Public Document Pack

Edinburgh Integration Joint Board

Notice of Meeting and Agenda

Edinburgh Integration Joint Board

10.00am, Tuesday, 21st July, 2020

Virtual Meeting - via Microsoft Teams

This is a public meeting and members of the public are welcome to watch the live webcast on the Council's website.

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 Any items under "Private Business" will not be published, although the decisions will be recorded in the minute.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

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1. Welcome and Apologies

1.1 Including the order of business and any additional items of business notified to the Chair in advance.

2. Declaration of Interests

2.1 Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

3. Deputations

3.1 If any.

4. Minutes

4.1	Minute of the Edinburgh Integration Joint Board of 28 April 2020 – submitted for approval as a correct record	5 - 8
4.2	Minute of the Edinburgh Integration Joint Board of 16 June 2020 – submitted for approval as a correct record	9 - 10

5. Forward Planning

5.1	Rolling Actions Log	11 - 18

6. Items of Governance

6.1	Edinburgh Integration Joint Board Governance Report – Report by the Chief Officer, Edinburgh Integration Joint Board	19 - 66

7. Items of Strategy

7.1	Return to Transformation – Report by the Head of Strategic Planning, Edinburgh Health and Social Care Partnership	67 - 86
7.2	Savings and Recovery Programme 2020/21 – Report by the Chief	87 - 172

Finance Officer, Edinburgh Integration Joint Board

7.3	2020/21 Financial Plan – Report by the Chief Finance Officer, Edinburgh Integration Joint Board	173 - 186
7.4	Mental Health Services (including Substance Misuse): Quality Assurance – referral from the Clinical and Care Governance Committee	187 - 246

8. Items of Performance

8.1 None.

9. Proposals

9.1 None.

Board Members

Voting

Angus McCann (Chair), Councillor Ricky Henderson (Vice-Chair), Councillor Robert Aldridge, Michael Ash, 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 28 April 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, Councillor Phil Doggart, Helen FitzGerald, Councillor George Gordon, Kirsten Hey, Councillor Melanie Main, Moira Pringle, Judith Proctor, Ella Simpson and Richard Williams.

Officers: Ann Duff, Rachel Gentleman, Lauren Howie, Gavin King, Jenny McCann, Angela Ritchie and David White.

Apologies: Andrew Coull, Christine Farquhar, Martin Hill, Jackie Irvine, Ian McKay and Peter Murray.

1. Minutes

Decision

1) To approve the minute of the meeting of the Edinburgh Integration Joint Board of 4 February 2020 as a correct record.

2) To approve the minute of the meeting of the Edinburgh Integration Joint Board of 14 April 2020 as a correct record.

3) To note the minute of the meeting of the Futures Committee of 21 October 2019.

4) To note the minute of the meeting of the Audit and Assurance Committee of 8 November 2019.

5) To note the minute of the meeting of the Clinical and Care Governance Committee of 14 November 2019.

6) To note the minute of the meeting of the Performance and Delivery Committee of 20 November 2019.

7) To note the minute of the meeting of the Strategic Planning Group of 14 January 2020.

8) To note that the Chair would arrange a meeting of the committee chairs to discuss the approach to reporting of committees to the Board.

2. Rolling Actions Log

The Rolling Actions Log for April 2020 was presented.

Decision

1) To close the following actions:

- Action 2 (point 1) - Primary Care Transformation Programme
- Action 3 – Evaluation of 2018/19 Winter Plan
- Action 6 – Rolling Actions Log re. NHS Lothian Board Escalation
- Action 10 - Rolling Actions Log – Integrated Older People's Service
- Action 12 – Finance Update

2) To otherwise note the remaining outstanding actions.

(Reference – Rolling Actions Log, submitted.)

3. 2020/21 Financial Plan

The report provided information on the financial plan for 2020/21 and the progress towards a balanced position for the year. It was noted that a number of workshops had been held with members to discuss the plan and the savings and recovery programme, but that the response to the Covid-19 pandemic had impacted progress and the level of certainty in relation to costs.

Details of the proposed savings and recovery programme required to support the balanced budget were attached to the report. A further update would be provided at the next meeting.

Decision

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

2) To note the resultant financial plan based on the revised delegated budgets and expenditure forecasts.

3) 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.

4) 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.

5) To agree to receive an update on progress made towards balancing the financial plan at the next meeting.

6) 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.

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

4. Provision of General Medical Services – Edinburgh South

The Board resolved that the public be excluded from the meeting during consideration of the item of business on the grounds that it involved the disclosure of exempt information as defined under Standing Order 5.9.

Approval was sought for the re-provision of Dalkeith Road and Boroughloch Medical Practices in fit for purpose accommodation. If approved, the Initial Agreement, attached to the report, would progress to NHS Lothian's Finance and Resources Committee for consideration.

During discussion, it was noted that the proposal had been previously considered by the Chair and Vice-Chair in terms of Standing Order 15.

Decision

1) To agree the proposal to re-provide Dalkeith Road Medical Practice and Boroughloch Medical Practice in fit for purpose accommodation.

2) To 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 2019-20 Capital Prioritisation Process.

3) To approve the proposal and agree the presentation of the Initial Agreement to NHS Lothian's Finance and Resources Committee.

4) 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.

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

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Edinburgh Integration Joint Board

Minute

Edinburgh Integration Joint Board

10.00am, Tuesday 16 June 2020

Held remotely by video conference

Present:

Board Members:

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

Apologies: Jackie Irvine and Jacqui Macrae

1. Ongoing Procurement Exercises

The Board resolved that the public be excluded from the meeting during consideration of the item of business on the grounds that it involved the disclosure of exempt information as defined under Standing Order 5.9.

The Board considered a report which sought approval to defer a decision on the award of contracts for Carers and Thrive to the Board meeting on 21 July 2020. If approved, the investments would be able to be considered in the context of the overall financial position which remained unbalanced and required significant measures to deliver further savings to address the gap.

Decision

To agree to postpone the awarding of new Carer and Mental Health (Thrive) contracts associated with new investment. This would allow them to be considered in the wider context of the financial plan which would be presented to the EIJB on 21 July 2020.

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

Declarations of interest

Ella Simpson declared an interest in the above item as EVOC worked with organisations affected by procurement decisions.

Edinburgh Integration Joint Board

Rolling Actions Log

July 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~~	**Update** Report on 21 July, covering TORs. The briefing will be produced following agreement of terms of reference for the committees.
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.

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
			2) To agree that the next report to the Joint Board would include more details on how the Programme was being delivered and its impact on stakeholders	Chief Officer, Edinburgh Health and Social Care Partnership	October Board ~~December 2019~~ ~~October 2019~~	**Update** 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~~	**Update** Report on the TORs for Committees are on the agenda for 21 July EIJB.
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	October 2020 ~~December 2019~~ ~~October 2019~~	**Update** A report is scheduled to come to next P&D in October A situation report on the performance and evaluation framework

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
Page 13						for the Carers' Strategy was 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.
5	Home First	22-10-19	1) To require a report on progress no later than April 2020. 2) To agree that timescales would be added to the Direction.	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

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
						plank of the Partnership's response to Covid-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.
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.
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	July 20 ~~January 2020~~ ~~April 2020~~	**Update** To be circulated by the end of July 2020

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
				Social Care Partnership		
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 RAL – 10 March 2020	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	
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	Chief Officer and Chief Finance Officer,	July 2020	**Update** P&D held a workshop on 29th May to discuss the

No	Subject	Date	Action		Action Owner	Expected completion date	Comments
				be arranged to allow members to fully scrutinise the proposal.	Edinburgh Health and Social Care Partnership		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	**Update** Report on budget savings to come to IJB on 21 July.
			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 Social Care Partnership	July 2020	**Update** Financial plan report is on the agenda for IJB on 21 July 2020
			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,	October 2020	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
				Edinburgh Health and Social Care Partnership		
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.

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Edinburgh Integration Joint Board

REPORT

Edinburgh Integration Joint Board Governance Report

Edinburgh Integration Joint Board

21 July 2020

Executive Summary	The purpose of this report is to provide the Edinburgh Integration Joint Board (EIJB) with an update on the following areas of governance: 1. Resumption of committees 2. 2021 calendar of meeting for the EIJB 3. Terms of Reference for Committees This report proposes to resume committees from the end of July, proposes 2021 meeting dates for the EIJB meetings and development sessions and gives an update on the Terms of Reference (TORs) for committees.

Recommendations	It is recommended that the Edinburgh Integration Joint Board: 1. Agree to the resumption of committees with the proposed changes contained within this report 2. Agree the 2021 dates for the EIJB meetings and development sessions. 3. Agree the Terms of Reference for EIJB committees

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 circulated to any EIJB committee, however the TORs have been agreed by their respective committees.

Main Report

Resumption of Committees

2. The EIJB agreed at its meeting on 14 April 2020 to suspend Board and committee meetings until the end of June 2020.

3. As staff continue to deal with the Covid19 pandemic, and have limited operational capacity, it is not possible to operate the EIJB committees in the same way as before. Therefore, this paper proposes some options to allow resumption of committees from the end of July 2020.

4. It is proposed the following changes would support the resumption of committees:

    a. Papers (agenda and reports) will be sent out 5 days before committee
    b. The length of committees would be reduced from 2 ½ hours to 1 ½ hours
    c. The Executive Lead in consultation with the Chair would consider / review the annual cycle of business to allow for streamlined agendas
    d. Committees will meet virtually to the end of 2020, as staff will not be returning to the office until October 2020 at the earliest

5. The biggest proposed change is to the agenda planning process. There would be no agenda planning meeting, however the Executive Lead would have a virtual meeting with the Chair to discuss and agree the agenda (which should reflect the annual cycle of business) and proposed reports for committee. A draft agenda will be shared, but draft reports will not be circulated.

6. Subject to agreement with the Chairs, it is proposed that committees will resume at the end of July, on a phased approach and will utilise the committee dates previously agreed.

7. Therefore, it is proposed that the committees will meet on the following dates:

    a. Clinical and Care Governance Committee - 6 August
    b. Performance and Delivery Committee - 19 August
    c. Strategic Planning Group - 15 September
    d. Futures Committee - 9 September

8. The one exception to this would be the Audit and Assurance Committee, where due to the timeline for scrutinising the unaudited accounts and receiving the Internal Audit opinion, the Audit and Assurance Committee will meet on the 28 July.

9. It is proposed the arrangements for committees would run to the end of December 2020, and a report will be submitted to the EIJB on 15 December reviewing these arrangements.

Calendar of meetings

10. Standing Orders require the EIJB to agrees its calendar of meetings. The current schedule runs until December 2020. This report also proposes dates for EIJB and development sessions for 2021. The recommended dates are as follows:

EIJB dates

    a. Tuesday 2 February
    b. Tuesday 9 March - Budget setting EIJB
    c. Tuesday 27 April
    d. Tuesday 22 June
    e. Tuesday 17 August
    f. Tuesday 14 September – Annual Accounts only / development session
    g. Tuesday 26 October
    h. Tuesday 7 December

EIJB development session dates

    i. Tuesday 12 January
    j. Monday 25 January
    k. Thursday 25 February
    l. Wednesday 17 March
    m. Tuesday 18 May
    n. Tuesday 14 September
    o. Tuesday 5 October
    p. Tuesday 2 November

q. Tuesday 23 November
r. Tuesday 14 December

11. Most meetings are proposed for a Tuesday morning, however some of the development sessions are proposed for other days to avoid clashes with other Council committees scheduled. All meetings will run from 10am – 1pm. There are additional development sessions scheduled for October, November and December to allow for the development of the 22/23 IJB budget.

12. Considering the current position with Covid19, the intention at this point is the 2021 meetings will be carried out virtually via Microsoft Teams. However, the position on the meeting arrangements for 2021 will be reviewed as part of the report coming to the EIJB on the 15 December 2020 on the interim committee arrangements.

Terms of Reference

13. The EIJB agreed at its meeting of 14 December 2018 to implement the recommendations of the independent review of its governance undertaken by the Good Governance Institute (GGI). This included a revised committee structure, with revised Terms of Reference (TORs).

14. TORs for each for the committee was presented to the EIJB on 21 June 2019. The EIJB agreed the TORs in principle, however each committee would comment on the TORs at the end of the first cycle and report back to the EIJB within two cycles.

15. Each Committee has now met and formally agreed their respective TORs which are included as Appendix 1 – 5 of this report. Therefore, this report is asking the EIJB to formally approve the TORs for the EIJB committees.

16. There have been no material changes to the TORs compared with the version submitted to the EIJB on 21 June 2019. The main changes are:

a. a change in non-voting membership on Performance and Delivery from four to two members
b. a change in quorum from four to two members on Strategic Planning Group

17. The other changes include amendments to the core duties of committees and slight amendments to wording or language.

Implications for Edinburgh Integration Joint Board

Financial

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

Legal / risk implications

19. This report is asking the EIJB to agree the TORs for its committees, which will strengthen the EIJB's governance arrangements and mitigate any risks arising.

Equality and integrated impact assessment

20. An equality and integrated impact assessment is not required in this instance.

Environment and sustainability impacts

21. The proposal to meet virtually until the end of 2020, will have positive environmental impacts in terms of reducing the amount of travelling the EIJB will have to undertake.

Quality of care

22. Enhancing and establishment of new committees and the subsequent agreement of TORs provides the EIJB with a robust governance structure. The EIJB has a strengthened focus on quality of care through its Clinical and Care Governance Committee and Performance and Delivery Committee.

Consultation

23. The elements of this paper relating to the resumption of committees have been developed in consultation with the Chair and Vice Chair.

24. In terms of the dates for the EIJB meetings and development sessions, have been done in consultation with the Chair and Vice Chair and EIJB members have been given advanced sight of the proposed dates. The dates have also been checked with Committee Services within Edinburgh City Council and NHS Lothian to ensure there are no formal committee clashes.

25. EIJB members have had the opportunity to comment on the TORs for their respective committees.

Report Author

Judith Proctor

Chief Officer, Edinburgh Integration Joint Board or relevant Executive lead

Contact for further information:

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Background Reports

1.

Appendices

Appendix 1	Audit and Assurance Committee Terms of Reference
Appendix 2	Clinical and Care Governance Committee Terms of Reference
Appendix 3	Futures Committee Terms of Reference
Appendix 4	Performance and Delivery Committee Terms of Reference
Appendix 5	Strategic Planning Group Terms of Reference

Appendix 1

Edinburgh Integration Joint Board
Audit and Assurance Committee
Terms of Reference

1. Constitution of the Committee

1.1 The Audit and Assurance Committee is a statutory Committee established by the Integration Joint Board to monitor, review and report to the Board on the suitability and efficacy of the Partnership's provisions for governance, risk management and internal control.

2. Purpose and function

2.1 The purpose and function of the Committee is to:

a) provide assurance to the Integration Joint Board that it is fulfilling all its statutory requirements and all systems are performing as required, with appropriate and consistent escalation of notice and action;

b) review and continually re-assess their system of governance, risk management, and control, to ensure that it remains effective and fit for purpose;

c) approve and oversee the annual audit programme in respect of the Integration Joint Board's services;

d) develop Integration public reporting of the Integration Joint Board as an independent, objective process; and

e) ensure that its arrangements for delegation within the Integration Joint Board structures promote independent judgement and assist with the balance of power and the effective discharge of duties.

3. Authority

3.1 The Committee is:

a) a statutory Committee of the Integration Joint Board reporting directly to the Integration Joint Board, and has no executive powers, other than those specifically delegated in these Terms of Reference;

b) authorised by the Board to investigate any activity within its Terms of Reference, to seek any information it requires from any employee of an organisation within the Partnership, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required, taking due cognisance of their employing organisation's policies and procedures in doing so; and

c) authorised by the Integration Joint Board to require the attendance of individuals and authorities from outside the Partnership with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or office of the Chief Officer).

4. Membership and quorum

Membership

4.1 Members of the Committee shall be appointed by the Integration Joint Board and shall be made up of 4 Voting Members of the IJB, drawn equally from NHS Lothian and The City of Edinburgh Council. 2 non-voting members of the IJB will also be appointed by the Board as non-voting members of the Committee.

4.2 One of the Voting Members will be appointed by the Integration Joint Board as the Chair of the Committee. The Chair will be rotated between Voting members on a basis agreed by the Integration Board to ensure a suitable balance between partner organisations is maintained across the five main committees of the IJB.

4.3 A further Voting Member of the Committee can assume the role of Chair in the formal absence of the appointed Chair, with the agreement of the Committee members.

4.4 The Executive Lead (the Chief Finance Officer) or a designated alternative from the Office of the Chief Officer, will be in attendance at all meetings of the committee.

4.5 The Chair of the Integration Joint Board and the Chief Officer shall not be members of the Committee, but they may be in attendance.

4.6 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.7 Members and attendees are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.8 Secretariat support will be provided by a combination of the Office of the Chief Officer and CEC Committee Services' team.

4.9 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Integration Joint Board.

4.10 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

4.11 The Chief Officer and other members of the Executive team should be invited to attend as appropriate with an expectation that if invited they should attend in person. In addition, the Chief Officer should be required to attend, at least annually, to discuss the process for assurance that supports the Annual Governance Statement.

4.12 External Audit and Internal Audit representatives will meet at least annually and be invited to meet Committee members prior to the formal conduct of the business of the meeting without members of the Executive present.

Quorum

4.13 The quorum necessary for the transaction of business shall be 4 members, as defined in 4.1 above.

4.14 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee

5. Duties

5.1 The Committee will undertake the duties detailed in the NHS Audit Committee Handbook (HFMA latest edition). The Committee will carry out the duties below for the Partnership and major subsidiary undertakings as a whole, as appropriate. The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress. The duties of the Committee will include:

5.1.1 Financial reporting

The Committee will:

a) ensure that the systems for financial reporting to the Integration Joint Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided;

b) ensure the integrity of the Annual Report and Financial Statements of the Integration Joint Board before submission to the Integration Joint Board, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements that they contain, and including the meaning and significance of the figures, notes and significant changes; accounting policies and practices followed, and significant changes; explanation of estimates or provisions having material effect; the schedule of losses and special payments and any reservations and disagreements between internal and external auditors, and the executive directors, which are not resolved;

c) review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement;

d) review the consistency of, and changes to, accounting policies across the Integration Joint Board and its subsidiary undertakings including the operation of, and proposed changes to, the Corporate Governance Manual, Standing Orders, Standing Financial Instructions, Scheme of Delegation and Reservation of Powers, Matters Reserved to the Board and Standards of Business Conduct, including maintenance of registers and the Fraud Response Plan;

e) review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements);

f) review whether the Integration Joint Board has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor;

g) review the clarity of disclosure in the Integration Joint Board's financial reports and the context in which statements are made.

5.1.2 Governance, risk management and internal control

The Committee will review:

a) the establishment and maintenance of an effective system of Integration governance, risk management and internal control, across the whole of the Integration Joint Board's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

b) the risk environment of the Integration Joint Board to ensure that the governance system is adequately addressing the full range of current, and potential future, risks;

c) the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit Opinion, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Integration Joint Board;

d) the Board Assurance Framework and processes that indicate the degree of the achievement of the Board's priorities, the effectiveness of the

management of principal risks and the appropriateness of the above disclosure statements;

e) the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work related to counter fraud and security, as required by NHS Scotland Counter Fraud Services;

f) the policies for managing and investigating complaints and legal claims against the Integration Joint Board; and

g) the Register of Members' Interests; and Register of Gifts and Hospitality on a regular basis, and not less than annually.

