75.1 for men.



Key demographic information:

- 113,990 people live in the South West locality
- 49.7% are female and 50.3% are male
- 15.8% are aged under 16 and 14.6% are over 65
- 13.2% of the population reside within the 20% most deprived areas of Scotland
- life expectancy at birth is 83.2 years for women and 79.0 for men.



Key demographic information:

- 138,179 people live in the South East locality
- 52.1% are female and 47.9% are male
- 12.3% are aged under 16 and 13.0% are over 65
- 8.9% of the population reside within the 20% most deprived areas of Scotland
- life expectancy at birth is 82. 3 years for women and 78. 3 for men.

Priority 1
Prevention and early intervention

Context

Investing in prevention and early intervention services is a key part of our strategy. By identifying those people most at risk of poor outcomes and providing effective early support we can prevent problems occurring or minimise the impact on individual's health and wellbeing.

The EHSCP funds or directly provides a range of services all designed to support health and wellbeing through prevention or early intervention approaches. Some of these services are highlighted below.

EIJB grants programme

Following extensive co-production, the various EIJB grant processes were combined and redesigned into a single, three-year grant programme to enable better progress towards our strategic aims of preventing poor health and wellbeing and reducing health inequalities.

In year one (2019/20) of the three-year programme, £4.6 million was awarded to 67 projects. The funding helped provide activities and services aligned to the seven funding priorities:

- reducing social isolation
- promoting healthy lifestyles
- improving mental wellbeing
- supported self-management
- information and advice
- reducing digital exclusion
- and building communities.

We have received annual monitoring returns, which included service user surveys and case studies, and these show how the activities have helped support and encourage people to:

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

By both supporting those whose health is at greatest risk from inequality and by tackling the root causes of health inequalities, the projects helped:

- support individuals to maximise their capabilities and have control over their lives; and
- create healthy and sustainable communities that can resist the effects of inequality on health and wellbeing.

We have not yet finalised the comprehensive set of quantitative data we gather through the organisations' annual returns as delays have been inevitable due to the coronavirus pandemic and government restrictions, although we have received case studies. Many of the case studies contained in this report are from projects funded through the EIJB grant programme namely Steady Steps, South Edinburgh Lunch Club, Venture Scotland and Fresh Start.

Case study – Fresh Start

Joanne is in her 40s and lives alone. She had an eating disorder when she initially got involved with Fresh Start in 2017 after receiving information about their services from her occupational therapist. She took part in a Fresh Start cooking course but then her health deteriorated, and she couldn't continue.

Two years later she felt she was well enough to come back to Fresh Start. She had felt positive about the earlier experience even though she could not carry on. In 2019 Joanne completed a four-week cooking class where she worked in a small group with a volunteer learning to cook and then eat together. Joanne then felt confident enough to join in the eight-week Cook Club. The Cook Club uses produce donated from Fareshare, from Fresh Start gardens (in season) and purchased supplies for the group to come together to cook up to six meals. These are then shared out between everyone to take home for the week ahead/store in their freezer. The groups are led by experienced volunteers who create a relaxed, friendly and sociable environment for everyone attending, providing lots of individual support to enable people to participate.

Attending the cooking courses helped Joanne socially and she is now cooking more in her home. She no longer relies on microwave meals and is back to cooking at least part of her meal from scratch which makes her feel better.

Mental health

Thrive Edinburgh is committed to using the knowledge and skills of our communities, whether they are communities of interest or geographical communities, to mobilise change programmes which will promote mental health and wellbeing, address issues such as discrimination, stigma, loneliness and isolation, and make sure that Edinburgh's rich cultural assets are accessible to all.

Some examples of this are:

- GameChanger – our partnership with Hibernian Football Club is delivering lunch clubs, exercise classes, a venue for community groups and a new young person's programme which builds on their hopes and aspirations.
- A Sense of Belonging arts programme - this year-long programme offers numerous opportunities for people to explore the arts either as a participant or as an artist, recognising the important role that the arts have in keeping us connected, stimulated and inspired.
- LGBT Mind Matters programme – a programme of activities to support the mental health and wellbeing of the LGBTQIA communities and to provide training to agencies to ensure our services are inclusive to all.

Prevention of harm

The EHSCP has a responsibility for adult protection and the EIJB's Chief Officer sits on the multi-agency Chief Officers Group for Public Protection that is responsible for all areas of public protection across Edinburgh.

Between April 2019 and March 2020, there was a total of 1,954 adult protection contacts city-wide and 429 case conferences (both initial and review) were held.

Long-term conditions programme

As people get older, they develop more long-term conditions and their use of health and social care services increases. People with long-term conditions are twice as likely to be admitted to hospital, stay in hospital for a longer period, accounting for over 60% of hospital bed days.

The long-term conditions programme supports health and social care teams to improve care for people living with long-term health conditions and those who are at risk of falls. Our vision is for care and support for people with long-term conditions to be improved by:

- seeing the whole person rather than each individual condition

- engaging the whole team involved in the person's care, including third sector partners
- improving the way that care and support is planned across the whole system.

Our approach is in line with the national Health & Social Care Delivery Plan with delivery areas focusing on prevention and early intervention, anticipation and self-management.

Edinburgh's community respiratory hub supports people living with chronic obstructive pulmonary disease (COPD) who are at high risk of hospital admission. The percentage of people of living with COPD in Edinburgh has increased from 1.41% in 2014 to 1.68% in 2019 (rate per 100 patients). In December 2019 there was estimated to be 9,442 people living in Edinburgh with COPD. During the last year, the community respiratory team assessed 704 people with COPD, who were at immediate high risk of hospital admission because of an acute exacerbation of their COPD. Following assessment, the Community Respiratory Team supported 90% (634) of these people to be safely cared for at home, avoiding hospital admission.

By adopting a collaborative, partnership approach with the third sector, EHSCP is improving support for people to self-manage their conditions by building connections and support within local communities. Utilising digital health and care to support self-management is an important part of the approach. During 2019/20, EHSCP has scaled-up its home and mobile health monitoring resulting in 2,500 people from 50 GP practices being better able to self-manage their health conditions. Feedback from both GPs and patients has been positive. Four GP practices have introduced digital pods within their surgeries to enable patients to provide health information (for example, blood pressure, weight, smoking status) before their consultation.

Physical activity has been shown to help with the management of symptoms associated with many long-term conditions and improve quality of life. Working in partnership with Edinburgh Leisure, the 'Fit for Health' physical activity programme supports people living with long-term conditions to be more active. Between April 2019 and March 2020, 1,219 people were referred to Fit for Health with approximately 74% of those referred due to complete the full 16-week programme (the programme was disrupted because of the impact of COVID-19 restrictions).

National statistics show that falls are a common and serious health issue for older people, with around a third of all people aged 65 and over falling each year, increasing to half of those aged 80 and over. In around 5% of cases a fall leads to fracture and hospitalisation.

By proactively identifying people at risk of falls and fractures at an early stage and ensuring they access the right support at the right time, EHSCP aims to reduce the number of falls-related hospital attendances. Specialised staff support those at risk by carrying out home-based assessment leading to an individual falls plan. In addition, during 2019/20, over 200 staff from EHSCP and the third sector have attended a targeted falls prevention training

programme. The numbers of people attending A&E for a falls-related reason has reduced from an average of 380 people per month in 2018/19 to 360 people per month in 2019/20.

Care home residents are three times more likely to fall than older people living in the community, and ten times more likely to sustain an injury. In 2019, care home residents comprised 20% of the trauma orthopaedic hospital admissions despite only 4.6% of over 65s living in a care home. We put in place targeted support for care home staff to improve their knowledge of falls prevention and management, with the aim of reducing falls-related A&E attendances and unplanned hospital admissions. By October 2019, the first four care homes completed their training programme. For these care homes, falls-related A&E attendances reduced by 62% and falls-related unplanned admissions reduced 70% compared to the pre-intervention period.

Care home residents who use walking aids are known to be at an even greater falls risk. During winter 2019, seven care homes took part in a short improvement programme where 164 walking aids were assessed by trained physiotherapy assistants to check for safety. 11% were repaired and 15% were replaced.

Case study – Steady Steps

Bett, who is in her 90s, was referred to Steady Steps after she had a bad fall which resulted in a stay in hospital. Prior to attending Steady Steps, Bett struggled to walk and this impacted on her day-to-day life. She couldn't do very much around the house and leaving the house to go to the shops or run errands was impossible. She described herself as 'housebound' and felt isolated as a result.

When her physiotherapist suggested a referral to Steady Steps, Bett wasn't sure what to expect but was willing to give anything a go. On arriving at her first class Bett felt reassured as the instructor took time to talk to her about everything that was going to happen and suggest alternatives to the exercises Bett couldn't do.

Bett is now able to walk more easily and has regained her independence. Prior to COVID-19, she was able to get buses and do all her own shopping. The friends she has made through attending the classes have been as important as the physical gains.

Anticipatory care planning (ACP) is a person-centred, proactive, 'thinking ahead' approach, with services and health and care professionals working with individuals, carers and their families to make informed choices about their care and support. During the last year we have provided ACP improvement support to 66 teams across health and social care, and the third sector. Practitioners engage people they support in ACP conversations, helping people to understand what living with long-term conditions means for them now and how care and treatment options may change or fluctuate in the future. People's wishes, preferences and decisions about their care and treatment are shared with professionals through ACP key

information summaries. This ensures people have greater choice and control over their care and treatment should their condition deteriorate.

During 2019/20:

- 19,532 ACP key information summaries were created – an increase of 53% since the end of March 2019
- 37 ACP training sessions were delivered to 157 staff
- Edinburgh care homes and GP practices were supported to create or update ACP information to detail COVID-19 care and treatment options and preferences.

Our performance

The national health and wellbeing performance outcomes linked to this priority are:

- People are able to look after and improve their own health and wellbeing and live in good health for longer (HWB-1).
- Health and social care services are centred on helping to maintain or improve quality of life (HWB-4).

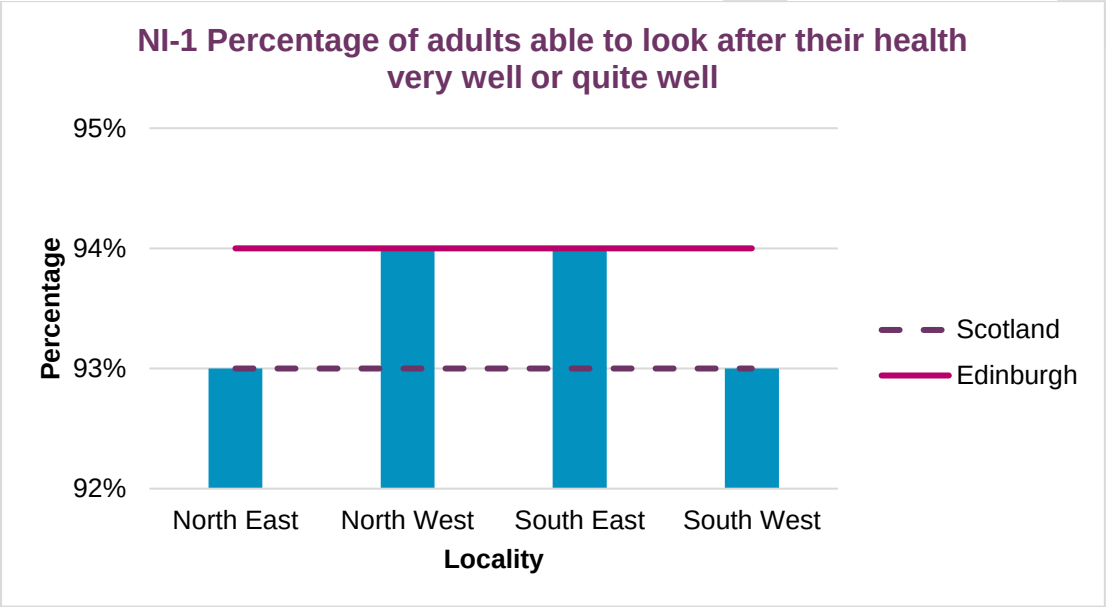
National Indicator (NI)		**Edinburgh 2018/19**	**Edinburgh 2019**	**Difference**	**Performance**
NI-1	Percentage of adults able to look after their health very well or quite well	No Health and Care Experience survey data is available for 2018/19, as the survey is conducted on a bi-annual basis. The publication of the 2019/20 survey was delayed by the Scottish Government due to the COVID-19 pandemic.			
NI-12	Rate of emergency admissions for adults (per 100,000)	8,558	9,464	+906	●
NI-16	Falls rate per 1,000 population aged 65+	21.9	25.5	+3.6	●

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

NI-1 Percentage of adults able to look after their health very well or quite well

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

	2017/18
Scotland	93%
Edinburgh	94%
North East	93%
North West	94%
South East	94%
South West	93%



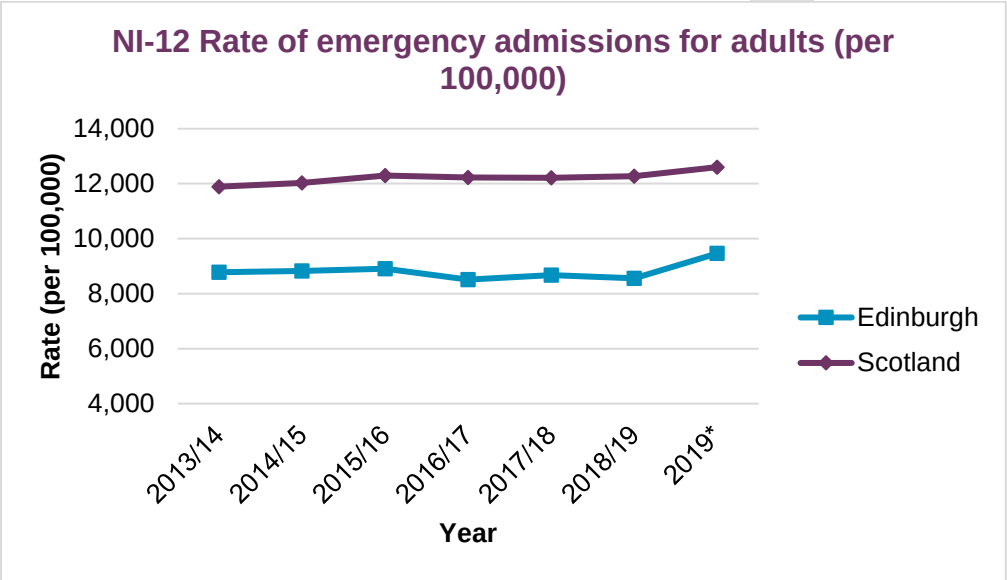
Source: Scottish Government HACE survey 2017/18

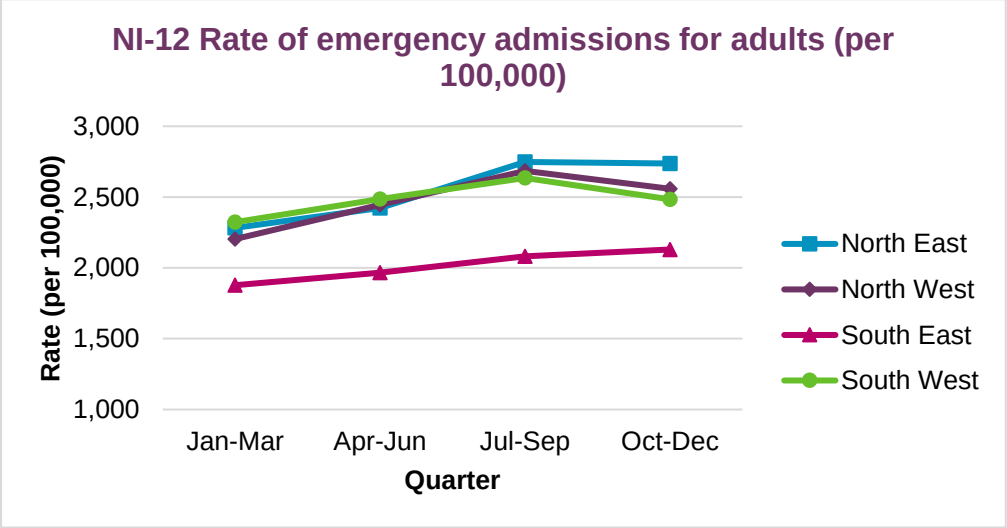
Based on the 2017/18 HACE survey, 94% of respondents stated that that they were able to look after their health very well or quite well which is very encouraging. This is higher than the Scottish average of 93%. There is a small amount of variation between the localities with North East and South West both responding with 94%, and North East and South West localities reporting only 1% less.

NI-12 Rate of emergency admissions for adults (per 100,000)

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	8,775	8,832	8,914	8,512	8,670	8,558	9,464
Scotland	11,892	12,026	12,295	12,229	12,210	12,275	12,602

	2019			
	Jan-Mar	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**
North East	2,283	2,423	2,748	2,738
North West	2,204	2,446	2,685	2,559
South East	1,878	1,966	2,081	2,130
South West	2,323	2,486	2,635	2,485





Source: Public Health Scotland

The rate of emergency admissions had been fluctuating between 8,000 and 9,000 from 2013/14 until 2018/19. The rate had started to reduce in 2015/16 but increased to 9,464 in 2019.

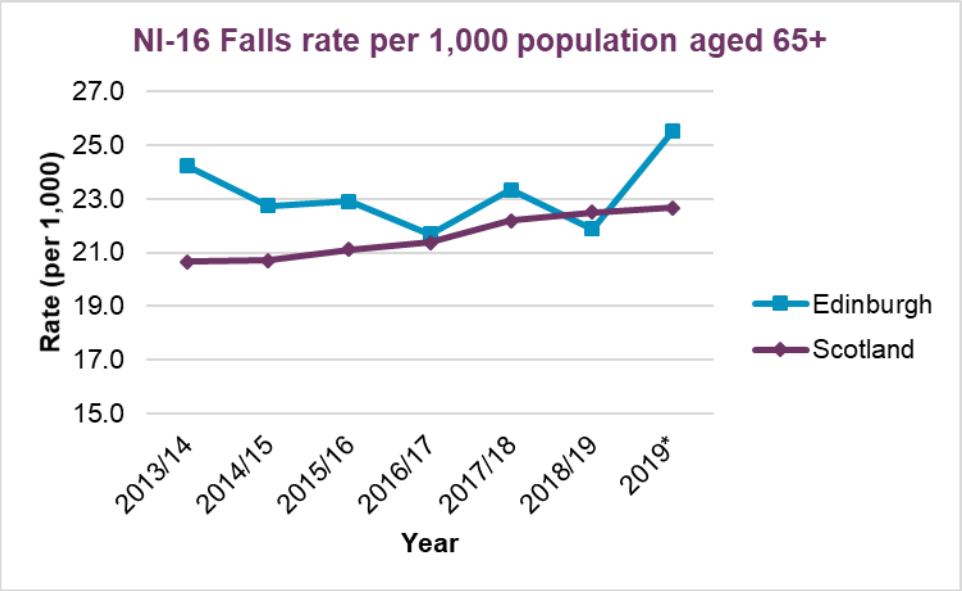
The increase in the emergency admission rate is due to a service change at the A&E at the Royal Infirmary Edinburgh in April 2019. Patients who are waiting on test results are admitted as an emergency inpatient to the Acute Assessment Unit. A large majority of these patients are discharged home on the same day as arrival, with a small number being admitted into a downstream acute ward. This change has artificially increased the number of emergency admissions.

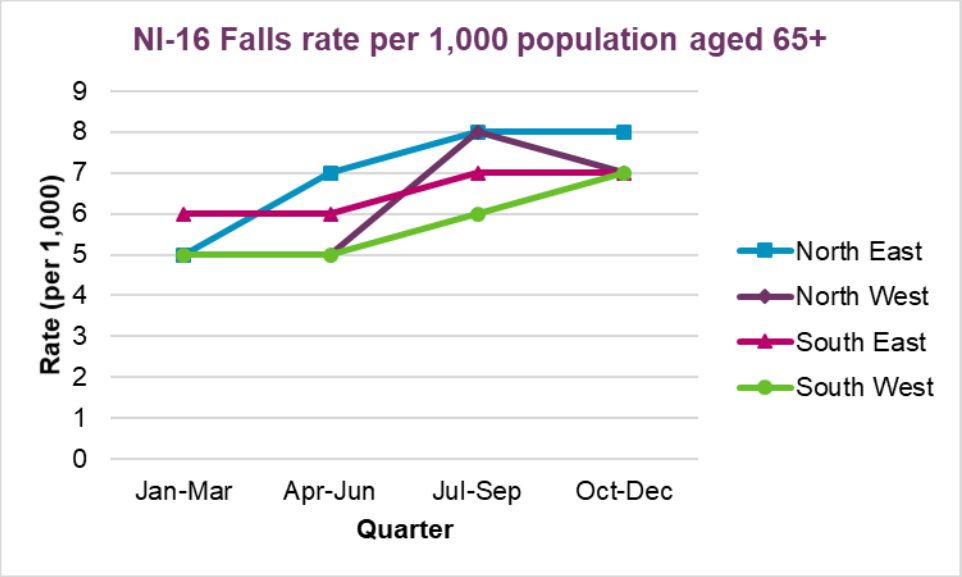
When breaking the figures down by locality, South East has the lowest rate of emergency admissions which is due to a younger population living within the locality.

NI-16 Falls rate per 1,000 population in over 65s

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	24.2	22.7	22.9	21.7	23.4	21.9	25.5
Scotland	20.7	20.7	21.1	21.4	22.2	22.5	22.7

	2019			
	Jan-Mar	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**
North East	5	7	8	8
North West	5	5	8	7
South East	6	6	7	7
South West	5	5	6	7





Source: Public Health Scotland

The long-term trend for the falls rate was steadily decreasing from 24 falls in 2013/14, to 22 falls in 2018/19. However, in 2019 the rate has increased to 25.5 which is higher than the Scottish rate of 22.7 falls per 1,000 people aged 65 and over.

Priority 2
Tackling inequalities

Context

The Edinburgh Poverty Commission was set up in 2019 to explore the extent and nature of poverty in Edinburgh. The Commission has found that poverty is not a marginal issue in the Edinburgh. Rather it affects a sizeable proportion of the population (some 80,000 people) and with much evidence to suggest its scale and impacts are growing larger over time. The emerging picture is one in which the majority of people in poverty in Edinburgh are of working age, probably in employment, probably living in rental accommodation in a family with children and do not always live in those areas traditionally considered as 'poor' or 'deprived'. You can find more information about the Poverty Commission on their website.

Edinburgh Poverty Commission

The EIJB is a member of the Edinburgh Partnership, the body responsible for community planning in the city. The Partnership's vision is that 'Edinburgh is a thriving, connected, inspired and fair city, where all forms of poverty and inequality are reduced' and the Community Plan sets out the priorities for delivering this vision. The plan focuses on prevention and early intervention, recognising the role of social disadvantage and poverty in creating inequalities for individuals and communities in the city, and identifies three priorities:

- to ensure that citizens have enough money to live on
- have access to work, learning and training opportunities
- and have access to an affordable, well designed, safe and inclusive place to live.

The EIJB has a key role to play in addressing inequality, in particular, health inequalities. Some of the workstreams we have to reduce inequalities are outlined below.

EIJB grant programme

As noted earlier, a key focus for the EIJB grant programme is supporting those whose health is at greatest risk from inequality. Funded projects include:

- Health All Round which covers South West and central Edinburgh
- the Health Agency which works mostly in Wester Hailes
- South Edinburgh Healthy Lifestyles run by the Edinburgh & Lothians Greenspace Trust
- the Ripple Project working in the North East locality

- Be Healthy Together, a community-led project in south west Edinburgh
- LGBT Health and Wellbeing Centre which works Edinburgh-wide.

Case Study – Venture Scotland

John had been living a chaotic lifestyle with very little structure before he came to Venture Scotland (VS). He was trying to deal both with his own issues and family problems and felt trapped. John ended up spending his time drinking so he didn't have to think about his problems or how to change anything in his life.

John was angry, depressed, isolated and felt 'broken'. Eventually he reached crisis point and tried to kill himself. He ended up in hospital and went through various mental health programmes before being introduced to Venture Scotland by his link worker.

The structured programme has four different group stages: challenge, discover, explore and leadership. All parts of the programme offer opportunities to take part in outdoor activities such as rock climbing and coasteering as well as group wilderness residentials.

The discover element introduced learning about mental health and involved a five-day stay at the VS bothy (an old shepherd's cottage in Glen Etive in the Scottish Highlands). John found 'discover' much more intense than the first trip as it meant confronting more serious issues in some sessions and sharing things about himself with the group. After taking part in 'discover' John realised that he needed to apply what he was learning at VS to his life, rather than just turning up to distract himself from his life and then expecting things to change by magic. In the final stage of the course 'leadership', the group has a lot more independence and input, planning two expeditions. Group members learned new skills including first aid and navigation.

At the end of the programme, John said 'Aside from the various activities, Venture Scotland has helped me get from some of the absolute worst pits of despair that I have ever been in, to feeling like I'm a person again, like I'm an actual member of society.'

Income maximisation services

Income maximisation services are funded as part of the EIJB's current grants programme alongside funding from partner agencies. We established an income maximisation consortium in March 2019 to lead on the development of modern, flexible, fit-for-purpose services across the city. The new model which has been developed through collaboration with the advice service providers, delivers a more targeted approach to improve access to income maximisation for the most vulnerable clients. This approach is guided by Scottish Government recommendations within the report A Review of Publicly Funded Advice Services in Scotland published in February 2018. The new service has been designed to be flexible and better able

to respond to changing patterns of need and is underpinned by the principles of co-location of services in other settings, collaboration and co-operation between providers and a focus on quality standards.

Income maximisation services include:

- checking entitlement to benefits and other sources of income
- helping with benefit claims and appeals
- carrying out 'better off' calculations
- help with managing problem levels of debt.

The new model makes provision for:

- welfare advice in GP practices delivered by 8 whole time equivalent (WTE) advice workers, offering 4,160 appointments a year with an estimated patient income gain £2 million a year
- welfare advice in drug and alcohol recovery Hubs – 2 WTE advice workers in four locality hubs, with 720 appointments and an estimated client gain £450,000 a year
- welfare advice in mental health hubs/Thrive centres – 2 WTE advice workers in four locality hubs, delivering 720 appointments reaching 300 individuals, estimated client gain £450,000 a year
- Locality-based provision – 13. 5 WTE advice workers, reaching 3,510 individuals per year, with an estimated client gain of £3.4 million a year.

Case study – advice workers in health settings

Julie is a 27 year old single parent, living in temporary supported accommodation following incidents of domestic violence. She suffers from post-traumatic stress, agoraphobia, anxiety and depression. She attended the service along with her support worker to get advice in relation to her PIP application.

Because of her mental health issues, Julie found the interview itself very challenging and she needed additional measures to be taken to make sure that the environment was safe and accessible for her to engage in the session. The adviser was sensitive to her needs and took time to understand how best to engage with her and the role the support worker could provide. Julie had been in receipt of DLA for many years. As well as providing income to support her care needs, this also included a mobility component for a bus pass, which is essential in supporting Julie to feel safe when travelling. Despite her long-standing and evidenced disabilities, Julie was turned down in transition to PIP and so was supported to complete an application for a mandatory reconsideration.

The impact of this decision has been significant for Julie and added to her levels of distress and anxiety. This also placed Julie and her child in financial hardship. As a result of the accessibility of our services and the breadth of knowledge and

expertise of the adviser Julie received the time, support and negotiation she needed to deal with these issues and successfully appeal the decision.

GP link workers

The community link workers (CLWs) programme was set up to address the finding that 5% of patients use 20% of GP resources. Additionally, approximately 45% of primary care support requests are classed as non-clinical in nature.

Community link workers are best defined as generalist social practitioners based in GP practices, serving the local community using a patient-centred model of care. They are not support workers or sign-posters but work with people to help them make informed choices about the services they use.

Link workers cover three main areas:

- as part of the national programme focusing on health inequalities, 13.5 WTE CLWs work across 21 practices serving an overall estimated patient population of 147,000 of which 46,000 are from the most deprived communities
- There is a specific 'test of change' focusing on older people, in particular those who are frail, have dementia or are experiencing social isolation, with 3.5 WTE CLWs deployed across nine practices
- a second 'test of change' focuses on issues of mental health, chronic pain and social isolation within the mainstream population. This covers three practices and employs 2 WTE CLWs.

Initial evaluation data from the project has shown:

- there were approximately 8,000 booked appointments across all CLW services. 'Did not attend' rates were 2% for the specific older people's service but much higher for those experiencing general health inequalities (around 20%)
- a broad range of issues including mental health, trauma and abuse, social isolation, housing, family and caring concerns, welfare and employability
- indications of improved mental wellbeing amongst service users over the period interacting with their CLW (measured using the short Warwick Edinburgh Mental Wellbeing Scale)
- indications of a decrease in some GP consultation and/or a more clinically-focussed consultation with the GP or nurse

A more in-depth evaluation of impact is currently underway. Next steps already identified include building referrals to the service and exploring and addressing the reasons for non-attendance.

“We have had a link worker at the practice for some time now and we are extremely happy with the service - they act as a link between the practice and the wider community. Most importantly, they help support our patients with complex social problems and mental health issues, thus freeing up GP time. They also provide us with up-to-date information about activities and events in the area.”

Edinburgh GP

Case study - GP link worker

I received a referral from a practice receptionist for Halima, a 34 year old Sudanese woman. Halima had arrived in Edinburgh only a month before and had mentioned in her practice registration form that she had already begun to feel isolated. Knowing the health effects that isolation and loneliness can have the receptionist quickly referred Halima on to me, the community link worker.

When I met with Halima, she told me she had not left her new home since arriving a month earlier, with her baby son. She was very keen to improve her English and meet new people and hoped this in turn would help her to become more independent.

I talked through a range of options available to her locally and she was keen to get involved. Halima did not feel confident enough to use the bus on her own, so I accompanied her on the bus, explained bus numbers, routes, costs, timings etc and we went along together to register for an English class. After being on the bus together Halima felt confident enough to start using the bus service on her own.

Halima was keen to meet other mums and for her son to have the opportunity to play with other young children. I accompanied Halima along to a local mother and toddlers’ group to meet the group leaders. Halima told me she felt she wouldn't have attended if she hadn't met the group leaders first and visited the venue but felt happy to start attending the groups the following week herself.

Halima is now regularly attending English classes and has established a small local friendship group through attending the mother and toddler group. She feels her confidence has grown and that she has become more independent. Her hopes for the future are to find employment and learn to drive.

Inclusive Edinburgh

The average age of death for people experiencing rough sleeping is 43 compared to 77 for the general population. People rough sleeping are 17 times more likely to experience a violent attack, and nine times more likely to commit suicide (Inclusive Edinburgh EIJB report, June 2019). Homeless people experience some of the worst health outcomes and tend to be amongst the highest users of urgent and emergency care, with four times the usage of hospital services and eight times the cost of inpatient services compared to the general population.

The Inclusive Edinburgh Board, (made up of members from health, social work, police, housing, third sector and the university sector) is contributing to reducing inequalities and improving the health and wellbeing of homeless people through inter-agency collaboration.

A specific priority has been delivering more integration between the Edinburgh Access Practice (primary care) and The Access Point (housing and social work) to provide wrap-around care and support that considers the person's physical, mental health, housing, and social care needs. Third sector partners work alongside statutory services in delivering this support. The model is focused on keeping the ambitions and support needs of the person at the centre within a single point of access. Work is well underway to relocate this integrated service at new premises within the Cowgate area of the city.

Alcohol and drug misuse services

The EIJB has delegated authority for adult social work and community health services including adult alcohol and drug services, and some hospital-based services including those relating to an addiction. Two voting members of the EIJB currently sit on the Edinburgh Alcohol and Drugs Partnership which has responsibility for all elements of drug and alcohol strategy as within the national strategy 'Rights, Respect and Responsibility'.

During 2019/20 the EIJB agreed to support the aims of the national strategy and improve health by preventing and reducing alcohol and drug use, harm and related deaths, through the delivery of services outlined in investment plans for 'Seek, Keep and Treat' (SKT) funding (EIJB report, June 2019 and EIJB report, December 2019).

As of March 2020, implementation of the SKT investment plans has delivered:

- employment of nurses, healthcare assistants, data analysts, and voluntary sector staff to carry out assertive outreach and rapid access prescribing for those identified as being at the highest risk of drug-related death
- increasing senior clinical staffing to respond to those with the most complex needs.

Our performance

The national health and wellbeing performance outcome linked to this priority is:

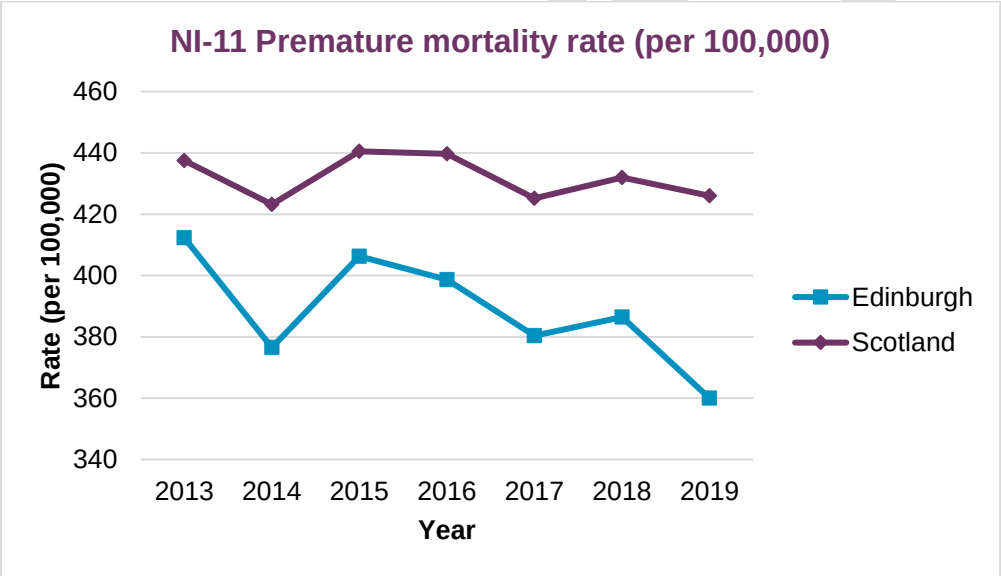
- Health and Social Care services contribute to reducing health inequalities (HWB-5).