5.1.3. Internal audit and counter fraud

The Committee will:

a) ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Officer, and Integration Joint Board;

b) consider and approve the Internal Audit Strategy and Annual Plan, and ensure it has adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee will also ensure the function has adequate standing and is free from management or other restrictions;

c) review all reports from the Internal and External Auditors which identify "limited assurance" or "no assurance";

d) review and monitor the Executive Management's responsiveness to the findings and recommendations of audit reports, and ensure coordination between Internal and External Auditors to optimise use of audit resource;

e) meet the Head of Internal Audit on a formal basis, at least once a year, without Executive directors or management, to consider issues arising from the internal audit programme and its scope and impact. The Head of

Internal Audit will be given the right of direct access to the Chair of the Committee, Chief Officer, Integration Joint Board and to the Committee;

f) assure itself that the Integration Joint Board has policies and procedures for all work related to fraud and corruption in line with requirements of NHS Scotland Counter Fraud Services;

g) assess the effectiveness of Counter Fraud services once every five years through a full process of review; and

h) monitor the implementation of the policy on standards of business conduct for directors and staff (i.e. Codes of Conduct and Accountability) in order to offer assurance to the Integration Joint Board on probity in the conduct of the Integration Joint Board's business.

5.1.4 External audit

The Committee will:

a) approve the External Auditor's remuneration and terms of engagement, including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

b) agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, taking into account relevant ethical guidance;

c) review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work;

d) meet the External Auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit;

e) establish with the External Auditors, the nature and scope of the audit, as set out in the annual plan before the audit commences; and

f) review all External Audit reports, including the report to those charged with governance (before its submission to the Integration Joint Board) and

any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

5.1.5 Other board assurance functions

The Committee will:

a) review the findings of other significant assurance functions, both internal and external, and consider the implications for the governance of the Integration Joint Board. These will include, but not be limited to, any reviews undertaken by Audit Scotland, Health and Social Care Regulators, and professional bodies with responsibility for the performance of staff or functions;

b) review the work of other Committees within the organisation and its subsidiaries, whose work can provide relevant assurance to the Audit and Assurance Committee's own scope of work and in relation to matters of quality affecting the Board Assurance Framework, including the Clinical and Care Quality Committee, the Performance and Delivery Committee, Strategic Planning Group and Futures Committee;

c) ensure there is no duplication of effort between the Committees, and that no area of assurance is missed as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Integration Joint Board;

d) receive details of Single Tender Waivers, as approved by the Chief Officer;

e) review registers relating to the Standards of Business Conduct Policy and consider any breaches and action taken;

f) review every decision by the Integration Joint Board to suspend their respective Standing Orders; and

g) in fulfilling its responsibilities, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of Integration governance, risk management and internal control, together with indicators of their effectiveness.

6. Reporting and accountability

6.1 The Committee Chair will report formally to the Integration Joint Board on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Terms of Reference shall be reviewed by the Committee and approved by the Integration Joint Board on an annual basis. (Normally at its June meeting).

6.3 The Committee will report to the Integration Joint Board annually on its work in support of the Annual Governance Statement. The Annual Report will:

a) set out clearly how the committee is discharging its responsibilities;

b) include a statement referring to any non-audit services provided by the external auditors, and if so, how auditor objectivity and independence is safeguarded;

c) provide explanatory details, where during the year the External Auditor's contract is terminated in disputed circumstances, on the removal process and the underlying reasons for removal;

d) be signed by the Chair of the Audit Committee; and

e) be presented to the Annual General Meeting, with the Chair of the Audit Committee in attendance to respond to any stakeholder questions on the Committee's activities.

7. Committee administration

7.1 The Committee will meet a minimum of four times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, will require allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Committee Secretary and Executive Lead, reflecting an integrated cycle of meetings and business,

which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, will be made available to each member of the Committee, no less than seven working days before the date of the meeting in electronic form. Supporting papers will be made available no later than five working days before the date of the meeting.

7.5 Committee papers will include an outline of their purpose and key points in line with the Integration Joint Board's committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair will establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

7.7 The Committee Secretary will minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings will be made available promptly to all members of the Committee, normally within ten working days of the meeting.

7.8 The Committee will, at least once a year, review its own performance, using a process agreed for all Board Committees by the Integration Joint Board.

Procedural control statement:
Date approved: 21 July 2020
Approved by: Edinburgh Integration Joint Board
Review date: July 2021 or earlier

Membership

Chair	Councillor Phil Doggart
Voting	• Martin Hill • Peter Murray • Councillor George Gordon
Non-voting	• Kirsten Hey • Andrew Coull
Executive Lead	• Moira Pringle
Attendees	• Lesley Newdall - Chief Internal Auditor • Nick Bennett – Chief External Auditor • Cathy Wilson – Operations Manager
Committee Secretary	• Helen Elder • Committee Services

Appendix 2

Edinburgh Integration Joint Board
Clinical and Care Governance Committee
Terms of reference

1. Constitution of the Committee

1.1 The Clinical and Care Quality Committee is established by the Integration Joint Board to monitor, review and report to the Board on the quality of care to the local population, specifically in relation to safety, quality of access and clinical effectiveness and experience.

2. Purpose and function

2.1 The purpose and function of the Committee is to gain assurance, on behalf of the Integration Joint Board:

a) on the systems for delivery of safe, effective, person-centred care in line with the Integration Joint Board's statutory duty for the quality of health and care services.

b) that clinical and care governance is being discharged within the Partnership in relation to the statutory duty for quality of care and that this is being led professionally and clinically with the oversight of the IJB.

c) to provide the strategic direction for development of clinical and care governance within the Partnership and to ensure its implementation.

d) to ensure that there are effective structures, processes and systems of control for the achievement of the Integration Joint Board's priorities, where these relate to regulatory compliance, service user experience, safety and the quality of service outcomes.

e) that services respond to requirements arising from regulation, accreditation (including staff accreditation and registration) and other inspections' recommendations

3. Authority

3.1 The Committee is:

a) a non-statutory Committee of the Integration Joint Board reporting directly to the Integration Joint Board, and has no executive powers, other than those specifically delegated in these Terms of Reference;

b) authorised by the Integration Joint Board to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Partnership, and to invite any employee of an organisation within the Partnership to provide information by request at a meeting of the Committee to support its work, as and when required, taking due cognisance of their employing organisation's policies and procedures in doing so; and

c) authorised by the Integration Joint Board to invite the attendance of individuals and authorities from outside the Partnership with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Leads of the Committee and / or Office of the Chief Officer).

3.3 The Committee shall have the power to establish, in exceptional circumstances, sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Integration Joint Board. In accordance with the Partnership's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Integration Joint Board.

3.4 The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups must be approved by the Integration Joint Board and reviewed on an annual basis.

4. Membership

4.1 Members of the Committee shall be appointed by the Integration Joint Board and shall be made up of least 4 Voting Members of the IJB, drawn equally from NHS Lothian and The City of Edinburgh Council. 2 non-voting IJB members

shall be appointed as members of the Committee by the IJB as non-voting members of the Committee.

4.2 One of the Voting members will be appointed by the Integration Joint Board as the Chair of the Committee.

4.3 A further Voting member of the Committee can assume the role of Chair in the formal absence of the appointed Chair, with the agreement of the Committee members.

4.4 The Executive Lead (Head of Operations or a designated alternative) shall act as the executive lead for the committee and shall attend all meetings.

4.5 The Chair of the Integration Joint Board and the Chief Officer shall not be members of the Committee, but they may be in attendance.

4.6 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.7 Members and attendees are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.8 The Secretariat support will be provided by the office of the Chief Officer who will act as the Committee Secretary who shall attend all meetings of the Committee.

4.9 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Integration Joint Board.

4.10 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.11 The quorum necessary for the transaction of business shall be four members, as defined in 4.1 above, including the Chair, and at least one other Voting Member.

4.12 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Specific Duties

5.1 Strategy

The Committee will:

a) inform the strategic priorities and investments needed to support high-quality clinical/care outcomes and improve clinical effectiveness in the Partnership, and advise the Board accordingly;

b) take account of international intelligence and research evidence on clinical/care safety and practice and distil their relevance to the Partnership's strategic priorities (including where necessary commissioning research to inform its work);

c) take account of the development and effective use of shared clinical/care intelligence and data with partners to shape the growth of high-quality care and services in the 'place' of Edinburgh and Scotland.

5.2 Risk

The Committee will:

a) receive regular reports on the high value risks in the Partnership and review the suitability and robustness of risk mitigation plans with regard to their potential impact on patient/citizen outcomes and quality of care;
b) triangulate and be assured of the robustness of the process of reviewing the trends, themes and patterns emerging from key quality indicators in the Partnership that inform and shape risk assessment, priority-setting and development of fit-for-purpose policies and procedures

5.3 **Outcomes and processes**

The Committee will:

a) be assured of the integrity of the Partnership's control systems, processes and procedures relating to critical areas of integration, to include:

- high quality care (through the Partnership's quality review processes);
- compliance with fundamental standards of quality and safety;
- patient/citizen safety and harm reduction;
- introduction of new clinical pathways and procedures;
- dissemination and implementation of statutory guidance;
- escalation and resolution of quality concerns; and
- seek assurance on patient/citizen and carer involvement and engagement;

b) ensure the effective operation of processes relating to clinical/care practice and performance, including early detection of issues and problems, escalation, corrective action and learning.

5.4 **Learning and communication**

The Committee will:

a) be assured of the effectiveness of systems and processes used for continuous learning, innovation and quality improvement, establishing ways of gaining assurance that appropriate action is being taken;

b) be assured that the robustness of procedures ensure that adverse incidents, complaints and events are detected, openly investigated, with lessons learned being promptly applied and appropriately disseminated in the best interests of patients/citizens, of staff and of the Partnership;

c) review how systematically evidence-based practice, ideas, innovations and statutory and best practice guidance are identified, disseminated and applied within the Partnership;

d) be assured of the effectiveness of communication, engagement and development activities designed to support patient/citizen safety and improve clinical governance.

5.5 Patient and public engagement

The Committee will:

a) be assured of the effectiveness of a credible process for assessing, measuring and reporting on the 'patient experience' in a consistent way over time, including the appropriateness and effectiveness of processes for patient/citizen engagement in support of the Partnership's strategic goals and programmes of work.

5.6 Progress and performance reporting

The Committee will:

a) review a range of evidence and data from multiple sources, including management and executive committees and groups, on which to arrive at informed opinions on:

- the standards of clinical and service quality in the Partnership;
- compliance with agreed standards of care and national targets and indicators; and
- Partnership organisation's quality performance measured against specified standards and targets;

b) review a succinct set of key performance and progress measures relating to the full purpose and function of the Committee;

c) review progress against these measures on a regular basis and seek assurance around any performance issues identified, including proposed corrective actions and reporting any significant issues and trends to the Integration Joint Board;

d) agree the programme of benchmarking activities to inform the understanding of the Committee and its work;

e) be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee and to the Board in relation to the Committee's purpose and function;

f) ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit Committee, Strategic

Planning Group, Performance and Delivery Committee, and Futures Committee.

5.7 **Statutory and regulatory compliance**

a) The Committee will be assured of the arrangements for ensuring maintenance of the Partnership's compliance standards specified by the Scottish Government Health and Social Care Directorate, Healthcare Improvement Scotland, NHS Scotland, and statutory regulators of health care professionals.

5.8 **Cycle of Business**

a) The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

6. Reporting and Accountability

6.1 The Committee Chair will report formally to the Integration Joint Board on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Terms of Reference shall be reviewed by the Committee and approved by the Integration Joint Board on an annual basis. (Normally at its June meeting).

7. Committee Administration

7.1 The Committee shall meet a minimum of four times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Committee Secretary and executive lead, reflecting an Integration cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than seven working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than five working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the IJB's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Integration Joint Board.

Procedural control statement:
Date approved: July 2020
Approved by: Integration Joint Board
Review date: June 2021

Membership

Chair	Richard Williams
Voting	• Martin Hill • Councillor Robert Aldridge • Councillor George Gordon
Non-voting	• Jackie Irvine, Chief Social Work Officer • Citizen Representative • Helen Fitzgerald, EHSCP Lead Partnership Representative • Jacqui MacRae, Interim Chief Nurse • Ian McKay, Medical Director • Colin Beck, Co-Chair, Professional Advisory Group (PAG)
Executive Lead	• Tom Cowan, Head of Operations
Attendees	• Jo Bennett, NHS Lothian (invited to attend when relevant) • Philip Brown / Jenni Boyd (invited to attend when relevant) • Sylvia Latona, ATECH24 (invited to attend when relevant)
Committee Secretary	• Helen Elder • Committee Services

Appendix 3

Edinburgh Integration Joint Board
Futures Committee
Terms of reference

1. Constitution of the Committee

1.1 The Futures Committee is a non-statutory Committee established by the Integration Joint Board (IJB) to provide and evaluate the strategic focus of the Partnership over a ten-year period.

2. Purpose and function

2.1 The purpose and function of the Committee, on behalf of the Integration Joint Board, is to:

a) provide strategic focus and stimulus on long-term issues relevant to the vision and purpose of the Integration Joint Board;

b) evaluate assurance to the Integration Joint Board about strategic approach to capacity building, community development, consultation and engagement; and

c) provide protected time and space for consideration of the core narratives for change and transformation on behalf of the Integration Joint Board.

3. Authority

3.1 The Committee is:

a) a non-statutory Committee of the Integration Joint Board reporting directly to the Integration Joint Board, and has no executive powers, other than those specifically delegated in these Terms of Reference;

b) authorised by the Integration Joint Board to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Partnership, and to invite any employee of an organisation within the Partnership to provide information by request at a meeting of the Committee to support its work, as and when required, taking due cognisance of their employing organisation's policies and procedures in doing so; and

c) authorised by the Integration Joint Board to secure the attendance of individuals and authorities from outside the Partnership with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Leads of the Committee and / or Office of the Chief Officer).

3.5 The Committee shall have the power to establish, in exceptional circumstances, sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Partnership's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Integration Joint Board.

3.6 The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups must be approved by the Integration Joint Board and reviewed on an annual basis.

4. Membership

4.1 Members of the Committee shall be appointed by the Integration Joint Board and shall be made up of 4 Voting Members of the IJB, drawn equally from NHS Lothian and The City of Edinburgh Council. 2 non-voting members of the IJB will also be appointed.

4.2 One of the Voting Members will be appointed by the Integration Joint Board as the Chair of the Committee. The Chair will be rotated between Voting members on a basis agreed by the Integration Board to ensure a suitable balance between partner organisations is maintained across the five main committees of the IJB.

4.3 A further Voting Member of the Committee can assume the role of Chair in the formal absence of the appointed Chair, with the agreement of the Committee members.

4.4 The Executive Lead (the Head of Strategic Planning) or a designated alternative from the Office of the Chief Officer, will be in attendance at all meetings of the committee.

4.6 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.7 Members and attendees are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.8 Secretariat support will be provided by a member of the Office of the Chief Officer who will act as the Committee Secretary and shall attend all meetings of the Committee.

4.9 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Integration Joint Board.

4.10 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.11 The quorum necessary for the transaction of business shall be 4 members, as defined in 4.1 above, including the Chair.

4.12 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Specific Duties

Core duties

- Implications of IT and AI for care and services
- Workforce of the future and changing work patterns
- Innovation in connecting with the public
- International models of best practice in integration and delivery
- Core narratives on change
- Capacity building
- Community engagement
- Design of consultative and engagement processes
- Clinical leadership and engagement
- Engagement with voices
- Community development – voluntary, commercial and entrepreneurial
- Investment and Infrastructure

Cycle of Business

5.2 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

6. Reporting and accountability

6.1 The Committee Chair will report formally to the Integration Joint Board on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Terms of Reference shall be reviewed by the Committee and approved by the Integration Joint Board on an annual basis. (Normally at its June meeting).

7. Committee Administration

7.1 The Committee shall meet a minimum of 5 times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the office of the Chief Officer and Executive leads reflecting an Integration cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than five working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the IJB's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Integration Joint Board.

Procedural control statement:
Date approved: July 2020
Approved by: Integration Joint Board
Review date: June 2021

Appendix 1 – Membership

Chair	Peter Murray
Voting	• Angus McCann • Councillor Ricky Henderson • Councillor Melanie Main
Non-voting	• AHP Lead • Ian McKay
Executive Lead	• Tony Duncan
Attendees	
Committee Secretary	• Jay Sturgeon • Committee Services

Appendix 4

Edinburgh Integration Joint Board
Performance and Delivery Committee
Terms of Reference

1. Constitution of the Committee

1.1 The Performance and Delivery Committee is a non-statutory Committee established by the Integration Joint Board to provide advice and assurance to the Board on the effectiveness on the operational and financial performance of the Edinburgh Health and Care Partnership.

2. Purpose and function

2.1 The purpose and function of the Committee, on behalf of the Integration Joint Board is to:

a) Oversee, a performance and progress reporting framework and supporting processes which provide assurance to the Integrated Joint Board about performance, progress and delivery of delegated services;

b) Receive and gain assurance from the **performance** framework and reports on services commissioned by the IJB and the financial consequences of delivering these services;

c) Overview and report on the **delivery** of health & social care in Edinburgh.

3. Authority

3.1 The Committee is:

a) a non-statutory Committee of the Integration Joint Board reporting directly to the Integration Joint Board, and has no executive powers, other than those specifically delegated in these Terms of Reference

b) authorised by the Integration Joint Board to investigate any activity within its terms of reference, to seek any information it requires from any officer of the Partnership, and to call any employee to be questioned at a meeting of

the Committee as and when required, taking due cognisance of their employing organisation's policies and procedures in doing so

c) authorised by the Integration Joint Board to secure the attendance of individuals and authorities with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Committee Secretary)

3.2 The Committee shall have the power, in exceptional circumstances, to establish task and finish groups for the purpose of addressing specific tasks or areas of responsibility. In accordance Standing Orders, the Committee may not delegate powers to a task and finish group unless expressly authorised by the Integration Joint Board.

3.3 The terms of reference, including the reporting procedures of any task and finish group, must be approved by the Integration Joint Board and be reviewed on an annual basis.

4. Membership and quorum

Membership

4.1 Members of the Committee shall be appointed by the Integration Joint Board and shall be made up of 4 Voting Members of the IJB, drawn equally from NHS Lothian and The City of Edinburgh Council. 4 non-voting IJB members shall be appointed to the Committee as non-voting members.

4.2 One of the Voting members will be appointed by the Integration Joint Board as the Chair of the Committee. The Chair will be rotated between Voting members on a basis agreed by the Integration Board to ensure a suitable balance between partner organisations is maintained across the five main committees of the IJB.

4.3 In the absence of the Chair, a Voting member of the Committee may assume the role of Chair in the formal absence of the appointed Chair.

4.4 The Chief Finance Officer or a designated alternative shall act as the executive lead for the committee and shall attend all meetings.

4.5 The Chair of the Integration Joint Board and the Chief Officer shall not be members of the Committee, but they may be in attendance.

4.6 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.7 Members and attendees are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.8 Secretariat support will be provided by named members of the Office of the Chief Officer and CEC committee Services until such time as the IJB Programme Office is set up.

4.9 All members of the Committee shall receive training and development support before joining the committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Integration Joint Board.

4.10 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.12 The quorum necessary for the transaction of business shall be 4 members as defined in 4.1 above, including the Chair and at least one Voting member.