National Indicator (NI)		Edinburgh 2018	Edinburgh 2019	Difference	Performance
NI-11	Premature mortality rate (per 100,000)	386	360	-26	●

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

NI-11 Premature mortality rate (per 100,000)

	2013	2014	2015	2016	2017	2018	2019
Edinburgh	412	377	406	399	380	386	360
Scotland	438	423	441	440	425	432	426



Source: Public Health Scotland

Edinburgh's premature mortality rate continues to show positive progress and has remained consistently below the Scottish average since 2013. In 2019, the premature mortality rate reduced to its lowest level of 360 deaths per 100,000 population aged 75 and over. The Scottish average in 2019 also decreased from 432 deaths in 2018 to 426.

Priority 3
Person-centred care

Context

Being person-centred is about focusing care on the needs of the person rather than the needs of the service and working with people to develop appropriate solutions, rather than making decisions for them. Key to this is viewing people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs and by putting people and their families at the heart of decision-making to achieve positive outcomes.

Developing the Three Conversations approach is a significant part of Edinburgh's approach to person-centred care and this is described more fully under the 'Overview' section. Our efforts to shift the balance of care and address delayed discharge are outlined under 'Priority 6 – Right care, right place, right time. '

There are, however, other examples of how the EHSCP delivers person-centred care and these are described more fully below.

Locality working

Local health and social care responsibilities are mainly managed through our four localities: North East, North West, South East and South West. This fulfils the legislative requirement to work at locality level and enables EHSCP to shape services to be more responsive to the different characteristics and needs of our distinct Edinburgh communities which benefits residents.

The four localities provide a front-door access point for health and social care services, and act as the co-ordination point for long-term support. The Three Conversations methodology underpins the locality approach and ensures person-centred planning and care.

Each locality is based around a hub and cluster model. The hub is an integrated, responsive and proactive team that offers short term input to prevent unnecessary admission and promote independence. Hubs work closely with hospital sites to deliver a Home First approach,

supporting people to return to home or a homely setting at the time that is right for them. Staff and teams included within the hub are social work, occupational therapy, physiotherapy and reablement. Hub staff work closely with people to identify what their needs are and liaise with a range of community supports across the NHS, local authority, third sector and community to meet their needs.

Clusters support people who need ongoing care, including those with ongoing clinical and/or care home needs. Each cluster offers a range of services: care homes, social work, occupational therapy, community nursing (including district nursing, community learning disability and older people's mental health) and home care and support. There are also designated clinical leads for general practice within each locality. Again, these integrated teams also work closely with community supports across the NHS, the City of Edinburgh Council, third sector and community to ensure people's needs are met.

Disability services

Providing person-centred services that promote independence for people with disabilities is key to our vision. The EHSCP provides a range of services for people with physical disabilities, learning disabilities and autism. These include: providing care and support to enable people to live at home with their families, enabling people to live independently by providing housing with support, local area co-ordination, and short breaks services. You can find more information on our approach to disability services within the EIJB's Strategic Plan.

Case Study - Firrhill short breaks service

Firrhill short breaks service offers residential respite care for up to eight adults with a learning disability and some physical disabilities. The periods of respite are negotiated and agreed in advance with people and their families/carers.

People are encouraged to make personal choices, establish relationships, and maintain independent living skills (or develop new skills if appropriate) during their short break. Key is understanding that people will have different preferences: some like to come and relax, whilst others like their stay to be active and full of fun. Some people choose to have a complete break, whilst others wish to continue with their daily routine, for example by attending day services.

The Care Inspectorate conducted an unannounced inspection in February 2020 and the service received two 'excellent' grades (grade 6) for the quality of care and support and quality of staffing, while the quality of management and leadership was classed as 'very good' (grade 5).

You can download the full report from the Care Inspectorate's website.

Older people's services

The EHSCP delivers and commissions a wide range of services for older people. These include support at home, technology-enabled care, providing adaptions and equipment, community-based services (for example day services and lunch clubs), and early intervention and prevention activities (for example exercise programmes and falls prevention).

Responding to the Older People's Services Joint Inspection (May 2017) and Progress review (June 2018) continued in 2019/20. We developed a revised improvement action plan including the Three Conversations approach, and progress was reported to the EIJB in December 2019 (Update on Progress – Older People Joint Improvement Plan). The monitoring report that went with the report showed the majority of recommendations and associated actions had been either achieved or were on track to be delivered within agreed timescales. We identified issues in two specific areas – developing workforce strategy and supporting a sustainable volunteer model – which has meant that progress has been limited. You will find more detail about how the EHSCP is addressing workforce issues n the next section of this performance report – making best use of our resources.

Case study – South Edinburgh lunch club

Stephen lives by himself and was struggling with loneliness and isolation. Stephen's social worker referred him to the South Edinburgh lunch club.

The lunch club put things in place to enable Stephen to attend. At the start staff gave him a welfare call on the days he was attending to make sure he was up and ready for the transport to the club. They also paired Stephen with other people who had similar interests so that he felt welcome and included.

It took Stephen a while to integrate into the group. However, he spoke more each week, then started to take on more of a leadership role. He started helping a volunteer with activities and became a mentor for new members coming into the service. Stephen also started taking part in the exercise activities, despite his initial reluctance, as staff gave him a lot of encouragement and took it at his pace.

Stephen's personal outcomes were to get into more of a routine and to find ways to manage his anxiety. As a result of attending the club, Stephen has been able to introduce routines at home to help him better manage his medication and meal planning. He also is coping better with his anxiety.

Around 8,000 people are living with dementia in Edinburgh. This includes just under 300 people under the age of 65 years. During 2019, 119 people with a dementia diagnosis were reported missing (3.5% of all missing people). Only 12 of the missing people returned to their

current home address independently, the others were located elsewhere mostly having been traced by the police.

The Herbert Protocol was launched in Edinburgh during April 2019 as a joint initiative between EHSCP, Police Scotland, Alzheimer Scotland and Scottish Care. The Herbert Protocol has been designed to aid efforts to find people with dementia who go missing. By encouraging family members to record key information about a person's interests and significant places, it can help to speed up the tracing people with dementia who go missing.

Mental health services

Since September 2018, the Partnership has been co-designing the Thrive open-access model. We have collaborated with the voluntary and public sector, people with lived experience, and carers. We are currently prototyping this model across localities and we will use the learning from this work to inform any changes prior to the formal start in October 2020.

A Thrive welcome team is the access point for mental health support in each locality. It is a multi-disciplinary and multi-agency team that works with people to find the right help when needed (including social, therapeutic and medical support) through guided conversations. Thrive collective services are commissioned directly through this process and include statutory mental health services. There will be a range of services, programmes and activities which give interconnected social, practical, emotional, medical and clinical support which people need to improve their lives. The Thrive network relates to the wider range of services and support that exist across Edinburgh including primary care practices, welfare advice and income maximisation services, and support for people with drug and alcohol problems.

Thrive procurement activity started in September 2019. This builds on the partnership working of Edinburgh Wellbeing Public Social Partnership and will deliver a range of services and programmes to support the delivery of the Thrive welcome team and the Thrive collective. This work is on track with new contracts set to start on 1 October 2020.

Care Inspectorate reviews

There are 36 individual, registered, in-house services under the auspices of the EIJB. Inspection regimens for these services vary between care at home services, support at home services and care homes but all graded within a framework comprising a suite of national standards.

These categories are:

- how well do we support people's wellbeing?
- how good is our leadership?
- how good is our staff team?
- how good is our setting?
- how well care and support are planned?

These key questions are underpinned by a set of six principles.

Inspection results are graded on a scale from 1 ‘unsatisfactory’ (urgent remedial action required) to 6 ‘excellent’ (outstanding or sector leading), with the grades 3 and 4 being assessed as ‘adequate’ and ‘good’ respectively.

During 2019/20, 24 inspections took place. Here is a summary of the gradings awarded:

Service type	Number of services	Frequency of inspection	Inspections undertaken	Lowest grade	Highest grade	% with grades good or above
Adult placement	1	Yearly	0 *			
Care home service - older people	9	Yearly	9 **	1	5	55%
Combined housing support/care support	16	Yearly	13 *	4	5	100%
Support service – other than care at home	6	Every 3 years	0			
Housing support	2	Every 2 years	0 *			
Care home service - adults	2	Yearly	2	4	6	100%
* indicates service areas where the Care Inspectorate did not conduct all its planned inspections because of the COVID-19 pandemic						
** The COVID -19 inspection undertaken in two care homes for older people consisted of a review the intelligence held by the Care Inspectorate (CI), risk factors identified by the CI and a letter to the Registered Manager asking for an assurance statement regarding the quality of service delivered. The outcome of which was to be no change to the grades awarded at the end of the 2018/19 inspection visit.						

We have established two care home improvement oversight groups: one in December 2019 and one in February 2020. One oversight group was set up because of Care Inspectorate enforcement action in the form of an improvement notice and the other in response to the award of grades of 2.

Each oversight group is chaired by the relevant locality manager and is supported by officers from across EHSCP and the City of Edinburgh Council to develop and implement actions which show improvements which deliver better life outcomes for people using the service.

Our performance

The national health and wellbeing performance outcomes linked to this priority are:

- people who use health and social care services have positive experiences of those services, and have their dignity respected (HWB-3)
- people who use health and social care services are safe from harm (HWB-7).

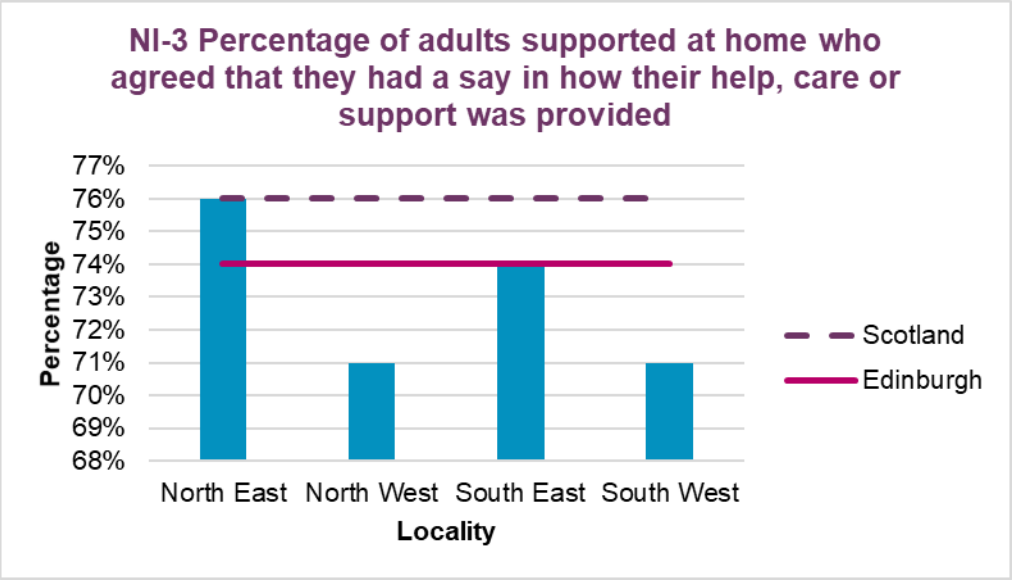
National Indicator (NI)		Edinburgh 2018/19	Edinburgh 2019	Difference	Performance
NI-3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	No Health and Care Experience survey data is available for 2018/19, as the survey is conducted on a bi-annual basis. The publication of the 2019/20 survey was delayed by the Scottish Government due to the COVID-19 pandemic.			
NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated				
NI-5	Total percentage of adults receiving any care or support who rated it as excellent or good				
NI-7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life				
NI-9	Percentage of adults supported at home who agreed they felt safe				
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	84%	82% *(2019/20)*	-2%	●

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

NI-3 Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-3	2017/18
Scotland	76%
Edinburgh	74%
North East	76%
North West	71%
South East	74%
South West	71%



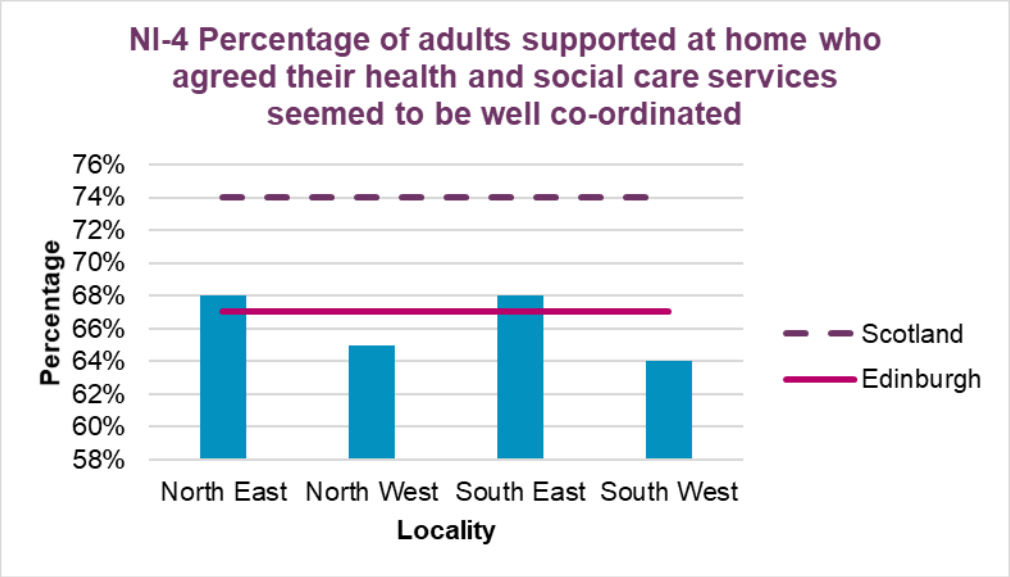
Source: Scottish Government HACE survey 2017/18

The percentage of adults supported at home agreed they had a say in how their help, care or support was provided decreased by 3% from 77% in 2015/16 to 74% in 2017/18, as we reported last year. This is lower than the Scottish average which is currently 76%. There is variation between the four localities with North East matching the Scottish average of 76%, whilst North West and South West have the lowest percentage at 71%.

NI-4 Percentage of adults supported at home who agreed their health and social care services seemed to be well co-ordinated

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-4	2017/18
Scotland	74%
Edinburgh	67%
North East	68%
North West	65%
South East	68%
South West	64%



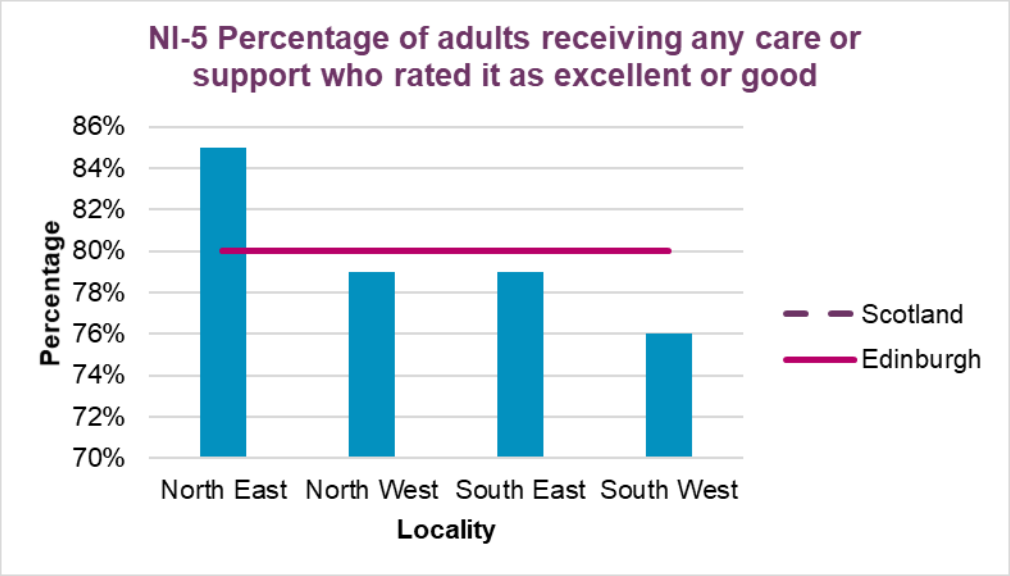
Source: Scottish Government HACE survey 2017/18

Edinburgh's performance around adults who are supported at home who agreed that their health and social care services seemed well co-ordinated decreased slightly by 4% from 71% in 2015/16, to 67% in 2017/18. The Scottish average is 74%. Both North East and South East scored 68%, whilst South West has the lowest percentage of 64% which is 10% lower than the Scottish average.

NI-5 Percentage of adults receiving any care or support who rated it as excellent or good

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-5	2017/18
Scotland	80%
Edinburgh	80%
North East	85%
North West	79%
South East	79%
South West	76%



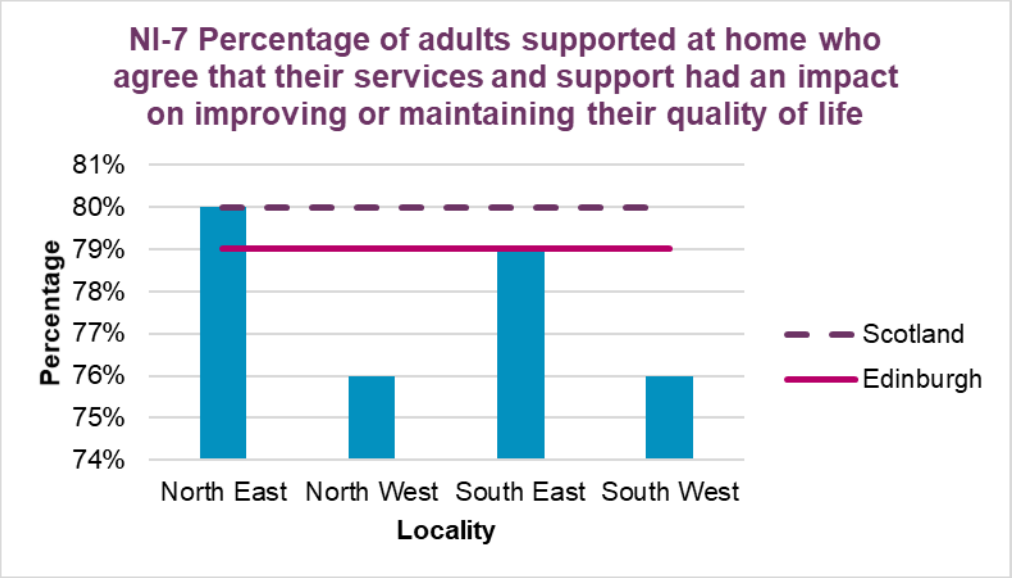
Source: Scottish Government HACE survey 2017/18

The percentage of adults receiving any care or support and rated it as excellent or good increased by 2% from 78% in 2015/16, to 80% in 2017/18. The Scottish average is also 80%. Interestingly, North East has the highest percentage of the four localities at 85%, which is higher than the Scottish average. The South West locality has the lowest score at 76%.

NI-7 Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-7	2017/18
Scotland	80%
Edinburgh	79%
North East	80%
North West	76%
South East	79%
South West	76%



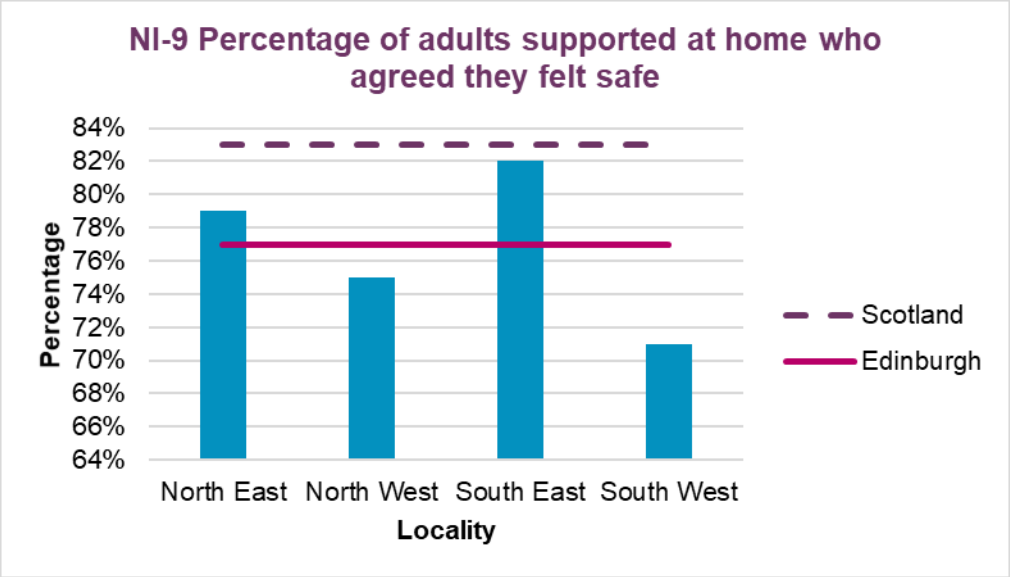
Source: Scottish Government HACE survey 2017/18

The percentage of adults supported at home who agreed that their services and support had an impact on improving or maintaining their quality of life reduced from 83% in 2015/16, to 79% in 2017/18. The Scottish average is 80%. There is very slight variation between the four localities with North East scoring the highest at 80%, which is the same as the Scottish average, with North West and South West both achieving 76%.

NI-9 Percentage of adults supported at home who agreed they felt safe

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-9	2017/18
Scotland	83%
Edinburgh	77%
North East	79%
North West	75%
South East	82%
South West	71%

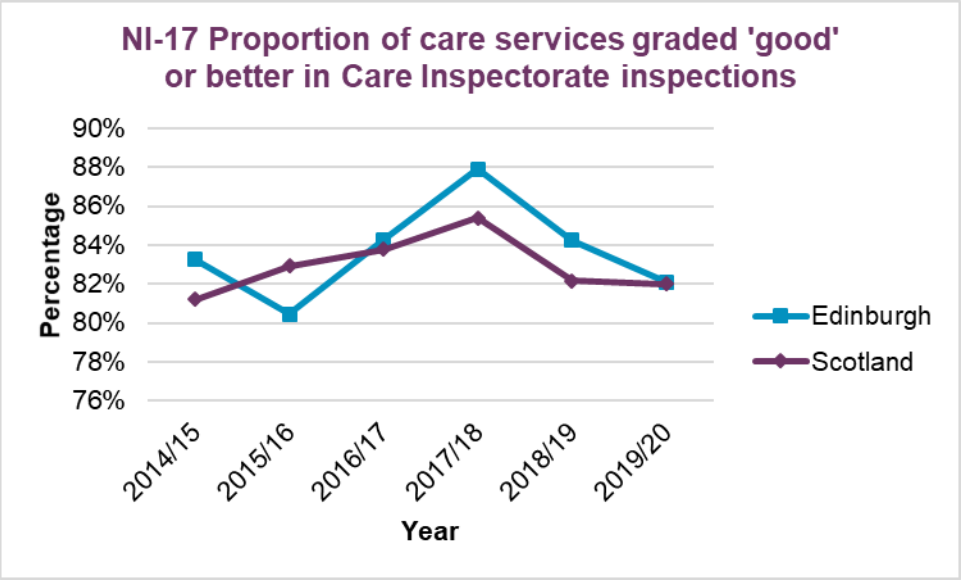


Source: Scottish Government HACE survey 2017/18

The percentage of adults supported at home who agreed that they felt safe reduced from 82% in 2015/16, to 77% in 2017/18. This is below the Scottish average of 83%. There is a large variation between the localities with the South East locality scoring close to the Scottish average with 82%. The South West locality score is the lowest at 71%.

NI-17. Proportion of care services graded 'good' or better in Care Inspectorate inspections

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Edinburgh	83%	80%	84%	88%	84%	82%
Scotland	81%	83%	84%	85%	82%	82%



Source: Care Inspectorate

There were 339 out of 413 services within Edinburgh which were graded as ‘good’ (4) or better by the Care Inspectorate in 2019/20 which equates to 82%. This is a slight reduction of 2% compared to 2018/19. Edinburgh’s rate is the same as the Scottish average of 82%.

Priority 4
Managing our resources effectively

Context

In a climate of increasing need for services and continuing pressures on budgets, it is vital that the EIJB makes best use of its available resources.

Workforce planning

Our workforce is made up of approximately 5,000 staff, with 56% employed by the City of Edinburgh Council and 44% by NHS Lothian. Ensuring a sustainable workforce continues to be a significant challenge for the EHSCP. Our workforce is ageing, with the three largest cohorts falling within the following age ranges: age 50-54 (18.5% of total workforce); age 55-59 (15.8%) and age 45-49 (14.45%). Less than 9% of our workforce is under the age of 30.

The EIJB considered an initial baseline workforce plan in December 2018. This set out the specific risks and issues for EHSCP and the potential implications for future service delivery. A core workforce group is now developing a workforce strategy with a whole-systems approach which aligns to strategic and financial planning priorities. Part of this approach will be taking forward strategies relating to learning and development, recruitment and retention, as well as the opportunities afforded through new digital and technological advancements.

During 2019/20, following the Scottish Government's national recruitment drive, the EHSCP has been working to resolve capacity imbalances within care home settings. Work has also taken place within localities to analyse their own workforce profile and to implement local approaches to workforce planning challenges. This will continue in 2020-21. The impact of the COVID-19 pandemic will also shape our future workforce plans going forward.

Staff feedback

The iMatter survey was introduced to all EHSCP staff across health and social work services in 2019. The response rate for this year's return was 55% and the directorate's Employee Engagement Index (EEI) score was 77.

Overall, 24 of the 28 questions fall within the highest 'strive and celebrate' category: the remaining four need monitoring to 'further improve'. All teams have been asked to discuss individual report findings, identify areas for improvement and develop an action plan.

Contracts and commissioning

We have had a renewed focus on strengthening our approach to contracts and commissioning during 2019/20. Part of this work has included developing a draft market facilitation framework. The draft framework sets out the EHSCP approach to commissioning and contracting services and will be subject to sector-wide consultation and engagement later in 2020.

We are committed to moving away from the transactional behaviours and processes of traditional market management and encouraging greater partnership working, believing that effective relationship-building rests on:

- transparent decision-making
- good collaborative structures
- cross-sector leadership
- a focus on sustainability.

We already know of areas where we need to improve and where we need the market to be able to support more reliable, sustainable services. These areas include:

- seasonal fluctuation – summer and winter problems need to be planned for and mitigated better
- boom and bust – when providers fail or withdraw from packages resulting in a tremendous impact on people
- the challenges associated with delivering small packages of care such as medication prompts and meal preparation
- the move towards outcomes-based commissioning and greater personalisation
- transformation of traditional models of care and better use of digital technology.

Addressing these issues will be key to our approach moving forward.

An enhanced health and social care contract management framework (CMF) was introduced and piloted with a small number of providers in December 2019 with a view to rolling out in the 2020/21 financial year. Unfortunately, we have had to delay full implementation because of the impact of COVID-19.

This enhanced CMF has been designed to:

- focus resources where they are required most
- allow for early identification and addressing of issues, concerns and risks
- collect and record more structured and consistent information across care groups
- allow autonomy for contract managers in how they conduct contract management activity
- promote more robust monitoring of financial and governance arrangements within service providers
- allow service provider monitoring to be conducted in a standardised format, with frequency determined by level of risk. A key objective of service provider monitoring is for EHSCP staff to gain insight into and understanding of the work service providers are doing on our behalf.

Financial management and performance

Financial information is a key element of our governance framework with financial performance for all delegated services reported at each meeting of the EIJB. Budget monitoring of delegated functions is carried out by the finance teams in the City of Edinburgh Council and NHS Lothian, reflecting the EIJB's role as a strategic planning body which does not directly deliver services, employ staff or hold cash. However, the board needs oversight of the in-year budget position as this highlights any issues that need to be accounted for when planning the future delivery of health and social care services.

Each year we produce a financial plan which sets out how we ensure our limited resources are targeted to support delivery of the Strategic plan. For 2019/20 our financial plan was set with a deficit of £10 million which we committed to address, in collaboration with our partners, during the year. Financial performance for the delegated services was reported throughout the year and, by the end of the year, we had bridged the £10 million gap through a combination of:

- funding confirmed by the City of Edinburgh Council after the initial budget was set
- slippage on some specific investments
- the agreed use of EIJB reserves.

This position reflected the need to balance existing commitments, our ambitions for supporting transformational change and the need to balance the in-year financial plan.

You will find financial performance for the year summarised in the table on the next page.

	19/20 budget £k	19/20 actual £k	Variance £k
NHS DELIVERED SERVICES			
Community services	77,403	77,420	(17)
General medical services (GMS)	84,173	84,024	149
Prescribing	81,181	81,690	(509)
Reimbursement of independent contractors	55,502	55,502	0
Services hosted by other partnerships	88,812	87,894	918
Hospital 'set aside' services	99,538	100,776	(1,238)
Other	33,985	33,293	692
COUNCIL DELIVERED SERVICES			
External purchasing	151,077	151,814	(737)
Care at home	29,906	30,722	(816)
Day services	17,143	15,675	1,468
Residential care	18,056	18,074	(18)
Social work assessment & care management	14,932	14,904	28
Other	9,935	9,860	75
Additional contributions from partners	5		5
Total	**761,648**	**761,648**	**0**

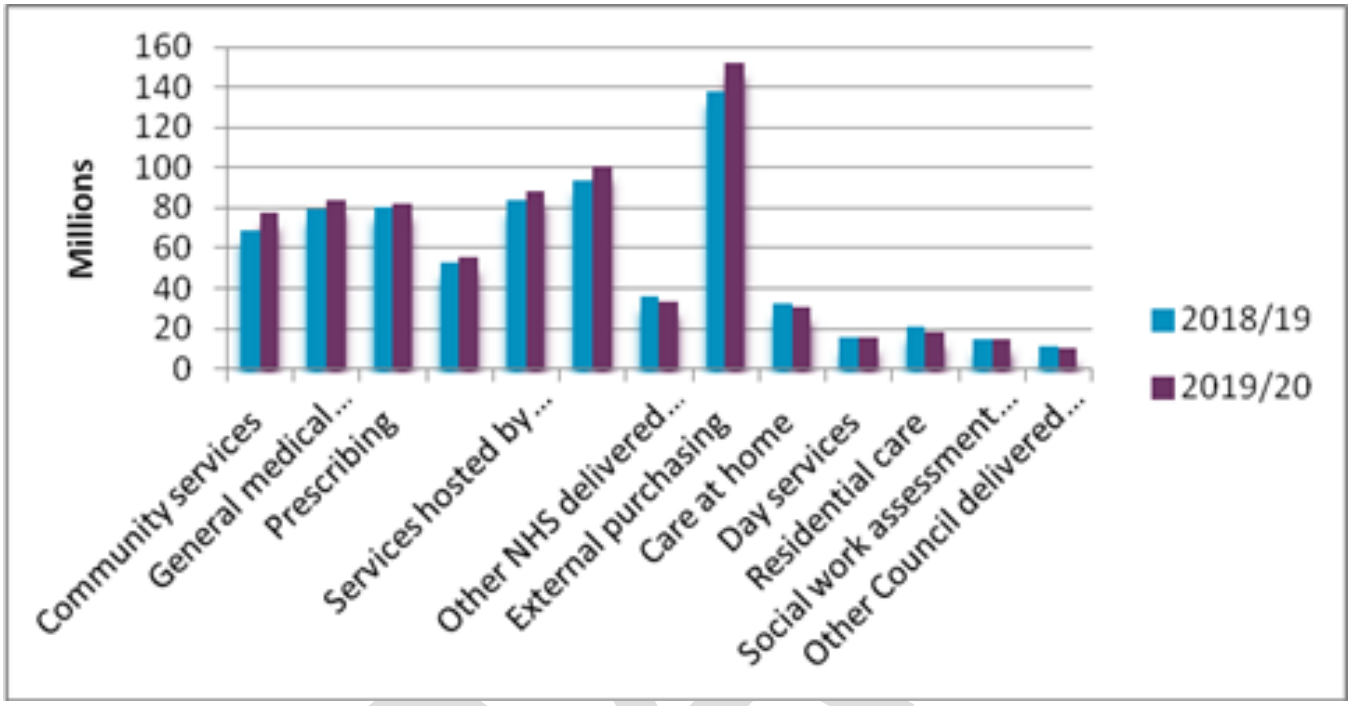
Whilst there is no doubt that we will continue to face significant financial pressures, there were some notable improvements in financial planning and performance in 2019/20. This was the first year that the EIJB has not relied on one-off contributions from our partners in the City of Edinburgh Council and NHS Lothian. Also, for the first time, we not only met but exceeded the target within our planned savings and recovery programme.

Although the positive progress with the 2019/20 savings and recovery programme marks a departure from previous non-delivery, the financial pressures facing us have not materially changed. Key pressures include:

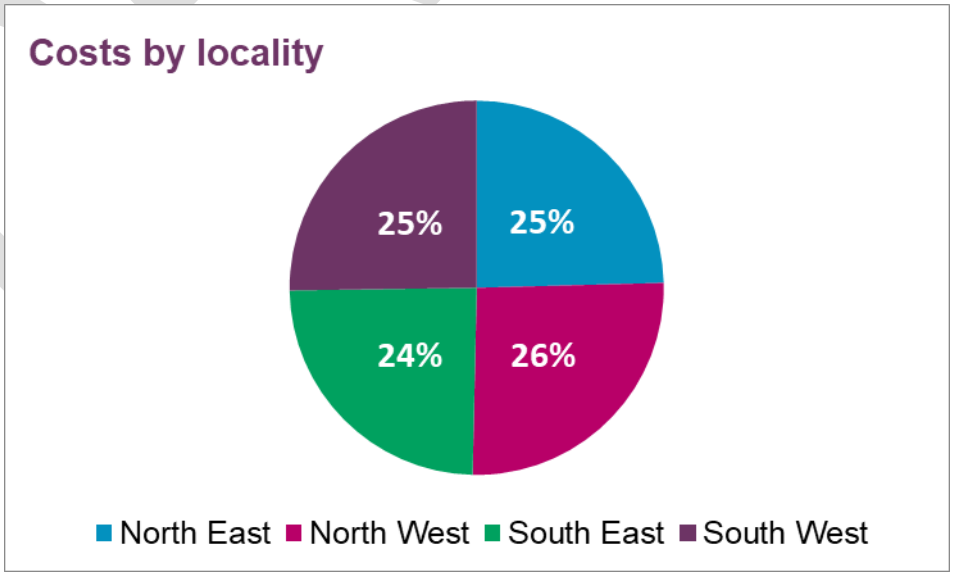
- Increasing demand and spend on externally-purchased services. Despite breaking even against budget for the first time in some years, this area of spend continues to increase year-on-year. Demographic factors continue to drive demand for these services, which is also evidenced in the continuing growth in direct payments and individual service funds. Costs rose by £14 million (or 9%) from the level of the previous year.
- Increasing prescription costs. Medicines prescribed by GPs cost almost £82 million in 2019/20, an increase of £1 million (or 1%). Although Edinburgh has one of the lowest prescribing costs per head of population, we see costs rising year-on-year as volumes increase and prices fluctuate.
- Increasing demand for equipment to enable people to live independently at home. Costs for equipment supplied continues to rise in line with increased demand.

- Continuing overall pressures in set-aside budgets. NHS Lothian set-aside budgets overspent by £1.2 million in the year. This is a focus of continuing discussions with NHS Lothian and the three other Lothian IJBs.

The table below shows how costs in key areas for financial year 2019/20 compared to those from the previous financial year (2018/19).



Although many of the delegated services are delivered directly in localities, a significant proportion are run on a city-wide basis. Showing how the associated costs are incurred within each locality means a degree of estimation and assumption. This exercise shows that the cost of services is relatively consistent across the four localities, as shown in the diagram below.



Our performance

The national health and wellbeing performance outcomes linked to this priority are:

- people who work in health and social care services feel engaged with the work they do and are supported to improve continuously the information, support, care and treatment they provide (HWB-8)
- resources are used effectively and efficiently in the provision of health and social care services (HWB-9).

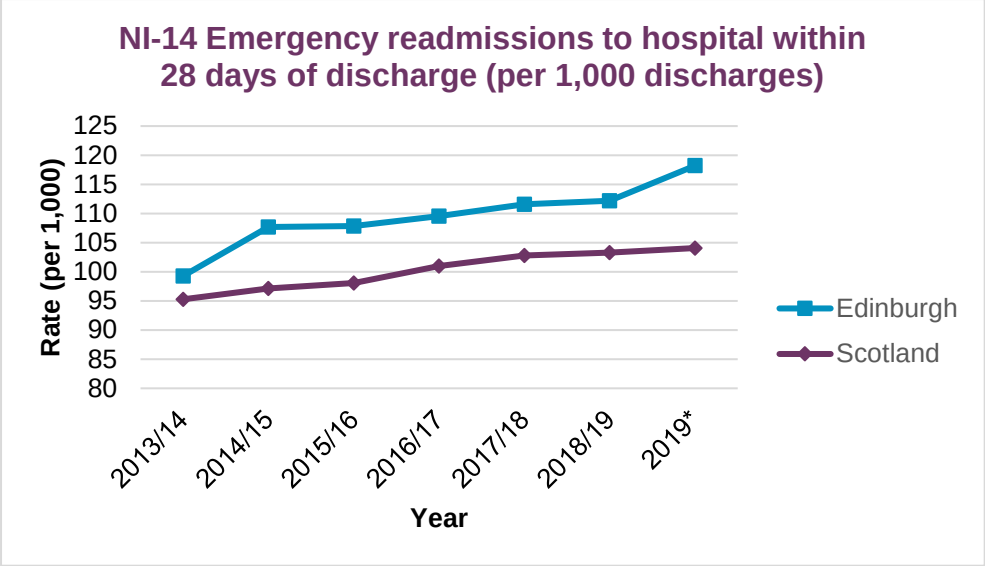
National Indicator (NI)		Edinburgh 2018/19	Edinburgh 2019	Difference	Performance
NI-14	Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges)	112	118	+6	●
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	24%	23%	-1%	●

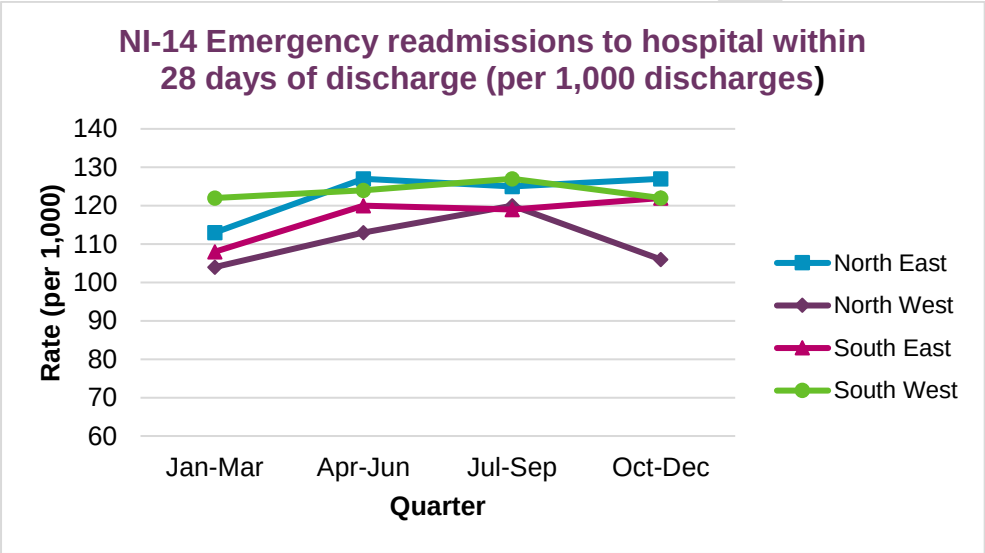
RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

NI-14. Emergency readmissions to hospital within 28 days of discharge, per 1,000 discharges

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	99	108	108	110	112	112	118
Scotland	95	97	98	101	103	103	104

	2019			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
North East	113	127	125	127
North West	104	113	120	106
South East	108	120	119	122
South West	122	124	127	122



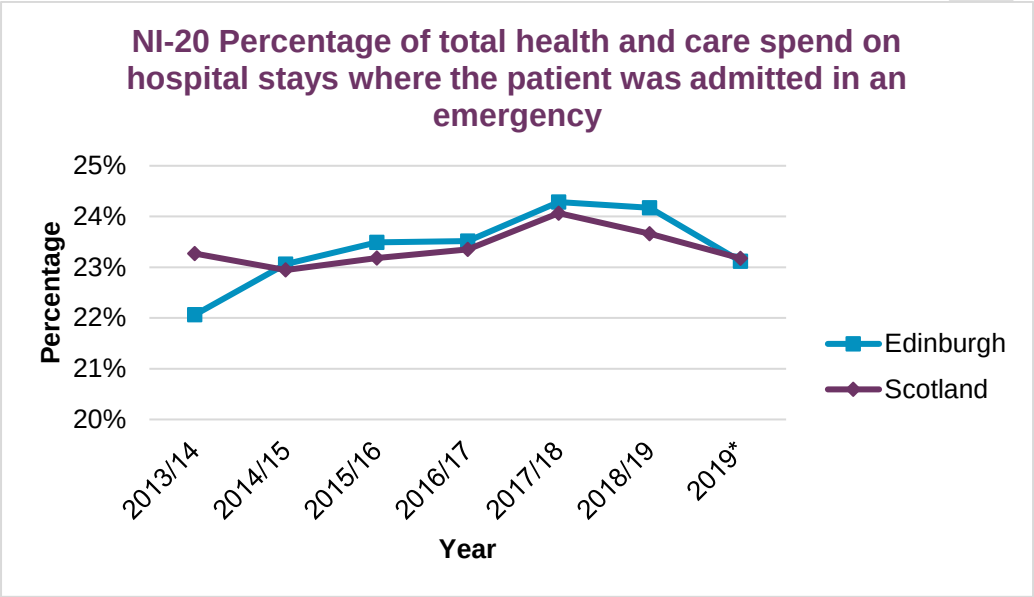


Source: Public Health Scotland

Edinburgh's readmission rate to hospital within 28 days remains higher than the Scottish average. The long-term trend has been increasing from 99 in 2013/14 to 118 in 2019. There is little variation between the four Edinburgh localities in 2019, although there was a slight decrease in the North West locality in the last quarter.

NI-20 Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	22.1%	23.1%	23.5%	23.5%	24.3%	24.2%	23.1%
Scotland	23.3%	22.9%	23.2%	23.4%	24.1%	23.7%	23.2%



Source: Public Health Scotland

The percentage of health and care resources spent on hospital stays where the patient was an emergency admission slightly decreased from 24% to 23% in 2019.

Priority 5
Making the best use of capacity across the whole system

Context

In a climate of increased demand for services and a challenging financial situation, it is crucial that the EIJB and EHSCP continue to take every opportunity to deliver more effective ways of working to make best use of available resources.

Developing primary care capacity

Population increase and the availability of a suitably trained workforce remain the major concerns for Edinburgh in respect of primary care provision. In the 11 years since 2009, the practice-registered population of the city has grown by 67,000. This steady increase of approximately 6,000 new patients a year is predicted to continue for the next 20 years. Across the UK the shortage of GPs (in particular) has been highlighted as a key challenge to all health and social care systems.

There are 70 GP practices in Edinburgh networked into four localities, each of which has two GP quality clusters. Edinburgh also recognises five demand groupings which help to broadly describe the different populations served across the city. As of January 2020, around half of the practices were operating restricted lists, indicating they were unable to immediately register all patients who requested access to their lists, as would be the case in a stable population.

In order to increase the capacity of primary care, significant investment through the national new GP contract is being made to expand the primary care workforce across six clinical areas. The vehicle for this investment is the Primary Care Improvement Plan (PCIP) agreed by the EIJB and supported by NHS Lothian. By March 2020, a total of 116 WTE staff had been recruited city-wide, broken down by locality as follows: North East 29 WTE; North West 31 WTE; South East 24 WTE and South West 32 WTE. These staff are mainly a mixture of pharmacists, nurses, physiotherapists and community link workers, in accordance with what each practice considered would best contribute to their stability and the transformation of general practice.

Over the last two years, funding has also been made available to encourage the use of technology within Edinburgh's practices. While most of the investment has been on routine items such as automatic check-in facilities and laptops for use during home visits, the availability of these items has helped teams work more efficiently. Almost every city practice had benefitted from this technology fund by March 2020. We have also made investment in improved pathways and encouraged practices to develop their administrative staff to help with the clinical workload.

Edinburgh has a significant challenge in respect of GP premises with around 12 out of 60 current premises meriting immediate replacement because of the physical condition or capacity limitations. In addition, developments are needed to accommodate the new growing population and where existing practices cannot expand. NHS Lothian has limited capital to support new developments and there are limited opportunities to develop new premises owing to a competitive market for any site opportunities.

During 2019/20, we have made significant steps towards an improved balance between population and appropriate primary care premises, in particular:

- South East Edinburgh initial agreement, March 2020 - this sets out proposals to address GP capacity issues resulting from extensive housing developments under construction in the outer area of the South East locality together with proposed re-provision of two existing practice premises. The initial agreement was submitted to the NHS Lothian Capital Investment Group as part of the capital prioritisation process. You can find more information within the EIJB report from October 2019.
- Brunton Medical Practice re-provision - this practice is based in the North East locality and has been a long-standing priority for new premises because of the building's functional unsuitability for delivery of primary care services. Following the EIJB's and NHS Lothian's approval of the initial agreement, work has continued to develop the standard business case.
- The relocation of the Inclusive Edinburgh practice (part of the integrated homelessness service) as part of the wider joint work to integrate homeless services at Panmure St Anne's. Construction was due to commence in March 2020, but the site start was delayed because of COVID-19 restrictions.
- Consideration of an opportunity to relocate two city practices into an adapted commercial property was progressed with support from both NHS Lothian and EIJB.
- During 2019/20 almost half of city practices benefitted from a programme of small grants run by EHSCP with funding from a combination of NHS Lothian, Scottish Government and non-recurrent PCIP funds.
- The community link workers programme continues to go from strength-to-strength – see the tackling inequalities chapter for more detail.

Increasing capacity for psychological therapy services

The current standard for psychological therapies is for at least 90% of patients to start treatment within 18 weeks of referral. Edinburgh has been challenged in meeting this target for a prolonged period of time resulting in a significant number of people waiting for longer than 18 weeks. The EIJB therefore agreed in August 2019 (Psychological Therapies Additional Investment report) to allocate reserves to fund the appointment of 17 WTE temporary staff for a period of 18 months to deliver psychological therapies to the people who have been waiting for services for over 18 weeks.

Supporting carers

The EIJB recognises the crucial contribution young and adult carers make to their communities across Edinburgh and is committed to providing personalised services to support carers in their caring role and enable them to look after their own health and wellbeing.

In August 2019, the EIJB approved a new Edinburgh Joint Carers' Strategy and associated implementation plans aligned to the requirements set out in the Carers (Scotland) Act 2016. The strategy was developed through a comprehensive partnership approach involving the Edinburgh Carers Strategic Partnership Group, the EHSCP and the City of Edinburgh Council's Communities and Families service.

The strategy is focused on supporting carers, ensuring sustainability of caring, and valuing carers as equal partners in care. The strategy is focused around six priority areas:

- identifying carers
- information and advice
- carer health and wellbeing
- short breaks
- young carers
- personalising support for carers.

During 2019/20 we have seen progress in delivering the implementation plans, namely:

- provision of a dedicated carer support worker within the Edinburgh Community Stroke Service to identify carers earlier in their caring journey
- published the 'short breaks service statement' which outlines how carers can access short breaks from caring and the types of support available in Edinburgh
- the Hospital Discharge Carers Support Service has continued to complete adult carer support plans with carers across the city, completing 445 plans over 2019/2020
- we have made approximately £34,000 of carer payments to meet the needs 80 carers, identified through adult carer support plans
- worked with third sector partners to test young carer statements across Edinburgh which inform the roll-out of statements in 2020/2021
- worked with carer support organisations across the city to develop specifications to meet future demand for carer support.

Case study – carer support

Amanda has been looking after her husband for over ten years since he suffered strokes which resulted in long-term physical and cognitive impairments. Amanda was not connected to any sources of support until staff from her husband's day care service linked her to a dedicated carer support worker (CSW) in 2019.

Amanda and the CSW completed an adult carer support plan (ACSP) together. This conversation highlighted the need for Amanda to focus on her own health and wellbeing and to take some time out, which she found difficult to do due to her caring role. Accessing complementary therapies was seen as a way Amanda could support her physical and mental health.

Amanda accessed subsidised treatments through a carers' organisation and funding was utilised via the ACSP and a carers payment. When reviewing her ACSP eight months later, Amanda reported significant improvements to her overall health from both the complementary therapies and linking with the carer organisation and their other short break options. A further carer payment has been provided to enable Amanda to continue receiving support for the next year until her plan is reviewed again.

Telecare and technology-enabled care

In 2018, EHSCP teamed up with Blackwood Homes and care group to create an innovative SMART home for Edinburgh's citizens, their carers, health and social carer staff and third sector agencies within Edinburgh.

The SMART home and technology service is a small team of occupational therapy staff, technology development workers and a team lead from our Assistive Technology Enabled Care (ATEC24) service. The team provide a variety of services, including:

- assistive technology occupational therapy assessment and intervention
- training, smart home tours
- information and advice
- complex telecare assessment.

By adopting a mixed economy approach to delivering technology solutions, the team ensures people have the technology systems and solutions that best meet their desired outcomes, needs, abilities and environment. The smart home resource is an interactive space for Edinburgh citizens and EHSCP staff to explore, test and engage with the latest technology-enabled care options, and discover how they have the potential to transform the day-to-day lives of people living with disabilities and those who have a caring role.

Between April and December 2019, the team delivered:

- telecare training for 32 partnership staff
- developed a digital champion model and delivered associated training for 20 partnership staff
- twelve digital technology drop-in sessions for digital champions plus ongoing training and development including three continuous professional development sessions
- responded to over 100 information and advice enquiries
- over 500 smart home tours involving Edinburgh citizens, EHSCP staff and third sector organisations
- over 20 complex technology assessments for telecare
- over 60 referrals for assistive technology occupational therapy assessment, support and guidance.

As with every other service across the EHSCP, the service has had to adapt to a new way of working since the emergence of COVID-19 with clients supported through video-conferencing and a training plan to support practitioners working in localities.

Our performance

The national health and wellbeing performance outcome linked to this priority is:

- 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. (HWB-6).

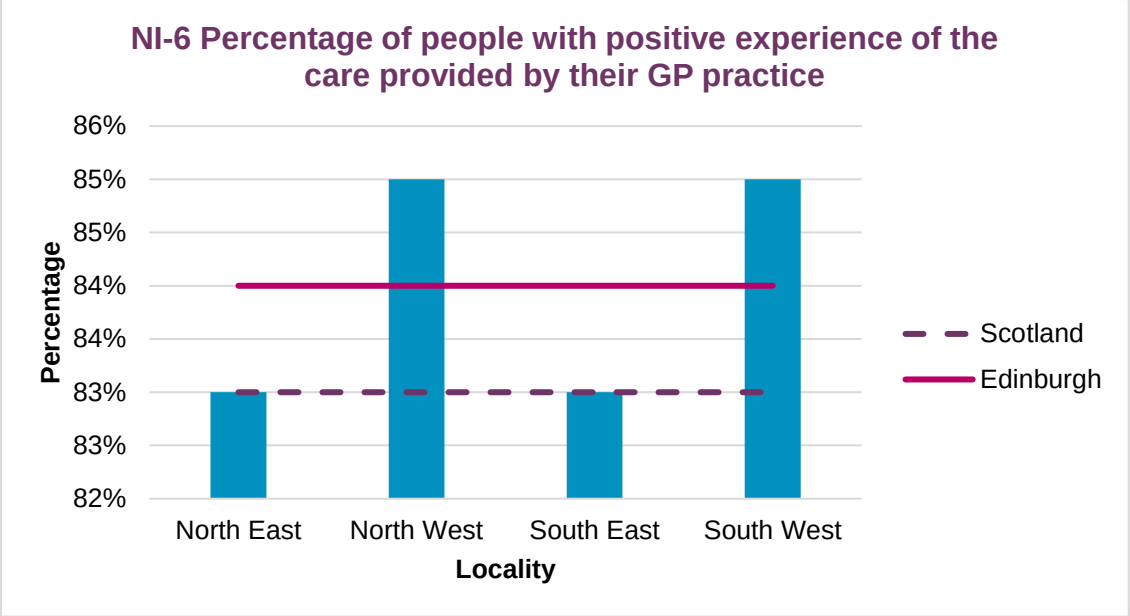
National Indicator (NI)		Edinburgh 2018/19	Edinburgh 2019	Difference	Performance
NI-6	Percentage of people with a positive experience of the care provided by their GP practice	No Health and Care Experience survey data is available for 2018/19, as the survey is conducted on a bi-annual basis. The publication of the 2019/20 survey was delayed by the Scottish Government due to the COVID-19 pandemic.			
NI-8	Total combined % carers who feel supported to continue in their caring role				

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

NI-6 Percentage of people with positive experience of the care provided by their GP practice

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-6	2017/18
Scotland	83%
Edinburgh	84%
North East	83%
North West	85%
South East	83%
South West	85%



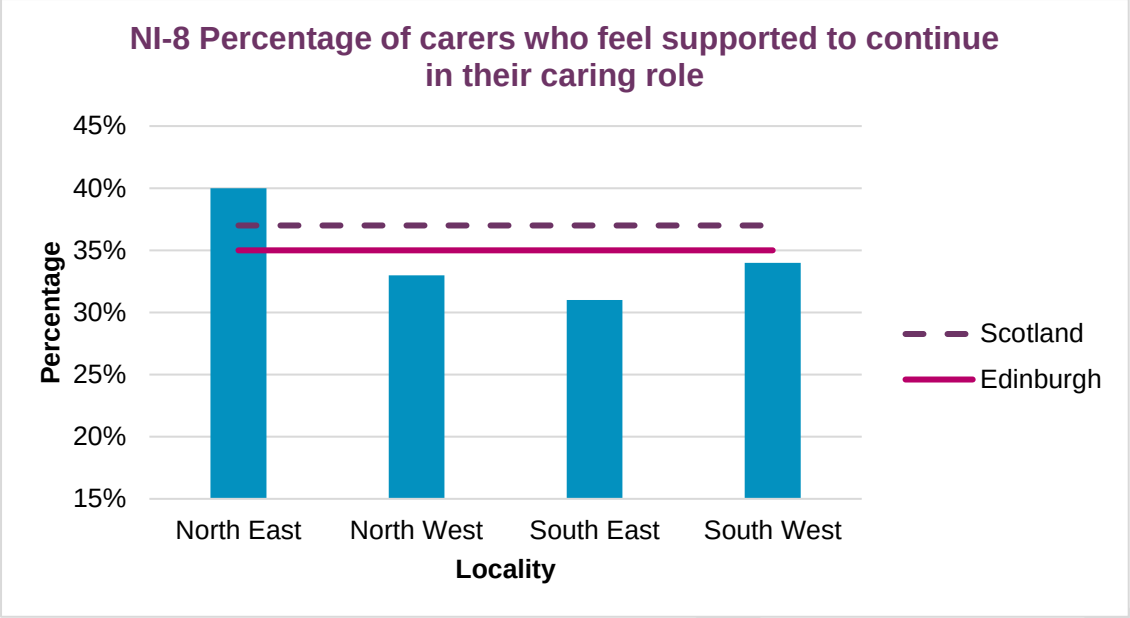
Source: Scottish Government HACE survey 2017/18

In the Heath and Care Experience survey, 84% of respondents stated that they had a positive experience of the care provided by their GP practice, which is higher than the Scottish average of 83%. There is a slight variation once broken down into the four localities with North East and South East reporting slightly lower rates compared to North West and South West.

NI-8 Percentage of carers who feel supported to continue in their caring role

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-8	2017/18
Scotland	37%
Edinburgh	35%
North East	40%
North West	33%
South East	31%
South West	34%



Source: Scottish Government HACE survey 2017/18

Only 35% of carers feel supported to continue in their carer role. This is slightly below the Scottish average of 37%. There is variation when examining the results by locality. The South East locality has the lowest percentage of 31%, whilst the North East has the highest rate of 40%, which is higher than the Scottish average.

Priority 6
Right care, right place, right time

Context

As part of making sure people receive the right care in the right place at the right time, the EIJB is committed to ensuring:

- people are safe and protected
- people are supported at home and within their communities whenever possible and are admitted to hospital only when clinically necessary
- people are discharged from hospital as soon as clinically fit to do so and receive the necessary support at home to recover and regain their independence
- there are smooth transitions between services and care is reviewed regularly to ensure it remains appropriate.

Throughout 2019/20 we have focused on redesigning services to ensure timely discharge from hospital, prevent avoidable hospital admissions, and to shift the balance of care to ensure that more community provision is available.

Addressing delayed discharge

Being delayed in discharge from hospital is bad for patients, bad for staff, and bad for the financial health of the health and social care system. Home First is a key plank of our approach to ensure timely discharge from hospital. You can find out more about this innovative transformation project within the 'overview' section of this report and a report to the EIJB in October 2019.

Ensuring that people receive the care they need to enable them to continue to live at home or to return home after a hospital stay is also important. Edinburgh has faced challenges in providing a care at home service for those who need it because of a lack of capacity within the care sector. However, we have seen progress during 2019/20 with the continuation of the Sustainable Community Support Programme (SCSP) which has resulted in improved recruitment and retention of staff in independent sector providers, allowing an expansion of capacity. As part of the SCSP, the current care at home contact was extended in October 2019 for a further 22 months.

For some people care homes will be the most appropriate setting for their care and support needs. The EHSCP has nine care homes for older people which can support a maximum of 404 residents. This includes 15 beds set aside for respite at one of our care homes. We care for people with complex care and medical needs, those who have dementia or other cognitive impairment and those with palliative or end of life care needs. People can be admitted from

hospital but also from the community. The EHSCP also holds contracts with other care home providers and we have increased this capacity in response to the COVID-19 pandemic.

The EHSCP continued to support and promote a national Power of Attorney campaign during 2019. There has been a 15.76% increase in Power of Attorney registrations during 2019.

Shifting the balance of care

We know that long and protracted stays in hospital are not good for people or in keeping with rights-based care. Moving people from long-stay institutional or hospital care to greater independence in the community shows success in shifting the balance of care in Edinburgh.

As of February 2020, 29 people from Edinburgh with a learning disability were living in hospital, mainly in the Royal Edinburgh Hospital (REH). Many have been hospitalised for a long period of time and have no medical reason to be there. The EIJB has already made a commitment to developing 22 community placements over the next two years, so that people with a learning disability can leave hospital. The EIJB has also agreed to create a small 'step-down' community resource to support a transition for people who have become stuck in hospital because of a breakdown of care, for example the loss of a tenancy or families no longer able to provide care. The likely step-down period would be around six months, however, this would vary with individual needs and a clearly defined entry and exit strategy.

You can find more information about these plans within the Learning Disability – Step Down report.

The Thrive workstream 'A Place to Live' is focused on ensuring that people with mental health issues have a place to call home where they feel safe, receive the support they need and are able to connect with and be part of their local community. There are currently 272 supported accommodation places across the city with additional support for people across the five Wayfinder grades of support. Through Edinburgh's affordable housing allocations policy, people ready to leave hospital and grade 5 supported are prioritised through the application of the gold status award. Recent developments include commissioned Grade 5 and Grade 4 units in the south east, south west and north east of the city.

We spot-purchase visiting support services for people with complex mental health needs living in their own tenancies. Currently over 760 people are receiving a care and support spot-purchased service which includes visiting support and supported accommodation.

Future plans include creating a new framework agreement for commissioning all the current supported accommodation services and visiting support services for people with mental health issues. This will give a better fit with the Three Conversations approach and more flexibility between multiple providers and Partnership staff in clusters and localities.

Palliative and end-of-life care

The EIJB hosts palliative and end-of-life care on behalf of the four Lothian IJBs and is committed to ensuring that high quality and person-centred care is available for all who need it, when they need it.

There are two hospices within the city of Edinburgh, both providing a range of specialist inpatient and community-led palliative and end-of life care services to those residing across the whole of Lothian. The IJB approved a new Memorandum of Understanding with the hospices was approved in principle in February 2020. This sets out a new approach to commissioning based on transparency and openness, as well as a focus on outcomes and effectiveness.

Our performance

The national health and wellbeing performance outcome linked to this priority is:

- people can live, as far as reasonably practicable, independently and at home or in a homely setting in their community (HWB-2).

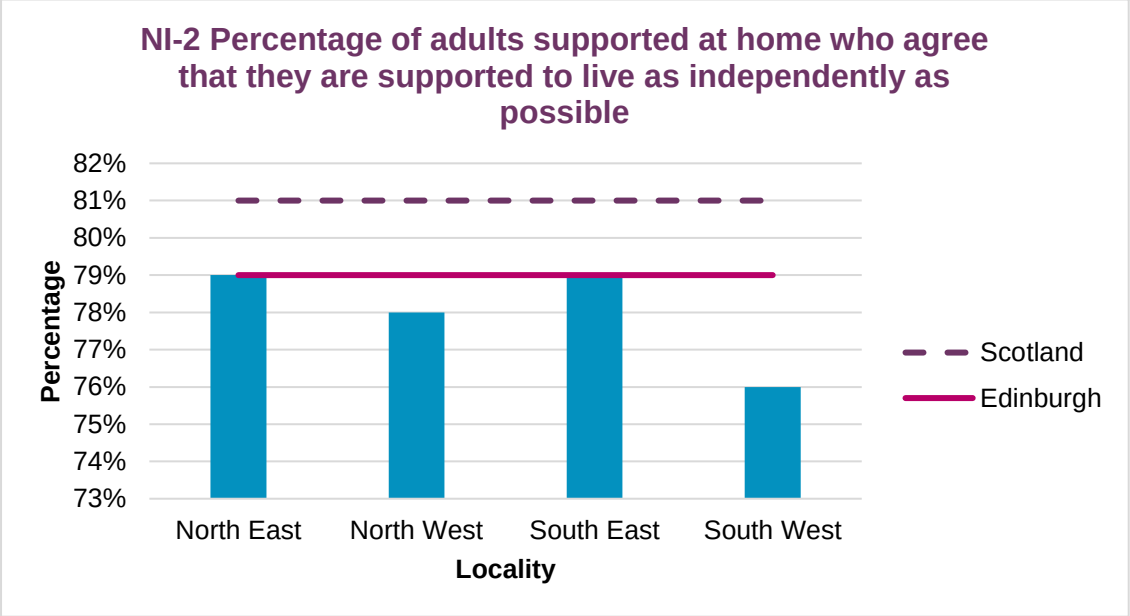
National Indicator (NI)		Edinburgh 2018/19	Edinburgh 2019	Difference	Performance
NI-2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	No Health and Care Experience survey data is available for 2018/19, as the survey is conducted on a bi-annual basis. The publication of the 2019/20 survey was delayed by the Scottish Government due to the COVID-19 pandemic.			
NI-13	Rate of emergency bed days for adults (per 100,000)	112,108	104,707	-7,401	●
NI-15	Proportion of last 6 months of life spent at home or in community setting	85%	87%	+2%	●
NI-18	Percentage of adults with intensive care needs receiving care at home	62% *(2018)*	N/A	N/A	N/A
NI-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	1,621	1191 *(2019/20)*	-430	●

RAG Key:
● Performance fell and is behind Scottish average ● Performance fell but is not behind Scottish average ● Performance improved

NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible

Data relating to this indicator is only available for 2017/18. The Scottish Government has delayed the publication of the 2019/20 HACE survey due to staff redeployment during the COVID-19 pandemic.

NI-2	2017/18
Scotland	81%
Edinburgh	79%
North East	79%
North West	78%
South East	79%
South West	76%



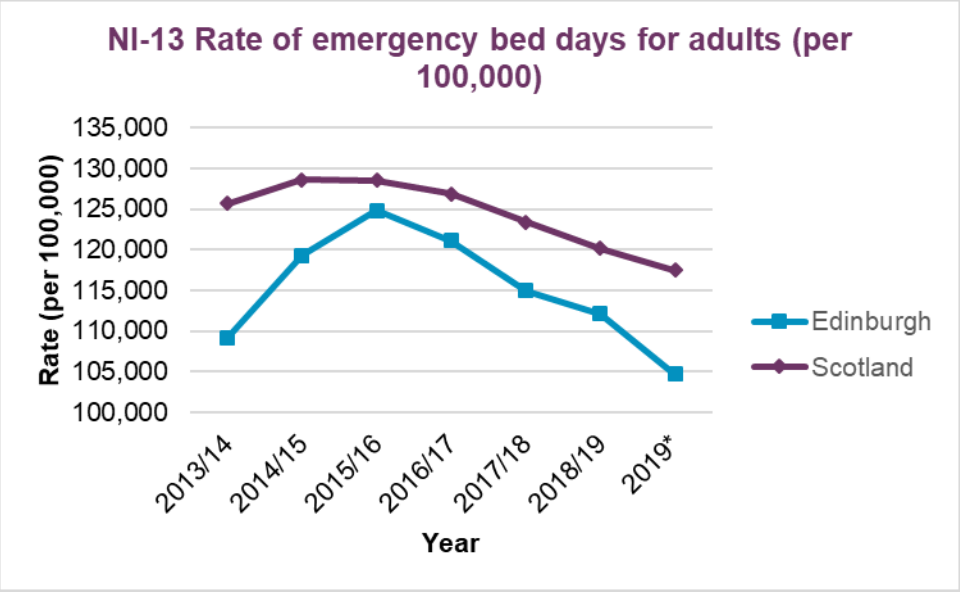
Scottish Government HACE survey 2017/18

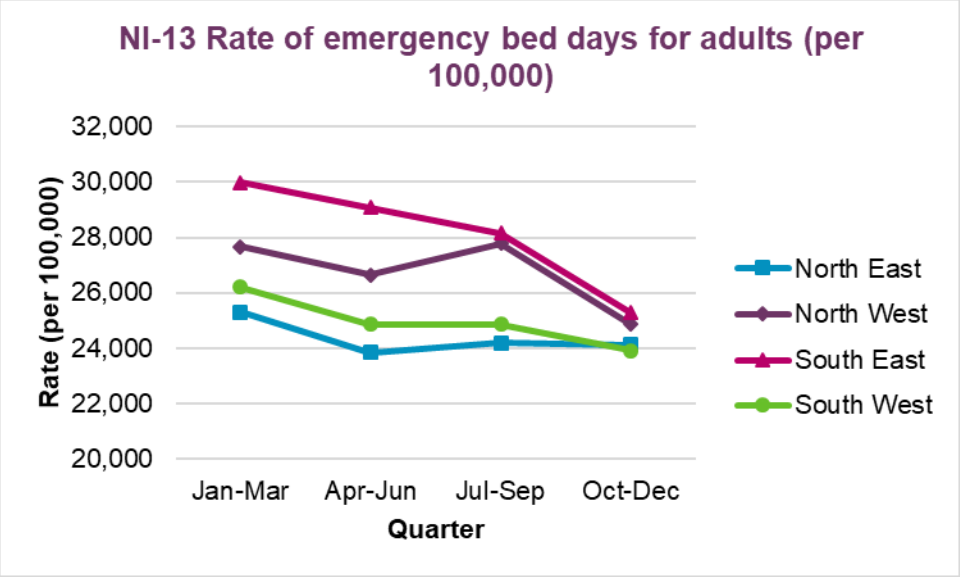
Edinburgh's performance decreased by 2% from 81% in 2015/16 to 79% in 2017/18. The Scottish average is 81%. There is a slight variation between the four Edinburgh localities with South West achieving 76%, and both North East and South East scoring 79%.