4.13 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers, and discretions delegated to the Committee.

5. Duties

Core duties

5.1 The core duties of the committee will be to:

d) Develop and review a comprehensive performance management system (5.1.3 of the Integration Scheme), including the Performance and delivery

framework and financial reporting in respect of delivery of the delegated functions.

e) Consider performance reports which examine the relevant data, as defined by the relevant directions, and explore the level of assurance the committee can recommend to the IJB on the delivery of each Direction.

f) Make use of risk registers and directions register to inform work plan priorities, and produce an annual work plan for the committee.

g) Review annually the integrated data set and Directions Register.

h) Review performance reports to EIJB in advance of the Board considering them in order to give assurance when required.

i) Consider the information on delegated functions for Edinburgh, which will be included in the Annual Report for adoption and approval by the IJB.

j) Liaise with CEC and NHSL to receive assurance that CEC and NHSL continue carry out their remits for assurance and scrutiny. (5.1.5 of the Integration Scheme).

k) The Committee reserves the right to examine any aspect of the delivery of any delegated functions, but it will define 'exception and variance' limits in order to focus its work to the most important areas and those at risk. This approach will also ensure that appropriate management action can be taken or, if necessary, the Committee can recommend to the IJB if a Direction needs to be modified. Where it appears that neither of these will address the issues identified, the Committee will refer this to the IJB.

Cycle of Business

5.2 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

6. Reporting and accountability

6.1 The Committee Chair shall report formally to the Integration Joint Board on its proceedings after each meeting outcomes and exception issues within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 An Integration report with narrative will be provided by the Executive to each Integration Joint Board meeting.

6.3 The terms of reference shall be reviewed by the Committee and approved by the Integration Joint Board on an annual basis. (Normally at its June meeting).

7. Committee Administration

7.1 The Committee shall meet *bi-monthly* and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Committee Secretariat support and executive lead, reflecting an Integration cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than seven working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than five working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the IJB's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

7.7 The Committee secretariat support shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

Procedural control statement:
Date approved: 21 July 2020
Approved by: Integration Joint Board
Review date: June 2021

Membership

Chair	Councillor Melanie Main
Voting	• Richard Williams • Mike Ash • Councillor Phil Doggart
Non-voting	• Helen Fitzgerald • Colin Beck • Another to be appointed • Another to be appointed
Executive Lead	• Moira Pringle/Tony Duncan
Attendees	• Philip Brown/Jenny Boyd - Performance • Graeme McGuire/David Walker – Finance
Committee Secretariat support	• Helen Elder • Committee Services

Appendix 5

Edinburgh Integration Joint Board
Strategic Planning Group (Committee)
Terms of Reference

1. Constitution of the Committee

1.1 The Strategic Planning Group is a statutory Committee established by the Integration Joint Board (IJB) to monitor, review and report to the Board on the strategy, plans and delivery of the delegated Partnership's services.

2. Purpose and function

2.1 The purpose and function of the Committee, on behalf of the IJB, is to:

a) oversee strategic planning processes to meet statutory obligations placed on the Integration Joint Board in respect of strategies and plans

b) provide assurance to the IJB that processes are fully inclusive of stakeholders and partners and formal consultative processes are followed;

c) identify on behalf of the IJB key priorities, progress arrangements and outcomes in relation to the planning of services;

d) approve Directions, in line with the current IJB Directions policy, in order to deliver the Strategic Plan. If the SPG accepts these Directions, they will be recommended to the IJB for formal adoption; and

e) consider ideas from all interested groups, including IJB committees, on ways to deliver the objectives of the Strategic Plan. If adopted this will initiate revised Directions.

3. Authority

3.1 The Committee is:

a) a statutory Committee of the IJB reporting directly to the IJB, and has no executive powers, other than those specifically delegated in these Terms of Reference;

b) authorised by the IJB to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Partnership, and to invite any employee of an organisation within the Partnership to provide information by request at a meeting of the Committee to support its work, as and when required, taking due cognisance of their employing organisation's policies and procedures in doing so.

c) authorised by the IJB to secure the attendance of individuals and authorities from outside the Partnership with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Leads of the Committee and / or Office of the Chief Officer).

3.7 The Committee shall have the power to establish, in exceptional circumstances, sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the IJB. In accordance with the Partnership's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the IJB; and

3.8 The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups must be approved by the IJB and reviewed on an annual basis.

4. Membership

4.1 Members of the Committee shall be appointed by the IJB and shall be made up of 4 Voting Members of the IJB, drawn equally from NHS Lothian and The City of Edinburgh Council. 2 non-voting members of the IJB shall be appointed to the Committee by the Board as non-voting members of the Committee.

4.2 The Vice Chair of the IJB will be the Chair of the Committee. The Chair of the IJB will act as Vice Chair of this committee.

4.3 A further Voting member of the Committee can assume the role of Chair in the formal absence of the appointed Chair, with the agreement of the Committee members.

4.4 The Executive Lead (the Head of Strategic Planning) or a designated alternative from the Office of the Chief Officer, will be in attendance at all meetings of the committee. Other attendees at the Committee shall be appointed by the IJB and shall be made up of representatives drawn from the following groups:

- Non-voting members of the IJB
- NHSL Director of Planning
- Health professionals;
- Service users of health care;
- Carers in health care;
- Social care professionals;
- Service users of social care;
- Carers from social care;
- Independent providers of social care;
- Staff side representative;
- Registered Social Housing organisations; and
- Third sector bodies carrying our activities related to health care or social care

4.5 The Chief Officer shall not be a member of the Committee but may be in attendance.

4.6 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.7 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.8 The Secretariat support will be provided by the office of the Chief Officer who will act as the Committee Secretary and shall attend all meetings of the Committee.

4.9 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the IJB.

4.10 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.11 The quorum necessary for the transaction of business shall be 2 members, as defined in 4.1 above, including the Chair, and at least one other Voting Member.

4.12 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Specific Duties

Core duties on behalf of the IJB:

- Review reports (with business cases as necessary) and related Directions measured against the Strategic Plan.
- Ensure appropriate consultation and engagement activity has taken place with Partners in the development of reports and Directions.
- Ensure Directions have appropriate finance and performance measures in place.
- Provide a forum to debate the implications of emerging health and social care themes and any local or national initiatives; to include input from Locality Planning Groups.
- Review the Strategic Plan annually and recommend any proposed amendments to the IJB.
- Consider the implications of future Joint Strategic Needs Assessments and input provided by the Futures Committee.
- Collaborate on and oversee the production and delivery of future Strategic Plans.
- Monitoring of Financial Framework

Cycle of Business:

5.2 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

6. Reporting and Accountability

6.1 The Committee Chair will report formally to the IJB on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Terms of Reference shall be reviewed by the Committee and approved by the IJB on an annual basis. (Normally at its June meeting).

7. Committee Administration

7.1 The Committee shall meet a minimum of six times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the office of the Chief Officer and Partnership Executive leads reflecting an Integration cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than seven working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than five working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the IJB's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the IJB.

Procedural control statement:
Date approved: July 2020
Approved by: Integration Joint Board
Review date: June 2021

Membership

Strategic Planning Group	
Chair	Councillor Ricky Henderson
Voting	Angus McCann (Vice Chair)
	Mike Ash
	Councillor Robert Aldridge
Non-voting	Christine Farqhuar
	Ella Simpson
Executive Lead	Tony Duncan
Specified Members	Two vacancies – Health and social care services citizen representatives / service users
	Colin Briggs – NHSL Director of Planning
	Colin Beck – Social Care Professional
	Belinda Hacking – Health Professional
	Peter McCormick – Social Care Commercial Provider
	Rene Rigby (TBC) - social care commercial provider
	Stephanie-Anne Harris – Health Care non-commercial provider
	Nigel Henderson - social care non-commercial provider
	Hazel Young - Social Housing non-commercial provider
	Nigel Henderson - Third sector organisations delivering health and social care activity
	Michelle Mulvaney - Community Engagement Manager
	Philip Brown - Performance Lead

	Dermot Gorman - Public Health Consultant
Committee Secretary	Jay Sturgeon Committee Services

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Edinburgh Integration Joint Board

REPORT

Return to Transformation

Edinburgh Integration Joint Board

21 July 2020

Executive Summary	
	1. In February 2019 the Edinburgh Integration Joint Board (EIJB) approved the proposal to ringfence £2M to support transformation over the period of the 3-year strategic planning cycle 2019-22. 2. In August 2019 the EIJB approved the publication of the Strategic Plan 2019-22 which incorporated the transformation programme design. 3. Significant progress was made during Phase One (out to 31 March 2020) of the Strategic Plan 2019-22 to prepare and launch the transformation programme. 4. The impact of the COVID-19 pandemic in March 2020, and the resulting resource and capacity pressures have created delays, leading to an adaptation of the transformation programme informed by a comprehensive lesson learned process. This work is closely aligned with the Scottish Government framework of re-mobilise, recover and re-design and the national route map through and out of the COVID-19 pandemic. 5. An interactive session on Return to Transformation (R2T) was conducted with the EIJB on 24 June 2020. 6. This report is designed to further update the EIJB on our planning for R2T and seek approval for adapting the programme into a two-phased approach.

Recommendations	It is recommended that the EIJB approves the two-phase approach to the delivery of transformation as set out in this report.

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. In February 2019, the EIJB approved a report by the Chief Officer regarding plans to establish a transformation programme to deliver significant and sustainable change and improvement to health and social care services. The Board approval included ring-fencing £2 million of non-recurring funding from reserves to support delivery of the programme.

2. The Strategic Plan 2019-22, approved by the EIJB in August 2019, set out the scope of the transformation programme and the planned approach for initiation and delivery. The programme is structured around the Three Conversations model, with three main programmes of work aligned to the three conversation stages and a further programme of work delivering cross-cutting, enabling change.

3. Phase One of the Strategic Plan, which ran from August 2019 to the end of March 2020, involved significant development and refinement of the programme and the identification of key workstreams aligned to strategic priorities. Some key projects were initiated within this period, including the initial roll-out of the Three Conversations model, the commencement of Home First, the review of the hospital at home service and initial understanding and development of the bed-based transformation.

4. A new governance framework was established for the programme, with four programme boards each led by a member of the executive team, feeding into an overall portfolio board, chaired by the Chief Officer. The portfolio board considers outputs from the programme ahead of onward reporting to the EIJB.

5. During this period the transformation team was recruited in sufficient numbers to make rapid progress in the majority of projects. This integrated team of project and programme management professionals are working closely with staff and partners to drive and deliver the transformation programme.

6. The transformation programme is scheduled to run for approximately 24 months during Phase Two of the Strategic Plan (Continuation and Implementation) which concludes 31 March 2022.

Impacts of COVID-19 and lessons identified

7. Development and delivery of the transformation programme has been adversely impacted by the COVID-19 pandemic. Programme boards, due to meet for the first time in March/April 2020, were suspended at the outset of lockdown to allow a focus on operational priorities. Members of the extended senior management team who had been identified to act as Senior Responsible Owners (SROs) have had limited capacity to drive forward transformation projects alongside the significant operational pressures, and around 50% of the transformation team has been redeployed to directly support the operational response.

8. Despite the delay in progressing the transformation programme, work has continued where possible. There are some clear examples during the COVID-19 period where it has acted as a catalyst for the acceleration of transformational change. The Home First model has expanded, and we have seen considerable success in dealing with 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 provided an excellent foundation for how they are supporting people through the crisis.

9. A comprehensive lesson capture exercise was launched in early April and to date has captured over 450 responses and rising. Our existing transformation programme framework is a strong foundation for the kind of strategic change we want to see. However, the changing landscape due to the COVID-19 pandemic has necessitated a review of the programme, both to ensure that it remains strategically aligned and reflective of the EIJB's key priorities and to ensure timelines are realistic and achievable.

Scottish Government Coronavirus Framework and Route Map

10. In May 2020, a project steering group was established, chaired by the Head of Strategic Planning, to oversee planning and coordination to meet the requirements of the Scottish Government's route map for relaxing lockdown. This project provides a clear framework to manage the activity needed in each

of the four stages of the route map, to ensure that health and social care services can successfully re-mobilise, recover and re-design.

11. There are strong synergies between this immediate work and the transformation programme. One of the key principles in both is that there will be no presumption of a return to previous ways of working or the old 'business as usual. In all cases we will seek to accelerate change and innovation, retaining and building on the positive changes and adaptations implemented through COVID-19.

Revised programme scope and timelines

12. Proposals have been developed to adapt and re-set the transformation programme informed by lessons learned, and to re-scope, plan, and prioritise key transformation opportunities. The proposed changes to prioritisation and phasing will optimise available capacity and exploit opportunities identified during COVID-19. The revised approach will focus staff effort on an agreed set of immediate strategic priorities; this work to begin in August 2020. The remaining project workstreams will be placed into a planned, follow on phase, due to commence from January 2021. There will continue to be a focus on planned 'quick wins' to build momentum and confidence, whilst simultaneously developing overarching plans and business cases for longer-term change, recognising that transformation provides the best opportunity for delivery of both financial sustainability and high quality and modern delivery of services.

13. Appendix 1 sets out the proposed new scope and phasing for the transformation programme. The changes to the programme architecture and scope have been minimal. The programme framework will continue to align with the Three Conversations model, with three main programmes of work and a further programme of enabling change. The review of the programme scope confirms that the vast majority of identified projects remain well aligned with the EIJB strategic vision. Only one identified workstream, a review of Adult Support and Protection processes within programme 2, has been removed from the programme. It is now proposed that this is dealt with as a priority within normal routine business, due to the limited opportunity for true transformation within an area largely governed by statute.

14. The immediate priorities to be considered are:

- Three Conversations
- Digital and Technology Enabled Care
- Home First
- Bed Based Review
- Home Based Care
- The Edinburgh Pact
- Workforce and Cultural Development

15. A development session with EIJB members on 24 June 2020 explored some of these strategic priorities and the learning from that session is being built into projects as scoping is refined. Discussions focused on some of the main elements of the programme, including: community engagement and the Edinburgh Pact; whole-system changes to embed our Home First model; the roll-out of the Three Conversations approach and digital transformation opportunities.

16. Good progress has been made to date with the development of the Edinburgh Pact. A comprehensive research and engagement workstream has recently started to gain insights to inform the content of the Pact. This involves qualitative and quantitative research through individual interviews with key stakeholders, a series of focus groups and an online survey with partners, service users and citizens. The Pact will build on lessons learned throughout COVID-19, with a focus on supporting communities and optimising recent advances in community involvement and resilience. An initial framework draft of the Edinburgh Pact is scheduled for presentation to the Strategic Planning Group in September 2020 as part of the strategy review.

17. The Home First approach has seen considerable success throughout recent months and is a clear example of an area where planned transformational change has been accelerated. A focus on discharge to assess and access to additional 'Safe haven' beds resulted in historically low levels of delayed discharges in the City. Home First remains a key priority in our adapted transformation programme and it is vital we maintain and building on recent success to embed a sustainable operating model.

18. Development and roll-out of the Three Conversations model has continued throughout the COVID-19 crisis. Most existing innovation sites have continued to engage with individuals and their families using the principles of the approach, often utilising digital technology to remain connected. Governance meetings, suspended at the beginning of the pandemic, have recently been re-established. Further roll-out of the approach is already underway and the expansion of two existing innovations sites will go live in July 2020. A detailed plan has been developed for the next stage of the roll out and is due to be considered by the Executive Management Team in July 2020. This includes a business case setting out how additional resource could assist with the faster scaling up and embedding of Three Conversations. The evaluation report for the first phase of the project has been finalised and shows early indications of positive improvements, for example, waiting times for first contact in innovation sites average 3.8 days in comparison to the previous average wait of 40 days. The evaluation report will be submitted to the Performance and Delivery Committee at the next opportunity.

19. One of the most visible changes over recent months is the rapid upscaling in the use of digital technology, both to facilitate home-working for many of our staff, but also to ensure continuity in the provision of services to some of the

most vulnerable. The transformation programme will seek to capitalise on these changes, using technology and digital tools to facilitate different ways of working and offer choice and flexibility where possible and appropriate. The first phase of the project will focus on digital provision of services, considering opportunities to use both digital tools and technology enabled care aids and adaptations to support people to remain independent at home or in a homely setting for as long as possible.

20. Governance arrangements for the transformation programme are being reinstated from August 2020. The four programme boards will meet monthly to drive progress in each project against a series of planning milestones. The progress and outputs from these programme boards will then be presented to an overarching portfolio board chaired by the Chief Officer. Resources within the transformation team have been re-aligned to ensure project management support is in place for all phase one projects.

21. Appendix 2 sets out the programme dashboards demonstrating the status of all phase one projects and the progress made as at the end of June 2020. Programme progress will be reported to the Strategic Planning Group (SPG) and core EIJB on a regular basis.

22. More detailed timings linked to milestones will de developed in the early stages of project development from August 2020.

Implications for EIJB

Financial

23. The EIJB has invested £2 million in unallocated reserves over a two-year period to support the delivery of transformation.

24. The transformation programme will play a significant part in ensuring that health and social care services are financially sustainable. As the programme progresses, details will be provided to the EIJB in relation to progress with the delivery of financial benefits against agreed targets.

Legal / risk implications

25. There are no legal implications arising from this report.

26. There is a risk that any loss of momentum in delivering transformation and service redesign may adversely affect confidence and will slow down the pace of necessary change. This will be mitigated by the re-establishment of appropriate governance boards and the phased approach to delivery set out in this report.

27. 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

28. The transformation programme aims to ensure good outcomes for the population of Edinburgh and across Lothian where applicable. Including those groups with protected characteristics who are often experience poor outcomes.

29. Full equality and integrated impact assessments will be completed for all transformation projects as they develop to ensure the impacts of any changes are fully understood and managed.

Environment and sustainability impacts

30. There are no environment and sustainability impacts arising as a direct result of this report. However, 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

31. The improvement and recovery programme seeks to improve the quality of care and people's experience and access to care in Lothian.

Consultation

32. The transformation programme will reach out to a wide stakeholder group to encourage participation in project teams and programme boards.