NI-13 Rate of emergency bed days for adults (per 100,000)

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	109,231	119,311	124,858	121,090	114,972	112,108	104,707
Scotland	125,730	128,596	128,541	126,891	123,383	120,177	117,478

	2019			
	Jan-Mar	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**
North East	25,292	23,845	24,194	24,107
North West	27,664	26,645	27,776	24,869
South East	29,992	29,086	28,148	25,269
South West	26,201	24,869	24,853	23,916





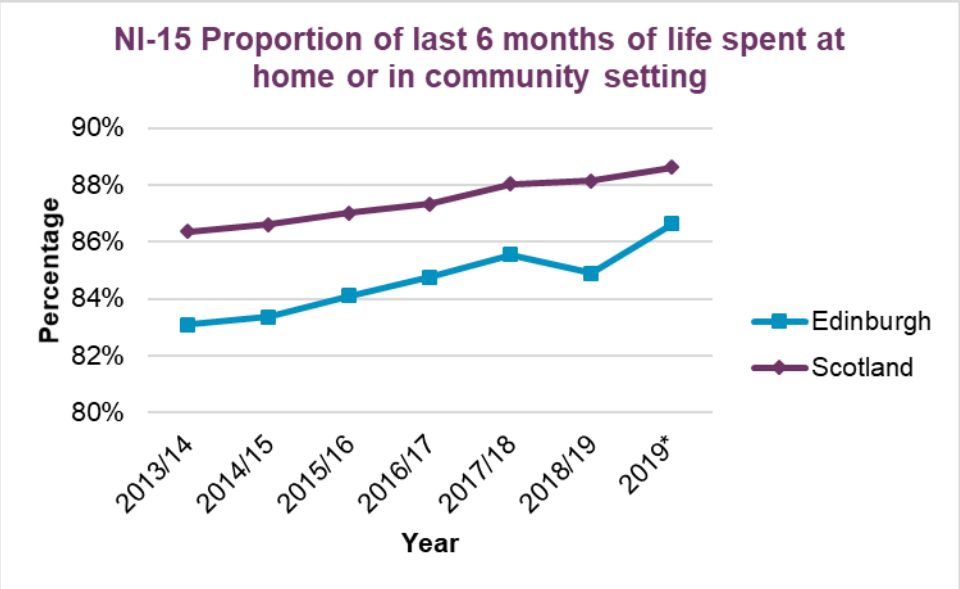
Source: Public Health Scotland

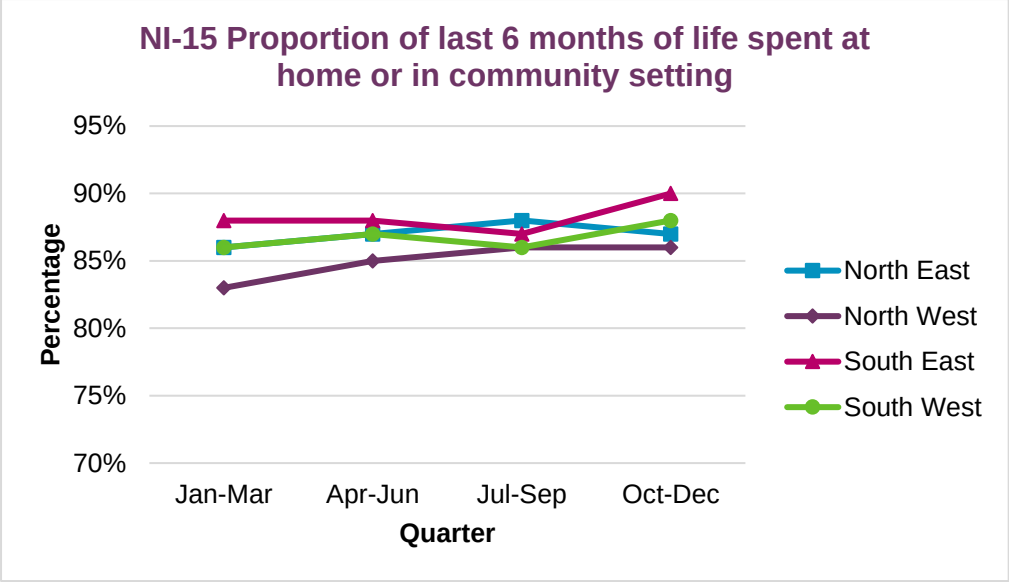
Edinburgh's long-term trend for emergency bed day rate per 100,000 population of adults age 18 and older has been steadily decreasing since 2013/14 to 2019. Performance between 2018/19 and 2019 improved by 7% from 112,108 bed days in 2018/19, to 104,707 in 2019. Edinburgh has been consistently outperforming the Scottish average since 2013/14. The Scottish average in 2019 was 117,478 emergency bed days per 100,000 adult population. All four localities have seen a decrease in emergency bed days, with the South East locality seeing the biggest decrease.

NI-15. Proportion of last 6 months of life spent at home or in community setting

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019*
Edinburgh	83%	83%	84%	85%	86%	85%	87%
Scotland	86%	87%	87%	87%	88%	88%	89%

	2019			
	Jan-Mar	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**
North East	86%	87%	88%	87%
North West	83%	85%	86%	86%
South East	88%	88%	87%	90%
South West	86%	87%	86%	88%



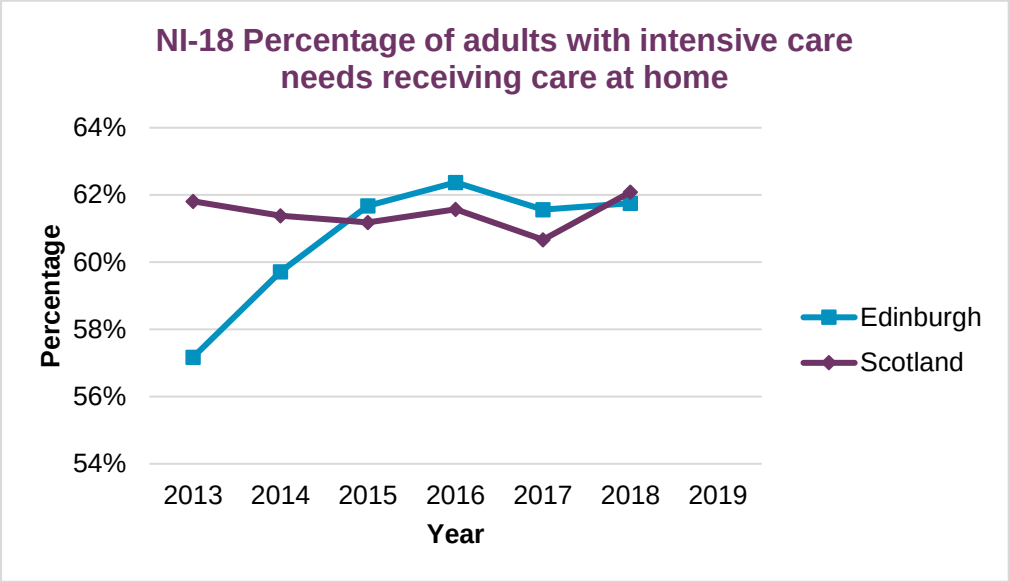


Source: Public Health Scotland

The percentage of the last six months of life is spent at home or in a community setting has been improving in Edinburgh with an increase of 2% from 85% in 2018/19, to 87% in 2019. This is slightly lower than the Scottish average in 2019 was 89%. All four localities have reported an increase, although the South East locality has a higher proportion with 88%.

NI 18. Percentage of adults with intensive needs receiving care at home

	2013	2014	2015	2016	2017	2018	2019
Edinburgh	57.2%	59.7%	61.7%	62.4%	61.6%	61.8%	N/A
Scotland	61.8%	61.4%	61.2%	61.6%	60.7%	62.1%	N/A



Source: Public Health Scotland

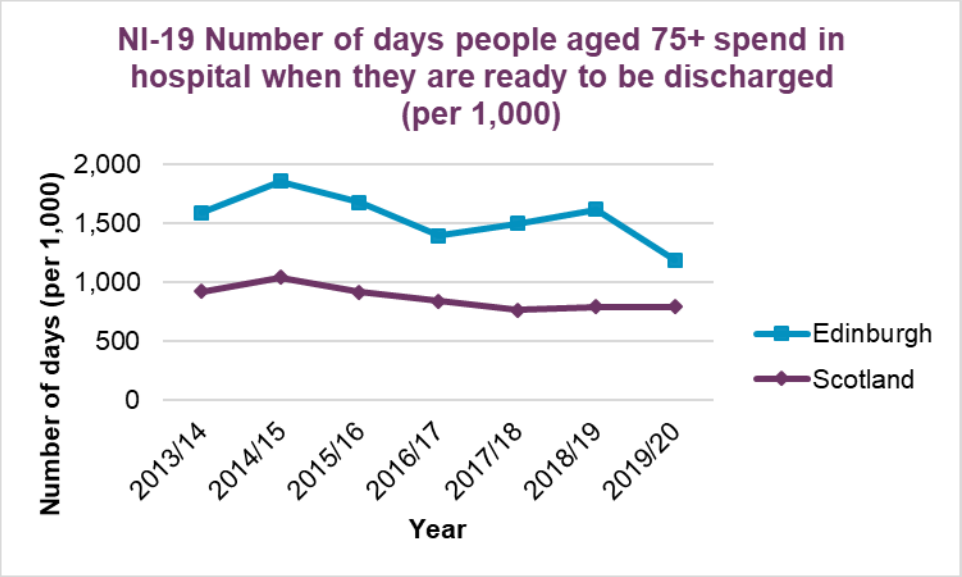
Edinburgh's long-term trend for adults with intensive care needs are receiving care at home has been increasing from 57% in 2013, to 62% in 2018.

The information for this indicator (NI-18), is published by the Insights in Social Care release produced by Public Health Scotland. The data relating to 2019/20 is not due to be published until later in the autumn and is not available for inclusion in this report.

NI-19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Edinburgh	1,592	1,861	1,679	1,395	1,502	1,621	1,191
Scotland	922	1,044	915	841	762	793	793

Edinburgh's performance improved by 27% from 1,621 days in 2018/19 to 1,191 in 2019/20. The Scottish average in 2019/20 was 793 days per 1,000 population.



Source: Public Health Scotland

We have made positive progress in reducing the number of days which people aged 75+ spend in hospital, per 1,000 population. The number of delayed discharges has reduced from a high of 1,861 in 2014/15, to 1,191 in 2019/20 and reducing. The Scottish average was 793 in 2019/20.

Looking ahead to 2020/21

In April 2020 we entered phase two of the current strategic planning cycle; a continuation and implementation of the transformation programme. Our transformation framework gives a strong foundation for the level of strategic change we want to deliver for the city. The framework applies a programme management approach to major service redesign and innovation and includes widespread collaboration and stakeholder engagement. The programme will respond to a significant number of challenges and work towards creating modern and sustainable services that optimise resource and meet the needs of our citizens in the years ahead. To deliver the transformation at pace, the programme provides a wide-ranging and ambitious programme of change supported by a dedicated transformation team.

Despite inevitable disruption to the transformation programme caused by the COVID-19 pandemic, work has continued where possible. We have seen some clear examples during the pandemic where response to the crisis has been a catalyst for the acceleration of transformational change. The Home First Edinburgh model has expanded, and we have seen considerable success in reducing delayed discharge and improved flow across the system. A wide variety of teams have embraced digital opportunities, with the use of 'Near Me' systems in primary care being particularly successful. Staff have also reported that the Three Conversations approach has given an excellent foundation for supporting people through the crisis.

We carried out a comprehensive lesson capture exercise in early April. Informed by these lessons, we have adapted the transformation programme to target priorities and optimise available capacity and exploit opportunities identified during COVID-19. We will now focus staff effort on an agreed set of immediate strategic priorities and work will begin in August 2020. The remaining project workstreams will be placed into a planned, follow on phase, due to start from January 2021. We will continue to focus on planned 'quick wins' to build momentum and confidence, whilst at the same time developing overarching plans and business cases for longer-term change, recognising that transformation gives us the best opportunity to deliver both financial sustainability and high quality and modern services.

We will review our current strategic plan in the second half of 2020. Until then we will continue with our existing strategic framework:

Vision: To deliver together a caring, healthier and safer Edinburgh

What means do we have?	How will we get there?	Where do we want to get to?
Scottish Government Direction	Implementation of Strategic Plan and Change Programme aligned to priorities	An affordable, sustainable and trusted health and social care system
Good Governance	Develop modern Edinburgh Offer	A clearly understood and supported 'Edinburgh Offer' which is fair, proportionate and manages expectations
Budget	Roll out Three Conversations Approach	A person centred, patient first and home first approach
Workforce	Strong Partnership with the voluntary and independent sectors	A motivated, skilled and representative workforce
Infrastructure	Shift balance of care to communities	An optimised partnership with the voluntary sectors
Data and Performance Management Framework	Tackling Inequality	Care supported by the latest technology
Technology	Unity of purpose and momentum	A culture of continuous improvement
Communications and Engagement		

Principles *Home First, Integration, Engagement, Respect, Fairness, Affordable and Sustainable, Safer*

Our Values *Empowering, Inclusive, Working Together, Honest and Transparent*

For more information

Visit: www.edinburghhsc.scot

E-mail EHSCP@edinburgh.gov.uk

Telephone: 0131 553 8444

Twitter: @EdinburghHSCP

Mail: Edinburgh Health and Social Care Partnership
Waverley Court, Level 1:7
4 East Market Street
Edinburgh EH8 8BG

EIJB Annual Performance Report 2019/20, published August 2020

Edinburgh Integration Joint Board

REPORT

Evaluation of 2019/20 Winter Plan

Edinburgh Integration Joint Board

24 August 2020

Executive Summary	The purpose of this report is to present the following: 1. Scottish Government DL (2017)19 guidance on Preparing for Winter 2017/18 is the most recent government circular outlining the requirement for Health and Social Care Partnerships to produce an action plan to ensure health and social care services are well prepared for winter. Further to this Malcolm Wright, Chief Executive NHS Scotland and Director General Health & Social Care, wrote to the Chief Officers of Health & Social Care Partnerships and the Chief Executive of NHS Lothian on 04 September 2019 regarding preparing for Winter 2019/20 2. The winter plan 2019/20 was outlined at the IJB meeting on 28 November 2019. 3. This report and its appendices provide an overview of the suite of winter planning actions and services, and an evaluation of the impact of each. In addition, this year, the plan sets this in the context of the Edinburgh Health and Social Care Partnership's (EHSCP) performance for key performance indicators, compared to last winter. 4. Winter Planning for 2020/21 has commenced, with priorities based on the lessons learned from COVID-19 thus far.

Recommendations	It is recommended that the Edinburgh Integration Joint Board (EIJB): 1. Note the Local Review of Winter 2019/20 Report, the full version of which is included in Appendix 1. One of the successful outcomes of Winter 2019/20 is that the additional Social Work and Mental Health Officer posts have been funded on an ongoing basis 2. Note the Lessons Learned from the COVID-19

	pandemic attached at Appendix 2, which will inform future planning 3. Note that planning is underway with regards to our key priorities for Winter 2020/21.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations		✓
	No direction required	✓
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Report Circulation

1. The report will be circulated to the Edinburgh Integration Joint Board for the meeting on 24 August 2020.

Background

2. Planning for winter is an important part of the Partnership's service delivery, given the additional pressures placed on local systems from seasonal influenza, norovirus, severe weather and public holidays.

3. Malcolm Wright, Chief Executive NHS Scotland and Director General Health & Social Care, wrote to the Chief Officers of Health & Social Care Partnerships and the Chief Executive of NHS Lothian on 04 September 2019 confirming the amount that NHS Lothian was allocated for 2019/20 and instructing Health Boards and IJBs to use this allocation to specifically target the delivery of 5 priorities:
   - Reducing attendances wherever possible by managing care closer to home, preferably at home, with services focussed on assessment and care closer to home
   - Managing/avoiding admission wherever possible, with services developed to provide care at home across 7 days

- Reducing length of stay
- Focus on flow through acute care
- Workforce

4. The letter requested that Winter Plans were submitted by the end of October 2019. A supplementary checklist of winter preparedness: self-assessment was included for completion. A copy of this is available on request.

5. A subsequent Scottish Government communication on 30 October 2019 requested that all winter plans meet the following criteria:
   - Include an Opening Summary contextualising the plan, expanding on what worked last year, what learning has gone into developing it and what existing policies or plans underpin the winter plan
   - Provide a full breakdown of the specific additional activity/capacity that will be put in place with additional investment to support performance over winter alongside the measurable outcomes this will achieve
   - Outline the actions planned to sustainably reduce attendances and how this will be measured
   - Detail the planned level of provision over the festive period
   - Provide reassurance of the resilience arrangements in place over the festive period and indeed throughout the whole of winter
   - Demonstrate how sustainable reductions will be made on delayed discharges
   - Clarify how NHS Lothian plans to monitor predicted unscheduled care demand to avoid cancellations and plans in place to protect electives throughout winter
   - Describe the actions planned to achieve the national target of 60% uptake of the seasonal flu vaccination for health and social care staff

6. A copy of the EHSCP Winter Plan for 2019/20 is attached at Appendix 3.

7. The EHSCP Winter Planning Group, which includes multi-agency and multi-disciplinary representation, led on the planning and evaluation of the Winter Plans. Monthly meetings were held in the lead up to and throughout Winter 2019/20.

Main Report

8. The provision of unscheduled care for the people of the Lothians is the responsibility of five organisations: the 4 Lothian IJBs and NHS Lothian; working with partner national organisations Scottish Ambulance Service and NHS24. The Unscheduled Care Committee was originally established to add rigour and governance to the process of developing robust and resilient winter plans that align with local priorities. The Committee recently widened this remit in order to support the newly established Unscheduled Care Programme Board to ensure a whole system approach is taken to delivering a sustainable model of unscheduled care. The aim is to provide timely access to care in the right place at the right time, avoiding delays anywhere in the whole system. A copy of the Committee's Terms of Reference is available on request.

9. A total of 7 bids were funded by the Lothian Unscheduled Care Committee for EHSCP, and 2 bids were funded by EHSCP. These were:

Bids	Achievements and Impact on Budget Pressure
Funded by Lothian Unscheduled Care Committee	
Festive Public Holiday Enhanced Primary Care Service Model for City	The Festive Practice was operational on 1 and 2 January, providing a service to a total of **46** patients: **32** patients were seen by a GP, **8** patients were seen in CPN appointments and **6** patients were seen by a Practice Nurse - **6** district nurse visits saved
Enhancement of Community Respiratory Team (CRT+)	CRT+ provided a specialist community based service for **65** people with acute respiratory infection, **40** of whom might otherwise have been admitted to hospital; **64**% of admissions prevented. The service successfully supported a prevention of admission of **94%** at 48 hours and **89%** at 7 days. Weekend statistics for the CRT team also noted Physio@Home assessed **3** patients over weekends and retained **2** of them on their active caseloads
Winter Support Team	The Winter Support Team received **71** referrals in 16 weeks, of which **58** were appropriate. The majority came from the Flow Centre (**22**) and the Hub Prevention of Admission (POA) Teams (**31**). **55** people out of the 58 referrals were prevented from going into hospital, totalling a reduction **658** bed days

Social Work to Support Home First Model	**5** WTE Social Workers were recruited over the winter period to work across the city. The aim of the additional capacity was to ensure that people were allocated within the 24 hour target and then assessed appropriately within the aim of completion of 72 hours, however, due to very high levels of staff sickness and social work vacancies throughout the period, the overall capacity still fell short of that required
Care at Home	Call In Homecare started **49** packages from Reablement totalling **390.5** hours, and Reablement started **86** hospital discharge packages totalling **1034.5** hours. This was an increase of **33** packages and **396** hours from a similar period in the weeks immediately prior to the incentive commencing, when Reablement started 53 hospital discharge packages totalling **638.5** hours.
Adults with Incapacity (AWI):	One additional Mental Health Officer was employed increasing the availability for case conferences to be held which reduced the length of time waiting for such decision-making forums. This enabled the least restrictive option to be explored promptly leading to some people moving on from hospital without the need for guardianship applications being made. It also enabled work to commence without further delay. Between December 2019 and March 2020, there were a total of **250** delayed discharges for AWI, a reduction of **34**% from the same period the previous year
Open House	EVOCs Open House proposals had significant engagement from all providers. Support Minds Scotland supported **110** people over 11 sessions, and the Caring in Craigmillar Phonelink service supported **12** people. Data is still outstanding from Health All Round and Artlink Edinburgh, however, we have been unable to collect the data due to the impact of the COVID-19 pandemic on these organisations
Funded by EHSCP	
Walking Aid Safety Assessments in Care Homes	**164** walking aids were assessed across 7 Edinburgh care homes (which were chosen due to the high falls rates within these homes) with **18** (11%) needing repairs and **25** (15%) needing replacements, either due to age or being irreparable. Therefore **38** of **164** (23%) needed repaired or replaced and the remaining 77% were considered safe for appropriate use. A&E attendances and falls related admissions data collected via Tableau to evaluate the impact of this work will not be available until 6 months post project delivery
Psychotherapeutic support for carers (VOCAL):	VOCAL provided targeted support for **216** very vulnerable people who might otherwise have requested or sought support from statutory services. 30 carers on VOCAL's waiting list were called and offered therapeutic support, with **7** referrals made for counselling as a result. **3** carers were highlighted with the Carer Support Team to check any immediate support requirements were met. VOCAL also hosted 'Open days' for carers to drop in on 30 and 31/01/2020, when **9** carers 'dropped in' for support and an additional **5** were spoken to on the telephone either to take referrals or give support. **6** carers benefited from complementary therapy sessions.

10. In 2019, Scottish Government released a Winter Debrief template for completion, however, this was not requested in 2020 as a result of the COVID-19 pandemic. Lothian Unscheduled Care Committee did, however, request

that a similar template be completed to evaluate winter planning in 2019/20. The Partnership provided comprehensive details of actions taken, and commentary on what went well and what could have gone better, under each of the following headings:

- Clear alignment between hospital, primary and social care
- Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods
- Local systems to have detailed demand and capacity projections to inform their planning assumptions
- Maximise elective activity over winter – including protecting same day surgery capacity
- Escalation plans tested with partners
- Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings
- Delivering seasonal flu vaccination to public and staff
- Third Sector Services
- Adults with Incapacities
- Top Five Local Priorities for Winter Planning 2020/21

11. The full report is detailed in Appendix 1.

Flu Vaccinations

12. Staff flu vaccination clinics were well advertised on both CEC/NHS Intranet systems, and staff were invited to attend any clinic on a number of sites and locations across Edinburgh and the Lothians to be vaccinated.

13. Staff Uptake rates: This year **19,186** vaccines were issued across Lothian. Of the total **13,228** completed consent forms returned by mid-March (some are still coming back to be counted), **1,975** were for non NHS staff (mainly council staff and some volunteers). It is therefore estimated **16,175** vaccines were used for

NHS staff. With a head count of 26,679 this gives an uptake of **64%** among NHS staff.

14. EHSCP Staff Uptake rates: **837** consent forms were received for EHSCP CEC staff (585 in 2018/19), an increase of **30%** from last year. **781** consent forms were received for EHSCP NHS staff, bringing the total number of staff vaccinated in EHSCP to **1,618**.

15. Support was provided from the vaccination team for care homes and for housebound individuals (who are not currently on the district nurse caseload)

16. A total of 6,816 individuals across Lothian who were housebound or resident in care homes received their flu vaccinations from the vaccination team, potentially reducing pressure on admission to acute and community services. 4,692 (4,596 in 2018/19) patients were vaccinated at home and 2,124 (1952 in 2018/19) residents vaccinated in care homes

Festive Staffing Cover

17. For the second year, a spreadsheet was developed mapping the annual leave arrangements during the 2 week festive period for all managers and team leads in the 4 EHSCP localities, hospital and hosted services, and the Executive Management Team. This provided a quick reference tool for cover arrangements and points of contact in each service. Managers and Team Leads were also asked to provide assurance about the level of staffing in place throughout this period, particularly on the weekends and public holidays

Winter Weather Resilience Arrangements

18. The EHSCP Severe Weather Resilience Plan was updated and released on 07/11/2019. Key principles were agreed involving escalation protocols, key contacts and transport sharing arrangements via a ‘Transport Hub’.

19. EHSCP coordinated the provision of 4x4 vehicles across the localities which could be accessed in the event of an episode of severe weather, to allow staff to visit the homes of service users where poor weather might have otherwise prevented travel to these homes.

Communications for Winter 2019/20

20. The Partnership focused on:
    - Communicating with staff to provide advice to support service users
    - Supporting the NHS Lothian flu vaccine campaign for frontline staff, particularly on social media and through the various newsletters
    - Communicating with key audiences, particularly vulnerable groups, with specific information

21. Winter 2019/20 communications started from 19/12/2019, with a series of targeted communications for:
    - High risk/frontline staff about getting the flu vaccine
    - Care home staff and GP Practices
    - Homecare staff on keeping themselves and clients safe and healthy over winter
    - Those with long term conditions
    - Those most at risk of falling
    - Unpaid carers

Implications for Edinburgh Integration Joint Board

Financial

22. The Partnership received a total allocation of £535,661, of which £364,642 was committed. A full breakdown is attached at Appendix 4

23. It should be noted that some proposals did not utilise the full amount of funding allocated. The Festive Practice only opened on 2 days but was funded for 3 days. Hub Managers were unable to recruit to all of the available Social Work hours. The Winter Support Team funding was not used in its entirety as, due to

timescales, external recruitment was unfeasible, therefore staff were redeployed from each of the locality teams. A similar proposal has been submitted this year, however, a detailed plan is in place to recruit to the posts within timescales.

Legal / risk implications

24. Ability to recruit to short term posts that are only required for surge capacity and do not require permanency

25. Ongoing contractual limitations to facilitate weekend working beyond that which is voluntary

Equality and integrated impact assessment

26. An integrated impact assessment was undertaken in December 2017 to consider both the positive and negative outcomes for people with protected characteristics and other groups. Improvements have been made in subsequent years for both these groups in collaboration with our third sector partners. The general findings were very positive. Areas for improvement were unpaid carers and hard to reach groups. It was noted that there has been an impact on staffing due to the Council and NHS staff having different contracts and the ability to pay enhanced rates to incentivise staff to work weekends or public holidays based on different terms and conditions. This remains the case. A new integrated impact assessment will be undertaken for 2020/21.

Environment and sustainability impacts

27. A positive outcome for future sustainability is the ongoing funding of the social work and Mental Health Officer posts

28. Going forward, the Unscheduled Care Programme Board, under the chairmanship of the Chief Officer of the West Lothian Health and Social Care Partnership, will consider any proposals relating to new and/or enhanced services all year round.

Consultation

29. Winter plans were developed in close consultation with key stakeholders through the NHS Lothian Unscheduled Care Committee, the EHSCP Winter Planning Group and the planners and operational managers who generated the proposals.

30. A communication plan was developed for the EHSCP to ensure that staff in health and social care, partner organisations, the public and visitors to the city were aware of the services available over the festive period and how to access these.

31. The key target groups were people using the largest proportion of health care resources, primarily vulnerable older people, people who receive a care at home, people with long-term health conditions, and unpaid carers.

32. Winter plans have been developed in very close consultation with relevant parties, led by the NHS Lothian Unscheduled Care Committee and locally through the EHSCP Winter Planning Group. This group has membership from acute sites, Social Care Direct, and includes leads for flu, carers, third sector, resilience, and communications.

Report Author

Judith Proctor

Chief Officer, Edinburgh Integration Joint Board

Contact for further information:

Name: Angela Lindsay

Email:angela.lindsay@nhslothian.scot.nhs.uk Telephone: 07971 336 292

Appendices

Appendix 1	Local Review of Winter 2019/20
Appendix 2	COVID-19 Lessons Learned Debrief
Appendix 3	EHSCP Winter Plan for 2019/20
Appendix 4	Financial Breakdown

Health & Social Care: Local Review of Winter 2019/20

NHS Board H&SCP s:	NHS Lothian Edinburgh, West, East & Midlothian H&SCP	**Winter Planning Executive Lead:**	Angela Lindsay, Locality Manager – North East Edinburgh

1	**Clear alignment between hospital, primary and social care**
	• The Community Respiratory Team Plus (CRT+) is an enhanced service reintroduced over the December 2019 – March 2020 winter period. The third year of the service was aimed at widening the referral criteria of CRT capacity over the winter period to include acute respiratory infections in frail elderly (referrals coming from GPs) without a diagnosis of chronic respiratory conditions, in addition to providing community specialist respiratory physiotherapy assessment and treatment for patients with acute respiratory infections; preventing admissions or, where applicable, readmission to secondary care. • The Winter Support team was established this year to boost capacity through an additional 16 frontline staff and 2 Home Care Coordinators. The recruited staff were focused on providing care to prevent admission as part of the Reablement assessment processing. The proposal increased each Hub area by 2 teams of 2 staff working back to back over 7 days. Their focus was on pushing a Home First model through admission avoidance and supporting discharges, allowing real time discharge rather than waiting on a package of care. When a patient was ready for discharge the Winter Support Team would be utilised to bridge until the POC could start. The service prevented admissions to the front door by offering an alternative to admission and allowed the flow centre to have options as an alternative to admission. • The walking aid assessment proposal was established this year to support a service to assess, identify, repair and replace unsafe walking aids in Edinburgh care homes. Initial assessments of all walking aids used by care home residents were followed by ordering repairs and replacements of unsafe aids through the equipment store (ATEC24), and constructive recommendations to support the care home towards setting up and acting upon weekly in-house walking aid checks. All 7 core criteria were met by this proposal: 1. It promoted collaborative working of healthcare professionals in a social work environment. 2. Services were delivered onsite so residents were not required to go elsewhere. 3. The aim of ensuring walking aids are safe is to directly reduce the rate of falls related A&E attendances and hospital admissions by reducing falls. 4. By setting up a system of weekly checks this project aimed to improve care homes ability to independently manage this process. 5. By introducing a system of early identification of unsafe walking aids and facilitating links with equipment and rehabilitation services as needed, care homes are empowered to make relevant referrals. 6. All services are delivered within the non-acute care home setting, and aim to reduce the rate of admissions. 7. Should a resident have an unplanned admission, already having safe walking aid equipment in place will help facilitate discharge.

1.1	**What went well?**
	• The CRT+ service ran from Dec 19 –April 2020 and offered community patients respiratory assessment, treatment and management from specialist physiotherapists embedded in CRT. Sources of referrals were primarily GPs but also Secondary Care. During the service period, **65**

	referrals were received; **40** of these were deemed at risk of hospital admission (**64%**). The service successfully supported a prevention of admission of **94%** at 48 hours and **89%** at 7 days. Weekend statistics for the CRT team also noted Physio@Home assessed **3** patients over weekends and retained **2** of them on their active caseloads. • Co-location of services - Allows sharing of resources between services when there is increased capacity in either CRT or CRT+ • Rapid Assess treat and discharge model of care is appropriate for referrals into this winter service • Another respiratory referral option for GP's to avoid hospital admission in winter • Has up skilled staff in respiratory and community working • The Winter Support Team received 71 referrals in 16 weeks, of which **58** were appropriate. The majority came from the Flow Centre (**22**) and the Hub Prevention of Admission (POA) Teams (**31**). **55** people out of the 58 referrals were prevented from going into hospital, totalling a reduction **658** bed days. This reduction included patients either returning to their baseline or managing without a further package of care, or through the handover of the POC to another provider. The figure of £500 per night, per bed was used at the beginning of the Project. Therefore, 658 x £500 = savings of £329k in NHS bed days making this an extremely worthwhile and successful project. • **164** walking aids were assessed across 7 Edinburgh care homes with **18** (11%) needing repairs and **25** (15%) needing replacements either due to age or being irreparable. Therefore **38** of **164** (23%) needed repaired or replaced and the remaining 77% were considered safe for appropriate use. Each care home cost on average £120 in terms of equipment supplied and replaced, a much lower cost than anticipated. Staff recruited to the project from the Physio@Home team reported benefits to understanding of care homes, care home understanding of Physio@Home, and improvement on existing working relationships with care home staff. The Walking Aids team stated excellent initial care home engagement with project as expected. The hope is to run this project in Edinburgh annually, and with the data available so far consider it both highly effective and highly affordable.

1.2	**What could have gone better?**
	• There were issues recruiting staff for CRT+, given the late start to the recruitment process • Due to the initial 'soft start', the Winter Support team referrals and contacts from GPs were slow. Second rounds of communications were sent to the GPs, including face to face presentations by team members, however referrals via the Flow Centre were expected to be higher. The Winter Support Team did not have any referrals at the weekends. Frontline staff were utilised 7 days a week however, working a 4 on 4 off shift pattern. The Navigator and Home Care Coordinators worked Monday to Friday. Weekend activity was discussed with referrers and they felt this would be welcomed and utilised going forward if people were made aware this was an option open to them. • Recruiting staff from the staff bank created significant issues for the Walking Aids Project. Lengthy delays in recruitment impacted capacity for delivery stage. It was also difficult to coordinate team members who were often working in different teams and sites to ensure scheduling for care home visits. The project was also taken on and funded by the Long Term Conditions programme with an initial proposal of £22789 rejected. The LTC programme funded this project with £8711, resulting in reduced capacity and resources. Due to the COVID-19 epidemic, restrictions were put in place for all non essential visits in care homes, affecting some scheduled visits. A&E attendances and falls related admissions data collected via Tableau to evaluate the impact – data will not be available until 6 months post project delivery. There will be a delay in reporting on impact of project.

1.3	Key lessons / Actions planned
	• CRT will explore the possibility of seconding staff from other services (including Physio@home/Pulmonary Rehab Teams etc.) earlier in the year to ensure the service is sufficiently staffed for winter months. • More emphasis around communications e.g. weekly snapshots to GP's to raise awareness. • Differentiate between CRT and CRT +, as there is some confusion between the two. • Demonstrate the need for enhanced service throughout the year to manage a wider group of respiratory patients. • The Winter Support Team noted for future practice, one contact number should be utilised for the Prevention Team, making it easier for everyone to refer and get straight through to the Team. GP feedback outlined they found it time consuming having to pass on information via the Flow Centre staff and then reiterate it to the WPT Navigator and Co-ordinator. The Winter Support team also noted, given the front-line staff were identified by their managers in their localities quickly at the beginning of the project, the team quickly discovered that some staff felt they hadn't been given a full understanding about what their new role entailed. Going forward it would be imperative that staff had the opportunity to apply for these positions and the full remit of the post explained prior to them doing so. This proposal has confirmed the need additional permanent, prevention team positions all year round. • Lack of tableau dashboard updates of care home data is an issue for evaluation as this represents falls leading to A&E attendances or hospital admissions from each care home. The Walking Aid team hope to have this data in the upcoming months. Staff bank recruitment was not an easy or efficient process for this project. Other routes of recruitment are to be assessed for a similar project.

2	Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods
	• The Social Work to Support Home First model has significantly contributed towards the reduction in number of people delayed in hospital. The current model of hospital flow waits for the person to be ready for discharge before a referral is made to social work, which then causes additional unnecessary delays. However, the recruited social work posts from this model aimed to support early intervention and a home first approach through actively linking with locality hubs to encourage assessments to take place earlier in the hospital patient pathway, with a focus of transition to follow up assessment to take place in the person's own home. Working closely with clinical colleagues at an early stage, the model enabled an earlier flow through community services from acute and ensured management of additional demand during winter. • This year's Care at Home model was established to support additional care at home capacity. The proposal aimed to create increased flow and facilitate reablement teams across the city to meet the increased demands over winter. To do so, the project aimed to incorporate 500 additional care at home hours to unblock reablement teams.