33. Engagement and consultation plans will be created for individual projects as appropriate.

Report Author

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Background Reports

1. Transformation and Change - EIJB report February 2019
2. Strategic Plan 2019-22 – EIJB report August 2019

Appendices (on powerpoint slides)

Appendix 1	Transformation Programme Scope and Phasing
Appendix 2	Transformation Programme – Phase One Dashboards, June 2020

RETURN TO TRANSFORMATION

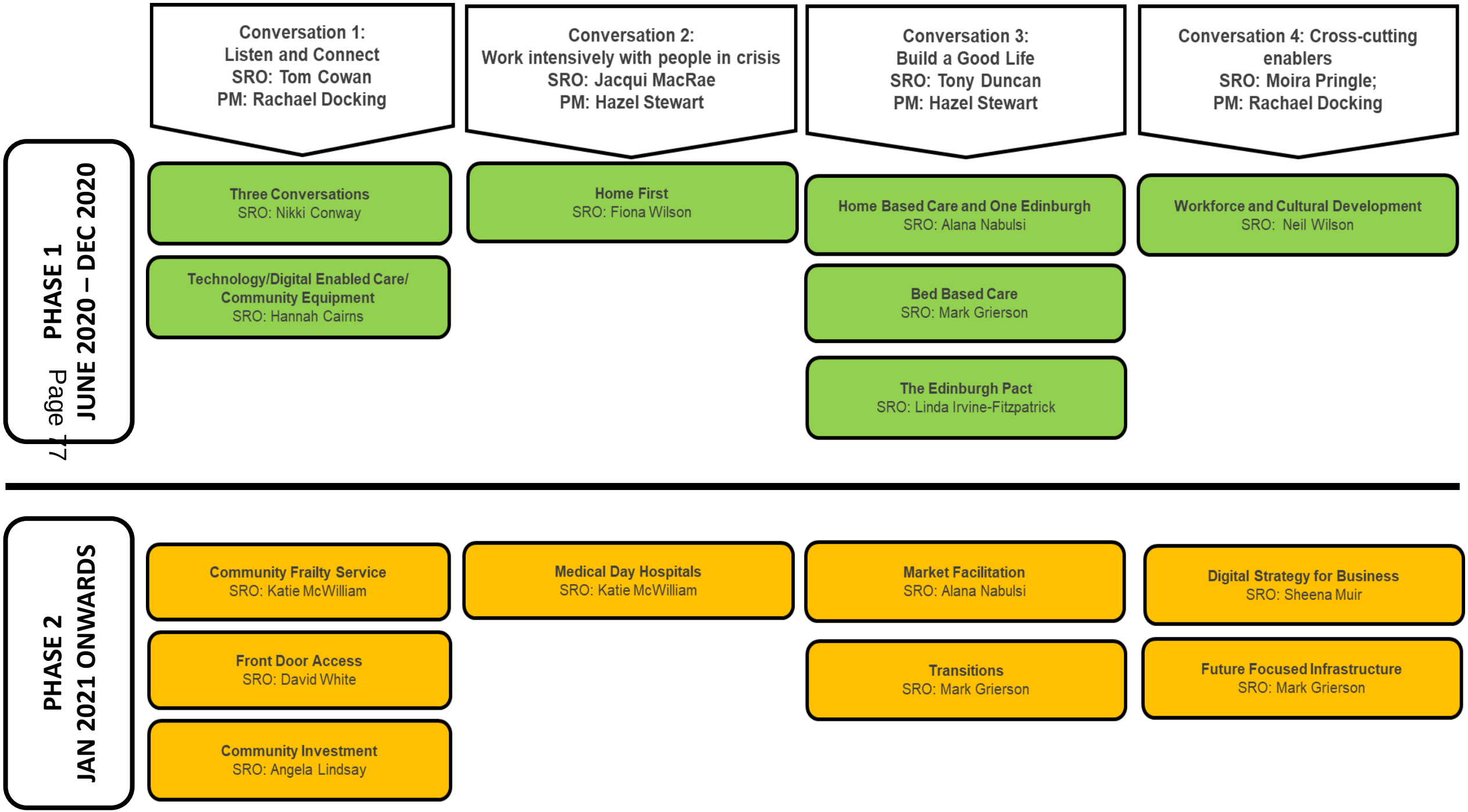
Report Appendices – 21st July 2020

Edinburgh **Health and Social Care** Partnership

Edinburgh Health and Social Care Partnership

Appendix 1

Programme Scope and Phasing


Conversation 1:
Listen and Connect
SRO: Tom Cowan
PM: Rachael Docking
Conversation 2:
Work intensively with people in crisis
SRO: Jacqui MacRae
PM: Hazel Stewart
Conversation 3:
Build a Good Life
SRO: Tony Duncan
PM: Hazel Stewart
Conversation 4: Cross-cutting enablers
SRO: Moira Pringle;
PM: Rachael Docking
PHASE 1
JUNE 2020 – DEC 2020
Three Conversations
SRO: Nikki Conway
Technology/Digital Enabled Care/ Community Equipment
SRO: Hannah Cairns
Home First
SRO: Fiona Wilson
Home Based Care and One Edinburgh
SRO: Alana Nabulsi
Bed Based Care
SRO: Mark Grierson
The Edinburgh Pact
SRO: Linda Irvine-Fitzpatrick
Workforce and Cultural Development
SRO: Neil Wilson
PHASE 2
JAN 2021 ONWARDS
Community Frailty Service
SRO: Katie McWilliam
Front Door Access
SRO: David White
Community Investment
SRO: Angela Lindsay
Medical Day Hospitals
SRO: Katie McWilliam
Market Facilitation
SRO: Alana Nabulsi
Transitions
SRO: Mark Grierson
Digital Strategy for Business
SRO: Sheena Muir
Future Focused Infrastructure
SRO: Mark Grierson

Edinburgh Health and Social Care Partnership

Appendix 2

Phase 1 Portfolio/Project Dashboards – June 2020

Edinburgh Health and Social Care Transformation: Phase 1 Portfolio Dashboard – June 2020

Edinburgh **Health and Social Care** Partnership

PROGRAMME/PROJECT RAG STATUS – JUNE 2020			
PROGRAMME / PROJECT NAME	**May 2020**	**June 2020**	**Trend**
Conversation 1: Listen and Connect			
Digital/Technology Enabled Care/Community Equipment			→
Three Conversations			↑
Conversation 2: Work Intensively with People in Crisis			
Home First			→
Conversation 3: Build a Good Life			
Home Based Care			→
Bed Based Care			→
Edinburgh Pact			↑
Programme 4: Cross-cutting Enablers			
Workforce & Cultural Development			→

KEY PORTFOLIO RISKS – JUNE 2020			
ID	**Risk Name**	**Risk Description**	**Mitigating Actions**
1	Staff resourcing	Due to delays caused by Covid-19, there is a risk that funding for the Transformation team will end without all programme activities being completed.	EMT is prioritising and phasing projects to manage current resource. Some projects/workstreams are proposed to be moved to 2nd phase (2021). Detailed resource planning and options appraisal to be completed in 2021.
2	Delay to financial benefits	There is a risk that Covid-19 related delays to delivery of the programme could have knock on implications for the delivery of financial saving.	Project risks will be reviewed and assessed once the programme amendments are agreed and in place. Early focus on defining financial benefits and agreeing delivery plans.
3	Wider internal capacity	There is a risk that there will be limited capacity within management and frontline teams to provide subject matter expertise and support transformation projects, leading to delays.	The proposed two-phase approach to delivery will reduce demands on teams and managers. The management team is prioritising and phasing project work to support some anticipated capacity issues.
4	Project resourcing	There is a risk that the additional impacts and challenges of Covid-19 could mean that funding/investment in specific projects will funding for specific projects will no longer be available due to changing landscape and different priorities.	All project funding requirements will need reviewed when the programme scope is agreed. Any funding requirement for projects within scope will be identified and agreed at the project planning stage.

C1. Digital/TEC/Equipment

MAY 2020

JUNE 2020

To increase and improve our use of digital solutions to delivery of services, technology, and equipment in a more coherent, joined up, and personalised way, to support people to remain at home for longer

Edinburgh Health and Social Care Partnership

SUMMARY OF CURRENT STATUS

This updated project in R2T combines elements of 3 projects from the previous Transformation Programme (Digital Strategy for Business; Technology Enabled Care; Community Equipment), with a focus on technical or digital solutions to delivering our services. Workstreams will be created to recognise the key elements. A new SRO has been identified to lead the combined project, due to her expertise and knowledge in this area and PM resource has been confirmed. Initial meetings with SRO and programme team are scheduled and key focus is now to agree project scope and timescales. During Covid, we have seen an incredible response across our services in how quickly digital advances were put in place, and how flexible and adaptable staff were. We have been reviewing digital lessons learned from Covid-19 to identify opportunities, and discussing these in detail with service managers. Stakeholder engagement with ATEC24 and partnership leads for Community Equipment in East and Midlothian has taken place this month to inform priorities and opportunities.

COMPLETED ACTIONS THIS MONTH

- Review of the Lessons Learned related to Digital
- Virtual meetings with colleagues across EHSCP to understand digital changes during C19
- Engagement meetings with ATEC24 staff to understand current issues and recent changes in service
- Facilitated workshop held with ATEC24 to develop a vision and carry out SWOT analysis
- Meetings held to understand budget position and financial challenges
- Engagement with locality OTs/PTs to understand needs of service

PLANNED ACTIONS NEXT MONTH

- Induction for new SRO and agreement of project scope and workstreams
- Update Project brief & establish project board
- Draft first version of a report about digital opportunities and challenges during Covid-19 (and agree those that are Transformation V BAU)
- Follow up CE benchmarking exercise with leads/ further examples
- Work on options appraisal for Comm Equipment (including workshop and data analysis)

KEY MILESTONE PLAN

MILESTONE	Jul	Aug	Sep	Oct
Initial meeting with new SRO (6th July)				
Agree project scope				
Report on digital opportunities				
Establish project board				
Work on options appraisal CEM (including workshop and data analysis)				

KEY RISKS AND MITIGATIONS

Risk of a second wave of Covid-19 stalling activity, in particular stakeholder engagement opportunities	Detailed resource planning within transformation team to ensure continuity for vital projects
Risk that due to work to date we rush to a solution before identifying vision and how we get there	Ensure adequate scoping to understand work to date and let it inform thinking, while also being clear what the problem actually is, what people really need, and we might get there
Risk that project scope is too broad	Ensure clarity of scope and where appropriate phased approach to delivery of workstreams. Assess PM resource and adjust if needed.

C1. 3 Conversations

MAY 2020

JUNE 2020

To incorporate the 3C approach across the EHSCP

Edinburgh Health and Social Care Partnership

SUMMARY OF CURRENT STATUS

As the Partnership begins to establish a 'new normal', the 3C project is transforming to meet the new situation. Good progress has continued to be made over recent months. Discussions are underway to expand two of the existing sites (Longstone and South West), with the first of these anticipated to go live in early July. Making It Happen meetings resumed on 19 June for operational staff and the Project Board. A paper setting out the recommended strategic direction and resourcing of the project will be discussed by EMT in July, with options for faster scaling up of the model. The Year 1 evaluation report has been circulated to EMT for approval and highlights some key improvements in waiting times and some early indications of potential financial benefits. The project was discussed at the IJB Development session on 24 June and strong support and interest in rolling out quickly was expressed.

COMPLETED ACTIONS THIS MONTH

- MIH resumed on 19 June with reps from all sites
- IJB Development session 24 June
- Swift development work nearing completion
- Integrated Impact Assessment completed
- Longstone North site proposal approved by Project Board
- South West expansion initiated
- Strategy paper first draft discussed by Project Board
- Social Work Scotland interest in 3C approach explored

PLANNED ACTIONS NEXT MONTH

- Strategy paper (inc resource plan) to go to EMT
- Evaluation report to be approved and circulated
- Swift approval meeting to be arranged
- Discuss potential cost avoidance savings with Finance. 3C is the mechanism for delivery of purchasing savings, as set out in the Savings Governance workstream
- Longstone North innovation site go-live
- Develop South West expansion proposal
- Restart strategic MIH meetings

KEY MILESTONE PLAN

MILESTONE	July	Aug	Sep	Oct
Strategy paper and resource plan approval /implementation				
Longstone North site go live and 13 weeks				
South West proposal development				
South West go live and 13 weeks				

KEY RISKS AND MITIGATIONS

Coronavirus – risk that reduced community resources will limit the effectiveness of the 3C approach	As lockdown lifts, day service/respite/other resources are beginning to reopen. Edinburgh Pact project will pick up aspects of community activity and resource during Covid-19
Risk that available resources for roll-out will limit the project's ability to capitalise on the IJB's support	Business case developed for increasing 3C support by creating a dedicated post to support implementation.

C2. Home First

MAY 2020

JUNE 2020

The Home First project will look to transform pathways between acute and community settings. It will include the transformation of services to better support people to remain at home or in a homely setting, preventing admission to hospital where it is safe to do so.

Edinburgh Health and Social Care Partnership

SUMMARY OF CURRENT STATUS

The COVID-19 pandemic has presented an opportunity to accelerate the roll out of Home First across the city. Initially, this focused on discharge to assess and the use of safe haven beds to get those who do not need acute care back home or to a homely setting. Delayed discharges are at historically low levels however, with services scaling up and routine hospital procedures being reintroduced it is possible that these could start to rise again. To maximise on the learning and progress gained throughout this period we need to build on the momentum and scale up our Home First service offering. This will include consideration of a sustainable staffing structure for the service.

COMPLETED ACTIONS THIS MONTH

- Data capture exercise underway to understand demand and capacity
- Increased use of Hospital @ Home
- Home First resource requirements to sustain BAU identified
- Links to Bed Based review project established

PLANNED ACTIONS NEXT MONTH

- Analysis of Lessons Learned to inform project scope
- Analysis of data capture to understand demand and capacity
- Review of referral process
- Plan to scale up existing Home First service
- Link to other Lothian Partnerships to try and have a consistent approach

KEY MILESTONE PLAN

MILESTONE	July	August	Sept	Oct
COVID-19 response				
Project brief and scope agreed				
Options appraisal				
IIA				
Home first model developed				

KEY RISKS AND MITIGATIONS

There is a risk that the project progresses throughout the COVID-19 pandemic due to necessity without the relevant controls in place	Project will be restructured to incorporate the work that has taken place throughout the pandemic
There is a risk that demand is too high for the existing team to manage resulting in reputational damage to the service	Roll out of the service to be staggered to ensure the resources are available across the city to manage demand
Due to the accelerated nature of the roll out of Home First, further work will be required to embed the process into BAU.	Comms and engagement strategy to be developed to ensure all staff are aware of Home First and the service it offers. Home First Edinburgh definition to be developed to provide clarity

C3. Home Based Care

MAY 2020

JUNE 2020

The Home-Based Care project will look to transform the approach to supporting people in their own homes. It will consider both internally provided and externally commissioned home care services, along with other specialist support provided within the home. The project will look at capacity and redesigning services to improve outcomes and increase efficiency. It will consider both day time and night time supports.

Edinburgh Health and Social Care Partnership

SUMMARY OF CURRENT STATUS

The project has progressed well during the COVID pandemic. It remains vital that timelines do not slip as a number of contracts are up for renewal in October 2021. Funding was recently secured by the Contracts Manager to use Price Waterhouse Cooper (PWC) to undertake the discovery phase for a "One Edinburgh" approach to the provision of care at home. PWC joined the Partnership for a 3 week piece of work which focused on gathering information from a select number of providers plus our internal care at home service. They used this to develop a reporting dashboard ,the structure of a command centre and a comms and engagement plan which proves the concept that we could change our service delivery model and achieve efficiencies. The focus of the project will now shift to the implementation of a new model, including consideration of the shape in internal home care services.

COMPLETED ACTIONS THIS MONTH

- One Edinburgh discovery phase (PWC)
- One Edinburgh outputs delivered
- Identified gaps in internal data
- Presentation of outputs to EMT

PLANNED ACTIONS NEXT MONTH

- Presentation to Scottish Government
- Bid for additional funding / resource to progress One Edinburgh workstream at pace
- Care at Home delivery model to be agreed
- Provider engagement to be planned

KEY MILESTONE PLAN

MILESTONE	July	August	Sept	Oct
COVID-19 response				
One Edinburgh progression				
Project brief and scope agreed				
Options appraisal				
IIA				

KEY RISKS AND MITIGATIONS

There is a risk that further funding is not available impacting on the pace at which the One Edinburgh workstream can progress	The outcome of these discussions will inform the project scope, if funding is not available, an options appraisal would be needed to agree how best to progress and incorporate the work completed to date
There is a risk that the Home First project increases the demand for Home Based Care services resulting in capacity challenges especially in light of the current situation with Covid-19	Consider the impact of the Home First project when modelling the future service volumes to ensure the provision that is tendered is adequate to support future requirements. Over 65+ external provision inter-dependency on decisions about internal provision and levels

C3. Bed Based Care

MAY 2020

JUNE 2020

The projects objectives are to transform and redesign a broad range of bed-based services across the Partnership, taking into consideration demand and capacity and, will design and implement the optimum model for the provision of sustainable bed-based care services.

Edinburgh Health and Social Care Partnership

SUMMARY OF CURRENT STATUS

Elements of work have been completed in the past relating to bed based services but a defined scope for the Bed Based project has yet to be agreed. The intention was to use a Bed Base Workshop (scheduled by the Chief Officer's office) on 17th March 2020 to bring together the various service leads to define the scope but due to lockdown measures this was postponed. Through work that was initiated as a direct response to the COVID pandemic, elements of the BBC project have progressed. A high level discussion paper was presented to the EMT on 18th June and an options appraisal on the move of services from Liberton Hospital to the Jardine Clinic at the REH will be presented on the 2nd July.

COMPLETED ACTIONS THIS MONTH

- Discussion paper and recommendations developed on wide range of Bed Based service areas
- Agreement from EMT to review options around move from Liberton to the Jardine Clinic
- Options paper drafted for presentation at the EMT on 2nd July

PLANNED ACTIONS NEXT MONTH

- Establish project team to progress work on preferred option for Liberton Hospital
- Integrated impact assessment of preferred option
- Rearrange bed based workshop from March
- System wide demand and capacity review

KEY MILESTONE PLAN

MILESTONE	June	July	August	Sept	Oct
Recommendations paper					
Options appraisal (Liberton)					
Integrated Impact assessment (Preferred option)					
Bed Base Workshop					
Bed Base strategy					

KEY RISKS AND MITIGATIONS

There is a risk that stakeholders may feel disengaged with project activity due to the timeframe for delivery of key documents	Ensure key stakeholders are aware and involved in discussions relating to their service areas as early as possible to alleviate any concerns
There is a risk that work on a number of workstreams within this project needs to progress at pace to capitalise on the unique opportunity COVID-19 has presented - via capacity in care homes, capacity in care @ home etc	Project activities to proceed at pace to maximise opportunities presented by Covid-19. Priority workstreams will be planned and dependencies incorporated into the overall plan

C3. Edinburgh Pact

MAY 2020

JUNE 2020

Re-address the relationship between the citizens of Edinburgh and the Health and Social Care Partnership

Edinburgh Health and Social Care Partnership

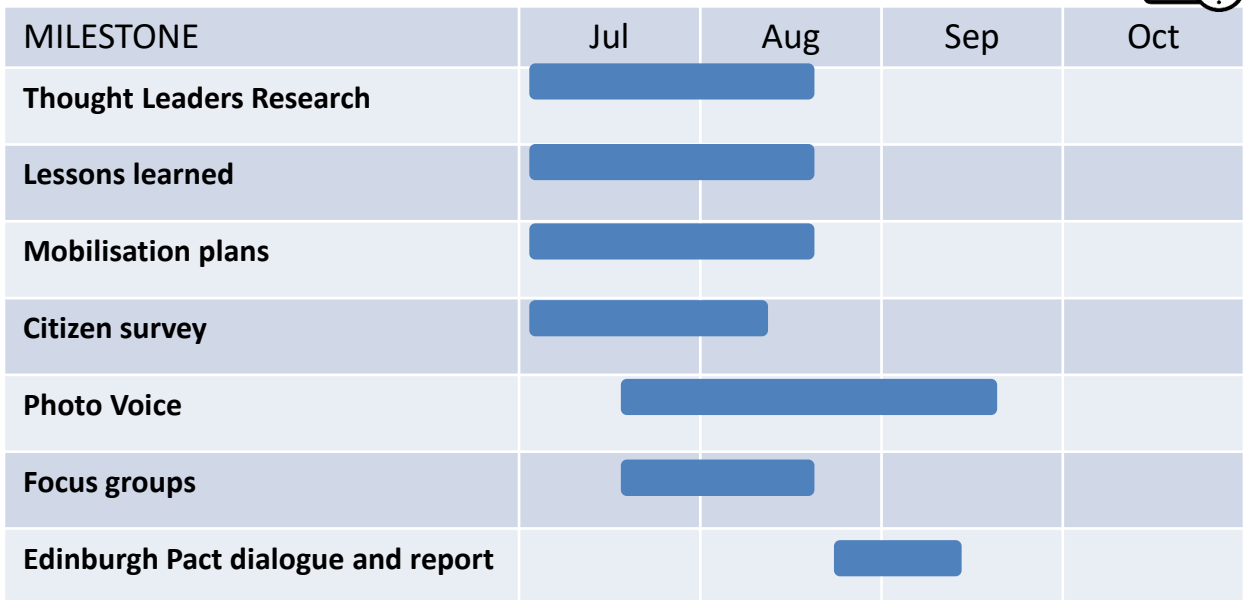
SUMMARY OF CURRENT STATUS

The impact of coronavirus (COVID-19) has meant the approach of the Edinburgh Pact has had to be adapted, to account for the likely continuation of physical distancing for some time. An approach has been devised which turns many of the recent challenges into opportunities, to start a dialogue and learn from some of the ways the Partnership and citizens have adapted during the pandemic. Research work has commenced with "Thought Leaders" across a wide range of partners and stakeholders. The Edinburgh Pact will be a collaborative piece which will fold in many different workstreams. To ensure we do not lose opportunities to capitalise on community and third sector activity prompted by Covid-19, while the wider work to establish a 'Community Investment Strategy' is proposed to be delayed, we will pick up aspects of community resilience and activity within the Edinburgh Pact. This project will be iterative to ensure it remains relevant. It is anticipated the first iteration will be contextualised by the pandemic.

COMPLETED ACTIONS THIS MONTH

- Revised project approach devised
- Project brief completed
- Thought Leaders research interviews conducted

KEY MILESTONE PLAN



PLANNED ACTIONS NEXT MONTH

- EMT sign off revised project approach
- Complete Thought Leaders research and begin analysis
- Develop and launch public survey (with promotion on digital channels)
- Launch PhotoVoice (tool for gathering community views)
- Preparation for focus groups
- Build in aspects of community and third sector activity into project scope

KEY RISKS AND MITIGATIONS

Significant operational effort is needed across the project team in BAU activities. There is a risk that capacity will not be available as the Scottish Government guidelines evolve.	The COVID continuity plan has been developed to plan and mitigate for additional capacity in the future. The approach has also been devised to utilise existing channels of communication to best effect, limiting duplication.
We may have an unrepresented group of citizens who engage.	Thought Leaders research encompasses views from public, private and 3rd sector agencies. Key community agencies will also be contacted to encourage engagement.

C4. Workforce and Cultural Development

MAY 2020

JUNE 2020

Develop and implement an ambitious and overarching strategy to build high quality, skilled and sustainable workforce, including staff training, development, future workforce plan, retention and recruitment

Edinburgh Health and Social Care Partnership

SUMMARY OF CURRENT STATUS

During the Covid-19 situation the Programme Manager has started initial scoping for the project, including reviewing Scottish Government guidelines for workforce plans that are due in March 2021, and initial development of a project brief. However this project has not moved significantly forward in the current climate and in the absence of a project manager. PM resource has now been identified from within the transformation team to maintain oversight of the project ahead of recruitment of a dedicated PM in the coming months. Initial focus of the project will be on developing a clear workforce strategy for Scottish Government and a focus on "quick wins" to support staff and improve processes in areas such as recruitment and retention.

COMPLETED ACTIONS THIS MONTH

- Meetings held to identify immediate workforce opportunities post Covid-19 and longer-term development of a workforce strategy
- Reviewed Scottish Govt workforce strategy guidelines
- Initial scoping of mental health support and wellbeing for staff across NHSL and CEC

PLANNED ACTIONS NEXT MONTH

- Agree SRO and project scope, aligned with BAU activity on workforce
- Initial meeting with project SRO
- Update Project brief & establish project board
- Detailed project planning to commence

KEY MILESTONE PLAN

MILESTONE	Jul	Aug	Sep	Oct
Initial meeting with new SRO				
Agree project scope				
Establish project board				

KEY RISKS AND MITIGATIONS

Due to Covid-19 this project is underdeveloped and likely to be impacted by changes to workforce guidance	PM now identified to maintain oversight of the project until recruitment to the vacant PM posts is complete.
EHSCP workforce likely to have changed post Covid-19	Data gathering needed on return to BAU to understand impacts on existing workforce
Potential impact on staff mental health and wellbeing as a result of Covid-19	Project scope will include a focus on organisational culture and immediate MH and wellbeing staff support

Edinburgh Integration Joint Board

REPORT

Savings and Recovery Programme 2020/21

Edinburgh Integration Joint Board

21st July 2020

Executive Summary	The purpose of this report is to present the proposed 2020/21 Savings and Recovery Programme for approval. If agreed, this will allow the Edinburgh Integration Joint Board (EIJB) to set a balanced budget for the year.

Recommendations	It is recommended that the Edinburgh Integration Joint Board: 1. Agree Phase 1 of the Savings and Recovery Programme 2. 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. Agree to award the Carers contracts from the 1st January 2021 4. Note Phase 3 of the Savings Programme 5. Agree that more details about the proposed three year Savings Programme is brought back for consideration by the Edinburgh Integration Joint Board (EIJB) by the end of the year

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 presented elsewhere.

Background

IJB Financial Position (Financial Gap)

2. The Edinburgh Integrated Joint Board (EIJB), like others across Scotland, continue to face unprecedented challenges to the sustainability of our health and care system; an ageing population; an increase in the number of people living with long term conditions; a reduction in the working age population which compounds the challenge in workforce supply and fundamentally resource availability cannot continue to match levels of demand. As such there is a discrepancy between the level of funding available and the projected costs for delivering the IJB's delegated services.

3. Following a combined budget offer of £682.26m from the City of Edinburgh Council and NHS Lothian, and the projected costs for delegated services totalling £706.4m, the EIJB had an estimated £21.9m savings requirement going into 2020/21 as shown in table 1 below:

	CEC £m	NHSL £m	IJB £m	Total £m
Indicative delegated budgets	232.7	451.9		684.6
Projected delegated costs	251.7	458.4	*(3.7)	706.4
Savings requirement	**19.0**	**6.5**	**(3.7)**	**21.9**

Table 1: projected IJB savings requirement 2020/21

*full year effect of savings from Gylemuir closure

4. Additional mitigating actions totalling £6m have been identified to help address the financial gap and are further detailed in the EIJB financial plan paper also included on the agenda. Following these mitigating actions the total savings requirement is £15.9m.

Three Horizons: The lens for the Savings and Recovery Programme

5. It is in response to these challenging circumstances, that the IJB has developed its savings and recovery strategy which recognises that efficiencies are delivered in 3 "phases": grip and control; redesign; and transformation. The savings and recovery strategy is displayed graphically in figure 1 below:

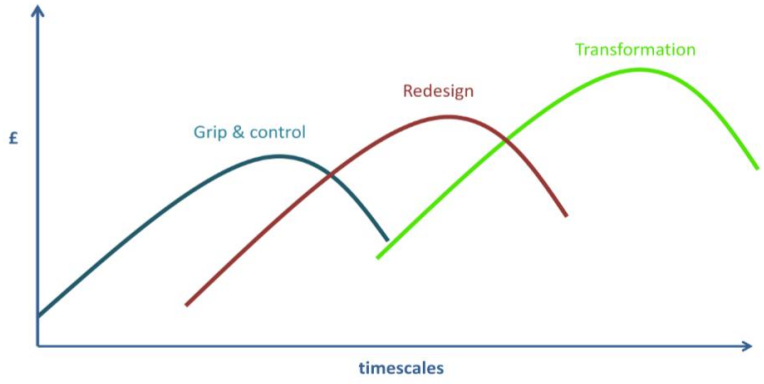


Figure 1: IJB savings and recovery strategy

6. It is recognised that the greatest gains are delivered via transforming services (horizon three). In response to this, an ambitious transformation programme was set out. The aim of the overall programme is to develop a fit for purpose organisation, with an optimised operating model and focus on prevention and enablement within a sustainably sized estate.

7. Whilst our organisational capacity to deliver the programme is now in place, and there is intention to ensure deliverables and benefits are realised at pace, we must ensure the foundations of the programme are firmly established before savings will be realised. Progress with delivery of the programme has slowed in recent months due to the additional operational pressures of the COVID-19 pandemic, however there is a separate paper on this agenda setting out plans for the "return to transformation". This includes proposals for a two-phase delivery approach, with the first phase focused on seven key strategic priorities.

8. It is therefore necessary to deliver shorter term efficiencies through the introduction of and reinforcement of controls (horizon one: grip and control) and smaller scale redesign (horizon two) to bridge the gap.

EIJB Savings and Recovery Programme

Developing the Savings Programme

9. The EIJB has consistently reiterated its desire to have a savings and recovery programme which aligns, as far as possible, with our strategic aims. As such there is intent to continually strive to improve outcomes for people, to maintain and improve performance and maintain the scope and quality of services. However, the enormity of our savings targets and funding gap, has meant that approval of the Savings Programme will require decisions and the implementation of changes of a scale that have the potential to have a direct impact on service delivery and services and there is a significant risk that this will impact performance across social care and health services.

10. The Savings Programme has been developed over a period of 10 months. Appendix 1 provides an overview of the timelines of this process. Proposals were developed by officers (between September and November 2019) through a series of four workshops, based initially upon a whole system review of budgets, with potential options that balanced strategic intent, risk, impact and ease of implementation to provide options that would both ensure effective service delivery and realise efficiencies. These were further refined through a process of peer and management review and in consultation with finance colleagues from both NHS Lothian and The City of Edinburgh Council. The outcome of this process was the preparation of savings proposal templates that articulated the scope, impact, benefit, risks (to people, reputation and outcomes) and dependencies of each proposal which were shared with board members.

11. Alongside this process the EIJB members participated in four EIJB budget workshops. At these workshops officer proposals were presented to members, which they were able to consider, inform, scrutinise and challenge. Following these discussions a number of proposals were not progressed because the level of risk or impact was deemed unacceptable or not aligned with our strategic aims.

Developing a Savings Framework

12. There was recognition of the need to start to develop a clear framework for the Savings Programme, that considers not only the requirement for immediate savings to ensure financial balance, but that provides a clear and structured approach for future years, that aligns with our partners financial planning processes. As such an initial Savings Programme Framework has been established with support from the Council's internal audit team.

13. As part of the framework, identified proposals have been structured into phases that span both this and next financial year detailed in Appendix 2.

14. The four phases under which the proposals have been grouped are

    - Phase 0 - Includes proposals that have already been approved by EIJB
    - Phase 1 - proposals for which we are seeking approval
    - Phase 2 - proposals which we have identified as our route to financial balance, but which will require ongoing work in year
    - Phase 3 - proposals at planning stage, to ensure savings can be realised in the next financial year

15. In addition, we have taken steps to demonstrate strategic alignment, and as such the proposals have also been grouped under programme focuses in recognition of interlinkages and potential interdependencies between proposals which must be monitored to both ensure benefit realisation and identified adverse consequences mitigated.

16. These programme focuses (which will grow and adapted as the programme evolves in this and future financial years) currently include:

    1. Bed based review
    2. Purchasing
    3. Building based services
    4. Workforce
    5. Lothian Services
    6. Other

17. As appropriate, we have also recognised within the framework, links to the transformation programme to ensure that proposal development, delivery and benefits realisation (including savings) are monitored collaboratively to avoid duplication.

18. However, we recognise that this framework must be further developed, to ensure strategic alignment and links with the transformation programme are strengthened. Furthermore we recognised that the development of a risk matrix as part of the framework would aid and inform decision making.

The 2020/21 Savings Programme

19. Within the Savings Programme there are 8 savings proposal (in Phase 1 for which we are seeking approval and have produced High Level Project Briefs detailed in Appendix 4. Steps have been taken to develop detailed implementation plans for each proposal with risks from across the proposals and programme captured in an appropriate Risk Register. Furthermore Integrated Impact Assessments (IIAs), have been completed both for individual schemes and the programme as a whole (details of which can be found in Appendix 4 and Appendix 5 respectively) which provides a cross-system overview of the impacts on all groups, to ensure that no group or area is cumulatively, disproportionately impacted by the savings programmes.

20. The impact of Phase 0 and the proposed Phase 1 savings proposals on the Savings and Recovery Programme is summarised in table 2 below, with further detail included in Appendix 3:

	£m
Savings requirement	15.9
Savings and Recovery Programme	
Phase 0	2.96
Phase 1	8.95
Total	**11.91**
Net position	**3.99**

Table 2: Impact of identified Savings Proposals 2020/21

21. In order to address the remaining gap it will be necessary for us to progress with additional proposals under Phase 2 which we have identified as our route to financial balance. Phase 2 proposals will require further work in year and more detailed plans about the proposals will need to be brought back to a future meeting of the EIJB. The impact of the total Savings and Recovery Programme is summarised in table 3 below, with further detail included in Appendix 3:

	£m
Savings requirement	15.9
Savings and Recovery Programme	
Phase 0	2.96
Phase 1	8.95
Phase 2	3.99
Total Savings and Recovery Programme	**15.90**
Net position	**0**

Table 3: Impact of Savings and Recovery Programme 2020/21

22. Both the scale and pace of the delivery of the proposed programme will be challenging. To monitor progress and provide scrutiny the delivery of the programme will be overseen by the savings governance board, chaired by the Chief Officer.

Risk and Impact

23. Every effort has been made by officers to ensure that the Savings Programme, and the proposals within it align as fully as possible with the EIJBs strategic aims. However, the significant and challenging financial landscape means the options presented to balance the financial plan will require the board to make difficult decisions which may impact adversely on a combination of: service quality; the level of services provided; outcomes for people; and our ability to maintain performance improvements.

24. To this end and to aid a properly informed decision making process for each of the proposals, we have clearly identified and articulated the associated impacts. These impacts have been identified through the completion of IIAs.

25. The process of completing the IIA allows us to set equality considerations alongside our social policy objectives e.g. tackling poverty, it also considers the impact of our decisions in relation to the environment and the economy. The IIA identifies the nature and importance of these effects, and the need for any additional measures to mitigate them. Through the completion of this standardised process we are able to present in as fair and equal way as possible the impacts of each of the savings proposals and highlight the mitigating actions necessary to manage these.

26. The IIAs completed for all proposals will be evolving documents that will need to be refreshed and updated as proposals themselves develop. This is in recognition that the gathering of additional evidence and further consultation will inform the proposals (if they are approved) as they are refined and implemented.

27. In addition to individual IIAs for each of the proposals, a cumulative, programme IIA has been completed. This highlights that particular attention should be given to the impact on older people, those with a disability and carers and steps to mitigate against any negative impact, have been identified within the IIA recommendations and actions.

28. Risks, including reputational risk, our ability to meet our statutory duties and the stability of the external market have also been detailed for each of the proposals (contained with appendix 4), with mitigations identified as appropriate. Ongoing risks associated with the individual proposals and programme as a whole will be monitored and managed via the Savings Governance Board, and escalated as appropriate.

29. It is important to note that given the ever changing landscape presented by COVID-19 it has been necessary to apply a degree of estimation and assumption based on experience and knowledge available, when developing the proposals. Where assumptions have been made and constraints or dependencies identified these have been articulated as clearly as possible within the savings proposals and as with any risks, mitigations identified as appropriate.

The future: Rolling Savings Programme

30. As detailed above work will be ongoing to further refine the Savings Framework that has been established and to ensure strategic alignments and links with the Transformation programme are strengthened. These steps will not only aid decision making, they also align with our partners financial planning process, and will help us achieve the ambition of rolling Savings Programme and support the route to financial balance in future years.

Implications for Edinburgh Integration Joint Board

Financial

31. Are outlined in the main body of this report.

Legal / risk implications

32. The key risk to the EIJB is the ability to fully deliver the savings programme to ensure financial balance within 2020/21.

Equality and integrated impact assessment

33. Integrated impact assessments have been undertaken for both the individual savings proposals and the programme as a whole. Particular attention should be given to the impact on older people, those with a disability and carers and steps to mitigate against any negative impact have been identified within the IIA recommendations and actions.

Environment and sustainability impacts

34. There are no specific implications arising from this report.

Quality of care

35. Integrated impact assessments have been undertaken for both the individual savings proposals and the programme as a whole.

Consultation

36. This report has been prepared with the support of the finance teams in the City of Edinburgh Council and NHS Lothian.

Report Author

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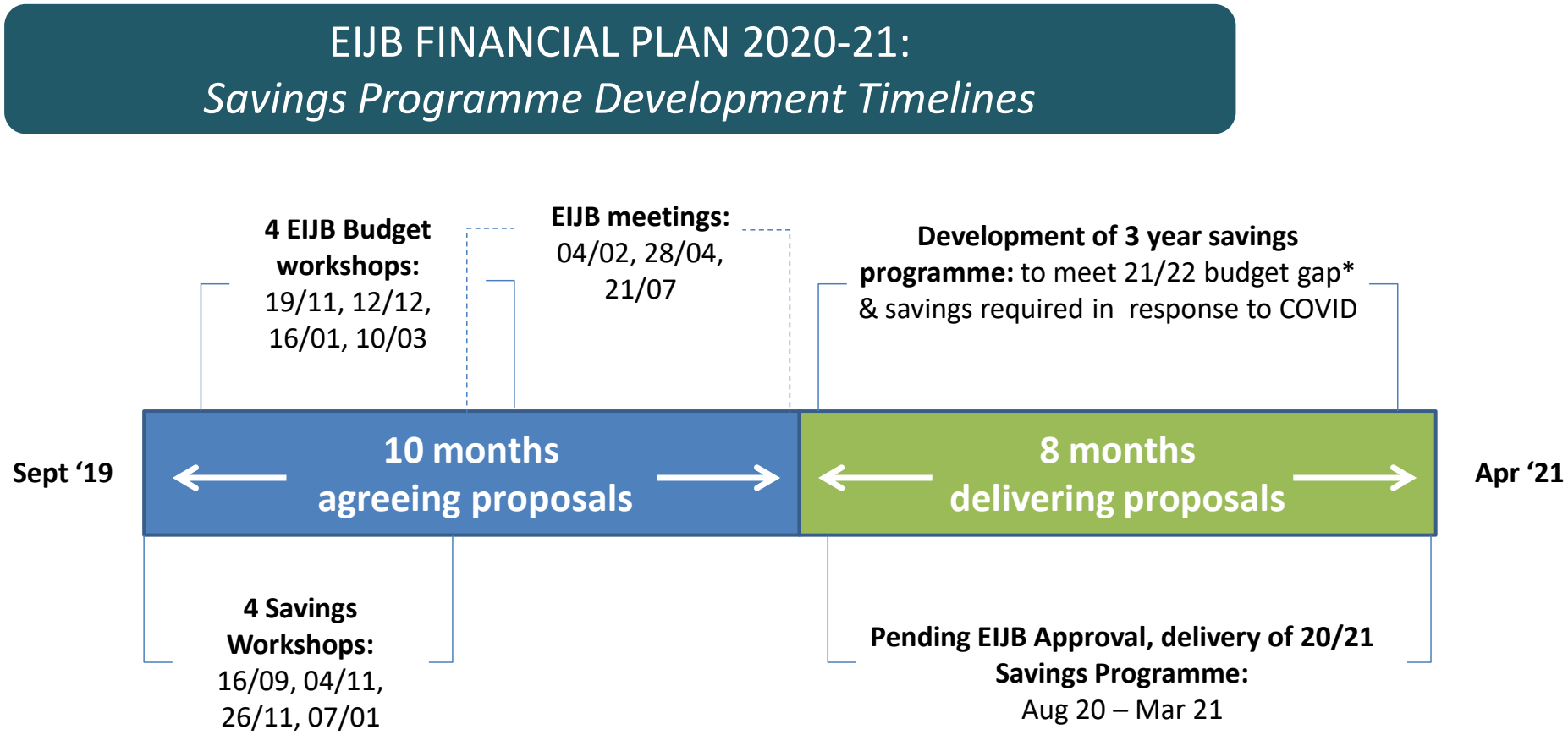
Background Reports