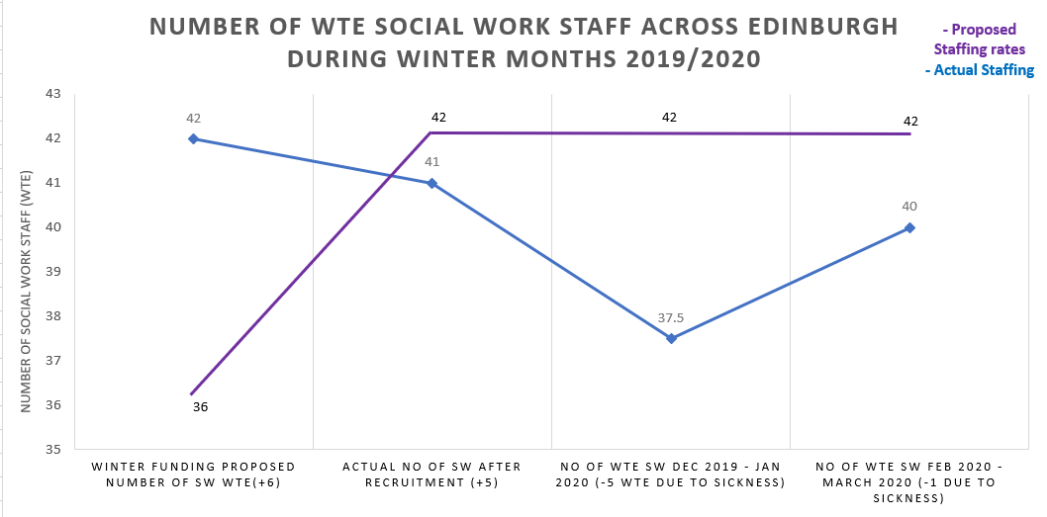
2.1	What went well?
	• The social workers recruited over the winter period equated to **5** WTE positions available to work across the city. With this capacity, it ensured people were allocated within the 24 hour target and then assessed appropriately within the aim of completion of 72 hours. The project has influenced a collaborative working across localities to ensure that work is not left uncovered across the city, with team members, including

Hub Managers, working together to support each other with challenges where possible. Working with a Home First ethos has allowed the teams to share a culture of planning for people to stay in their communities and own homes as long as possible.

- The Care at Home initiative commenced 25/11/19, with the last hospital discharge incentivised package of care starting with EHSCP Reablement team on the 20/12/19. Between 25/11/19 and 20/12/19 Call In Homecare started **49** packages from Reablement totalling **390.5hrs** (average package of care size 7.97hrs). Between 25/11/19 and 20/12/19 Reablement started **86** hospital discharge packages totalling **1034.50hrs** (average package of care size 12.03hrs). This was an increase of 33 packages and 396 hrs from a similar period in the weeks immediately prior to the incentive commencing, when Reablement started 53 hospital discharge packages totalling 638.50hrs (average package of care size 12.05hrs). This increase in Hospital Discharges reflected an equivalent return from Reablement on the hours transferred from Reablement to Call In homecare and funded through this initiative.

2.2 What could have gone better?

- The 4 Locality Hubs had an existing establishment of 34 WTE Social Workers, and funding was allocated for 6 WTE Social Worker posts, taking EHSCP to a proposed establishment of 42WTE. Due to recruitment issues, EHSCP was only able to employ an additional 5 WTE, taking the service to a total of 41 WTE. Due to sickness absence levels of staff and vacancies, there were only 37.5 WTE staff available to work in December and January, and 40 WTE in February and March, meaning that the service never reached the proposed total of 42WTE. This is detailed in the graph below:



- The number of people waiting for a care home bed fluctuated within the winter period, with a peak of 46 in the first week of February. Care at Home demand is still high but has shown some reduction with a peak of 96 mid-January. This data reflects the challenges faced by Hubs who have also been challenged by having to provide resources to cover in the community and prevent admissions.
- The Care at Home team noted that formalised data control documentation for regular submission during programme via nominated

	individuals internally would have benefitted the project. Individuals responsible for this information should be based at an operational level instead of contractual level. The team recognised that there was a tendency to forget to record results locally when responsibility to produce report sat with another team who had no direct sight of operational activities.

2.3	**Key lessons / Actions planned**
	• Due to high demand from acute sites, future work should advise services of other Home First routes including D2A and Prevention teams to relieve the pressure on social work teams and ensure the service is utilised in the full potential. • Through our Transformation Programme we are currently evaluating how home based care services are re-designed and delivered going forward in Edinburgh. This will pave the way for new arrangements to be put in place, before the current care at home contracting arrangements end in September 2021. An important consideration will be how we support and maximise home based services at all times during the year and deliver the best outcomes and quality of care to residents in Edinburgh. Through this planning exercise and many of the other initiatives already implemented e.g. 3 Conversations and Home First and additional learning/opportunities highlighted through the COVID-19 responses, we would envisage a very different model of delivery for home based care will be the likely outcome of the collaborative engagement ongoing. Our aspiration is that there are suitable and appropriate home based support services available for individuals at their immediate point of need, regardless of where we are on the calendar. What these home based services will consist of, how they will be delivered and who will deliver them is very much open for discussion just now, so it would be difficult to suggest at this time that we will always need additional resource in the Winter. If nothing else COVID-19 has shown us that we need to be able to step up and step down capacity rapidly, safely and flexibly at any point during the year and capacity challenges are not just linked to Winter pressures alone. It is important to add that all the aforementioned strategic planning is in development and unlikely to mitigate impact of next winter. Experience may be further amplified by further peaks of covid, and any associated pressures on care capacity within the system and as a result winter planning contingencies are still likely to be a sensible consideration for the coming year.

3	**Local systems to have detailed demand and capacity projections to inform their planning assumptions**
	• For the third year running over winter, the enhanced Festive Practice service provided additional urgent primary care, minor injury care and treatments, and wider social care support at periods of peak demand during the festive period. Based at the Chalmers Centre, Lauriston and supported by a multidisciplinary team, the service provided a path from pressurised services such as Emergency Departments, LUCS and mental health services. Through coordinating clinician monitoring work flows and managing demand, patients were able to be redirected to alternative care services. • For the second year, a spreadsheet was developed mapping the annual leave arrangements during the 2 week festive period for all managers and team leads in the 4 localities, hospital and hosted services, and the Executive Management Team. This provided a quick reference tool for cover arrangements and points of contact in each service. Managers and Team Leads were also asked to provide assurance about the level of staffing in place throughout this period, particularly on the weekends and public holidays.

3.1	What went well?
	• The Festive Practice service opened the 1st and 2nd January 2020. The location of Chalmers Sexual Health Centre was recognised as a favourable location due to the parking facilities and easy access for bus routes. Over both of the public holidays, 32 patients were seen by a GP, 8 patients were seen in CPN appointments and 6 patients were seen by a Practice Nurse – resulting in 6 district nurse visits saved. • Senior and middle grade leaders available throughout the festive period. • Local arrangements for managed annual leave plans, ensuring bank/agency staff were not being used to provide cover.

3.2	What could have gone better?
	• The Festive Practice service intended to run clinics on 26th and 29th December 2019, but there were difficulties in recruiting GP cover. The service usually recruits GPs from members of LUCS after their staffing is established. However the LUCS service had significant difficulties in staff cover for these dates, therefore the decision was made not to run the Festive Practice service on these dates.

3.3	Key lessons / Actions planned
	• For the continuation of the Festive Practice service over the winter months, it is essential to ensure sufficient staffing of GP's is available.

4	Maximise elective activity over Winter – including protecting same day surgery capacity
4.1	What went well?
	Non-applicable for Community Health & Social Care
4.2	What could have gone better?
	N/A
4.3	Key lessons / Actions planned
	N/A

5	Escalation plans tested with partners

5.1	What went well?
	• The EHSCP Severe Weather Resilience Plan was updated and released on 07/11/2019. Key principles were agreed involving escalation protocols, key contacts and transport sharing arrangements via a 'Transport Hub'. • EHSCP coordinated the provision of 4x4 vehicles across the localities which could be accessed in the event of an episode of severe weather, to allow staff to visit the homes of service users where poor weather might have otherwise prevented travel to these homes.

5.2	What could have gone better?
	• The EHSCP Severe Weather Resilience Plan did not benefit from a live trial this year due to this year's mild winter.
5.3	**Key lessons / Actions planned**
	• Test of resources: table top exercise of 'Transport Hub' still to be held (this was scheduled for Summer 2020, but has been delayed by COVID-19 pandemic)

6	Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings

6.1	What went well?
	• No visible increase in rates of norovirus across the partnership. • Information on closures and outbreaks provided by Public Health.

6.2	What could have gone better?
6.3	**Key lessons / Actions planned**
	• Continued focus and link with escalation plans.

7	Delivering seasonal flu vaccination to public and staff

7.1	What went well?
	• Staff clinics were available at many sites and locations across the partnership • Staff Flu Vaccinations were advertised well on both CEC/NHS Intranet systems • Staff Uptake rates: This year 19,186 vaccines were issued across Lothian. Of the total 13,228 completed consent forms returned by mid-March (some are still coming back to be counted), 1,975 were for non NHS staff (mainly council staff and some volunteers). It is therefore estimated 16,175 vaccines were used for NHS staff. With a head count of 26,679 this gives an uptake of **64%** among NHS staff. • EHSCP Staff Uptake rates: **837** consent forms were received for EHSCP CEC staff (585 in 2018/19), an increase of **30%** from last year. **781** consent forms were received for EHSCP NHS staff, bringing the total number of staff vaccinated in EHSCP to **1,618**. • Support was provided from the vaccination team for care homes and for housebound individuals (who are not currently on the district nurse caseload) • A total of 6,816 individuals across Lothian who were housebound or resident in care homes received their flu vaccinations from the

	vaccination team, potentially reducing pressure on admission to acute and community services. 4,692 (4,596 in 2018/19) patients were vaccinated at home and 2,124 (1952 in 2018/19) residents vaccinated in care homes

7.2	**What could have gone better?**
	• Currently vaccinators are allocated to care homes by General Practice (patients in care homes can be registered to different practices) resulting in vaccinators requiring to attend the same care home on multiple occasions. • Data collation and analysis of staff flu vaccinations remains an issue as consent forms are counted manually. A sub group from the Lothian Immunisation Coordinating Group (LICOG) was formed to consider electronic solutions available with a view to undertaking a pilot of an electronic consent form, however this was put on hold as could it could not meet information governance guidelines. • The uptake figure continues to be calculated by the number of vaccines used.

7.3	**Key lessons / Actions planned**
	• Accurate available data to support ongoing targeted flu vaccination programme is needed • Introduction of electronic consent form to allow better and more timely reporting of data • The implications of the current Covd-19 pandemic will need to be considered at every stage of planning for both the Housebound and Staff Flu Vaccination Programmes. • It is planned to move the Housebound Flu Vaccination Programme to the HSCPs for ownership through joint working with community nurses and there is acknowledgement that community nurse teams will require additional resource to vaccinate patients not on their caseload. Although the wider Vaccination Transformation Programme work is currently on hold and has been extended by 1 year, there is a need to establish if the housebound programme is to continue in its current format. • Commence the Housebound Flu Vaccination Programme as soon as the vaccine is available in September. • Care home residents should be prioritised in the first tranche of the vaccination plans. • Vaccines should be allocated per care home. • Increase the number of peer vaccinators, through a mandatory requirement, to enable as many staff as possible to get their flu vaccination within the immediate workplace.

8	**Third Sector Services**
	• VOCAL services have provided additional emotional and psychotherapeutic support between Christmas and New Year 2019 to individual carers (through counselling support) and groups of carers (through planned mainstream peer activities) to relieve isolation and depression over the festive period. Carers who find the festive period a particularly difficult time were supported on a one to basis over the telephone by trained councillors and able to engage with carer support staff through planned drop in events scheduled during this time period. As well as socialise with other carers on peer group planned activities. • Edinburgh's third sector providers, (EVOC) Open House proposal added 5 projects to support winter. The proposals created capacity for additional ring-fenced befriending, telephone befriending and telephone medication prompt capacity to older people who are either

	engaged with H@H, D2A or are being discharged from a hospital setting.

8.1	**What went well?**
	• VOCAL's carers counselling service supported **216** carers in total. 30 carers on VOCAL's waiting list were called and offered therapeutic support. Most reported appreciating the check in call and **7** referrals were made for counselling as a result. Caring situations were often extremely challenging and resulted in safeguarding and signposting to crisis intervention services to some extent. **3** carers were highlighted with the Carer Support Team to check any immediate support requirements were met, which has now been done. VOCAL also hosted 'Open days' for carers to drop in between 10am-4pm on 30/31 January. **9** carers 'dropped in' for support and an additional **5** were spoken to on the telephone either to take referrals or give support. **6** carers benefited from complementary therapy sessions. • EVOC's Open House proposals had significant engagement from all providers. Support Minds Scotland had over the 11 sessions involving **110** people. Of those who attended, people shared their love of hot food, peer support and volunteer opportunities. This proposal allowed front-door staff a clear referral route to avoid admission and ensured appropriate community support for people with mental health and substance misuse challenges. • Additionally from Open House proposal, the Caring in Craigmillar Phonelink service offered light-touch telephone befriending and medication prompts throughout the day. The service received **12** appropriate referrals in total. One particular success story: '*A lady who was admitted to WGH with suspected delirium, Mrs W, was calling NHS 24, her GP and the Police most days. When calling NHS she stated she was unwell and confused and when calling Police, Mrs W was saying she had people in her house. When either service responded they found she was fit and well and no cause for concern. She was then admitted with a suspected UTI, displaying confused and with poor mobility. She was referred to Phonelink on day of discharge. The service made contact with Mrs W 2 x per day to offer reassurance and distraction by talking to her about other things. The team received confirmation that she is no longer calling the emergency services as she has twice daily contact from the team.'* **3** of the referrals were Medication Prompt clients to bridge the gap until their package of care was put in place; these clients have stayed on the service. All 12 clients are still receiving the Phonelink service, receiving calls twice a day, 7 days per week.

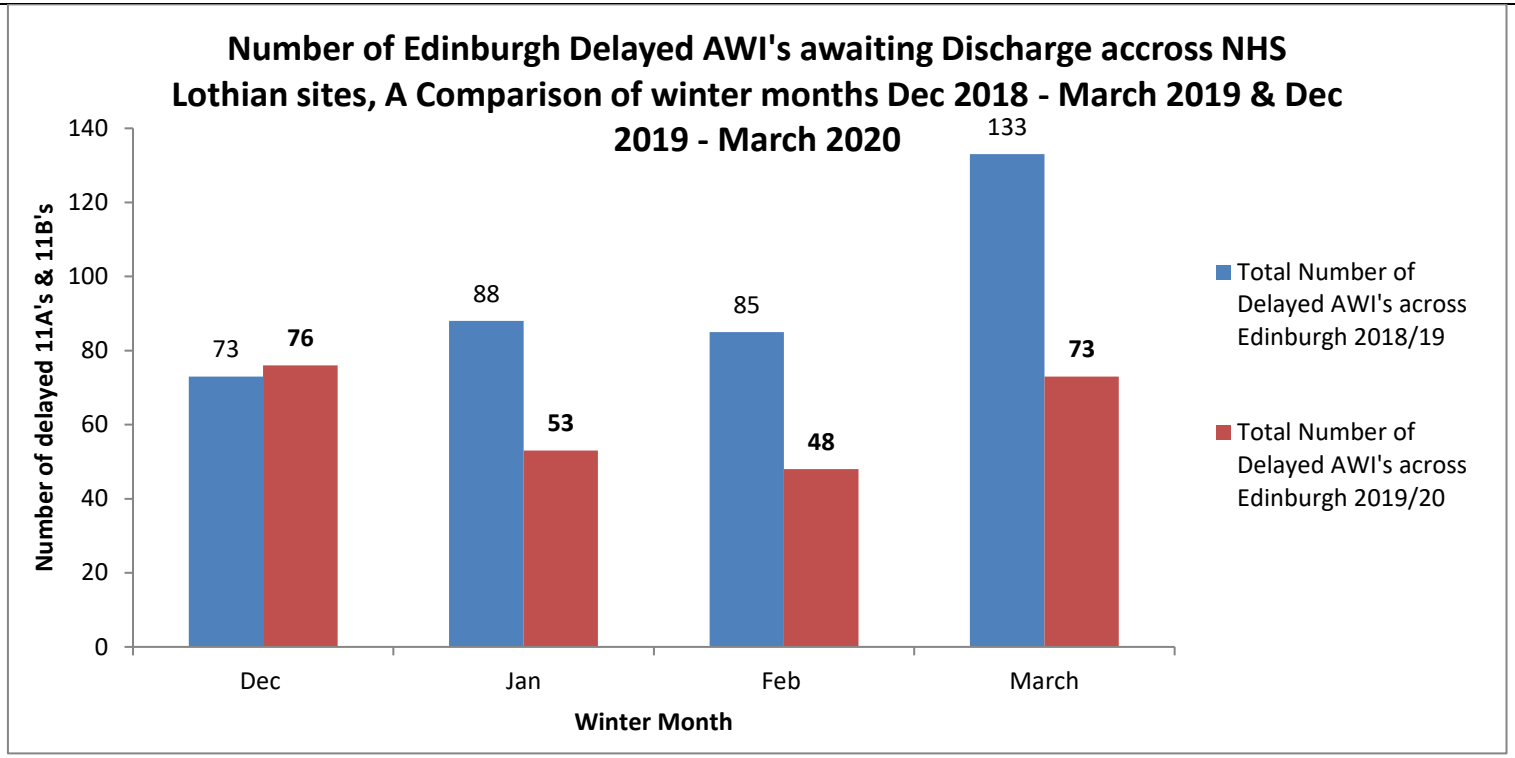
8.2	**What could have gone better?**
	• People prioritised for VOCAL's therapeutic support were from the carer support waiting list, rather than from Carer Support Workers existing client list. The team found this surprising that no existing carers were identified from existing caseloads and this will be investigated further with the team to ascertain why this might be the case. • Projects within the EVOC's Open House proposal outlined the need to ensure all potential participants are aware of the services. It was noted that a few families had not been informed of the referral opportunity or a full explanation of what the service entails.

8.3	**Key lessons / Actions planned**
	• VOCAL aims to increase engagement by ensuring carers are aware of the service available. The service was promoted widely by a variety of carer organisations, including but not exclusively, VOCAL, The Edinburgh Carer Support Team, the Edinburgh Carer Network to ensure as many carers as possible are aware of the support opportunities. The service aims to advertise more widely for future engagement.

	• A key lesson from the Open House projects is to ensure future projects run during specific times of the day which suit people taking part. Often services had to change timing of when services ran to ensure optimum engagement • 2 of the Open House projects have been unable to provide data at this time due to focussing on the response to the COVID-19 pandemic. This information is awaited and will be added to the evaluation on receipt

9	**AWI (Adults with Incapacities)**
	• The AWI proposal for winter 2019/2020 included the provision of 2 WTE Mental Health Officers to enhance current mental health provision to help identify and follow the appropriate path for people in respect of their incapacity. Current delays in hospital discharges include people awaiting legal intervention to allow selected individuals to make decisions on their behalf. Previous staffing of the AWI project team meant these people were not always fully supported. Discharge time can be significantly reduced if lawyers, family and other concerned parties are supported by this team. This is particularly critical over the winter period to enhance flow and ensure people are cared for in the right environment.

9.1	**What went well?**
	• The addition of one extra Mental Health Officer increased the availability for case conferences to be held which reduced the length of time waiting for such decision-making forums. This enabled the least restrictive option to be explored promptly leading to some people moving on from hospital without the need for guardianship applications being made. It also enabled work to commence without further delay. • The overall outcomes are fewer people delayed in hospital than there were in the same period 2018/19 and a shorter on average length of stay. The additional staffing also enabled the permanent members of staff to identify training needs throughout the Partnership. The aim of identifying and addressing these needs are to increase staff knowledge around capacity issues for in-patients and relevant referrals carried out at the earliest opportunity with all discharges carried out lawfully without further delay.



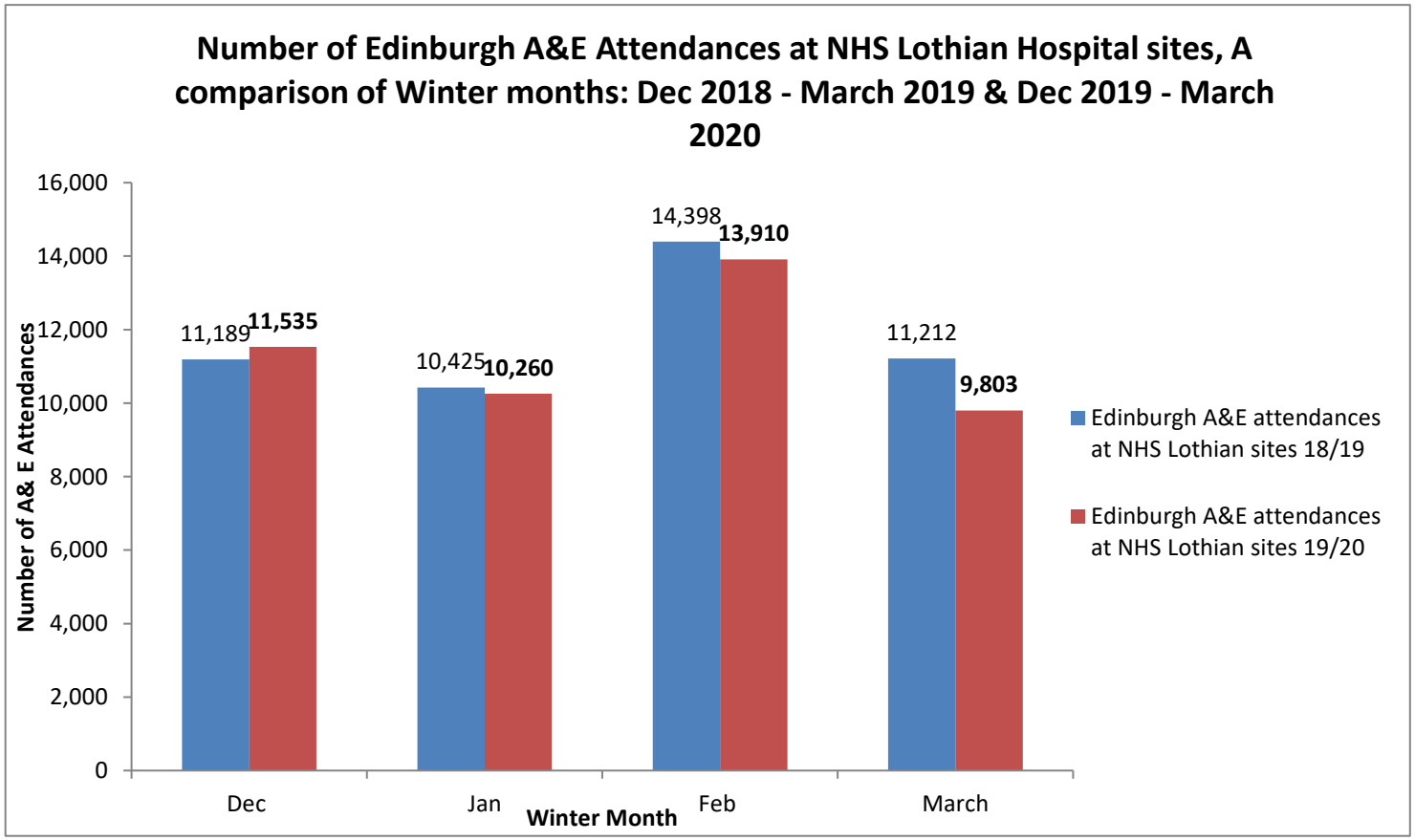
- The number of delayed AWI's awaiting discharge across Edinburgh has decreased dramatically. The introduction of 1 dedicated MHO has allowed AWI's to be more effectively supported and discharged from hospital more efficiently.

* Figures extracted from Hospital Flow Dashboard for Edinburgh correct as of 08/05/2020.

9.2	**What could have gone better?**
	• Only one of the two funded posts was recruited to

9.3	**Key lessons / Actions planned**
	• The key lessons are that extra staffing reduces the number of delays and the length of delays. • 1WTE MHO post has now been ringfenced permanently to support this and 1 additional MHO post has been funded on a permanent basis

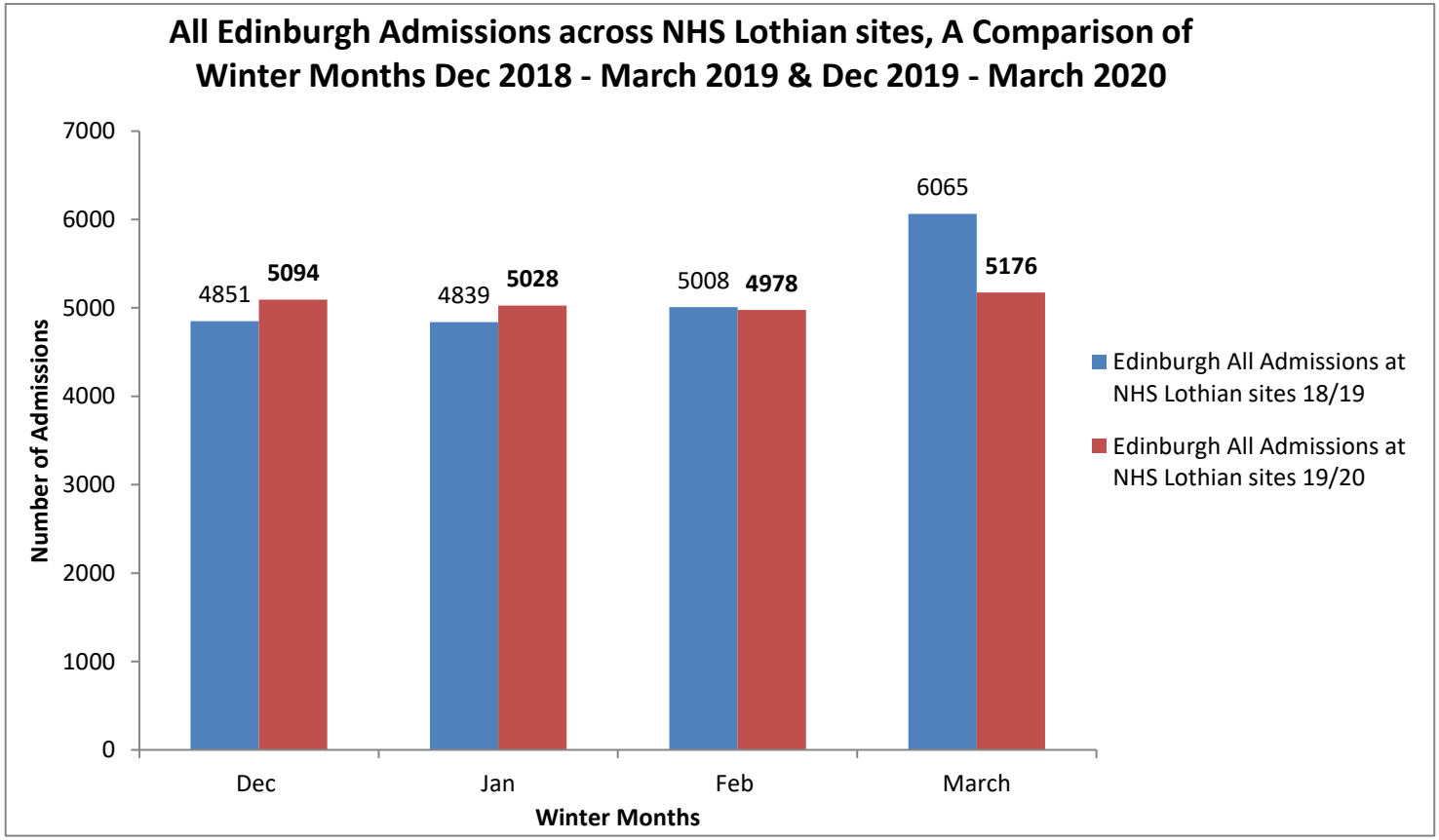
10	**Data Comparisons from 2018/2019 to 2019/2020** Figures from winter months (Dec-March) have been analysed for comparisons between 2018/19 to 2019/20 to highlight any significant changes in winter period outputs. **ALL FIGURES EXTRACTED FROM HOSPITAL FLOW DASHBOARD FOR EDINBURGH CORRECT AS OF 08/05/2020.**
10.1	**A&E ATTENDANCES ACROSS EDINBURGH**



- Rates of A&E attendances for NHS Lothian sites across Edinburgh have been produced by NHS Lothian ISD. The data shows a slight decrease in attendance rates across winter months between 2018/19 and 2019/20. This drop could be a direct result of the successful winter projects which have focused on preventing admissions such as CRT+, Care at Home and Winter Support team who all had alternative patient care

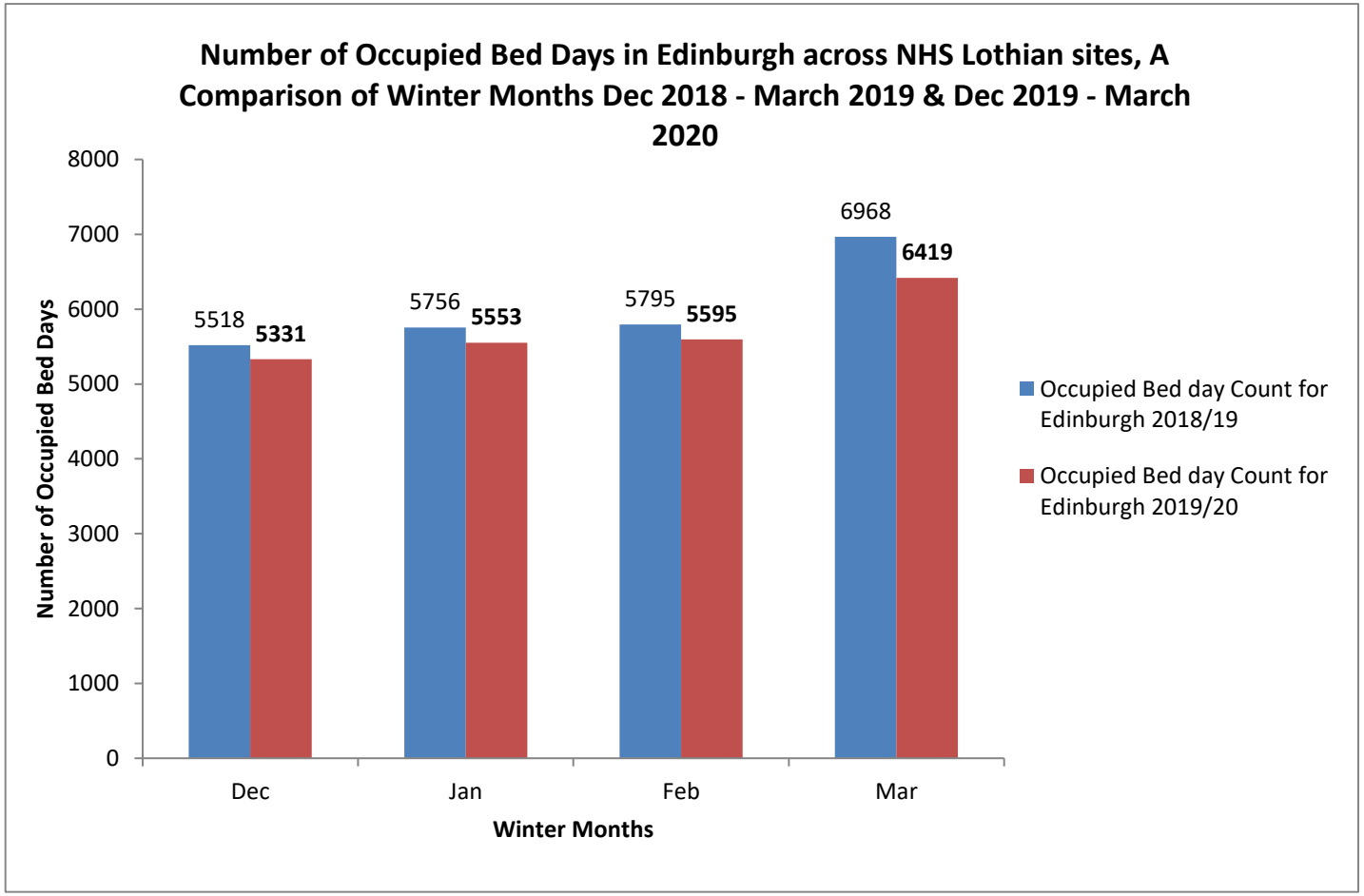
options than hospital admission.

10.2 **ADMISSION ACROSS EDINBURGH**



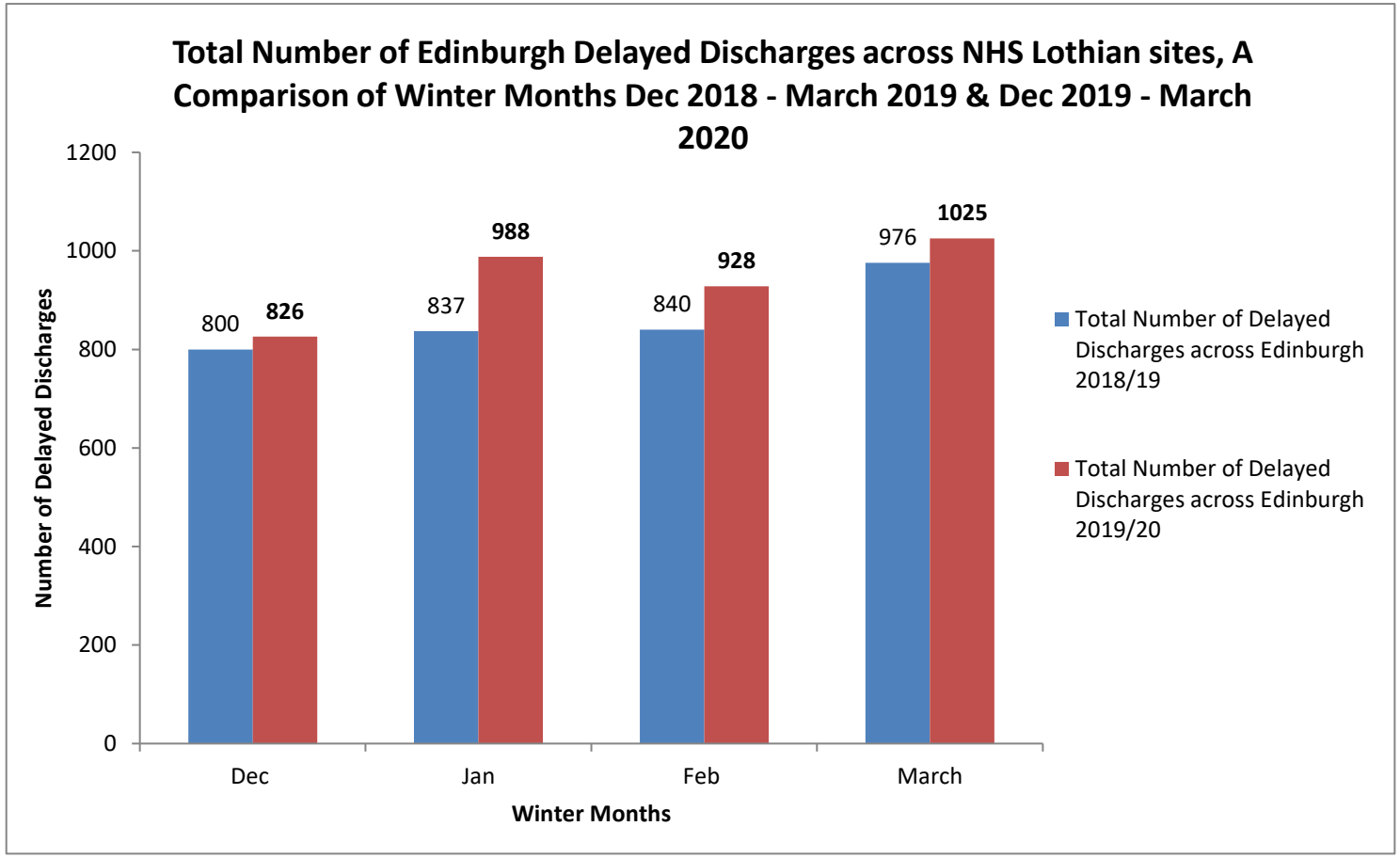
- Rates of Unscheduled Admissions for Edinburgh have been produced by NHS Lothian ISD. During March a significant drop can be noted for both A&E attendances and unscheduled admissions. However further analysis highlights some variance but no significant difference in months between 2018/19 and 2019/20.