1. Integrated Impact Assessments have been completed for Proposals 8-15 which can be found on the EHSCP Website: *https://www.edinburghhsc.scot/the-ijb/integrated-impact-assessments/*
2. Agreement of Adult Sensory Impairment Services *https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=473&Ver=4*
3. *Proposal already agreed as part of 2019/20 Savings Programme: https://democracy.edinburgh.gov.uk/Data/Edinburgh%20Integration%20Joint%20Board/20190329/Agenda/$item_56_-_201920_financial_plan.xls.pdf*
4. *Agreement of External Housing Support at IJB on 28th April 2020: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=475&Ver=4*

Appendices

Appendix 1	Savings Programme Proposals Development Timeline
Appendix 2	Savings Programme Framework - Proposal Phasing
Appendix 3	Savings and Recovery Programme - Detailed Table
Appendix 4	Savings and Recovery Programme High Level Project Briefs
Appendix 5	Savings and Recovery Programme IIA

Appendix 1: Savings Programme – Proposal Development Timeline



** Anticipated gap for 2021/22 = £25m*

Appendix 2: Savings Programme Framework – Proposal Phasing

Programme Focus	Phase 0 *(Already approved)*	Phase 1 *(Seeking approval)*	Phase 2 *(Route to financial balance)*	Phase 3 (Future programme - planning stage)
1) Bed Based Review*		8. Home First*	16a. Review Hospital bed base	21. Review provision of ICF
			16b. Review Care Home Capacity	22. Phase 2 HBCCC review
				23. Review MH bed
				24. Review provision of hospital based medicine for the elderly
2) Purchasing	1. Adult Sensory Impairment Services	9. Purchasing	17. Additional Purchasing target	25. Contribution based charging
			18. Thrive – Mental Health and Wellbeing	26. Review Grants
3) Building Based Services	2. LD Services (A)	10. LD Services (B)	19. Medical Day Hospitals*	27. Review future delivery model of building based services[2]
	3. External Housing Support			
	4. Day Centres & Be Able*			
4) Workforce	5. Vacancy Freeze (G&C[1])			28. Home to work payments
				29. Review Management Resource
5) Lothian Service		11. Review Rehabilitation Services		
		12. Review Sexual Health Services		
		13. Prescribing		
6) Other	6. Hosted (by NHSL/ other 3HSCPs)	14. Community Equipment*	20.E ADP	30. Internal Home Care*
	7. Set Aside			
		15.Carers investment		

Programme Focuses recognise where proposals may be interlinked and therefore have interdependencies e.g. purchasing and community investment

** Projects with elements that also fall within the Transformation Programme*

[1] *Grip & Control*

[2] *Informed by SG Route map and to incorporate Internal & External Services*

Appendix 3: Savings Programme - Detailed Table

	Proposal	Phase	Saving (£m)
1	Adult Sensory Impairment Services*	0	£0.03
2	LD Services (A)**	0	£0.52
3	External Housing Support***	0	£0.25
4	Day Centres & Be Able**	0	£0.04
5	Vacancy Freeze	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	LD 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***
16a.	Review Hospital bed base	2	£0.00
16b.	Review Care Home Provision	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**
21	Review provision of ICF	3	
22	Phase 2 HBCCC review	3	
23	Review MH Beds	3	
24	Review provision of hospital based medicine for the elderly	3	
25	Contribution based charging	3	
26	Review Grants	3	
27	Review delivery model of building based services	3	
28	Review Management Resource	3	
29	Home to work payments	3	
30	Internal Home Care	3	
TOTAL 2020/21 SAVINGS			**£15.90**

* Agreed at IJB on 10th December 2019: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=473&Ver=4
** *Already agreed as part of 2019/20 Savings Programme:*
https://democracy.edinburgh.gov.uk/Data/Edinburgh%20Integration%20Joint%20Board/20190329/Agenda/$item_56_-_201920_financial_plan.xls.pdf
***Agreed at IJB on 28th April 2020: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=475&Ver=4
**** Savings planned within NHS Lothian Set Aside

Appendix 4: Savings Programme - High Level Project Briefs

Integrated Impact Assessments have been completed for Proposals 8-15 and can be found on the EHSCP website: https://www.edinburghhsc.scot/the-ijb/integrated-impact-assessments/

High Level Project Brief: 8. *Home First*

Project Brief

Home First is a key strategic driver for the EIJB and has been fully embraced as part of the transformation programme. It supports and enables the strategic direction of the IJB is to redesign care to ensure people have the opportunity to be treated at home or in a homely setting wherever possible. This requires a hospital discharge process which is focused on recovery and ensures assessment for long-term care and support needs is undertaken in (a) the most appropriate setting and (b) at the right time for the person.

The Home First model of care is designed to reduce the number of people being delayed leaving hospital and provide opportunity for people to be cared for at home or in a homely setting in their community.

The principles of Home First are; No decision about me, without me; Prevention of Admission and never having to make a decision about long term care in a crisis situation.

Through the use of the Home First model the reprofiling of Ward 71 at the Western General and Ward 120 in the Edinburgh Royal Infirmary has been enabled.

Constraints and Assumptions

Constraints:

High level constraints include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual. This includes colleagues in the acute sector.
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.
- Ability to continue to iteratively redesign and deliver services within the context of Scottish Government Guidelines in response to COVID-19 (e.g. physical distancing)

Assumptions:

High level assumptions include:

- Capacity of people to engage fully with the project, whilst also responding to the consequences of the first wave of COVID-19, and any future waves
- Programme and project management support will continue to be available via the new transformation team

Dependencies

- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19

Impact

Strategic Links

Expansion and implementation of the Home First model contributes to the following Strategic priorities:

- Person Centred Care
- Managing our resources effectively
- Making best use of capacity across the system
- Right care, right place, right time

High level impacts:

1. *Transformation Programme:* lessons learned from implementing changes through the savings and recovery programme will be utilised and help to inform the broader transformation programme
2. *Edinburgh Pact* - provide clarity on service and support offering and redefine what statutory services can contribute in terms of preventing crisis, and supporting people to manage their health and personal independence at home

People (citizens)

Positive

- People are involved in the decision-making process and have increased choice and control of their care
- Those who use the service are able to participate in a person-centred , strengths based approach to their care
- People will begin on their optimum pathway at an early stage and be able to influence the pathway
- People have the opportunity to be treated at home or in a homely setting wherever possible
- Increased opportunity for identification of unpaid carers and therefore access to support

People (staff)

Positive

- Empowered staff
- Increased control over their work
- Opportunity to support and enable person centred approaches to working that promote involvement, choice and control
- Culture change

Negative

- Change in approach may be anxiety provoking for some
- Some may experience additional stress as workloads and responsibility increases

System

Positive

- More effective service
- More efficient service
- Resources are allocated fairly across the system

Negative

- Increased demand for community services that cannot always be met e.g. care home places for those with complex needs, mitigated through ensuring appropriate links with the bed based review to right size our bed base

Benefits

Citizen Benefit

- Appropriate level of support when required
- Discharge facilitated in a timely manner
- Remaining at home enabled
- Independence maximised
- Person centred and collaborative approach adopted
- Improved communication

System Benefit

- Improved flow
- Improved systems and processes
- Appropriate use of beds

Staff Benefits

- Staff empowered and supported to make decisions in the best interest of the people being supported
- Clearer and fairer processes

Financial Benefit

- Improved overall value
- Spend incurred in the most appropriate setting
- Reduced spend

Finances

Financial Savings

The total set aside budget for 2020/21, from which the savings will be realised, is £93m.
The anticipated financial savings are laid out below:

Full year target 2020/21 (£k)	Forecast 2020/21 In Year Savings (£k)	Recurring £k (from 21/22)	Delivery Investment
£1,000	£1,000	TBC	Savings figures are net of reinvestment required.

Non-Financial

- Expanding Home First facilitates the EIJB's strategy to redesign care to ensure people have the opportunity to be treated at home or in a homely setting wherever possible.

Risk

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
1.1	**People:** confusion or misunderstanding of how and why new model is being implemented	Clear and appropriate engagement and communication with people and carers	Amber	Green
1.2	**Reputational damage:** service model does not meet existing expectations and perceptions	Ensure appropriate linkages are made with Edinburgh Pact Workstream and equivalent work streams across Lothian	Amber	Green
1.3	**Resistance to change:** by workforce/ stakeholders/ people	Clear and appropriate engagement and communication	Amber	Amber
1.4	**Change management**: pressures on staff from involvement and supporting change whilst delivering business as usual	Staff support through change management	Amber	Green
1.5	**Financial risk:** that the planned efficiencies are not achieved	Effective planning and monitoring process implemented	Red	Amber
1.6	**COVID-19:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months	Red	Amber

High Level Project Brief: *9. Purchasing*

Project Brief

To ensure the best use of the purchasing budget and to maximise the benefit to eligible individuals in the most fair and equitable manner possible, within available resources, it is necessary to review and implement appropriate changes. These changes will ensure that the Edinburgh Health and Social Care Partnership (EHSCP) is able to fulfils its statutory obligations including in relation to Self-Directed Support (SDS) and that it is aligned with approaches delivered across Scotland, whilst supporting a move away from a dependency model to an enabling model that supports people to utilise their assets, develop new skills and take responsibility for their own decisions.

The changes also seek to empower staff, by providing opportunities to support and share best practice, create space for learning and development and bring about sustained cultural change.

The proposed Grip and Control redesign and transformation of the Purchasing Budget will also contribute to the EHSCPS comprehensive Savings Programme, and will therefore support the delivery of a balanced budget for the 2020/21 financial year.

When considering how to implement changes to the purchasing programme of work it is important to recognise the complexity of the system, and layers that exist within it, as shown in Figure 1 below. Furthermore, it is particularly important to understand and be cognisant of; the interlinkages/ interdependencies between the purchasing workstreams; the mechanisms by which purchasing is delivered; and the importance of sharing and embedding learning and development (from the implementation of the mechanisms) to ensure best practice is applied and cultural change achieved consistently.

Figure 1: Layers of Purchasing Programme

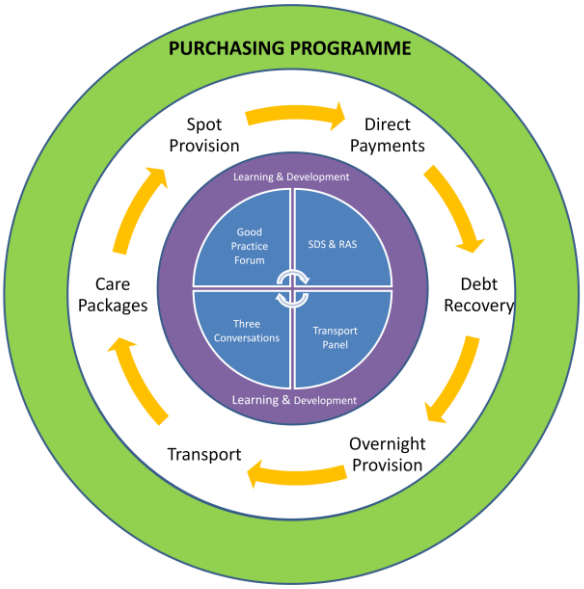


Figure 2: Purchasing Programme workstreams & mechanisms

The scope of the proposal will include a range of workstreams which will be reviewed including:

1. Review of purchasing, implementation and monitoring of care packages including
   - Small packages of care
   - Large packages of care
   - Out of Edinburgh placements
2. Direct Payments
3. Debt recovery
4. Overnight provision
5. Spot purchasing of specialist support including for mental health and learning disability
6. Corporate Appointee
7. Transport

However, it will be through the development and ongoing implementation of the mechanisms (as identified in Fig 2 above and listed below) that the changes will be realised:

1. **Good Practice Forum (GPF)** - This forum will consider requests for all packages of support that are more than £500 per week and care home placements that exceed the national care home contract rate. This forum will enable and promote positive discussion, exploration of options, progress towards consistency and equity, with all learning shared and embedded into practice going forward. The implementation of the 3 Conversations approach will provide the framework within which this will be done.

2. **Three Conversations**[1] - a model for achieving cultural change through enabling staff to work with individuals more closely, allowing them to engage in a higher proportion of prevention work and reducing bureaucracy within our system.

3. **Self-Directed Support (SDS)**[2] - Scotland's approach to social care support established to ensure that social care is controlled by the person to the extent that they wish; is personalised to their own outcomes (including where they receive social care support commissioned or delivered by the public sector); and respects the person's right to participate in society.

4. **Resource Allocation System (RAS)** - means by which an individual personal budget is identified based on their identified needs as part of the application of SDS

5. **Establishment of a Transport Panel*** to provide improved grip and control over the provision of transport to all adults (16+). The panel will reflect the approach currently taken by Children and Families within CEC, thus ensuring a fair and equitable approach is taken across services.
   ** The development of this will be informed by and aligned with the ongoing CEC review of Transport which has paused as a result of the COVID-19 pandemic*

6. **Learning & Development Programme** – developed to share learning, ensure consistency of practice, embed best practice and cultural change

These will ensure: legal compliance, application of best practice, alignment of delivery with that seen across the country and ultimately support better outcomes for the citizens of Edinburgh by maximising the benefit to eligible individuals in the most fair and equitable manner possible, within available resources.

Appropriate learning gained from the response to the COVID-19 pandemic, will be used to inform and shape how sustainable services are delivered.

[1] http://partners4change.co.uk/the-three-conversations/

[2] https://www.gov.scot/publications/self-directed-support-strategy-2010-2020-implementation-plan-2019-21/pages/2/

Constraints and Assumptions

Constraints:

High level constraints include:

- Capacity of people to engage fully with the project and appropriate changes, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.

Assumptions:

High level assumptions include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- Colleagues leading purchasing programme will be integral in the broader project or programme development of any areas that may impact on the purchasing budget:
    - Bed Based Review
    - Edinburgh Pact
    - Community Investment
- Leadership by example: Ongoing buy in, support and leadership from across EIJB leadership specifically EIJB and EMT
- Support services (e.g. finance and strategic insight) across the City of Edinburgh Council will have capacity and will be available to provide support to ensure the realisation of the workstreams
- Programme management support will continue to be available via the new transformation team
- Digital solution to be applied where possible
- The implementation of community investment to enable the shift to support self management – maximising community resources
- The implementation of Edinburgh Pact will be progressed to ensure clarity of services understanding and capacity to manage expectations
- Staff are able to adapt to new ways of working (e.g. utilising and embedding technology into practice)

Dependencies

- Successful roll out and implementation of this project will rely on appropriate linkages being made and consistent support with and from key workstreams within the Transformation Programme and Savings Governance projects. In particular integrated working with the development and implementation of:
    - C1.1 Community Investment
    - C1.3 Three Conversations
    - C3.4 The Edinburgh Pact.
- Ability to maintain the reduction in waiting lists seen since the start of the COVID-19 pandemic
- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19

Impact

Strategic Links

Implementation of the changes to Purchasing contributes to the following Strategic priorities:

- Prevention and early intervention
- Person Centred Care

- Managing our resources effectively
- Making best use of capacity across the system
- Right care, right place, right time

High Level Impact

People (citizens)

Positive

- Best use of purchasing budget to maximise the benefit to eligible individuals
- Provision of care and support in the most fair and equitable manner possible, within available resources.
- Improved consistency and equity in practice and application of existing policy
- Person centred care using a collaborative approach which promotes choice and control

Negative

- Increase in the number of challenging and complex conversations
- Period of inconsistency as new systems and processes are implemented, mitigated by communication
- Some people may no longer receive the same level of funding to access the same level of care and support previously provided to them

People (staff)

Positive

- Clarity, support and consistency of practice
- Investment in staff via the Learning and development programme and time to support this
- Culture change

Negative

- Change in approach may be anxiety provoking for some
- Increase in the number of challenging and complex conversations
- Period of inconsistency as new systems and processes are implemented, mitigated by communication

System

Positive

- New and improved mechanisms e.g. RAS, Good Practice Forum
- Updated IT systems e.g. SWIFT/AIS to ensure they are fit for purpose
- Resources are allocated fairly across the system

Negative

- Period of inconsistency as new systems and processes are implemented, mitigated by communication

Reputation

Positive

- Services are delivered which ensure legal compliance, application of best practice, alignment of delivery with that seen across the country

Negative

- Increase in the number of complaints as we deliver new ways of working, mitigation: communication
- Perception that a selective and inequitable service is delivered, mitigation: communication about implementation of mechanisms

Benefits

Citizen Benefit

- Consistency in assessment and provision of care
- Improved communication
- Appropriate level of support when required
- Discharge facilitated in a timely manner
- Remaining at home enabled
- Person centred and collaborative approach adopted

System Benefit

- Improved practice, systems and processes
- Consistency of decision making
- Improved accountability and transparency of processes including decision making
- Improved audit trails

Staff Benefits

- Clarity of purpose through the provision of a position statement
- Improved communication
- Clearer and fairer processes
- Increased training
- Increased job satisfaction

Financial Benefit

- Improved budget grip and control
- Improved accountability for spend
- Reduced spend

Finances

Financial Savings

The total annual Purchasing Budget is £193m. The anticipated financial savings for 2020/21 are laid out below:

Full year target 2020/21 (£k)	Forecast 2020/21 In Year Savings (£k)	Delivery Investment
£8,000	£4,100	• Dedicated time from senior managers, budget holders etc • Learning and development programme – to be developed including L&D support and any required finance • Time from people to commit to developing and implementing processes – finance; transport managers; operational managers; front line staff • Finance support • Strategy and Insight support Delivery of other co-dependent work streams

Risks

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	**Inherent RAG**	Residual RAG
9.1	People: confusion or misunderstanding of how and why new model is being implemented	Clear and appropriate engagement and communication with people and carers	Amber	Green
9.2	People: Increase in population health risk and inequalities	Service priorities will be based on health risks and need	Amber	Green
9.3	Reputational damage: new service model does not meet existing expectations leading to increased complaints	Ensure appropriate linkages are made with Edinburgh Pact Workstream	Red	Amber
9.4	Reputational damage: Perceptions of actions taken to reduce spend being at odds with the principles of 3 Conversations approach and improved outcomes for people	Clear and appropriate engagement and communication Ensure appropriate linkages are made with Edinburgh Pact Workstream	Amber	Amber
9.5	Skill and knowledge gap: inconsistency in the skills, knowledge and confidence of current decision makers and assessors	Skills gap analysis completed and learning and development programme developed and implemented	Amber	Green
9.6	Resistance to change: by workforce/ stakeholders/ people	Clear and appropriate engagement and communication	Amber	Amber
9.7	Change management: pressures on staff from involvement and supporting change whilst delivering business as usual	Staff supported through change management	Amber	Green
9.8	Scale: the work required does not match the capacity of assessors to undertake	Effective planning, allocation and monitoring process developed and implemented	Red	Amber
9.9	Volatility of the market: challenges with managing purchasing spend due to the volatility and nature of the market	Consistent, effective planning and monitoring process implemented	Amber	Amber
9.10	Financial risk: that we do not achieve the planned efficiencies	Effective planning and monitoring process implemented	Red	Amber
9.11	Clear vision and leadership: Inconsistent understanding of the situation and what we are trying to achieve	Consistent, positive messaging and communication. With proactive engagement across all stakeholders Ensure appropriate linkages are made with Edinburgh Pact Workstream	Red	Amber
9.12	COVID: Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months	Red	Amber
9.13	Inclusive involvement: purchasing leads are not involved in major strategic workstreams that change the way EHSCP conducts its business, which impact on the purchasing budget and ability to achieve savings target	Purchasing Leads must be involved in all EHSCP major strategic workstreams	Red	Amber

High Level Project Brief*: 10. Learning Disabilities*

Project Brief

The proposed changes for this project, sit under 4 key headings:

1. ***Review internal housing and support***
   - *The ground work for this proposal will be completed in this financial year, to enable delivery for the 1st April 20201*

2. ***Consider people using day support who live with care providers to move to a single service***
   - *The experience of COVID-19 has significantly impacted on the way people are able to receive their day support. Current SG guidelines have meant people have not been access any day support and are unlikely to be able to do so before the autumn at the earliest. Under these circumstances alternative day support has been provided. This proposal seeks to have a conversation to understand if individuals would wish to make this change for the longer term*

3. ***Transfer to shared support where appropriate***
   - *This proposal had two phases of work involving refurbishment work. Both phases have been impacted by the restrictions to construction COVID-19 shut down. It is estimated that the two individuals would be in the position to move into the shared resource by the end of the year.*

4. ***Phase out Adult Resource scheme***
   - *This is a non essential service that has been reduced in demand overall several years. Due to the COVID pandemic this service was paused as of 23rd March. It is proposed that this service is phased out due to diminishing demand.*

Constraints and Assumptions

High level constraints include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.