10.3	NUMBER OF OCCUPIED BED DAYS ACROSS EDINBURGH



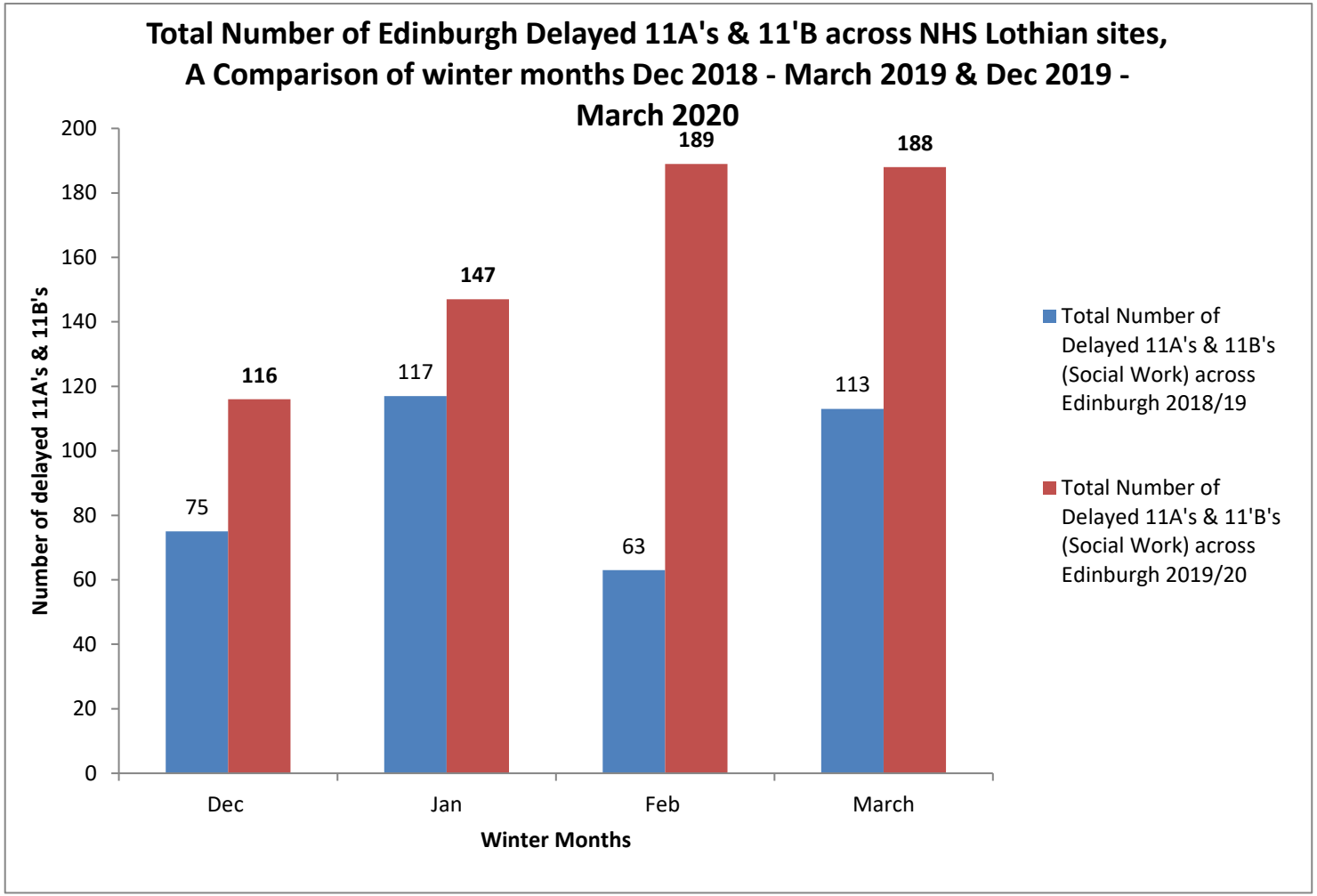
- Occupied Bed Days Figures have been extracted from Hospital Flow Dashboard. As presented above, figures for 2019/20 have decreased steadily in comparison to 2018/19. This was a key priority of last years reflections to ensure occupied bed days to decrease. This success could be reflective of the winter projects which have focused heavily on reducing the number of people in hospital. Projects such as the AWI, Social Work to support home first model, Care at Home and Winter Support Team all actively contributed to reducing bed days across Edinburgh by creating alternative packages of care.

10.4	NUMBER OF DELAYED DISCHARGES ACROSS EDINBURGH



- Delayed Discharge figures have been extracted from Hospital Flow Dashboard. As displayed in the graph above, average numbers of Delayed Discharges in Edinburgh have increased from 2018/19. This will be a priority of next winter to ensure projects are successful in increasing discharge flow across the city. Learning from the response to COVID-19, and the resultant reduction in delayed discharges, will heavily influence this planning

10.5	NUMBER OF DELAYED 11A'S/11B'S ACROSS EDINBURGH



- (11A- Number of Patients in Edinburgh awaiting commencement and completion of post – hospital social care assessments (including transfer to another area team), Social Care includes home care and social work occupational therapy). The average number of 11A's/11B's has unfortunately increased across Edinburgh during winter 2019/20. A priority for next year's projects is to ensure the effectiveness of Social Work enhancement projects which in turn will deliver the target of reducing unallocated work and the time to allocation.

11	**Top Five Local Priorities for Winter Planning 2020/21**
	1) It is expected that the answer to the priorities will lie in the lessons learned from COVID-19 thus far; this work is underway being led by the transformation team, so any priorities submitted will be subject to that caveat. 2) Renewed focus on Community Respiratory Team +, particularly in light of the COVID-19 pandemic, and the possible permanent expansion of this service, as well as continuation of the COVID-19 Advice Line 3) Care at Home winter planning contingencies are a sensible consideration for the coming year, based on experience from Winter 2019/20 and this may be further amplified by experience from COVID-19 4) Continued provision of the Festive Practice on 4 public holidays 5) Augmentation of Home First

Health & Social Care: Local Review of Covid 19 Pandemic

NHS Board H&SCP s:	NHS Lothian Edinburgh, West, East & Midlothian H&SCP	**Unscheduled Care Committee Executive Lead:**	Alison MacDonald / Jacquie Campbell

1	**There is a visible cohesion and alignment across Acute, HSCP, Primary Care and NHS Lothian Board**

1.1	**What went well?**
	Home First The Home First approach helped drive a reduction in delayed discharges with particular reference to those in acute. ○ 9th March- 169 delays with 114 on acute sites ○ 30th March- 144 delays with 82 on acute sites ○ 5th May- 60 delays with 21 on acute sites. There was a clear focus on discharges through the home first team and access to beds and funding to support this. There was the ability Able to have realistic conversations at an early stage and cooperation from acute colleagues. Home First applied a community approach, with the whole system being engaged in this and the external market geared on a single objective. Usual cultural behaviours were effectively disrupted, with acute services recognising the need to handover to locality once the acute episode was dealt with. **Primary Care** In relation to Primary Care, all H&SCPs quickly ceded authority to the primary care tactical Group for GMS (and other contractor groups). This allowed a consistent approach from a group well used to working with each other , engagement from all H&SCPs and NHS Lothian and firm reporting links. More generally, the ability to make decisions quickly and report rather than request permission, was appreciated by all and made the decision-making process more focused. Decisions could be taken quickly – and then reversed when necessary, without the requirement of unhelpful formality. **Carer Support** The service has continued to function and receive referrals across all sectors. A helpline for carers was set up, with new systems such as Microsoft Teams and Near Me enabling staff to operate the helpline from home. Carers COVID-19 information

	pack co-produced with the Edinburgh Carer Support Team (ECST) and partner organisations and sent out to all known carers in Edinburgh via carer organisations mailing lists. The pack includes details about appropriate use of Personal Protective Equipment (PPE) and supply options for carers - a policy that changed and developed quickly. **Rehabilitation** Acute hospital services were updated by EHSCP about community rehabilitation provision to support hospital discharge. This was done via email, and early in the COVID-19 response. Musculoskeletal Physiotherapists, Social Workers, Occupational Therapist and Community Care Assistants all underwent rapid additional training in manual handling, infection control and low-level medication prompting to allow them to be deployed into Care Homes and Home Care settings. There has been limited requirement to redeploy staff but it has happened in various settings. **Mental Health & Substance Misuse Services** Vulnerable groups of people were quickly identified and services adapted in order to support them at home, for example, monitoring of patients on high doses of medication. In one locality, the Substance Misuse Service was split into 2 teams to prevent infection outbreak across the team, and to enable good safe physical distance working for staff. Prompt response to enquiries submitted by the service to the Caldicott Guardian, which enabled staff to provide information to patients about wellbeing services and coping strategies; for example, the Caldicott team were able to turn around a request in 4-5 days, giving nursing and occupational therapists permission to share information with people by text and email about resources that can help people maintain good health and wellbeing.

1.2	**What could have gone better?**
	Home First Care at Home capacity was a challenge initially which created the need for more Safehaven beds. Planning around the ongoing needs of people going into Safehaven was challenging – issues with people getting rehab when care homes were not giving access to therapy. Challenges with the prioritisation for OT - often the assessment came late in the pathway. The Home First approach experienced some challenges with conflicting information coming from localities, emphasising the need to work in a city-wide home first structure. **Primary Care** The links between Primary Care and acute were less well developed at the outset and it took more time for the picture to emerge and for GMS to understand what was happening in acute services

1.3	Key lessons / Actions planned
	There is an urgency for the Home First approach to be formalised with a staffing structure- currently it relies too heavily on negotiation with different parts of the system and this makes it difficult for acute teams to know who to contact. Home First is not being routinely being applied by acute teams- flow is seen as key rather than a whole system approach of getting the person to the correct place. There is too much emphasis on delayed discharge, rather than Home First being community facing and preventative. **Carers** Detailed mailing lists need to be kept up to date. This enables information to be provided quickly when requested. Identify categories for casework lists. **Rehabilitation** Action planned for having a Single Point of Access for all post COVID-19 referrals into EHSCP for post COVID-19 rehabilitation.

2	Arrangements in place to across the whole system to facilitate consistent discharge rates across weekends and public holidays periods

2.1	What went well?
	There was Home First cover over public holidays and discharges took place. The prevention team was in place to prevent admissions where there may be additional care required.

2.2	What could have gone better?
	Seven day working in the partnership would have allowed for more effective responses. There was limited weekend cover.

2.3	Key lessons / Actions planned

3	**There were clear actions between Acute Services (Unscheduled and Scheduled Care), Health and Social Care Partnership and Council, and Primary Care to provide safe, effective patient care**

3.1	**What went well?**
	In general, there was very good engagement from staff across the systems to be flexible in their working approaches and environments, often taking on additional responsibilities and learning new skills. There was a high level of person-centred practice to support safe, effective care across the system. There was recognition across the system of the importance of PPE to support **safe** care to protect the most vulnerable members of our society as well as protecting the staff. **Long Term Conditions (LTC)** Improved Anticipatory Care Planning (ACP) facilitating Key Information Summaries to be shared across the whole system. The Long Term Conditions Programme within EHSCP has taken a lead on these improvements. Guidance developed to support GP Practices, Care Homes and community health professionals to create COVID-19 relevant anticipatory care plans. This included development of recommended Key Information Summary (KIS) quality criteria to encourage people to think ahead and ensure information is meaningful and can be shared. Through working with District Nurses, ACP questions were developed for people with severe frailty at home, enabling specific treatment options to be included in their Key Information Summaries (KIS). District nurses gave green key shaped 'KIS' fridge magnets to give to people who have a KIS in place. The fridge magnets helped prompt Out of Hours practitioners and Scottish Ambulance Service paramedics to check for a KIS. Provided support to the Edinburgh Community Respiratory Team to have COVID-19 ACP conversations and input to shielding cohort ACP-KIS ECHO (Extension of Community Healthcare Outcomes) provides an education model for connecting communities of practice through teleconferencing and web-based technology. The Long-Term Conditions team virtually hosted two ECHO Network sessions to provide ACP implementation and peer support for all care homes in Edinburgh. **Mental Health & Substance Misuse Service** Made good use of daily MATT meeting to ensure people could be prevented from being admitted and support/ prevent delays in discharge. REH has had some capacity throughout the pandemic. This has been a testament to people's own resilience and not wanting to be in hospital, but also to the efforts adopted by EHSCP staff in maintaining a good level of contact with people to ensure they are keeping well and safe.

3.2	What could have gone better?
	Workforce There appeared to be a significant national movement to boost the workforce by bringing in those who had recently left without consideration of the availability of staff already within the system. EHSCP took considerable ownership of the work force issues and instigated a link with NHSL, until this point there was no clear connection (other than with nursing) between EHSCP and NHSL Covid-19 workforce planning teams until very late in the day. The pressures were anticipated to be in acute however in reality were spread across the system including care at home (including unpaid carers) and Care Homes. **Primary Care** Whilst primary care responded immediately to lock down with a different way to operate, some acute services attempted to carry on as normal, causing tensions and avoidable confusion where community service were operating from a quite different approach. **Mental Health & Substance Misuse Service** Some discharges were delayed as housing staff and social care providers were only offering telephone support.

3.3	Key lessons / Actions planned
	In relation to Primary care, we are working with SG to develop and implement the nursing workforce tools for community nursing – including care homes. For care homes, we are working to implement the new government guidelines. This will include building on existing good work and implementing systems to give assurance about the care of residents. Requirement for very clear authority to be vested in one place for acute services, rather than individual depts. adopting operational arrangements which best suited their interests. **Mental health and Substance Misuse** It is anticipated that there will be a surge in mental health referrals for people that have been traumatised by events related to this pandemic. The service is, however, starting to think of ways to respond to this need and have trained up all mental health nursing, occupational therapy and social work staff in Decider Skills training in order to provide a collective response to this potential need.

4	Preparing effectively for infection control in Acute and Community settings

4.1	What went well?
	The newly established Care Home Support Team are now working 7 days per week. Following an initial self-assessment discussion, the team are visiting care homes to provide education and training on infection prevention and control and with PPE. Activity is prioritized through working closely with public health using the PAGs/ IMTs daily sit rep and through the Lothian care home daily operational group. We are reviewing the current structures to support care homes in line with the recently issued SG guidance. Due to the personnel involved in the Command Centre and link with the PPE distribution Hub, EHSCP were able to respond rapidly to the numerous and ever-changing PPE guidance and processes. Quick responses from Procurement helped to reinforce the supply chain, with active and responsive supply. Effective working relations with Infection Prevention and Control colleagues when patients in community hospitals were diagnosed with Covid-19; working together ensured there was clarity on ‘red and green’ areas, when admissions had to be restricted or managed carefully to limit the risk to other patients. Additional uniforms were purchased for Home Care staff. The service was also able to procure uniforms for Community Psychiatric Nurses at relatively short notice – this built confidence in the workforce. Swift response to request to increase domestic services to help maintain cleanliness and reduce potential spread of infection in the building.

4.2	What could have gone better?
	More preparation time for care homes would have been helpful at the outset. Guidance at the outset was unclear and came from a variety of sources – it was not sufficiently clear which guidance care homes should listen to. Multiple changes to guidance in a short space of time. Care Home staff were not sufficiently well trained or confident using PPE. Staff encountered difficulties in dealing with negative press and needed better support in managing the impacts of this. Earlier testing of non-NHS staff and people being discharged to care homes. Integrated PPE advice from outset. PPE supply should have been centralised at a very early stage, with a clearly articulated process for the ordering and delivery of equipment. At one point PPE was being ordered from three different sources.

	If the care Home deaths had been reported on the COVID dashboard this issue would not have taken us 'by surprise'. Work was going on with the Health Protection team but not at the scale required and time was lost before the seriousness of the situation was recognised. Whilst it would most likely not have protected patients from infection the care homes would have been better supported during what continues to be a very challenging period. There was a vast range of information and changes in process with regards to PPE which made it extremely difficult to keep on top of. The link with NSS was very challenging and created additional challenges across the system. Poor communication and direction within the EHSCP Command Centre and between NHSL resulted in additional challenges which required very rapid actions within the operational services. Improved communication between EHSCP personnel and, EHSCP and NHSL, with a recognition for expertise already in the system would have improved the tactical approach to PPE provision. Sometimes difficult to keep up to date with changing guidance on red and green flows and how these were applied locally to ensure patients were admitted to the right area. Occasional different views from Infection Prevention and Control colleagues would cause confusion for local staff as to what actions they needed to take for safe patient management. Also a need to manage staff heightened anxieties about how long patient infectivity lasts especially for those who had a prolonged stay in ICU. This included the Scottish Government / NHS Scotland / HPS information and guidance vs what staff were reading in the media or hearing from other centres in the UK.

4.3	**Key lessons / Actions planned**
	Better training to be implemented for care home staff in relation to infection control. There have recruitment issues over the last 12 months and that has resulted in us going into this crisis with many vacancies which further exacerbated the situation. The Care Home Tactical Group appears not to have the requisite authority to take decisions – e.g. the confusion and delay over the establishment of testing for care home patients. It became clear that an 'arms length' contractual relationship between the H&SCP and local care homes was not adequate under these circumstances. The disinvestment in 'linking' capacity was made by the H&SCP several years ago. GPs know their Care Homes well and are valuable sources of insight – this should be built into any future plans to respond to such circumstances. Ensure that clearly articulated process pathways for pandemic response are developed as part of future resilience plans.

5	**Additional services/pathways were developed (for example, Community Covid-19 pathway) to manage increased demand for health and social care**

5.1	**What went well?**
	Primary Care The speed at which the COVID clinics were established to take the symptomatic patients out of GMS. Speed at which individual GP practices moved to a completely different way of operating. After initial hesitancy the speed at which staff testing was scaled up and developed to provide both capacity and quick results was hugely influential in ensuring primary care practices were able to continue to function and not forced to merge as was originally presumed as inevitable. **Home First** Home First looked at all health delays which has dramatically reduced the number of people transferring to intermediate care beds when then may be able to go home. Safehaven- additional capacity as an interim move – resulted in reduced length of stay and moved people off site. Also supported when care home providers were not able to pick up. **Hospital** The AAH Discharge Hub have changed their processes to support the Home First approach in Edinburgh by directing patients for a Home First review first rather than automatically adding to a waiting list for bed based rehabilitation including intermediate care. Able to flex intermediate care beds in Liberton Hospital when additional capacity was required due to a loss of access to the intermediate care beds at Fillieside during a Covid-19 outbreak. In addition 'red and green' areas were able to be established quickly when patients in Liberton were diagnosed with Covid-19. **Community Support** The creation of a shielding phone number/email address and Vulnerable People phone number/email address linked to a range of support services including third sector responses (coordinated response across CEC/EHSCP/third sector). This clarity has been really important from user perspective – one number to refer to/contact. Pharmacy Deliveries to those in shielded and vulnerable groups using redeployed staff and volunteers – initial teething problems seemed to have been ironed out quite quickly **Locality Responder Teams** In one locality, the Hub and Clusters have split into 4 broad spectrum responder teams, comprising social workers, occupational therapists, physiotherapists and community care assistants, and will each take responsibility for being initial responders. A backup team is also in place that can be used should staffing levels fall below safe staffing levels, and to meet essential demand. The immediate allocation of work to a person who has ownership of that work until it is completed. Live

	screening - actively responding to critical referrals, but all referrals have some form of contact/Conversation One. The service is no longer actively adding to waiting lists and are therefore able to respond to people w straight away. **Carer support** The Coronavirus Act temporarily relaxes the duty in the Carers (Scotland) Act 2016, which provides all carers with the right to an Adult Carer Support Plan (ACSP) or a Young Carer Statement. The ECST have, however, continued to offer ACSP via telephone consultation or Near Me video conferencing and are still able to access carer support payments where applicable. The team were able to access and be set up to use the Near Me video conferencing option. **Rehabilitation** New post-COVID-19 Advice Line set up to support people in their recovery and rehabilitation. New collaborative working with community neurological rehabilitations teams to create one team which allows for a sustainable and responsive rehabilitation team supporting neurological hospital discharges. Using technology to support rehabilitation/ assessments/ welfare. Community Respiratory Team has broadened its referral criteria beyond Chronic Obstructive Pulmonary Disease and now accepts referrals for all respiratory conditions, from both primary care and acute services. Development of the COVID-19 self-referral line, which is staffed by Pulmonary Rehabilitation Physiotherapists. 50 calls were received in week 1. The COVID-19 Community Rehabilitation Single Point of Contact is very close to launch – giving Acute referral sources a dedicated referral point to refer those patients not requiring bed based rehabilitation and advice to seek multi-disciplinary team assistance and rehabilitation. Increased telephone consultations and extended use of Florence/ Attend Anywhere/ Skype/ NearMe offering telephone support and other telehealth. **Long Term Conditions** Creation of COVID-19 Digital Guide led by the Long Term Conditions Programme to support practitioners within EHSCP. The guide provides quick and accessible information on safe digital options to connect staff with peers and people in their homes, taking into account information governance across both the council and health systems. The use of Florence Telehealth was upscaled to support Home Health Monitoring for rehabilitation, welfare checks, anxiety management and to support people to stay active. Community health and social care services increased telephone consultations and implemented video consultations using Attend Anywhere/Near Me and Business Skype. The Scale Up BP (Digital) programme was expanded through the Long Term Conditions Programme – 12 GP practices opted to move to an enhanced national protocol to assist home monitoring of patient's blood pressure. Within the Long Term Conditions Programme, Falls Coordinators developed guidance for Care Homes to help support residents to stay active and reduce the risk of falls. A Falls Coordinator Near Me account was set up to provide advice using video consultations. All Edinburgh Care Homes were offered the opportunity to connect with the Falls Coordinators in this way.

5.2	What could have gone better?
	Early assessment and determination of home first pathway by the acute teams. Home First should have been embraced at an earlier stage. Care Homes were reluctant to allow professionals in to carry out rehab. Risks of Covid meant that some people reluctant to go to a care home. Issue around internal care homes – reluctance to take safehaven due to high clinical needs they were balancing in the care home. Speed at which the 111 telephone response was staffed up to capacity required – but extremely difficult to have foreseen the scale. Message to patients that their GPs continued to be 'open for business' should have started immediately. Perhaps did not happen as people were reeling from initial demand on practices and staff shortages. The poor communications around BOTH the supply and distribution networks for PPE. **Community Support** Better public communication from early on that GP practices and A&E departments remained open for non-COVID-19 symptoms too, and reassurance to public that measures had been put in place to allow for either a virtual consultation or safe(r) in-person assessment. This reassurance did come later, but services still not seeing normal levels attending, indicating at least some people are still staying away. Community organisations were reporting confusion on this issue until at least four weeks into lockdown. Reasonable to expect significant 'catch-up' demand for consultations once lock-down measures are reduced.

5.3	Key lessons / Actions planned
	Home First Ongoing learning and development both for acute and partnership staff. The Home First message is not yet fully understood. Constant review of the pathways,- are we getting the correct pathway for the people of Edinburgh? Direction of staff under acute - would the Home First/ Community message be easier if teams were embedded into the Partnership but still have the gains of flow? **Locality Responder Teams** Any perceived barriers between Hub and Clusters are now gone. Staff time is being better utilised – no passing work around the locality or between teams. There is a need to ensure that all staff who need it have access to TRAK. The team needs to monitor how overdue reviews, current reviews and guardianship are managed and what this means for future. Continue to use responder team model to manage Discharge to Assess referrals. This will need to be reviewed. **Home Care & Reablement**

	Improve communications at point of discharge and appoint a lead person. Haven beds for immediate discharge from hospital while awaiting POC. Reduction of Home Care services agreed with person/ family members/carers to critical cover only, creating capacity for discharge to reablement. **Rehabilitation** Balance of face to face initial assessments versus telephone assessments. This is person specific (depending on whether it is for a service user or carer) and dependant on circumstances/ confidence. Rehabilitation and keeping well – what is our role? Evidence base – physiotherapy and occupational therapy team leads to start thinking about how some of the non-critical occupational therapy work is managed in this model as lockdown is eased. Dedicated team/ rota to manage call volumes/ call backs.

6	**Modifications were made across sites and services to manage staff absence, well-being and recruitment of supplementary staff**

6.1	**What went well?**
	Workforce Planning EHSCP Covid-19 workforce planning group set up at an early stage to have an oversight of key workforce issues and routes to obtain additional staff/volunteers and reassign existing staff to meet demand. The group established prompt contingency plans and processes to manage the potential and anticipated workforce challenges. In reality, the demands on the work force were lower than expected as service managers worked internally and with others to reassign individuals and teams to meet demands. In general, staff have willingly volunteered to take on new roles and responsibilities to assist in meeting new and existing demands which allowed a significant amount of reassignment of staff across the system. Essential training was set up and accessible very promptly to allow the reassignment and recruitment of staff across the system. There were considerable resources available to support staff wellbeing across CEC and NHSL. Good access to confidential support services for staff within care homes, many of whom are traumatised and sad. Despite the crisis and the need to adapt their processes, the recruitment teams in CEC and NHSL have mobilised to allow for recruitment to continue throughout this challenging time.

	Primary Care Teams re-organised almost overnight to provide a different shape of service and facilitate home working for those who could. The NHS Lothian Primary Care IT team seemed to be able to operate with a pace and effectiveness which was hugely reassuring. A process is now in place which provides care homes with NHS mutual aid once all local resilience plans have been exhausted. A small pool of bank staff can be accessed by care homes through a single point of contact to EHSCP. **Mental Health & Substance Misuse Service** The team acted early in the pandemic to implement public health guidance around social /physical distancing of staff, and this provided reassurance to staff that their health and wellbeing was of fundamental importance. This in turn reduced levels of anxiety. **Locality/ Responder Teams** Daily Microsoft Teams meeting with all responder groups to ensure staff stay connected, ensuring wellbeing support is directed as required. Daily Microsoft Teams meeting with Senior group at 10am to plan the work for the day and to discuss any barriers, create solutions and identify staff anxieties/provide support, ensuring work is planned and ownership taken. This has worked really well. The creation of a fully up to date staff database, with key information about current role (band/grade, whole time equivalent), about personal circumstances which may impact upon their ability to attend work (for example, whether an individual has dependents, a caring role, or if they rely solely on public transport), and also information about additional skill set over and above their current substantive position, to aid in the appropriate redeployment of staff where required. The principle that staff work from home where possible. Wellbeing measures introduced such as a rota for a daily buddy call between members of the team. Daily check-in via WhatsApp. The use of Microsoft Teams for team meetings and keeping in touch where people could 'see' each other. File sharing on Microsoft Teams has been useful when mailboxes are full, which has been a regular occurrence during the pandemic. Daily team Skype handover to discuss service user issues. Supervision is still in place. **Homecare and Reablement** Despite staff sickness levels being higher than usual, together with staff shielding , POCs were reduced to critical care only to ensure appropriate staffing levels were maintained to care for people safely.

6.2	What could have gone better?
	Workforce Planning There was a reticence amongst some managers to fully engage with the Covid Workforce Group which appeared to question the value and role of this group as a support mechanism. As a result, the data submitted to the group was variable and often incomplete which meant it did not provide an accurate oversight of the workforce issues. This appeared primarily to be as locality managers were working to mobilise staff internally however meant it wasn't clear where staff availability/demand was and what staff were available to draw on. Additionally, the Nursing workforce was segregated from the remit of the group, this created a fragmented approach with a less than cohesive approach. An example being when CEC Care Homes had immediate demand it was nursing that was required to support that, without having oversight or access to data on their staff pool the group was hindered in its ability to fill the demand. Improved communication to/from the group, supported by the Command Centre and IEMT, with a more joined-up approach could have been much improved to encourage engagement in the value of the group across the system. The workforce guidance from SG and NHS Scotland was complex and untimely which resulted in boards/partnerships making individual decisions when required. This created confusion and a lack of consistency across the organisations which inhibited the effectiveness of the group. The NHS Lothian recruitment portal did not seem to be able to be responsive to what was a chronic shortage of capacity.eg a PC mental health nurse took 7 weeks to bring into post.

6.3	Key lessons / Actions planned

7	Acute Services, Health and Social Care Partnerships settings were modified to ensure a safe environments for staff and patients

7.1	What went well?
	Staff who knew their buildings immediately made modifications. Helpful check list document was quickly made available to all GPs thru the Primary Care tactical group. <u>Social distancing</u> For staff who need to attend work because home working is not an option there has been flexible use of office and other

	accommodation (such as meeting rooms) to ensure social distancing can be maintained. Most meetings are being held using technology but when a face to face meeting is required a suitable space is used to allow social distancing for the number of people attending. In mental health and substance misuse services, gel is provided at front door, chairs in waiting room spaced out, working from home for non-essential staff. The service is only providing essential support (medication prompts, shopping support, personal care and so on) and all other support is via telephone. PPE is worn, and social distancing measures apply. <u>Home working</u> Staff who already have a work laptop were able to get set up for home working relatively quickly. MS Teams is able to be used for them to engage with online meetings or 1:1 discussions. New equipment provided for some staff to enable healthy working from home and prevent postural pain and discomfort. <u>PPE</u> In addition staff identified and took on the role quickly to be Face Fit Testers in hospital based services including working flexible hours to see to see staff who need tested (e.g. evening / night working) <u>IT</u> All staff having access to MS Teams in the NHS although introduced quickly at the start of the Covid-19 response so staff had little opportunity to learn how to use it properly. This has resulted in staff learning from each other and learning as they go along.

7.2	**What could have gone better?**
	<u>Home working</u> Very difficult to get NHS staff set up for home working if they do not have a work laptop or a personal laptop of a suitable specification which allows them to get access via NTX Gateway. Laptops ordered from eHealth on 1st April have not yet arrived. Also some delays with getting set up at home in the first instance and then loss of connection is a common issue especially in the early days. <u>PPE</u> Staff anxieties were sometimes leading to the misuse of PPE, not helped by changing guidance. There has been a need to repeat face fit testing due to unavailability of some types of masks, so staff have to be fitted again. Confusion about ordering and supply processes although this has improved significantly recently. Mixed messages / understanding on what procedures

	are classed as Aerosol Generating Procedures (AGPs) particularly in relation to nebulisers. Increased anxiety from frontline homecare and reablement staff in relation to appropriate PPE, when it was an ongoing issue. Staff asking for masks to use on a daily basis to protect them and clients. Staff going off sick due to self-isolating and stress from pressure they feel attending clients who may be positive. <u>IT</u> As noted above there have been occasions when staff working at home (when we have been able to get them set up with home access) have lost connectivity so are limited in what work they can undertake. This has been less problematic more recently but frustrating when it does happen as staff are then limited what work they can do at home and in some instances have come into their own base or another base to get access. There seems to be an issue for staff getting access to MS Teams if they are using a Wyse computer as this relies on a virtual desktop. Many staff have an old version of Outlook which makes it harder to set up MS Team meetings in diary invites (there is a work around, but this is not clear in the guidance and most people have learned from someone else). Within the first two weeks of lockdown, guidance for video conferencing changed for EHSCP with the use of Zoom being withdrawn due to security issues. This was not communicated clearly across EHSCP, however, so many staff were unaware of the change.

7.3	**Key lessons / Actions planned**
	<u>Home working / IT</u> Need to have better access to laptops / mobile phones to allow NHS staff to be quickly set up for home working. Needs to be individual discussions with staff about whether they are able to work from home (if they have the equipment) as it is not possible for everybody depending on their personal / home circumstances. If the preference is to attend work then we have a responsibility to ensure they are safe such as social distancing. Some staff have felt quite anxious about working from home but have felt that they did not have an option even if it didn't suit their circumstances.

8	**Additional Costs Incurred (Please provide full details, staffing, grade, equipment associated with each intervention)**
	Moira Pringle is working on this information and will supply
9	**Additional Information**

NHS Lothian: Winter Plan 2019/20

Version 0.10 Status: Final Date Approved: 4th October 2019

Lothian NHS Board

Office of the Chair and Chief Executive
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 536 9000
www.nhslothian.scot.nhs.uk

NHS Lothian

To: Chief Executive NHS Scotland and Director-General Health & Social Care, Unscheduled Care Director

Cc: Chief Performance Officer NHS Scotland and Director of Delivery and Resilience

Date 11 November 2019
Your Ref
Our Ref TPD/WINTER

Enquiries to Tim Davison
Extension 35807
Direct Line 0131 465 5807
Email chief.executive@nhslothian.scot.nhs.uk
EA elaine.watters@nhslothian.scot.nhs.uk

Dear Malcolm,

PREPARING FOR WINTER 2019/20

Following on from your letter of 4th September 2019, we attach the Lothian Health and Social Care System's Winter Plan.

The development of this plan has been overseen by the Lothian Unscheduled Care Committee which is chaired by Alison MacDonald, Chief Officer, East Lothian Integration Joint Board.

The Committee is tasked to plan, implement and produce a Winter plan that demonstrates safe, effective, patient centred care for patients with the best outcomes for relatives and staff. This Winter plan has utilised a scoring framework to prioritise Winter schemes which have been derived from the learning from previous years and as noted in the 2018/19 Debrief to Scottish Government.