Assumptions:

High level assumptions include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- Programme management support will continue to be available via the new transformation team

Dependencies

- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19

Impacts & Benefits

Strategic Links

Implementation of the changes to the Learning Disability Services contributes to the following Strategic priorities:

- Person Centred Care
- Managing our resources effectively
- Making best use of our capacity across the system
- Right care, right place, right time

The following impacts were identified by completing an Integrated Impact Assessment (IIA) for each section of the proposal. The exception to this was section 3, for which it was identified that an IIA was not required, as it is a mutually agreed operational decision that will see the move of two people already receiving support. There are no objections or challenges from any family members.

1. Review Internal Housing and Support.

Impact on People (Citizen)

Positive

- The changes will provide a more consistent approach in the services being delivered, whilst ensuring relationships and contacts are maintained. This consistency will offer better health and wellbeing outcomes for individuals through flexibility, personalisation and consistency.
- Fair and consistent access to the same level of support in line with the assessed level of need.
- This change will increase capacity to support those awaiting discharge from in-patient services, which will free up treatment beds for those who require it and fits in with the Royal Edinburgh Hospital Modernisation Programme.
- Service provision for up to 20 adults with learning disabilities currently accessing internal housing support services.

Negative

- Some individuals and families may be concerned with the change in provider resulting in anxieties. This will be mitigated via clear and regular communication with individuals and families.

Impact on System

Positive

- The Framework Agreement will set out key performance indicators to ensure sustainability for the providers who sign up to the agreement.
- This work will provide a clear direction for the future and consolidate the staffing resources within disability services. It is envisaged that in the longer term this change will have a positive impact on both individual outcomes of those being supported and employee health and wellbeing.
- Will provide an opportunity for internal services to focus on specialist provision for complex care and forensic support in line with the strategic direction for Learning Disability

Financial Benefit

- There is anticipated growth in the voluntary and private sector organisations which will provide job opportunities within social care.
- The quality of the support services offered within the EHSCP will improve through the consolidation of staffing resources.

2. Single Provider

Impact on People (Citizens)

Positive:

- The changes will provide a more consistent approach in the services being delivered and ensure equity of support for people with learning Disabilities within Edinburgh, creating opportunity to enhance access to appropriate social care – more capacity within day services for people who currently have no access or other formal paid support.
- This will increase peoples understanding of their rights and participation within decisions about their support and enables people to discuss, understand and access the right support at the right time.
- Fair and consistent access to the same level of support in line with the assessed level of need. It is not foreseen that any individual will be affected due to any other protected characteristic.
- Individuals may be able to continue within their existing day service funding it through SDS option 1 or 2, if this is determined appropriate in line with the Partnerships 3 conversations approach. Both options encourage and enable people to have more control over their support and decisions.

Negative:

- Some individuals may feel that their right to choose a day support service is inhibited and believe a change to a single provider will have an adverse effect on them. Mitigation – option to change will be down to an individual's choice
- Individuals may feel that they are losing friendships or connections which are important to them.

Impact on System

Positive

- Consistency will offer better health and wellbeing outcomes through flexibility and personalisation in line with Self Directed Support (SDS).
- It would be expected that any forms of travel in and around the city will be utilising public transport and where available motobility vehicles rather than corporate transportation as well as general taxi use in providing transport for people travelling to their day service from home.
- The Framework Agreement sets out key performance indicators to ensure sustainability for the providers who sign up to the agreement. This includes a commitment from providers to ensure specific training and completion of an annual monitoring form which is audited by contracts team.
- Growth will be enabled in voluntary and private sector organisations. Single provider enhances employability for Care at Home Organisations and may encourage longer term sustainability.

Financial Benefit

- There is anticipated growth in the voluntary and private sector organisations which will provide job opportunities within social care.
- The quality of the support services offered within the EHSCP will improve through the consolidation of staffing resources.

3. Transfer to shared support where appropriate

Impact on People (Citizen)

Positive

- Decision led by choice of individual
- Fair and consistent access to the same level of support in line with the assessed level of need.
- Provision of more individualised outcomes

Financial Benefit

- Effective use of resources via the provision of equalised and appropriate supports.

4. Phase out Adult Resource Scheme

Impact on People (Citizens)

Positive

- The changes will provide a more consistent approach to receiving appropriate support where required, in line with SDS.
- Improved discussion around informal support arrangements and increased connecting to existing community based resources.
- This change will directly impact on 17 individuals currently receiving non- essential support from 12 Off Payroll as required contractual workers. This will provide opportunity to align supports that are assessed as essential and ensure any required provision is provided through Self Directed Support. (SDS)

Negative

- Some people being supported may be anxious about any changes as a result of this which may impact upon general health and wellbeing. Mitigation – clear and regular communication about alternative options where appropriate
- The support element within the Adult Resource Scheme will be phased out and will no longer be operational. Mitigation: it is a non essential service that has been reduced in demand overall several years.

Impact on System

Positive

- Carer unmet needs will be addressed where appropriate, this will potentially ensure better outcomes for carers.
- Improved discussion around informal support arrangements and increased connecting to existing community-based resources.
- Reduction in usage of private vehicles and, where possible, an increase in access to community transport and public transport.
- Enable a more consistent approach to ensure positive outcomes for individuals which will ensure sustainability long term.

Financial Benefit

- Provision of equalised and appropriate supports.

Overarching Benefits

Citizen Benefit

- The changes will provide a more consistent approach to receiving appropriate support where required, in line with SDS. This consistency will offer better health and wellbeing outcomes for individuals through flexibility, personalisation and consistency.
- Fair and consistent access to the same level of support in line with the assessed level of need.

System Benefit

- Carer unmet needs will be addressed where appropriate, this will potentially ensure better outcomes for carers.
- Improved discussion around informal support arrangements and increased connecting to existing community-based resources.
- Reduction in usage of private vehicles and, where possible, an increase in access to community transport and public transport.
- Enable a more consistent approach to ensure positive outcomes for individuals which will ensure sustainability long term.

Financial Benefit

- Provision of equalised and appropriate supports.
- There is anticipated growth in the voluntary and private sector organisations which will provide job opportunities within social care.

Finances

Financial Savings

The total annual Learning Disability Budget is £9m The anticipated financial savings for 2020/21 are laid out below:

Full year target 2020/21 (£k)	Forecast 2020/21 In Year Savings (£k)	Recurring £k (from 21/22)	Delivery Investment
£285	£62	£0	None noted

Risks

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
5.1	Provider unable to recruit staff	Extend the timescale for proposal	Amber	Amber
5.2	No providers willing to support	Work with providers to support through change process	Amber	Amber
5.3	Recruitment does not deliver enough staff	Extend the timescale for proposal	Amber	Amber
5.4	**Transition challenges**: affected people cannot move to suitable alternatives that meet their needs	Clear and appropriate engagement and communication	Amber	Green
5.5	**Financial risk:** that we do not achieve the planned efficiencies	Effective planning and monitoring process implemented	Red	Amber
5.6	**COVID:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months	Red	Amber

High Level Project Brief: *11. Review Rehabilitation Services*

Project Brief

- Through the establishment of the Integrated Rehabilitation Collaborative (IRC) deliver a Pan Lothian integrated and shared vision and model for rehabilitation services, incorporating plans proposed by the four Lothian HSCPS for community rehabilitation
- Review the existing models of care to identify where improvements can be made to support services to operate more efficiently and effectively
- Use learning from COVID-19 to inform approach

Constraints and Assumptions

Constraints:

High level constraints include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.
- Ability to continue to iteratively redesign and deliver services within the context of Scottish Government Guidelines in response to COVID-19 (e.g. physical distancing)

Assumptions:

High level assumptions include:

- Capacity of people to engage fully with the project, whilst also responding to the consequences of the first wave of COVID-19, and any future waves
- Capacity of all four HSCPs to engage and facilitate in service review and implementation
- Post COVID-19 remobilisation plans will be aligned with and shaped by the shared vision for specialist rehabilitation delivery
- Capacity to implement service review and appropriate changes, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual
- Programme management support will continue to be available via the new transformation team

Dependencies

- Ensuring that inpatient and outpatient models of care fit with the overall shared vision for the delivery of integrated rehabilitation services across Lothian.
- Dependant on a joined up approach with Community Rehabilitation Services in all four HSCPs
- Planning needs to be cognisant on non-Lothian usage of the inpatient service equates to 8 beds (6 neurorehabilitation and 2 amputee rehabilitation)
- Future re-provision of rehabilitation service and associated business case
- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19

Impact

Strategic Links

Completing a review of the existing model of Rehabilitation Services and implementing any recommendations contributes to the following Strategic priorities:

- Person Centred Care
- Managing our resources effectively
- Making best use of capacity across the system
- Right care right place right time

High level impacts;

People (citizens)

Positive

- Reduced length of stay and reduce time spent in bed based rehabilitation
- Support and enable locally focused rehabilitation by delivering this and any associated care closer to home wherever possible.
- Person centred approach

Negative

- Equity of access of technology: not everyone has equal access, mitigated via the continuation of face to face services where appropriate

People (staff)

Positive

- All staff will have an opportunity to inform and shape the new services through involvement in the recovery planning process

Negative

- Not all staff will be confident and comfortable with utilising technology within their practice – mitigation communication, training, peer support (within and beyond service) and ongoing feedback

System

Positive

- Approach is aligned with Home First a key strategic priority for EHSCP
- More effective service
- More efficient service
- Resources are allocated fairly across the system

Reputation

Negative

- Perception that a selective and inequitable service is delivered, mitigation communication of service redesign (Ensure appropriate linkages are made with Edinburgh Pact Workstream and equivalent work streams across Lothian)

Benefits

Citizen Benefit

- People requiring inpatient rehabilitation are able to access it as timely as possible and with the expected level of intensity to improve quality and drive better outcomes.
- People who no longer require inpatient rehabilitation can access their ongoing rehabilitation and care requirements in the community
- Supports people to reintegrate back into the community either in their own home or a homely setting at the earliest opportunity.

System Benefit

- Aligns with and will facilitate a continued move towards adopting the Home First Model where possible.
- Approach support the move to digital first in line with Health and Social Care strategic intent (Nationally, regionally and locally)
- Improved systems and processes

Financial Benefit

- Efficient use of resources
- Anticipated reduction in spend

Finances

Financial Savings

The total 2020/21 budget for Rehabilitation Services (excluding SMART which is out of scope for this proposal and Occupational Therapy and Physiotherapy budgets which currently sit within the SE Locality budge) is £11.25m. The total anticipated financial savings for 2020/21 are laid out below:

	Full year target 2020/21 (£k)	**Forecast 2020/21 In Year Savings (£k)**	**Recurring £k (from 21/22)**	**Delivery Investment**
Total Rehab Budget	£200	£150	£200	Support from NHS Lothian Strategic Planning Team
EHSCP share (based on NRAC)	£114	£85	£114	Support from NHS Lothian Strategic Planning Team

Non-Financial

- Establishment of the Integrated Rehabilitation Collaborative (IRC)
- Established, shared vision across all four Lothian Health and Social Care Partnerships for specialist rehabilitation
- Building on learning and experience of responding to COVID-19, incorporation of technology for service delivery where appropriate
- New integrated model for the delivery of inpatient, outpatient and community rehabilitation services

Risks

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
10.1	**People:** confusion or misunderstanding of how and why new model is being implemented	Clear and appropriate engagement and communication with people and carers	Amber	Green
10.2	**Reputational damage:** service model does not meet existing expectations and perceptions	Ensure appropriate linkages are made with Edinburgh Pact Workstream and equivalent work streams across Lothian	Amber	Green
10.3	**Resistance to change:** by workforce/ stakeholders/ people	Clear and appropriate engagement and communication	Amber	Amber
10.4	**Change management**: pressures on staff from involvement and supporting change whilst delivering business as usual	Staff support through change management	Amber	Green
10.5	**Consensus in approach**: lack of agreement across the 4 HSCPs on the model of care	Senior leadership engagement and direction	Red	Amber
10.6	**Governance processes reduced ability to work at pace:** working across 4 HSCPs may lead to a delay in decisions being made	Forward planning and engagement with/ representation from all HSCPs	Red	Amber
10.7	**Financial risk:** that we do not achieve the planned efficiencies	Effective planning and monitoring process implemented	Red	Amber
10.8	**COVID:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months	Red	Amber

High Level Project Brief: *12. Review of Sexual Health Services*

Project Brief

Review the Lothian Sexual and Reproductive Health Services (LSRHS) to ensure that models of care are as effective and efficient as possible, and are aligned with national and local public health and sexual health priorities.

In light of COVID-19 the recovery planning process will be used to facilitate the review. Appropriate learning gained from the response to the COVID-19 pandemic, when some LSRH services had to be paused and others reduced or adapted (e.g. through the use of technology), will be used to inform and shape sustainable and future proofed models of care. This will be aligned to nationally agreed stages of recovery for Sexual and Reproductive Health Services which provides a guide as to when to restart services. This is in recognition that users of sexual and reproductive health services are often transient, and where possible reducing variation in services supports continuity of care.

Constraints and Assumptions

Constraints:

High level constraints include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual.
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.
- Ability to continue to iteratively redesign and deliver services within the context of Scottish Government Guidelines in response to COVID-19 (e.g. physical distancing).

Assumptions:

High level assumptions include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- Post COVID-19 remobilisation plans will be aligned with and shaped by nationally agreed stages of recovery for Sexual and Reproductive Health Services
- Capacity to implement service review and appropriate changes, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual
- Programme management support will continue to be available via the new transformation team

Dependencies

- Ensuring that any new service model fits with the overall vision for the delivery of LSRHS
- Support of the LSRHS SMT in completing the review (in particular, ensuring necessary information including local policies, procedures and processes, activity and performance data is readily available) and implementing any recommendations
- That any services review meet Public Health requirements and associated budget priorities
- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19

Impact

Strategic Links

Completing a review of the Lothian Sexual and Reproductive Health Services (LSRHS) and implementing any recommendations contributes to the following Strategic priorities:

- Person Centred Care
- Managing our resources effectively
- Making best use of capacity across the system
- Right care right place right time

High Level Impacts

People (staff)

Positive

- All staff will have an opportunity to inform and shape the new services through involvement in the recovery planning process

Negative

- Not all staff will be confident and comfortable with utilising technology within their practice, mitigation: communication, training, peer support (within and beyond service) and ongoing feedback

People (citizens)

Positive

- More flexible provision of services through the utilisation of technology where appropriate
- Provision or care and services in the most fair and equitable manner possible, within available resources
- Person centred approach

Negative

- Equity of access of technology: not everyone has equal access, mitigated via the continuation of face to face services where appropriate
- Some groups may be less able to access care, mitigated by providing enhanced outreach service for vulnerable populations

System

Positive

- More effective service
- More efficient service
- Resources are allocated fairly across the system

Reputation

Negative

- Perception that a selective and inequitable service is delivered, mitigation communication of service redesign (Ensure appropriate linkages are made with Edinburgh Pact Workstream and equivalent work streams across Lothian)

Benefits

Citizen Benefit

- More flexible services as a result of the use of technology
- It is anticipated that there may be greater consistency in services between regions.
- Resources allocated based on identified need

System Benefit

- Approach support the move to digital first in line with Health and Social Care strategic intent (Nationally, regionally and locally)
- Improved systems and processes

Financial Benefit

- Efficient use of resources
- Anticipated reduction in spend

Finances

Financial Savings

The total budget for Lothian Sexual and Reproductive Health Services in 2020/21 is £6m.
The total anticipated financial savings for 2020/21 are laid out below:

	Full year target 2020/21 (£k)	**Forecast 2020/21 In Year Savings (£k)**	**Recurring £k (from 21/22)**	**Delivery Investment**
Total Sexual Health Budget	£200	£100	£200	None identified
EHSCP share (based on NRAC)	£114	£57	£114	None identified

Non-Financial

Provide assurance to the 4 IJBS on the extent to which LSRHS provides services which:

- Meet national clinical guidelines & quality assurance standards
- Are efficient, cost effective and deliver best value for money
- Meet access and performance standards
- Are delivered by a workforce with the appropriate skill mix and role optimisation.

Risks

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
11.1	**People:** Increase in population health risk and inequalities	Service priorities will be based on health risks and need	Red	Amber
11.2	**Reputational damage:** service model does not meet existing expectations	Ensure appropriate linkages are made with Edinburgh Pact Workstream and equivalent work streams across Lothian	Amber	Green
11.3	**Resistance to change:** by workforce/ stakeholders/ people	Clear and appropriate engagement and communication	Amber	Amber
11.4	**Change management**: pressures on staff from involvement and supporting change whilst delivering business as usual	Staff supported through change management	Amber	Green
11.5	**Consensus in approach**: lack of agreement across the 4 HSCPs on the model of care	Senior leadership engagement and direction	Red	Amber
11.6	**Governance processes reduced ability to work at pace:** working across 4 HSCPs may lead to a delay in decisions being made	Forward planning and engagement with/ representation from all HSCPs	Red	Amber
11.7	**Financial risk:** that we do not achieve the planned efficiencies	Effective planning and monitoring process implemented	Red	Amber
11.8	**COVID:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months and careful planning of the recovery process	Red	Amber

High Level Project Brief: 13. *Prescribing*

Project Brief

Each year, the NHS Lothian Primary Care Pharmacy team identify proposals aimed at delivering efficiencies in the prescribing budget of approximately £4m across NHS Lothian. The 2020/21 Lothian prescribing action plan includes an overall efficiencies target of £4.075m (adjusted to £3.794m as a result of COVID-19), of which £2.070m (adjusted to £1.963m as a result of COVID-19) (51% of Lothian total) is attributed to EHSCP.