A framework was developed through the Committee that encouraged prospective Winter objectives to be evaluated against:

- Supports Joint Working between Acute Services and Health and Social Care Partnerships (HSCPs)
- Supports a Home First Approach
- Admission avoidance
- Site and Community Resilience/Flow
- Supports a non Bed Based Model
- Facilitates 7 Day Working and Discharging

Headquarters
Waverley Gate
2-4 Waterloo Place
Edinburgh EH1 3EG

Chair Brian G. Houston
Chief Executive Tim Davison

Lothian NHS Board is the common name of Lothian Health Board

The allocation of Winter funding from Scottish Government has also been met with commitment from the NHS Lothian Board. NHS Lothian has therefore invested a further £2.0m into this plan.

Our focused investment from additional resources is intended to further support improvement priorities for Unscheduled Care. There are projects throughout Acute and Health and Social Care Partnerships that are already evidencing improving performance against the 4 hour Emergency Access Standard and Delayed Discharges. The improvement trajectories and Winter impact will be monitored through the Unscheduled Care Committee from December – March 2019/20.

Key Actions which the Board has taken and will progress through the Winter period are:

- Enhancement of senior medical and other clinical staffing at critical pressure periods across Acute, Community and Social care Services.
- Consistency of 7 day working principles for HSCP Teams
- Point of Care Testing (POCT) for Influenza for all Acute Sites
- Robust cross-system escalation, coordination and communication through senior Leadership at Chief Operating Officer/Chief Officer level.
- Increased capacity to support admissions, transfers and discharges through utilisation of additional vehicles through the Lothian Flow Centre.
- Contingency planning for additional bed capacity at WGH, Ward 15

As you are also aware, NHSL is adopting a programme approach to progress our unscheduled care performance, and this includes delayed discharges. We have discussed with you that we have complementary plans in place to deliver a trajectory of no more than 200 delays in the system by Christmas.

Yours sincerely

Mr Tim Davison
Chief Executive NHS Lothian

Mr Brian Houston
Chairman NHS Lothian

NHS Lothian

Ms Alison MacDonald
Chief Officer East Lothian
Integrated Joint Board

Ms Fiona O'Donnell
Chairman East Lothian
Integrated Joint Board

Ms Judith Proctor
Chief Officer Edinburgh
Integrated Joint Board

Mr Angus McCann
Chairman Edinburgh
Integrated Joint Board

Ms Morag Barrow
Chief Officer Midlothian
Integrated Joint Board

Ms Catherine Johnstone
Chairman Midlothian
Integrated Joint Board

Mr Allister Short
Chief Officer West Lothian
Integrated Joint Board

Mr Harry Cartmill
Chairman West Lothian
Integrated Joint Board

1. Winter Planning Process

1.1 NHS Lothian received notification from the Scottish Government that they would receive an allocation of £698,087 which should be specifically targeted to deliver winter performance with particular focus upon:

- Reducing Attendances
- Managing / Avoiding Admission
- Reducing Length of stay
- Focus on Flow in Acute Care
- Workforce

1.2 Through learning from previous years, it has been recognised that as a Board there is a degree of predictability in patterns of demand throughout the Winter period. This had led to a focus on robust flow throughout the system with seamless transition/intervention between hospital and community teams to support, wherever possible, rehabilitation nearest home.

1.3 The annual debrief to SG provided a platform to reflect and evaluate success from previous years and identify which schemes could be improved, replicated and which funded initiatives did not provide return on investment. Building from successful schemes from the Partnerships last year Festive Practice, additional Surge Capacity and POCT Flu Testing have been again prioritised in line with the process:

- Establishment of Festive Practice - This scheme has been successful over last 2 years at increasing capacity in GP out-of-hours services. This model will draw activity from pressurised services such as Emergency Departments, LUCS and mental health services.
- Additional Surge Capacity – Contingency planning for additional bed capacity at WGH, Ward 15 with capacity readied from January 2020.
- POCT – Flu Testing - Point of care testing for influenza in emergency medical patients (children and adults) attending Accident and Emergency and Medical Assessment areas the 4 hospital sites across Lothian. This was pre prioritised prior the scoring process and agreed to be of significant value across Lothian from the 18/19 Debrief.

1.4 Winter bids were solicited from across the whole system in Lothian and these were collated to a value of c.£6m. In order to rationalise these requests for funding a scoring framework was developed and referenced against each of the bids. This criteria was developed after a period of engagement with Acute and Partnership colleagues to ensure an inclusive / collaborative approach was undertaken to prioritising bids. This scoring framework was derived from the learning from previous years and as noted in the 2018/19 Debrief to Scottish Government.

1.5 This framework was developed through the Unscheduled Care Committee that encouraged prospective Winter bids to be evaluated and scored by 12 independent groups against the following criteria:

- Supports Joint Working between Acute/HSCP
- Supports a Home First Approach
- Admission Avoidance
- Site and Community Resilience/Flow
- Supports a non-Bed Based Model
- Facilitates 7 Day Working and Discharging

1.6 The schemes were subject to scrutiny and prioritisation by a Short Life Working Group workshop with Multidisciplinary input from all services.

1.7 The Winter Plan enclosed captures the response from NHS Lothian to deliver sustained performance and delivery of key operations over the Winter period to supplement year round plans. This plan demonstrates whole system engagement and collaboration between NHS Lothian, East Lothian, Edinburgh, Midlothian and West Lothian Health and Social Care Partnerships. The final plan is shown as Appendix 1.

1.8 The allocation of Winter funding from Scottish Government has been combined with reserve funding and slippage on the 6EA allocation to provide Winter funding of £3440k, the overall Winter plan is £3490k and it is assumed that there will be sufficient slippage in recruitment to cover this shortfall.

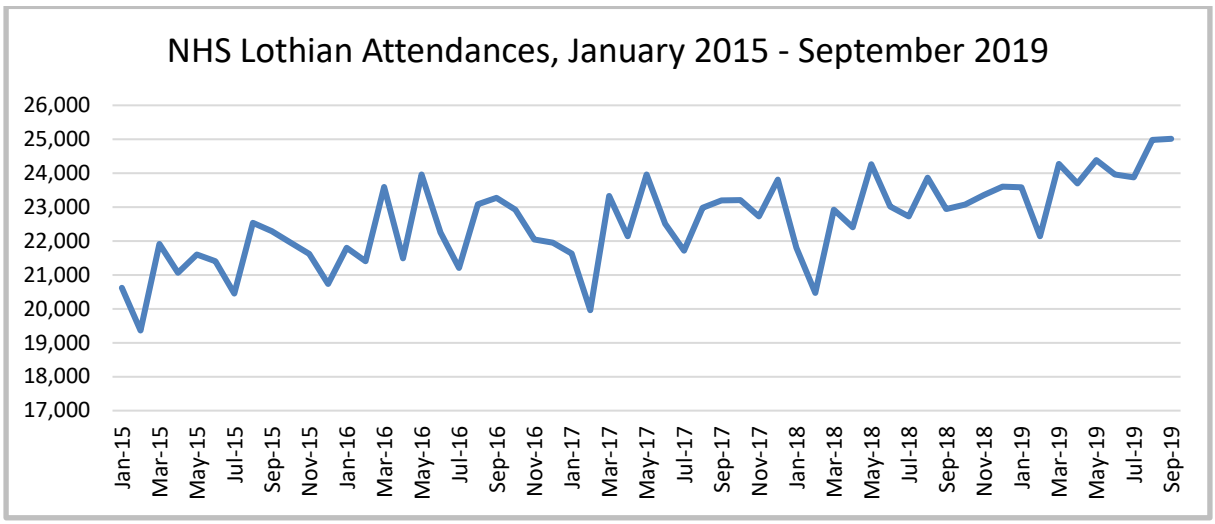
1.9 In 2018/19 NHS Lothian received a Scottish Government allocations to support Winter planning of £1392k, this has reduced by circa £700k in 2019/20.

1.10 In addition to the SG funding the plan is supported from the unscheduled care reserve. NHS Lothian holds recurrent reserves of £2.6m, against which there is £571k of commitment, leaving £2.0m reserve funding. This combined with an under commitment on 6EA funding and non-recurring slippage from 18/19 gives a total of £3440k to support the winter plan.

2. Projected Demand and Performance

2.1 Unscheduled Care activity has been increasing year and year since 2015. NHS Lothian experienced surge in demand during the summer of 2019 most notably during August 2019. The annual Edinburgh Fringe Festival brings higher number of tourists to Edinburgh and in doing so increases pressures on the adult Acute sites. This year the RIE had 11’579 attendances in the month of August. This represents an increase of 700 patients (c.6.5%) compared to the same dates for August 2018. Exhibit 1 below shows the gradual increase in attendances from January 2015 – September 2019 across NHS Lothian, all sites.

Exhibit 1: Attendances from January 2015 – September 2019 across NHS Lothian, all sites.



2.2 Performance against the 4 hour emergency access has fallen short of the national target throughout the 2019 calendar year although there have been signs of recovery during the mid- year period where 3/4 Acute sites maintained >90% for a period of 6 months. This performance must be contextualised against a backdrop of higher attendances, increased acuity and major capital works at one of the adult Acute sites (St John's Hospital).

2.3 Using data from January 2015 shows an annual increase in attendances from 69'896, 2015, to 69'993, 2019 which is c.13%. The uplift in attendances between the winter period 17/18 and 18/19 was 7.3%.

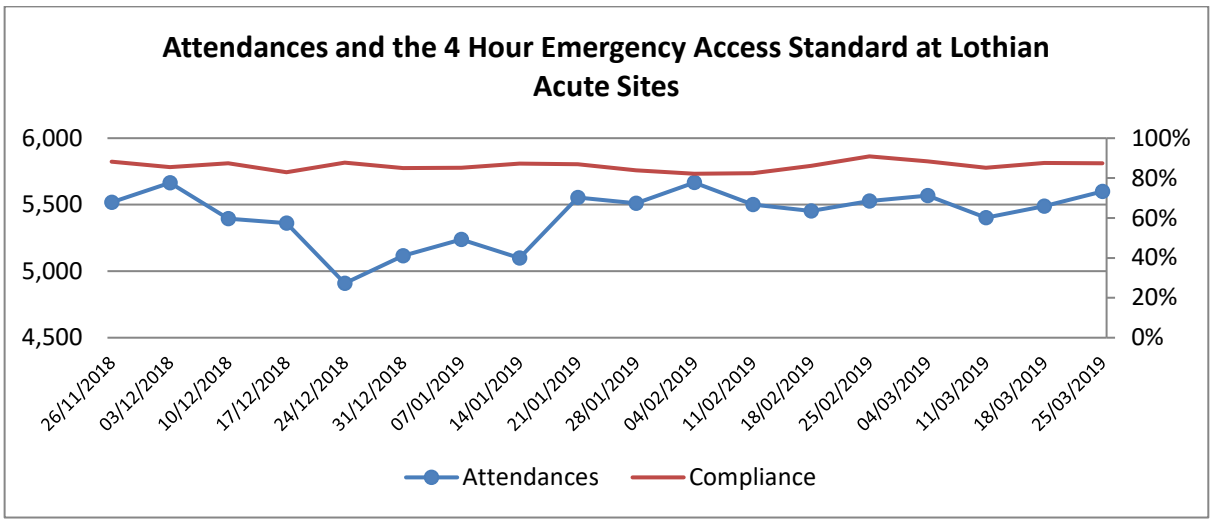
2.4 Extrapolating the performance to date across attendances gives the following predictions for January 2020 – March 2020:

Exhibit 2: Predicted Uplift for NHS Lothian, Jan – March 2020

Month	NHS Lothian
Jan-19	23,582
Feb-19	22,142
Mar-19	24,269
Predicted 6% Uplift	
Jan-20	24,997
Feb-20	23,470
Mar-20	25,725

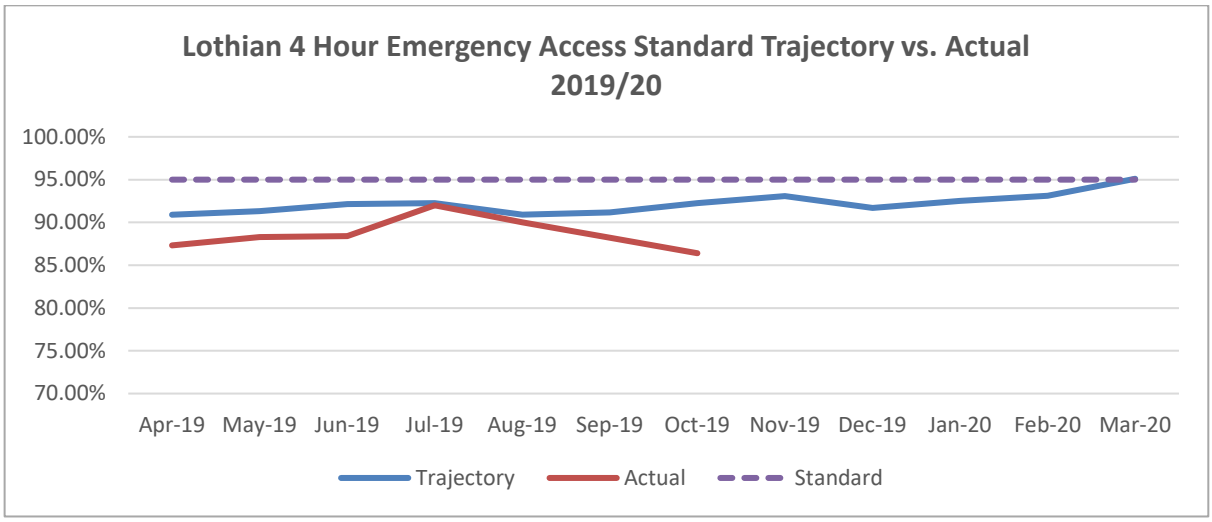
2.5 Weekly trends have been used to better understand the potential uplifts in admissions also, Exhibit 3 below show the 4 hour emergency access standard (4EAS) vs. Attendances for 2018/19. From this analysis we can predict that there will a drop in attendances end of December before these pick back up from January onwards.

Exhibit 3: 4 hour emergency access standard (4EAS) vs. Attendances for 2018/19.



2.6 Exhibit 4 below shows actual 4 hour Emergency Access Standard performance vs. the agreed Trajectory from April 2019 – March 2020. Note the axis is deliberately started at 70% in order to provide fuller representation of monthly variation and targeted improvement.

Exhibit 4: 4 hour emergency access standard (4EAS) Trajectory vs. Actual 2019/20.



2.7 Delayed discharges have been a significant challenge within Lothian and the resulting impact on patients, both those who are delayed in hospital and the corresponding impact on those waiting to access a hospital bed, is not an acceptable position. Whilst good progress is being made within Lothian to reduce the number of delays, it is recognised that Lothian still has a disproportionate number of delays compared to the rest of Scotland. The target for Lothian is to achieve **200 delays** by December.

2.8 Despite a scoring framework developed to avoid the reliance on bed based models during Winter there is a collective recognition from the unscheduled care committee that additional winter bed surge capacity will be required and this capacity will be functional from January 2020. The committee have acknowledged that while beds are likely to be opened further resilience will be

required to address demand across primary, community and Acute services. This has informed the key priority areas discussed in 1.4 above.

2.9 System Watch is recognised as a key tool to monitor demand and anticipate pressure points in admissions, bed days, GP consultations and Flu like presentations. At the time of writing the future prediction for admissions could only be reported to mid-December however this reporting will be used throughout Winter to ensure there is clarity and pro-active management of surge in demand.

3. Elective Capacity

3.1 A ring fencing policy has been developedand implemented to protect bed capacity for both elective surgical activity and emergency surgical activity. This is to ensure that all available surgical beds are not routinely used for medical borders but kept for surgical patients to ensure.

3.2 Sites will ensure patients are admitted on day of surgery unless clinically indicated otherwise and use day surgery wherever possible

3.3 There will be an earlier review of patients to ensure discharges are planned and managed robustly with an Estimated Date of Discharge (EDD).

4. Communications

4.1 A comprehensive and well targeted strategy is key to sign posting and educating the general population to the right service at the right time. Where possible the digital platform will be utilised using social media to drive prospective patients to NHS Lothian website and NHS Inform to get more details of all available options to them at home such as GP and pharmacy services. Last year, the Board a digital reach of 105,022 across social media, had 931 likes, shares, retweets and 46,722 impressions overall.

5. Staff Flu Activity across NHS Lothian and Lothian Health and Social Care Partnerships

5.1 Communications Teams, Public Health, and our clinical staff flu leads work together to promote the campaign. This season, we aim to increase uptake among our nursing and midwifery staff: our Executive Director for Nursing and Midwifery emailed staff directly to inspire participation. We are further encouraging staff to ‘Be Incredible’ through posters, the intranet, social media and payslip messages.

5.2 From Oct-Dec 2019, 260 staff flu clinics are planned across NHS Lothian. To date from October 7th to Nov 4th, 193 clinics have been completed. We estimate that between 8,000-10,000 staff have been vaccinated to date. The main clinics will run until December 20th followed by ‘mop up’ clinics in January.

5.3 Clinic locations range across acute hospital, community NHS and social care sites. All staff flu clinics are open to all Health and Social Care staff across Lothian. For social care, eligibility for these clinics includes staff who work with or have contact with people in the clinical at risk categories. Nursing home staff, including private nursing homes, are immunised on site or at staff flu clinics. To maximise staff access to vaccination, the ‘Flu email’ box will go live from mid-December to allow staff to request a suitable date and time to get their jab. The Flu email box will be live until March 2020.

5.4 In addition to scheduled clinics, roving teams of peer vaccinators attend clinical areas to vaccinate staff. Peer vaccinators immunise in acute and community NHS and social care sites. The Executive Director for Nursing and Midwifery wrote to all nursing staff to encourage them to become peer vaccinators; this led to more than 80 staff expressing an interest in supporting the campaign.

5.5 In 2018/19, a pilot was undertaken using a phone based app to record vaccinations. Results showed that whilst the app provided 'live' information, errors resulted from a lack of an electronic data entry process. The main recommendation from the pilot was the development of an electronic consent form. In preparation for the 19/20 season, a short life working group considered an electronic consent form but was not able to arrive at a solution within the timeframe. Real time data on uptake remains a longer term goal.

6. Key Actions taken by the Board

6.1 Key Actions taken under Enhanced staffing cover

Enhancement of senior medical and other clinical staffing at critical pressure periods across Acute, Community and Social care services
Acute Respiratory Nurse Specialist in-reach into ED and Medical Assessment Units
Cardiology Nurse Practitioner in-reach into ED
Increased Consultants on ward rounds
Increased staffing across all surge areas
Additional Consultants, Registrars and FY2 Cover during Winter months

6.2 Key Action taken to delivery consistent working practices

Consistency of 7 day working principles for HSCP Teams
Seven day working for Discharge to Assess teams
Seven day working for Patient Flow Teams
Social work support of Home First Model
Use of Day of Surgery Admission to supplement capacity and will move to a 7 day service
Additional Adult and Paediatric physiotherapy services

6.3 Key Actions taken under Flu

Point of Care Testing (POCT) for Influenza for all Acute Sites
Point of care testing for influenza in emergency medical patients (children and adults) attending Accident and Emergency and Medical Assessment areas the 4 hospital sites across Lothian. This was pre prioritised prior the scoring process and agreed to be of significant value across Lothian from the 18/19 Debrief.
Housebound Flu Immunisation Programme
Staff Flu Immunisation Programme – already underway

6.4 Key Actions taken under Effective Escalation

Robust cross-system escalation, coordination and communication through senior Leadership at Chief Operating Officer/Chief Officer level.
All Acute sites and Partnerships have tested business continuity arrangements. The Acute sector has already reinstated 3 times daily conference calls for the discussion and action of flow decisions across the system. During Winter, and if required, these calls are escalated to Chief Officers who are invited to join the calls in order to facilitate whole system decision making. Senior Leadership is provided by the chairmanship of the calls which is shared amongst the Deputy Chief Executive, Chief Officer, Acute Services and/or Chief Officer IJB.

6.5 The actions taken above provide a high level overview of priority areas as described in the Letter dated 14/10/2019 above. The full Winter submission from NHS Lothian can be found as Appendix 1 below. This details the Winter plan by priority action and the quantifiable impact of delivering these actions.

Reducing Attendances Wherever possible by managing care closer to home, preferably at home with services focussed on assessment and care closer to home.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
Midlothian Health & Social Care Partnership		
ED Redirection/Support for < 65	November 2019	• On average, 6626 Midlothian residents attend ED each year. • During June 2019 there were 1197 Royal Infirmary of Edinburgh ED attendances by Midlothian residents aged under 65. This is the highest monthly figure this year • On average, about 29 people were frequent attenders each year (attending ED 10 or more times within that year). • Top reasons for attendance included non-specific chest or abdominal pain, cellulitis, asthma, and lower respiratory tract infection. For the 18-44 age group, overdoses, wounds, and alcohol intoxication were unique top reasons. For ages 45-65, COPD, UTI, deep vein thrombosis, vasovagal syncope, and pulmonary embolism were unique top reasons. • 76% self-referrers to ED took not advice prior to attendance. Funding will support a reduction to repeat attendance by signposting and redirecting.
East Lothian Health & Social Care Partnership		
Enhanced Discharge to Assess	December 2019	• The intensive rehabilitation model has been very successfully implemented within the central cluster of East Lothian; it has been one of the initiatives that has successfully enabled a reduction in bed utilisation. This has been very successfully applied to those patients within the stroke unit. East Lothian patients are being pulled out of hospital by the team utilising the agreed stroke pathway up to 10 days earlier than before. They now have active rehabilitation in the community within the confines of their own home. • The COPD patients who would be admitted to Royal Infirmary of Edinburgh would be managed collectively with the advanced physiotherapy practitioner and hospital at home to team keep them within the community including administering IV antibiotics at home.
Edinburgh Health & Social Care Partnership		
CRT+	December 2019	• Number of referrals. • Source of referral. • Average time to contact. • Average home visits and telephone calls per patient. • Number of patients at risk of admission. • % of 'at risk' patients remaining at home at 48 hours and 1 week. • Number of 'supported discharge patients' • Number of supported discharge patients remaining at home at 48 hrs and 1 week

		• **This scheme will also support Admission Avoidance and Focus on Flow through Acute Care. Metrics include:** o Number of 'supported discharge patients' o Number of supported discharge patients remaining at home at 48hrs and 1 week
Festive Practice	20th December 2019	• Reduced number of attendances at A&E, LUCS, and Mental Health Services on public holidays • Reduce need for DN home visits for dressings
Winter Support Team	December 2019	• Reduction in attendances at acute hospitals • **This scheme will also support Admission Avoidance and Reducing Length of Stay.** • Metrics for Reduced Length of Stay include reduction in Delayed Discharges.
Open House (Stafford Centre)	December 2019	• Providing an alternative to A&E for those in mental health crisis o Numbers of people supported during a crisis o Numbers of people reporting increased resilience o Numbers of carers supported
Lothian Unscheduled Care Service (LUCS) and Flow Centre		
Weekend cover for Care Homes	December 2019	• For practices which are recognised as the lead practice for a care home or care homes to provide additional cover over winter weekends to improve continuity of care for patients, avoid hospital admissions, and reduce pressure on LUCS and A&E. • Between 10 and 14 practices participated over the dates covered last year and 18 to 21 care homes received cover from their lead practice. • 179 patients were visited at a total cost of £50,400 giving a cost per visit of £103 over the festive holidays and £142 on the other Saturdays • There was a positive impact on LUCS demand for care home visits. If all Lothian practices had participated and had the same impact as the practices that did participate the LUCS visits to care homes could have reduced from 153 in 2017/18 to 55 in 2018/19. A home visit for LUCS is estimated to cost £200-£250/visit (based on volume of work and cost of supporting the service (GPs/drivers/equipment/drugs/other) over the course of a year)
Increase number of alternatives to admission including access to these in evenings and at weekends.	December 2019	• % alternatives booked through Flow Centre • Increase availability of alternative pathways
Communications		
Winter Communications Plan	November 2019	• Last year, the campaign reach was 105,022 across social media, and 931 likes, shares, retweets and 46,722 impressions overall. • It is estimated that Bus advertising reached 89 per cent of adults visually and the aim is

		to replicate this again. • Radio advertising on Radio Forth reaches an audience of 405,000 and the target will be aimed to improve this reach 19/20. • The Plan will also support recruitment of flu champions and peer vaccinators via internal communications campaign using all channels: Intranet, staff magazine, social media and direct email cascade. Last year this tactic resulted in the recruitment of more flu champions and more peer vaccinators. • Roll out seasonal flu campaign Be Incredible 2 – the sequel to last year's effective promotion. We ask staff to "Be Incredible" and fight flu by being vaccinated.
Managing / Avoiding Admission Wherever possible with services developed to provide care at home across 7 days.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
Midlothian Health & Social Care Partnership		
Rapid Extended MDT Frailty Intervention	November 2019	• People identified with severe frailty are 4 times more likely to be admitted into hospital within 12 months than the non-frail population. • 716 frail people in Midlothian accounted for 20,000 unplanned OBD in 2018. • 190 were from two practices that will be supported in this project. • When someone with severe frailty presents to ED in 75% of presentations they will be admitted. For moderately frail patients the likelihood of admission is 60% (Midlothian analysis). • Access and Relational continuity of care in general practice is associated with a significant number of benefits to individuals and wider health systems, including: better clinical outcomes for an array of conditions; reduced mortality; better uptake of preventative services; better adherence to medication; reduced avoidable hospital admissions (Nuffield trust 2018). • A reduction of 20% hospital activity is achieved by this cohort, would equate to cost avoidance over £600K. This does not include the impact of the third practice.
West Lothian Health & Social Care Partnership		
REACT Care Home	January 2019	• Reduction in admissions from care homes at weekends
Edinburgh Health & Social Care Partnership		
Open House (Phone link & Befriending)	December 2019	• Providing an alternative to (for example) emergency Primary Care attendances for repeat medications • Providing support to augment existing community-based care (e.g. D2A, H@H) • Providing a link back to Locality Hub to intervene earlier in the event of a decline o Numbers of crisis appointments reduced in (for example) PC

		o Numbers supported o Numbers reporting increased resilience o Number of carers supported
St. John's Hospital		
Acute Respiratory Nurse Specialist (RNS) in reaching into ED and MAU	January 2020	• Patients presenting with Respiratory illness increases over winter period. By providing a RNS into front door, will allow a treatment plan identified for those who can be discharged and supported in the community, rather than being admitted, therefore reducing admissions. This links also with the Flu campaign • Monitoring impact will be through RNS activity : o Number of patients reviewed o Number of patients who were discharged o Length of Stay o Site admission profile o Reduction in overcrowding in ED
Cardiology Nurse Practitioner (NP) in reaching into ED	January 2020	• This would be a test of change for the site, where there would be a NP at front door. Troponin waits are the second largest reason accounting for clinical exception breaches. Buy having a NP at front door would allow them to assess patients and discharge all appropriate patients, with a view of moving into a planned clinic slot Monitoring impact will be evidenced through NP activity : o Number of patients reviewed o Number of patients who were discharged o Length of Stay o Site admission profile o Reduction in overcrowding in ED
Royal Infirmary of Edinburgh		
ED Hogmanay	December 2019	• Enhanced staffing model to ensure we can deliver safe and effective patient care throughout the Hogmanay period.
ED Resilience	December 2019	• The scheme will help reduce time to first assessment during the holiday period.
Therapy Services		
Adult Physiotherapy – Respiratory (APP) Royal Infirmary of Edinburgh /Community	December 2019	• Collecting data on the impact of APP working across acute and community managing acute respiratory patients. • Reducing Length of Stay, aided by clinical decision making from experienced, well-established community respiratory physiotherapy colleagues and knowledge of community capacity to support discharge. • Increased discharges on a Friday/later in week when confidence may previously be low

		for discharge over/towards the weekend, thereby a more consistent spread of discharges over the week. • Increased weekend discharge as improved knowledge of CRT
Paediatric Physiotherapy	December 2019	• Collecting data on the increased number of respiratory patients receiving physiotherapy in hospital and supporting hospital to home for immediate discharge from A&E and/or earlier supported discharge from wards will allow us to quantify the impact increased physiotherapy intervention has in contributing to decreased LOS and admission avoidance. • Collecting data on the those patients receiving physiotherapy in the community with chronic complex respiratory conditions and the long term ventilated patients who are often in hospital for extended periods will allow us to quantify the impact increased physiotherapy intervention has in contributing to avoiding admissions.
Lothian Unscheduled Care Service (LUCS) and Flow Centre		
LUCS winter (inc festive) provision	January 2020	• Patient capacity / avoidance of redirection to EDs due to inability to provide timely OOH service / turnaround of festive patients (Christmas and NY) / increased home visiting and base capacity, supportive of admission avoidance to hospitals
Increase number of Alternatives to Admission including Hospital @ Home including evenings and weekends	December 2019	• % H@H referrals booked through Flow Centre • Increase availability of alternative pathways
Reducing Length of Stay Through reduction in delayed discharges, discharge to assess, access to intermediate care services and provision of rehabilitation services at home or a community setting.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
Midlothian Health and Social care Partnership		
Seven day working for Discharge to Assess Team	December 2019	• To date the service has delivered: o 110 Patients supported home earlier from Royal Infirmary of Edinburgh o Saving 542 bed days o Financial savings of £135 000 o Provides ability for 7 days a week discharging
East Lothian Health & Social Care Partnership		
7 Day Working Patient Flow Team	December 2019	• This initiative will allow weekend and extended week day hours within the Partnership to work with discharge teams in the two Edinburgh acute sites. This will allow the commencement of needs assessment quicker and allow the relevant information to support discharge across seven days rather than 5.

		• Weekday working till 8.00pm and Saturday and Sunday working. • Enable discharge paper work and arrangements to be prepared and reduce length of time patients/clients are in the acute sector.
Increasing Hospital to Home Capacity	December 2019	• The Hospital to Home team within East Lothian has been in existence for several years. The service has increased year upon year from one team to six including a double up team. Over the last year they have successfully supported a total of 448 patients to return home. • The Emergency Care Service (ECS) is geared for rapid response to those in the community. It is currently a day time service and augmenting the service to run overnight will enhance their ability to maintain more people at home, avoiding a hospital admission. • Increasing the capacity within the hospital to home team to provide packages of care within the community will ensure that patients can be allocated a package of care at the point of discharge. • The further expansion of this service will reduce the number of patients waiting on packages within acute beds and will ensure that patient return to the community when medically fit. • To increase capacity within the Emergency Care Service (ECS) to ensure that those requiring care within the community during a crisis are provided with this rather than being admitted to hospital beds or care home beds overnight, this service will be implemented from 10 pm to 8 am.
West Lothian Health & Social Care Partnership		
7 Day Equipment Delivery	January 2020	• Reducing length of stay • Facilitating weekend discharges • Impact will be determined by demand • Earlier discharges on Mondays with planning over the weekend
Edinburgh Health & Social Care Partnership		
AWI (Adults with Incapacity)	December 2019	• Reduced length of stay for patients in hospital whose discharge is being impacted by issues of capacity to make welfare and/or financial decisions • Reduction in delayed discharges for this cohort of patients. Impact will be evidenced through Tableau and local systems to monitor capacity such as delays coding. All delays due to issues of capacity are coded 51X and are reported weekly.
Social Work to Support the Home First Model	December 2019	• Reduction in delayed discharges due to earlier intervention of social workers • Reduction in number of people waiting for an assessment
St. John's Hospital		

Managing patient flow 4- additional nurse practitioner at weekends	January 2020	• This will improve decision making at weekends, assisting in improving weekend discharges to meet demand on unscheduled care. • Monitoring impact will be evidenced through: o Discharges at weekends o Time of discharge o Length of Stay o Boarding numbers o Breaches associated with bed waits
Managing patient flow 6- Acute Consultant increase on Ward rounds	January 2020	• This initiative was trialled last year and was evaluated well. Essentially job planned clinic activity in January is converted to ward rounds, to maximise the number of decision makers on ward rounds, to expedite patient treatment and decision to discharge. To offset the closed clinics in January, patients are booked into extra clinic slots generally within their TTG. • Monitoring impact will be evidenced through: o Length of Stay o Time of Discharge o Breaches associated with bed waits o Out-patient TTG performance
REACH	January 2020	• This will allow service to expand into back door and Sundays. Frail patients can be followed through their pathway, with early interventions and identification as to where they could be discharged to home or other facility, which would be more appropriate with their care requirements. Close working with the discharge hub will integral and having a Sunday service, will allow better planning for week ahead • Monitoring impact will be evidenced through: o Activity by REACH o Reduced Length of Stay o Reduction in delays o Earlier in day discharge
Royal Infirmary of Edinburgh		
Boarding Team: Acute & General Medicine	December 2019	• Reduced length of stay • Weekend senior medical cover to facilitate discharge decisions
Boarding Team: MOE & Stroke	December 2019	• Earlier reviews for patients that are boarded out with their specialities.
Orthopaedic Supported Discharge	December 2019	• Enhanced support with ambulatory care pathways • Earlier access to services in the community

		• Earlier engagement with community teams • Prevents delays as patients are able to have ongoing rehab in the community and reduce the amount of inpatient rehab that is required.
Orthogeriatric Pathways Coordinator	December 2019	• Orthopaedic supported discharge has reduced 11,337 occupied bed days since commencing in feb 2017. This service supports on average 20-30 patients a day at home depending on their level of care/rehab dependency. Evidence supports that an additional 3 HCSWs would support a further 12 patients a day with OSD taking the service up to 32-42 a day.
Western General Hospital		
Optimising length of stay in patients with diabetes	January 2019	• Data analysis has demonstrated an increased length of stay for patients with diabetes. Evidence has also demonstrated that a focused **proactive** inpatient diabetes services (utilising e-health initiatives –which NHS Lothian are embedding) reduces length of stay. • CHI linkage of information will allow length of stay analysis. Focused MAU pick up in the morning will reduce length of stay for appropriate patients and will facilitate early review rather than wait for post take ward round review and time to subsequent referral. • QI work to data has focused 3 keys areas for intervention to improves length of stay / flow (based on tableau dashboard data) – inpatients on surgical wards, patients with type 1 diabetes and acute admissions which will be the targeted focused of this winter plan to facilitate timely discharge and improve flow.
Pharmacy		
Royal Infirmary of Edinburgh Weekend Working (1) Winter weekend clinical pharmacy service on the three anticipated busiest months Royal Infirmary of Edinburgh Clinical (2) Clinical pharmacy prioritising areas that did not have a pre-existing clinical pharmacy service	January 2020	• Pharmacy will be able to demonstrate quantifiable impact around the following elements for all initiatives: o Number of medicines reconciliation with error rate o Volume of patients assessed/reviewed by clinical pharmacists o No of IDLs & IPSs reviewed and error rate o Number of Interventions o Number of High Risk Patients o Increase in capacity of over labelling service o Time of receipt of requests to pharmacy o Turnaround time of prescriptions from pharmacy performance
Therapies		
Adult Physiotherapy - Royal Infirmary of Edinburgh /Western General Hospital MMOET	December 2019	• Reduction in average length of stay for physiotherapy patients • Patients being discharged faster from physiotherapy services • A clinically meaningful improvement in patient function in more than 80% of caseload • Patient flow was directed to a high degree of accuracy

		• Patients being discharged less frail and more independent
Physiotherapy - Activity Support Workers Royal Victoria Building/ Western General Hospital Royal Infirmary of Edinburgh	January 2020	• Reduction in average length of stay for physiotherapy patients • Patients being discharged faster from physiotherapy services • A clinically meaningful improvement in patient function in more than 80% of caseload • Patient flow was directed to a high degree of accuracy • Patients being discharged less frail and more independent
Occupational Therapy - Roving - Western General	December 2019	The target of increased Roving winter resource at Western General Hospital would be to decrease the length of stay of medical boarders and increase flow of patients to point of discharge. Medical boarding patients are predominantly: over 65yrs; fall under frailty groups; sit on medical wards outwith their specialities; and wait for assessment from under capacity teams. By improving links to OTs at the 'front door' and tracking patients from there who are boarded directly, roving team members can assist better handover and enable earlier intervention Measurement is aimed at collecting data on: 1. Point of admission to hospital 2. Point of transfer to boarding ward from admissions and when referral received by roving. 3. Response time of OT roving assessment and intervention date and type 4. Date of planned discharge plan 5. Actual discharge date and actions
Occupational Therapy - Roving – Royal Infirmary of Edinburgh	December 2019	The target of increased Roving winter resource at Royal Infirmary of Edinburgh would be aimed at general medical and boarding patients. These patients are currently scoring low on prioritisation parameters and are getting delayed response time from OT. Their average LOS subsequently is higher. Roving will have the specific role to target and screen these patient borders and give them a higher prioritisation status; earlier intervention and improved discharge planning. Measurement is aimed at collecting data on: 1. Point of admission 2. Point of transfer to boarding ward and when referral received. 3. Response time of OT assessment and intervention 4. Date of planned discharge plan 5. Actual discharge
Lothian Unscheduled Care Service (LUCS) and the Flow Centre		
Reduce Length of Stay for patients awaiting repatriation transport to their home board	December 2019	• Bed days saved for repatriations • Utilisation rates – Demand from service/ capacity utilised
Focus on flow through Acute Care Through adherence to discharge trajectories, earlier in the day discharges and improvements through ED flow.		

Winter Initiative	Live Date	Context/Quantifiable Impact
Midlothian Health and Social Care Partnership		
Single Point of Contact Older People Services	November 2019	• Local ownership of patients will reduce length of patient journey as a result of local planning and system knowledge of capacity and options available. • Reduced Length of Stay in Royal Infirmary of Edinburgh, Midlothian Community Hospital and Highbank Intermediate Care • Reduced delays • Easy to navigate system to reduce time to refer for Royal Infirmary of Edinburgh
Edinburgh Health & Social Care Partnership		
Festive Practice	December 2019	• Improvements to ED flow by drawing activity away from the front door during public holidays.
St. John's Hospital		
Efficiency of Discharge Lounge in supporting DDD	January 2020	• This scheme will allow the discharge lounge to increase opening hours, with staff attending huddle, prioritising and pulling patients into lounge. This expands on the work which is a focus for the site, in improving discharges to earlier in day, thus reducing patients waiting for beds • Monitoring impact will be through evidenced through: o Site discharge profile hour by hour o Reduction in breaches associated with bed waits o Improvement in pre 12 discharge
Expansion of discharge hub & DDD	January 2020	• This scheme will allow all back door wards to have support from discharge hub, providing support and focus in discharge planning around complex patients and will link to discharge lounge also. • Monitoring impact will be undertaken by: o Site discharge profile hour by hour o Reduction in breaches associated with bed waits o Reduction in delayed discharges o Length of stay reduction

Managing patient flow 3- PAA	January 2020	• This initiative continues to support GP flow going through Primary Assessment Area (PAA), rather than being diverted to ED. This allows for an expansion of the current model to meet the later demand surge that the site experiences in the evening, allowing patients to be assessed and treated as ambulatory unless identified as need to be admitted. This will continue to reduce admissions into MAU and assist with delays in patients being allocated beds between PAA and ED. • Monitoring impact will be undertaken by: o Breaches associated with bed waits o PAA time to bed allocation o Admission and discharge profile of MAU o Any diverts to ED of PAA flow o Time of discharge
Royal Infirmary of Edinburgh		
Surgical Observation Unit Additional Fellow	December 2019	• Reduced length of stay • Improving time of surgical review on patients in an OOH period to maintain surgical flow throughout the front door areas – this has been recognised as a pressure in the OOH periods previously • Increased patient moves into the inpatient areas • Improved morning discharge profile • More robust staffing profile during winter months to support flow and address the acuity that will present during the winter months
Surgical ANP	December 2019	
AMU Medical Cover	December 2019	
Ward 204: Consultant Cover	December 2019	
Ward 204: Registrar Cover	December 2019	
Ward 204: FY2 Cover	December 2019	
Respiratory Nurse Specialist	December 2019	
Western General Hospital		
Enhanced Nursing Support to OPAT Service	January 2019	• Supporting this bid would reduce patients attending the front door as unscheduled care activity • Additional resource would also provide capacity for nursing staff to attend consultant rounds with ID at the Western General Hospital and Royal Infirmary of Edinburgh to help identify patients who are suitable for the OPAT service in a timely way and improve discharge planning within wards.
Enhanced Medical cover (overnight, weekends and boarding patients)	December 2019	• Increased number of weekend discharges, effective management of boarding patients and average length of stay: further enhancement of weekend medical staffing would help support timely senior review of patients and support discharge.
Radiology		
Radiology Winter Plan - Increased demand for diagnostic imaging	December 2019	• Additional provision is proposed to ensure patient flow is not impacted by any delays to diagnosis for admission and discharge. • Additional reporting capacity is provided for the three month period as WLI sessions

		and some extended days, to keep on top of the additional workload and avoid delays in reporting. • Additional Radiographer cover, CSW/RDA and portering will meet front door additional demand and maintain inpatient flow through CT/MRI/US.
Pharmacy		
Western General Hospital Same as Royal Infirmary of Edinburgh above		• Pharmacy will be able to demonstrate quantifiable impact around the following elements for all initiatives: o Number of medicines reconciliation with error rate o Volume of patients assessed/reviewed by clinical pharmacists o No of IDLs & IPSs reviewed and error rate o Number of Interventions o Number of High Risk Patients o Increase in capacity of over labelling service o Time of receipt of requests to pharmacy Turnaround time of prescriptions from pharmacy performance
Lothian Unscheduled Care Service (LUCS) and the Flow Centre		
Increase number of alternative pathways for patients attending front door areas. Reduce time waiting for repatriation transport. Increase transport for discharges and transfers from acute sites	December 2019	• % alternatives booked through Flow Centre • Increase availability of alternative pathways • Bed days saved for repatriations • Utilisation rates – Demand from service/ capacity utilised • Number of patients transferred or discharged from sites across NHS Lothian
Seasonal Flu, Staff Protection and Outbreak Resourcing Ensure that there are adequate plans in place to manage the outbreak and vaccinations of multiple staff and patient groups as well as contingency planning for Norovirus outbreak control measures.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
Midlothian		
Local Flu Campaign	October 2019	• Midlothian Staff flu uptake was the Partnerships best ever at 59.9% in 18-19 Lothian wide. There have been reports that the additional clinics and clinics running in new areas were well received and attended. • Locally the Partnership built on NHSL 'Be Incredible' social media campaign with regular social media messages that began early October. This included a YouTube and Face Book video of Clinical Director being vaccinated which had over 5000 views and 26 shares. • Uptake amongst Over 65s continues to increase across the board at 74.9%, almost

		reaching the WHO target of 75%. Uptake amongst those at risk remains a challenge across the board at 43% for the year 18/19. • Comparing data from 2017 and 2018 there was a reduction in potentially preventable admissions due to flu. There was a change in the age profile of those that were admitted with an increase in the number of those aged 80+ and an increase in occupied bed days.
Public Health		
Housebound Flu	September 2019	• Last season 6,700 Housebound patients were vaccinated. The aim is to match this uptake for 2019/20 • The effect of not delivering the influenza vaccination to housebound patients could potentially impact on healthcare pressures – this can be evidence by the increase in acute winter admissions in 2017 when influenza virus was more potent and the vaccine less effective • A benefit of the centrally coordinated housebound vaccination programme could free up time for GP and District Nurse teams for other clinical activities • The timely launch of the programme and administration of the vaccine must be taken in to account as the immune response to vaccination takes about 2 weeks to fully develop • The programme is delivered by NHS L Bank staff vaccinators and this group of staff maintain their competencies and can be utilised to deal with flu outbreaks eg Nursing Home
Staff Flu Programme	September 2019	• Last season 17,200 staff were vaccinated. 15,800 NHS L staff (59% uptake) and 1400 of staff from social care partners • The NHS Lothian uptake for 2018/19 increased from the 51% achieved during 2017/18 season. For this coming season the aim is to improve uptake of clinical staff • The main benefit of delivering the staff flu programme is to maximise reduction of flu transmission in addition to providing individual protection. This will potentially reduce staff sickness rates and minimise local disruption/impact on local service delivery • This service also assists with the data collection and reporting process – could potentially enhance response rates should there be an outbreak
Point of care testing for influenza in emergency medical patients (children and adults) attending A/E and MAU at the 4 hospital sites across Lothian.	October 2019	• Rapid diagnosis, in this case POCT has been shown to reduce length of stay by 1 day. In NHS Lothian length of stay has been compared in periods where POCT is available to time periods where it is not and has found that length of stay is reduced overall in periods where POCT is available by 1 day. • Additionally the following impacts will be evidenced following funding of POCT Flu Testing: o Reduced bed closures o Improved patient flow o less patient moves

		o correct and appropriate use of antivirals o reduced spend of antivirals for prophylaxis owing to ward patients being exposed to flu Reduced nosocomial cases
Preparedness for Additional Surge Capacity across Health and Social Care services Planned dates for the introduction of additional acute, OOH and Social care services is agreed and operational before the anticipated surge period.		
Winter Initiative	**Live Date**	**Context/Quantifiable Impact**
St. John's Hospital		
1. Managing acute patient flow 1- ward 18 staffing	January 2020	• All 3 of these schemes are interlinked and relate to medicine taking capacity from ward 18 and cohorting medical patients into this area. To reduce impact on Head &Neck activity, DOSA will be used to supplement capacity and will move to a 7 day service between January- March, thus requiring additional staff. • To ensure that this is safe for patients and staff enhanced staffing is required in ward 18, to supplement the required care needs of this group of patients. Additionally medical staffing will be required to be increased to support this group of patients and any other patients that are boarding outside of medicine on the site. • Metrics which will be used: o Number of breaches associated with bed waits o Length of Stay o Time of discharge o Complaints/ compliments o Boarding numbers
2. Managing acute patient flow 2- medical staffing	January 2020	
3. Managing patient safety and dependency- DOSA	January2020	
Supporting Acute ORS flow over Winter	January 2020	• Historically the demand for Orthopaedic rehabilitation increases over winter months. This would allow for the addition 6 unfunded beds in ward 14 to open, to allow pull of West Lothian Orthopaedic patients requiring rehabilitation to be pulled over onto site, instead of being delayed at Royal Infirmary Edinburgh or other Orthopaedic centres and allow access to rehabilitation earlier in their journey. • Metrics which will be used: o Time to repatriation on site o Reduced length of stay
Royal Infirmary of Edinburgh		
DSU Winter Capacity	December 2019	• Enhanced site resilience in anticipation of increased attendances and admissions.
Western General Hospital		
Enhanced Medical cover (overnight, weekends and	January 2020	• Support system wide patient flow and the reduction of the number of delayed discharges in acute beds, optimising hospital capacity for acute admissions.

boarding patients) This proposal is to open 21 beds flexibly in Ward 15 to support delayed discharge patients		• To mitigate the risk associated with the reduction of 26 beds following ward 71 closure
Additional MDT Support for Medicine of the Elderly Team	January 2020	• Reduction in length of stay and number of delayed discharges • Improvement in Planned Discharge Dates in collaboration with MDTs • Support MDTs in the early initiation of realistic conversations with families to manage expectations • Support the reduction - to support length of stay post 71 ward closure
Workforce It is essential that the appropriate levels of staffing are in place across the whole system to facilitate efficient and effective patient care, to ensure consistent discharge during weekends and the holiday periods.		
Pharmacy		
St. Johns Extending hours would support safe supply of discharge medicines and manage staff welfare which requires additional manpower NOT additional hours to existing staff.	December 2019	• Pharmacy will be able to demonstrate quantifiable impact around the following elements for all initiatives: o Number of medicines reconciliation with error rate o Volume of patients assessed/reviewed by clinical pharmacists o No of IDLs & IPSs reviewed and error rate o Number of Interventions o Number of High Risk Patients o Increase in capacity of over labelling service o Time of receipt of requests to pharmacy o Turnaround time of prescriptions from pharmacy performance
Therapy Services		
Occupational Therapy - Ward 15 - Western General	December 2019	Impact is aimed at providing maintenance therapy to those who are awaiting NH or POC. The aim is to prevent de-conditioning / deterioration whilst continuing to work on improving function and reducing package of care requirements or requirements for complex discharge planning. Measurement will be aimed at: 1. Scoring functional capacity using pre and post measures of function to assess incremental gains or deterioration during length of stay 2. Improved patient experience
Adult Physiotherapy - Western General Hospital Ward 15	December 2019	Collecting data on those patients awaiting a Package of Care or Nursing Home placement. Physiotherapy to maintain/progress patients functional and mobility status and prevent de-conditioning whilst in hospital and increase patients' resilience at point of discharge. Collate impact of physiotherapy on: 1. reduction in falls

		2. reduced requirement for analgesia 3. reduction in re-admission rates

Edinburgh Health Social Care Partnership
Winter Planning Submissions 2019/20

Title	Lead	Amount Requested	Amount Awarded	Amount Spent		NHS Spend	CEC Spend	Slippage
Festive Practice	Eileen McGuire	£25,830.00	£25,830	£10,830		£10,830	£0	£15,000
CRT+	Orla Prowse	£32,000.00	£23,227	£18,088		£18,088	£0	£5,139
Winter Support Team	Fiona Wilson; Julie McNairn	£164,786.00	£180,858	£53,949			£53,949	£126,909
Social Work to Support Home First Model	Fiona Wilson; Steph Craig	£101,866.00	£101,866	£79,348			£79,348	£22,518
AWI	Colin Beck; Ian Waitt	£35,000.00	£17,500	£16,047			£16,047	£1,453
Open House	Stef Milenkovic	£22,000.00	£28,038	£28,038		£28,038		£0
NEW Additional Bid to support care homes	Alana	£158,342.00	£158,342	£158,342			£158,342	£0
TOTAL		**£539,824.00**	£535,661	£364,642		£56,956	£307,686	£171,019
							Available	**£293,619.00**

Edinburgh Integration Joint Board

REPORT

Finance update

Edinburgh Integration Joint Board

24th August 2020

Executive Summary	The purpose of this report is to provide the Integration Joint Board (IJB) with an update on projected in year financial performance.

Recommendations	It is recommended that the Integration Joint Board note: a. the current year end forecasts provided by our partners; b. the work ongoing to refine and further understand these; and c. that, given the inherent uncertainties, limited assurance on a break even position can be given at this stage.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations	No direction required	✓
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Report Circulation

1. A version of this report was considered by the Performance and Delivery Committee on 20th August 2020. A verbal update on this discussion will be given to the IJB.

Main Report

Background

2. At its meeting in July the IJB agreed the 2020/21 financial plan. Whilst the plan set out how financial balance could be achieved in year, this was heavily reliant on one off measures. The board also noted that both partners (the City of Edinburgh Council – the Council and NHS Lothian) had commissioned work to further understand the financial impact of COVID-19.

3. An update on financial performance is provided to each meeting of the IJB and, since its establishment, to the Performance and Delivery Committee. This paper summarises the initial output from the quarter 1 review carried out by NHS Lothian and the first set of monitoring information, based on the end of June position, produced by the Council. Both organisations recognise further work is required before the Chief Finance Officer can improve on the limited assurance provided in this report.

Forecast financial outturn - overview

4. As members are aware, the IJB "directs" budgets back to our partner organisations, the Council and NHS Lothian, who in turn provide the associated services. The majority of these services are delivered through the Partnership, with the balance being managed by NHS Lothian under the strategic direction of the IJB.

5. Previous finance reports to the board have highlighted the challenges of consolidating financial information provided by our partners. This is amplified as a result of the pandemic, with the Council and NHS Lothian taking different approaches to capturing and reporting costs attributable to COVID-19.

6. Table 1 below summarises the projected year end operational position for delegated services. Further detail is included in appendices 1 (the Council) and 2 (NHS Lothian).

	Annual budget £k	Forecast actual £k	Forecast variance £k
NHS services			
Core	298,006	299,126	(1,242)
Hosted	87,899	89,509	(1,488)
Set aside	88,637	92,952	(4,315)
Sub total NHS services	**474,542**	**481,586**	**(7,044)**
CEC services	**228,510**	**232,343**	**(3,833)**
Total	**703,052**	**713,929**	**(10,877)**

Table 1: IJB year end forecast 20/21

7. Interpreting these results at this time of particular uncertainty is not straightforward. Both partner organisations have commissioned further work to fully understand the underlying drivers. In particular, the financial impact of COVID-19, both in terms of the impact of the actual costs incurred to date, as well as the implication for the rest of the financial year. Finance teams in both organisations will determine the extent to which the £10.9m projected overspend relates to: the 'core' (i.e. underlying operational) position; the impact of COVID-19 on costs incurred to date; and any (future) financial consequences of mobilisation/remobilisation. The picture is further complicated by the extent to which costs can be recovered from the Scottish Government (SG) through the mobilisation/remobilisation planning processes. NHS Lothian will be making the next submission shortly, covering all non delegated NHS and delegated health and social care services. This will be based on the output from the quarter 1 reviews.

8. Finally, it should be recognised that forecasts will continue to be updated as remobilisation plans are developed and refined and the financial consequences become clearer.

9. Outputs from these concurrent pieces of work will be developed over the coming weeks and a more comprehensive update will be available for the IJB

meeting in October. This report sets out the high level highlights as they are currently understood.

10. The Council has just completed its period 3 monitoring report, the first of the financial year. This shows a projected overspend for the year of £3.8m, due mainly to care at home and reduced income. The forecast is predicated on the recovery of COVID-19 costs through the mobilisation planning process and current levels of spend across all cost headings.

11. NHS Lothian has now published the financial results to the end of July and is finalising their quarter 1 review. They have taken a different approach from the Council to additional COVID-19 funding and have not, at this stage assumed any additional monies. As discussed above the finance team are finalising an exercise to estimate the extent to which the pandemic has impacted on the forecast position.

Savings and recovery programme

12. In July 2020 the IJB agreed a phased Savings and Recovery Programme that will deliver in year savings of £15.9m, recognising that this was both achievable and challenging. Delivery is overseen by the Savings Governance Board, chaired by the Chief Officer. This group meets monthly with all project leads submitting progress reports which inform the overall dashboard prepared by the Programme Manager. This approach is part of the Savings Governance Framework which has been put in place following the recent internal audit review of the governance of the programme.

13. These strengthened arrangements brings a focus to the schemes which have been identified as needing support to progress, allowing us to concentrate on the actions required to deliver the agreed intent of the IJB. We recognise that via an iterative process, it is necessary to build on the Savings Governance Framework to support financial sustainability in future years and that this approach must ensure strategic alignment and links with the transformation programme are strengthened.

14. The current programme is attached at appendix 3 and forecast delivery will be reported to future meetings of the Performance and Delivery Committee as well as the board itself. It should be noted that the current target does not reflect the impact of the proposed contractual uplifts which are the subject of a separate paper to this board.

Implications for Edinburgh Integration Joint Board

Financial

15. Outlined elsewhere in this report

Legal/risk implications

16. Like any year end projection, the IJB relies on a number of assumptions and estimates each of which introduces a degree of risk. Of particular note are:

    a) forecasts will vary as service driven mobilisation and remobilisation plans are developed and financial impacts crystallised;

    b) the extent to which COVID-19 costs will be met by the Scottish Government through the mobilisation planning process;

    c) delivery of the savings and recovery programme in line with projections; and

    d) that there will be no further waves of COVID-19.

Equality and integrated impact assessment

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

Environment and sustainability impacts

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

Quality of care

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

Consultation

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

Report Author

Moira Pringle
Chief Finance Officer, Edinburgh Integration Joint Board
moira.pringle@nhslothian.scot.nhs.uk

Appendices

Appendix 1	Year end forecast for council delegated services
Appendix 2	Year end forecast for NHS delegated services
Appendix 3	Savings and recovery programme 2020/21
Appendix 4	Glossary of terms

Appendix 1

YEAR END FORECAST FOR COUNCIL DELEGATED SERVICES

	Annual budget £k	Forecast actual £k	Forecast variance £k
External services			
Assessment & care management	519	519	0
Care at home	30,564	32,792	(2,228)
Care and support	55,844	56,086	(242)
Day services	13,805	14,073	(268)
Direct payments & individual service fund	35,997	36,273	(276)
Residential services	10,771	10,760	11
Other services	65,822	65,031	791
Sub total external services	**213,322**	**215,534**	**(2,212)**
Internal services	114,027	113,183	844
Income	(43,000)	(40,535)	(2,465)
Funding	(55,839)	(55,839)	0
Total	**228,510**	**232,343**	**(3,833)**

YEAR END FORECAST FOR NHS DELEGATED SERVICES

	Annual budget £k	Forecast actual £k	Forecast variance £k
Core services			
Community Hospitals	12,989	12,706	283
District Nursing	12,084	11,789	295
Geriatric Medicine	2,883	2,789	94
GMS	84,507	86,705	(2,199)
Learning Disabilities	1,177	1,147	30
Mental Health	11,028	9,980	1,048
PC Management	48,214	47,999	215
PC Services	8,833	9,047	(214)
Prescribing	74,887	75,620	(733)
Resource Transfer	25,536	25,536	0
Substance Misuse	3,920	4,033	(113)
Therapy Services	10,261	10,231	30
Other	1,686	1,542	145
Sub total core	298,006	299,126	**(1,120)**
Hosted services	87,899	89,509	(1,610)
Set aside services	88,637	92,952	(4,315)
Total	**474,542**	**481,586**	**(7,044)**

EDINBURGH IJB SAVINGS AND RECOVERY PROGRAMME 2020/21

Proposal		Phase	Saving (£m)
1	Adult Sensory Impairment Services	0	£0.03
2	Learning Disability Services (A)	0	£0.52
3	External Housing Support	0	£0.25
4	Day Centres & Be Able	0	£0.04
5	Vacancy Control	0	£0.20
6	Hosted (by NHSL/other 3HSCPs)	0	£0.74
7	Set Aside	0	£1.18
Phase 0 Sub Total			***£2.96***
8	Home First	1	£1.00
9	Purchasing	1	£4.10
10	Learning Disability Services (B)	1	£0.06
11	Review Rehabilitation Services	1	£0.08
12	Review Sexual Health Services	1	£0.05
13	Prescribing	1	£1.96
14	Community Equipment	1	£0.25
15	Carers investment	1	£1.45
Phase 1 Sub Total			***£8.95***
16.	Bed Based Review (Phase 1)	2	£0.50
17	Additional purchasing target	2	£3.09
18	Thrive - Mental Health & Wellbeing	2	£0.30
19	Medical Day Hospitals	2	£0
20	EADP	2	£0.10
Phase 2 Sub Total			***£3.99***
TOTAL 2020/21 SAVINGS			**£15.90**

GLOSSARY OF TERMS

TERM	EXPLANATION
ASSESSMENT AND CARE MANAGEMENT	Predominantly social work, mental health and substance misuse teams
CARE AT HOME	Services provided to over 65s in their homes.
CARE AND SUPPORT	Services provided to under 65s in their homes.
DAY SERVICES	Services provided to clients in buildings owned by the Council or a third party.
DIRECT PAYMENTS	Option 1 of self directed support where the client has chosen to be responsible for organising their care.
HOSTED SERVICES	Services which are operationally managed on a pan Lothian basis either through one of the 4 Health and Social Care Partnerships or Royal Edinburgh and Associated Services (REAS).
INDIVIDUAL SERVICE FUNDS	Option 2 of self directed support where the client has chosen for a 3rd party (not the Council) to organise their care.
OTHER SERVICES	Mainly grants and block contract payments to organisations that provide more than one type of service. The internal element includes sheltered housing and supported accommodation.
RESIDENTIAL SERVICES	Services provided to clients in care homes.
SET ASIDE SERVICES	Acute hospital based services managed on a pan Lothian basis by NHS Lothian
THERAPY SERVICES	Mainly occupational therapy teams.
UNPAC	Services provided for Lothian residents out with Lothian.

Edinburgh Integration Joint Board

REPORT

Fair work and the living wage in adult social care

Integration Joint Board

24th August 2020

Executive Summary	The purpose of this report is to provide the Integration Joint Board (IJB) with an update on implementation of the nationally agreed contract uplifts and the implications for the 20/21 financial plan.

Recommendations	It is recommended that the Integration Joint Board: a. agree to implement the nationally agreed 3.3% contract uplift at a cost of £6.0m; b. note that this will increase the financial plan gap by £3.4m; c. note that the Chief Officer and Chief Finance Officer will continue to work with partners to identify how this will be addressed; d. agree to receive an update at the meeting in October; and e. issue the direction attached as an appendix to this report to the City of Edinburgh Council.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations	No direction required	
	Issue a direction to City of Edinburgh Council	✓
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Report Circulation

1. This report has not been considered elsewhere.

Main Report

2. At its meeting in July, the IJB agreed the 2020/21 financial plan. In doing so the board noted the reliance on one off measures to support financial balance and asked for an update on implementation of the nationally agreed contract uplift.

3. On 10th April 2020, the Cabinet Secretary and the COSLA Health & Social Care Spokesperson wrote to Local Authority Chief Executives and IJB Chief Officers and Chief Finance Officers setting out their agreed approach to Fair Work and the Living Wage in Adult Social Care:

   "To ensure that our workforce receive payment for the Living Wage and to recognise their efforts in the Covid response a national uplift of 3.3% to contract hourly rates has been agreed and should be applied from April 2020."

4. The letter also made clear that providers should use this uplift to pay their staff the living wage with effect from 1st April 2020.

5. When preparing the financial plan for 20/21 it was assumed that, in line with the commitment set out in the letter, the costs associated with this policy would be funded in full. Any differential between the money available and the cost of implementation would therefore increase the IJB's budgetary gap, and consequently the savings target. This is currently sitting at £15.9m.

6. In a subsequent letter, dated 8th June, the Cabinet Secretary confirmed the level of funding available and its distribution. This stated that an 'equitable approach' had been agreed with COSLA and 0.8% of the cost of the commitment would be allocated to integration authorities. This percentage was based on the assumption that areas would already have planned, and built into budgets, a 2.5% increase. From a total fund of £8.8m, Edinburgh received an allocation of £1.15m.

7. This letter also recognised that a settlement at this level would adversely impact some integration authorities and referred to the SG's commitment to continue to engage with integration authorities and local government and NHS partners to address any immediate financial challenges. With a significant shortfall in funding Edinburgh clearly fell into this category. The Chief Officer immediately initiated discussions with Scottish Government (SG) officers and several meetings have taken place over recent months. However, despite these best efforts, it is now clear that no further funding will be provided.

8. Accordingly the board is now in a position that implementing the national uplift with the consequent uplift in workers' pay will add £3.4m to the existing financial challenge. Despite this, it is recommended that the board now directs the Council to implement the 3.3% uplift. This proposal reflects the board's recognition of the work all heath and social care staff make towards keeping vulnerable people in our city safe. A contribution which has been clearly demonstrated by the workforce's response to dealing with the challenges of COVID-19.

9. Further, ensuring providers are enabled to maintain a fair working regime to suitably recompense workers for the key roles they are undertaking, supports our strategic intent to build and maintain a high quality, skilled and sustainable health and social care workforce

Implications for Edinburgh Integration Joint Board

Financial

10. Under direction from the IJB, the Council has a varied range of contractual arrangements with 238 providers for the provision of social care services. This includes c130 block contracts, framework agreements and associated spot contracts. Also covered by the proposed 3.3% uplift are direct payments, individual service funds and payments to personal assistants (PAs).

11. Baseline annual contractual spend for Health and Social Care is just over £200m. To date the only contractual uplifts which have been actioned relate to the national care home contract (NCHC) which covers residential placements for the over 65s. Each year a nationally agreed uplift is applied, for 20/21 this was 3.54%.

12. The total cost associated with uprating all other contracts by 3.3% is £6.0m. To fund this, the IJB has received £2.1m via the SG's budget settlement and a further £1.15m as referenced in paragraph 6 above. Taken together this would increase the IJB's budgetary gap by £3.4m, putting the IJB in a similar position to previous years with an unbalanced budget.

13. As this additional cost will lead directly to an increase in the savings target, in the first instance the financial impact will be recorded in the mobilisation plan. In parallel, discussions with partners will continue as we seek to identify a solution. Ultimately if these efforts are not successful then the Chief Officer will be required to bring forward a recovery plan for consideration by the board.

Legal/risk implications

14. Failure to implement the contractual uplift would put Edinburgh out of step with the national agreement. Further, providers would face challenges in meeting the living wage requirements and many could only do so by making offsetting efficiencies elsewhere in their operations. This in turn is likely to impact on the quality and/or volume of service with negative consequences for outcomes.

Equality and integrated impact assessment

15. As outlined in the report.

Environment and sustainability impacts

16. Enabling providers to pay the living wage supports sustainability of the workforce with consequent positive impact on outcomes for the people of Edinburgh.

Quality of care

17. As outlined in the report.

Consultation

18. Officers have had ongoing communication with a range of stakeholders during this time. As part of these discussions providers, trades unions and other interested parties have consistently highlighted the pressures at both an organisational (provider) and personal (workforce) level.

Report Author

Moira Pringle
Chief Finance Officer, Edinburgh Integration Joint Board
moira.pringle@nhslothian.scot.nhs.uk

Appendices

Appendix 1 Direction to the City of Edinburgh Council

DIRECTION FROM THE EDINBURGH INTEGRATION JOINT BOARD

Reference number	TBC		
Does this direction supersede, vary or revoke an existing direction?	No		
Approval date	TBC		
Services/functions covered	• All purchased services (with the exception of residential accommodation for over 65s where the uplift has already been applied) • All direct payments, individual service funds and payments to personal assistants		
Full text of direction	Implement a 3.3% contractual uplift in line with the letter of 10th April 2020 from the Cabinet Secretary and the COSLA Health & Social Care Spokesperson letter to Local Authority Chief Executives and IJB Chief Officers and Chief Finance Officers		
Direction to	The City of Edinburgh Council		
Link to relevant EIJB report	TBC		
Budget/finances allocated to carry out the detail		*NHS Lothian*	*City of Edinburgh Council*
	Specify financial year (2020/21)		£6.0m
	Specify financial year (2021/22)		£6.0m
Performance measures	Uplift to be actioned		
Date direction will be reviewed	October 2020		

Edinburgh Integration Joint Board

REPORT

Annual Review of Standing Orders

Edinburgh Integration Joint Board

24 August 2020

Executive Summary	The purpose of this report is to review the IJB's Standing Orders.

Recommendations	It is recommended that the Edinburgh Integration Joint Board agrees: 1. To note that the Standing Orders of the Integration Joint Board remain fit for purpose and to agree that no changes are made. 2. To note that the next annual review of the Standing Orders will be presented to the IJB in May 2021. 3. To note the decision taken under emergency powers in relation to the Interim Standing Order for deputations.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations		✓
	No direction required	✓
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Report Circulation

This report has not been considered elsewhere.

Main Report

1. Standing Orders are required by the Integration Joint Board under the Public Bodies (Joint Working) (Scotland) Act 2014 and the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 (No 285).

2. The Standing Orders encourage transparent and accountable decision making with sufficient provisions in place to ensure the smooth running of the Joint Board, including arrangements for such matters as the chairing of the meetings, the notice for the meetings and how voting will be carried out.

3. The current version of the Integration Joint Board's Standing Orders was approved in July 2015, with further amendments approved by the Joint Board to reflect Scottish Ministers' guidance in January 2016, May 2016 and January 2017. The IJB reviews its Standing Orders annually. This is usually done in May each year however due to the suspension of Board meetings this has been delayed this year.

4. When the Standing Orders were last reviewed by the Board in May 2019, changes were made relating to relating to substitutions, motions and amendments, a register of attendance and changing a decision of the Joint Board within six months.

5. During the current circumstances and while meetings are being held remotely, deputations are not able to appear in person to address the Board. A decision has been taken under emergency powers by the Chief Officer, in consultation with the Chair and Vice-Chair to amend Standing Order 8 to allow deputations to be considered by written submission on an interim basis. Therefore it is not necessary to amend the Standing Orders to address this at this time. The interim Standing Order reads:

   5.1 "8.1 Deputation requests must be in writing and submitted to the clerk by 5pm two days before the meeting takes place.

   8.2 Deputations should only be accepted from an office bearer or spokesperson of an organisation or group.

   8.3 The Chair has the discretion to waive the requirements in paragraphs 8.1 and 8.2 if they feel it is appropriate.

   8.4 Deputations must relate to an agenda item being considered at that meeting.

8.5 The written deputation should be considered by members of the EIJB when making a decision and can be discussed when its corresponding agenda item is considered."

Implications for Edinburgh Integration Joint Board

Financial

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

Legal / risk implications

7. Standing Orders are essential to the efficient running of the Board's meetings and are a key component of ensuring good governance controls are in place.

Equality and integrated impact assessment

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

Environment and sustainability impacts

9. There are no environment or sustainability implications arising from this report.

Quality of care

10. Not applicable.

Consultation

11. None.

Report Author

Judith Proctor

Chief Officer, Edinburgh Integration Joint Board

Contact for further information:

Name: Rachel Gentleman, Committee Services

Email: rachel.gentleman@edinburgh.gov.uk Telephone: 0131 529 4107

Background Reports

12. Standing Orders for The Proceedings and Business of the Integration Joint Board

13. Public Bodies (Joint Working) (Scotland) Act 2014

14. Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014

15. Integration Scheme

Appendices

None.