Efficiencies are derived from multiple sources, including embedded working practices and specific targeted projects. Additionally, generating these efficiencies requires multidisciplinary working between pharmacists, technicians, GPs, community and practice nurses and allied health professionals.

The following **embedded** workstreams will feed into the 2020/21 efficiencies target:

- Polypharmacy and practice initiatives - provided through the team's activity and includes Level 2/3 Reviews, Prescribing Support Work and S&V Locality Projects where not captured elsewhere.
- Specials - includes savings from Reclaims, Authorisation Process and individual practice level work.
- Scriptswitch® - derived directly from available reports each month detailing savings made through use of licensed software.
- PEAT – efficiencies made through activity of the Prescribing Efficiency and Analysis Team.
- Rebates – reported via NHS Lothian Finance team based on drug company rebates.
- GPIP – efficiencies made through activities covered in the General Practice Intervention Project workstream.
- Full year effect – savings derived from work initiated in the previous financial year and continuing to generate savings in current year.

The following **additional** workstreams are due to feed into the 2020/21 efficiencies target and may be supported from additional funding from the Sustainability and Value (S&V) project team*:

- Diabetes, Respiratory, Dietetics, Chronic Pain, Central Nervous System, Wound Management, Stoma.

Efficiencies will be derived from a basket of projects developed within the above clinical areas, the individual details of which are currently being developed by the Primary Care Pharmacy team.

Due to the impact of the COVID-19 pandemic a number of workstreams have been paused/ delayed, specifically:

- 2 months of the following have been missed: Polypharmacy, Specials, Rebates and GPIP,
- S&V efficiency programmes are paused (with the exception of dietetic projects, which has been continued in a reduced capacity)

A tracker to monitor the savings is reviewed at the monthly basic at NHS Lothian's Health and Social Care Partnership Prescribing Forum and provides a mechanism for identifying and responding to slippage.

Constraints and Assumptions

Constraints:

High level constraints include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual

- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.
- Variances in drug costs are outwith EHSCPS control
- Prescription item volume is also subject to variance throughout the year

Assumptions:

High level assumptions include:

- The efficiencies will continue to be led and delivered by the NHS Lothian Primary Care Pharmacy team in conjunction with the Health and Social Care Partnership Prescribing Forum.
- That the NHS Lothian Primary Care Pharmacy team and colleagues from the Health and Social Care Partnership Prescribing Forum will have the capacity to engage fully with the projects, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual
- Price per item will return to pre COVID-19 levels

Dependencies

Normal services within GP practices are yet to resume, and there is not yet a clear understanding of what impact this may have on prescribing and resultant costs.

GP Practices in the City of Edinburgh and across Lothian remain engaged in Year 2 of S&V funded projects and support the Primary Care Pharmacy team with delivery of efficiency work.

The Sustainability and Value programme is able to restart in this financial year following the COVID-19 pandemic.

The NHS Lothian Primary Care Pharmacy team skill mix is anticipated to change during 2020/21 with the addition of a large number of new roles coming into the team. The workload of the existing team will need to flex during induction and training of new staff and may impact in the ability to deliver the efficiencies plan.

Ability to continue to recruit pharmacists and their capacity to play a role in supporting workstreams that will realise savings.

Impact & Benefits

Strategic Links

Delivering efficiencies within the prescribing budget contributes to the following Strategic priorities:

- Making best use of capacity across the system
- Managing our resources effectively
- Right care, right place, right time
- Person Centred Care

High level impacts:

An Integrated Impact Assessment (IIA) was completed for the Lothian Prescribing Action Plan on 19th June 2020, no negative impacts were identified.

Prescribing projects are underpinned by quality improvement methodology aimed at improving clinical effectiveness.

Citizen Benefit

- Access to the right drugs to best support and address their conditions
- Increased opportunities for polypharmacy reviews
- Access to support from across a multi disciplinary team

System Benefit

- Implementation of projects underpinned b quality improvement to help improve clinical effectiveness
- Promotion of and increased opportunities to support collaborative working via multi disciplinary teams within primary care

Financial Benefit

- Efficient use of resources
- Reduced spend

Finances

Financial Savings

The total prescribing budget for 2020/21 is £82m. The anticipated financial savings are laid out below:

Full year target 2020/21 (£k)	Forecast 2020/21 In Year Savings (£k)	Recurring £k (from 21/22)	Delivery Investment
£2,070	£1,963*	£2,070	None noted

**amended to reflect the anticipated impact of COVID-19*

Risk

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
8.1	**Recruitment:** challenges with recruiting and retaining practitioners to roles due to a shortage of available and appropriately trained workforce in the area	Ongoing recruitment and investment in training for staff.	Amber	Amber
8.2	**People:** There will be an increase in the number of roles and changes in the skill mix of the NHS Lothian Primary Care Pharmacy team during 2020/21. The induction and training of these staff will require flexibility from the existing team and increase their workload potentially impacting on the ability to deliver the efficiencies plan.	Ongoing recruitment and investment in training for staff. Existing pharmacy resource will be targeted, using data, to maximise impact.	Amber	Amber
8.3	**Resistance to change:** Plans are built on existing programmes that involve engagement with stakeholders. Capacity within primary care will be the main challenge.	Ongoing recruitment and investment in training for staff. Existing pharmacy resource will be targeted, using data, to maximise impact.	Amber	Amber
8.4	**Financial risk:** Variance in drug costs can lead to increased/decreased levels of savings against those anticipated. The ability to predict these changes is not possible, therefore cannot be built into the plan.	Any identified variance will be raised and discussed at monthly Prescribing Forum with active engagement from stakeholders	Amber	Amber
8.5	**Financial risk:** Prescription item volume is also subject to variance throughout the year and may lead to increases and decreases in spend against projected budget.	NHS Lothian Finance monitor volume and cost trends throughout the year and advise on identified issues via the HSCP Prescribing Forum.	Amber	Amber
8.6	**COVID:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months	Red	Amber
8.7	**Operational priorities of Primary Care:** COVID-19 has necessitated a change in ways of working that are not yet fully understood and efficiency programmes were not seen as a priority during this period of readjustment. This has also resulted in changes in capacity to support new pharmacy staff.	Ongoing engagement and communication with general practice to monitor the ongoing impacts and to inform when efficiencies programmes can resume and capacity to support new pharmacy staff.	Red	Amber

High Level Project Brief: 14. *Community Equipment*

Project Brief

Ensure appropriate Grip and Control of the Community Equipment Service features. The proposed changes for the community equipment function as part of this proposal, sit under 6 key headings:

1. **Equipment Provision**- *Review the criteria for equipment, and what equipment should be available, ensuring that the key priority remains supporting people to leave hospital, prevention of admission and end of life care.*
2. **Processes** – *Undertake cost benefit analysis of recycling, refurbishment, and ensure clearer accountability through devolved budgets. Review of processes to determine what might benefit from automation*
3. **Behaviours** - *Support change in referrer behaviour in line with new criteria, equipment options, and accountability for spend, whilst supporting and managing public expectations about the emerging Edinburgh Pact, encouraging people to help themselves where possible.*
4. **Finances -** *devolvement of budgets to localities and hospitals, supported through improved financial processes and access to data, allowing greater scrutiny and accountability against budgetary spend.*
5. **Communications** - *Clearer communications and tailored messaging about what equipment is available, across wider community settings/on line, and how to access.*
6. **SLAs & Contracts** - *Review of SLAs with other HSCPs, and contracts with suppliers to ensure they remain fit for purpose through appropriate support from service, contracts, finance and procurement*

Appropriate learning gained from the response to the COVID-19 pandemic, when some services had to be paused and others reduced or adapted, and technology solutions optimised, and will be used to inform and shape how the service can sustainably be delivered in the longer term.

Constraints and Assumptions

Constraints:

High level constraints include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.

Assumptions:

High level assumptions include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- SRO will be able to commit to, and be supported in leading this work
- Project and programme management support will continue to be available from the transformation team
- Digital/Automation solution to be applied where possible
- The changes made and lessons learned will be used to inform the wider community equipment service review and redesign as part of the Transformation Programme.

Dependencies

- Successful roll out and implementation of this project will rely on appropriate linkages being made and consistent support with and from key workstreams within the Transformation Programme and Savings Governance projects. In particular integrated working with the development and implementation of:
    - C3.4 The Edinburgh Pact
    - C4.3 Community Equipment Model
    - Home first
    - 3 conversations
    - SDS
- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19

Impact

Strategic Links

Implementation of the changes to the Community Equipment function contributes to the following Strategic priorities:

- Prevention and early intervention
- Person Centred Care
- Managing our resources effectively

High level impacts:

1. *Devolved budgets:* will lead to more sustained grip and control over spend and greater scrutiny and accountability against budgetary spend
3. *Community Equipment Model:* review of equipment and criteria for Community Equipment; streamlining processes and introduction of a 'future proofed' strategy for provision of equipment, will contribute to supporting people to leave hospital, the prevention of admissions and end of life care. Aligned to both the prevention and crisis intervention work streams.
4. *Transformation Programme:* Lessons learned from implementing changes through the Savings Programme, and adaptations from COVID-19 19 will be utilised and help to inform the broader review and reform of the community equipment service which falls under the scope of the Transformation Programme
5. *Edinburgh Pact* - Provide clarity on service and support offering and redefine what statutory services can contribute in terms of preventing crisis, and supporting people to manage their health and personal independence at home
6. *Home First, SDS and 3 conversations*

People (citizens)

Positive

- More efficient processes, clearer criteria for equipment and improved communication
- Opportunity to promote active lifestyles and reduce sedentary behaviour
- Increased choice & control
- More flexible access

Negative

- People potentially having to incur additional costs if they choose to purchase equipment that is no longer provided by the service. Mitigation: promotion of income maximisation opportunities

- Changes to the way equipment is delivered and collected may mean some people have to travel further to collect equipment

People (staff)

Positive

- More efficient processes, clearer criteria for equipment and improved communication
- The provision of a position statement for the community equipment service, will provide clarity consistency and fairness in supporting people to access the most appropriate equipment for them
- Increased training opportunities
- Potential for more flexible working patterns

Negative

- Change in approach may be anxiety provoking for some. Mitigation: communication and training
- Increase in the number of challenging and complex conversations. Mitigation: communication and training

System

Positive

- New and improved mechanisms
- Updated IT systems
- Resources are allocated fairly across the system

Negative

- Period of inconsistency as new systems and processes are implemented, mitigated by communication

Reputational

Positive

- Application of best practice to service delivery and alignment of delivery with that seen across the country

Negative

- Increase in the number of complaints as we deliver new ways of working, mitigation: communication
- Perception that a selective and inequitable service is delivered, mitigation: communication

Benefits

Citizen Benefit

- Consistency in assessment and associated equipment
- Clearer and fairer processes
- Appropriate level of support when required
- Discharge facilitated in a timely manner
- Remaining at home for as long as possible enabled
- Requirements for end of life care supported

System Benefit

- Improved systems and processes
- Improved accountability and transparency of the process including decision making
- Improved reporting, and audit trails

Staff Benefits

- Provision of a position statement for the community equipment service
- Clearer and fairer processes
- Improved awareness and training for referrers
- Co-production of new working patterns in equipment service to enhance productivity

Financial Benefit

- Improved budget grip and control, reducing unnecessary spend
- Improved accountability for spend
- Improved processes for appropriate budget configuration and recharge model

Finances

Financial Savings

The total budget for 2020/21 is £10m.
The anticipated financial savings are laid out below:

Full year target 2020/21 (£k)	Forecast 2020/21 In Year Savings (£k)	Recurring £k (from 21/22)	Delivery Investment
£500	£250	£500	Nil yet identified, to be explored: • Automated systems • New referral processes • Devolved budget processes • Communication • Staff training and awareness

Non-Financial

- Clearer communications and tailored messaging for:
  - public about what equipment is available, across wider community settings/on line, and how to access it
  - referrers about what equipment is available for what circumstances, in line with national benchmarking and new criteria
- Staff training will be delivered (including behaviour change messaging) to support sustained change and continuous improvement

Risk

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
2.1	**Reputational damage:** associated with changing criteria, and altering equipment available	Ensure appropriate linkages are made with Edinburgh Pact Workstream	Amber	Green
2.2	**Resistance to change:** from Locality and Hospital staff regarding new criteria for products, and new budgetary responsibility	Clear and appropriate engagement, communication and training where appropriate. Lessons learned from COVID-19 situation has created condition for change	Amber	Amber
2.3	**Resistance to change:** from Equipment service staff, to new working patterns to improve productivity	Engage and involve staff and trade unions to co-produce new patterns, allow testing, adjustments and continuous improvement. Lessons learned from COVID-19 situation has created condition for change	Red	Amber
2.4	**Change management**: potential impact on equipment service workforce from involvement and supporting change whilst delivering business as usual	Staff support through change management, with transparency of aims indicated. Lessons learned from COVID-19 situation has created condition for change	Amber	Green
2.5	**Change management**: referrers reluctance to change patterns demand, despite better reporting and information on criteria	Clear and appropriate engagement and communication, with transparency of aims indicated. Lessons learned from COVID-19 situation has created condition for change	Amber	Green
2.6	**Change management:** reliance on other partners and HSCPs	Clear and appropriate engagement and communication	Red	Amber
2.7	**Change management:** SRO has not been confirmed for Transformation Programme, and PM redeployed	Proactive discussions about confirming SRO	Red	Amber
2.8	**Change Management:** key challenges associated with engagement and involvement owing to covid-19	continue to glean as much information as possible, and include colleagues where possible	Red	Amber
2.9	**Transition challenges**: ensuing that affected people can access suitable alternatives that meet their needs	Clear and appropriate engagement and communication, and financial assessment, to ensure those who do not have the means are supported	Amber	Green
2.10	**Financial risk:** that the planned efficiencies are not achieved	Effective planning and monitoring process implemented	Red	Amber
2.11	**Financial Risk:** that the devilment of budgets and efficiencies to recharge model are not achieved	Effective engagement and monitoring in process, and benchmarking across the country to achieve best recharge model	Red	Amber
2.12	**COVID-19:** Operational priorities due to COVD-19 mean that it is not possible to implement all the service changes	Operational priorities due to COVID-19 mean that it is not possible to implement the service changes, however lessons learned from COVID-19 situation has created condition for change in other ways	Red	Amber

High Level Project Brief: 15.*Carers Investment*

Project Brief

As part of the EIJBs 2020/2021 Financial Plan, a saving of £900,000 was identified from the Scottish Government Carers' Strategy funding, which had not been committed fully. This was presented to the IJB on 28 April 2020. Owing to the requirement to present a balanced budget, a further decision was made by the IJB on 16 June 2020 to pause the award of Carer Support Contracts due to commence on 1 October 2020, to provide an opportunity to consider all options across the Partnership, to achieve a route to break even.

The project objective is to make a financial contribution to the 2020/2021 break even position for the EHSCP, whilst continuing to:

- Implement actions from Edinburgh Joint Carers Strategy 2019-2022 to ensure carers are well supported and are able to access support.
- Ensure the Local Authority and IJB meet statutory duties set out in the Carers (Scotland) Act 2016 in areas of information and advice, adult carer support plans, and, access to support where carer needs meet defined threshold.

In addition to the previously identified £900k savings, additional financial contributions have been identified, via step one or two below:

Step 1 - Progress with proposed investment in contracted carer supports with a delay to January 2021, reducing some investment activity

Step 2 - Progress with proposed investments in contracted carer supports with a delay to January 2021, and reduce further investment activity

It is recognised that to ensure the sustainable delivery of carer supports that meet carers need, the next stage of the Carers strategy implementation will review and better understand existing replacement care and respite options, identify where gaps exist and develop an financial plan as to how we meet these.

Constraints and Assumptions

Constraints:

- Potential reputational damage, owing to not investing full amount to implement the Strategy
- Potential for trust between providers and EHSCP to be diminished

Assumptions:

- The Partnership will meet statutory duties under Carers (Scotland) Act 2016
- Previously agreed funding for Communities and Families associated with Young Carers will be honoured

- There will be a delay to the contract commencement of 3 months
- Investment in Performance and Evaluation Framework is maintained to ensure we can demonstrate impact, inform next strategy, and guide future service developments
- Core funding for existing block contracts will continue until new contracts commence
- Projected costs are based on expected Carers Implementation Act funding from 2019-2023
- Programme management support will continue to be available via the transformation team

Dependencies

- Availability of resources from commissioning, procurement and contracts to delay and implement new contracts, as required
- Resource Allocation System Transformation work stream will inform any additional demand and spend requirements from the Carers funding stream
- Contracted providers willing to continue working collaboratively and being financially sustainable as a result of any delays to funding
- Grant providers able to continue to extend provision if a delay in the contracted provision coming on line

Impact

The Carers Strategy Funding, and Strategy Implementation Plan, is in line with the following Strategic priorities:

- Prevention and early intervention
- Person Centred Care
- Managing our resources effectively
- Making best use of capacity across the system
- Right care right place right time

Considerations about how carers and the system will continue to benefit, alongside assumed savings and risks for each step is summarised below, with a more detailed risk assessment at the end of this brief. Ned to do more work and will need to bring it back.

The following impacts apply to both:

<u>Step 1</u> - ***Progress with proposed investment in contracted carer supports as close to original timescales as possible (Jan 2021), reducing some investment activity***

AND

<u>Step 2</u> - ***Progress with proposed investments in contracted carer supports as close to original timescales as possible (Jan 2021), and reduce further investment activity***

Citizen Impact

Positive

- Increased choice and access to support for carers
- Increased % of carers feel supported to continue in their caring role (National Indicator 8)

Negative

- Full funding will not be utilised in 2020-21 financial year
- Delay in the provision of services to January 2021

Staff impact

Positive

- Additional training and support for staff
- Access to support for employees that are carers

Negative

- Full funding will not be utilised in 2020-21 financial year
- Delay in the provision of services to January 2021

System Impact

Positive

- Improved confidence and willingness of providers to work with EHSCP.
- Innovation in service delivery supported as part of awarded contracts
- Very high degree of confidence Carers Joint Strategy can be delivered in full
- Very high degree of confidence statutory duties of Carers (Scotland) Act 2015 will be fulfilled
- Not onerous to implement

Negative

- Delay in the increase capacity to support Adult Carer Support Plans, in line with our statutory duty

Reputation

Positive

- Doubling investment in carers support

Negative

- Perception that we are not using the full funding

Benefits

Financial Benefit

<u>Step 1</u> - ***Progress with proposed investment in contracted carer supports as close to original timescales as possible (Jan 2021), reducing some investment activity:***

- Identified uncommitted monies of £900,000 in 2020/2021
- Review of estimated carer payments following analysis of data from testing Adult Care Support Plan and provision of carer payments identified £228,438
- Contribution to Older Peoples Day opportunities (for 2020/21 only) £42,839
- Delay in award of contracts for replacement care/day support to January 2021 identified a further £426,740
- *Additional spend for extension of contracts and transition grants £251,679*
- Total contribution to financial plan for 2020/21 = <u>£1,346,338</u>

<u>Step 2</u> - ***Progress with proposed investments in contracted carer supports as close to original timescales as possible (Jan 2021), and reduce further investment activity:***

- In addition to savings identified in step 1 a further reduction associated with future developments and innovation results in a further £100,000
- *Additional spend for extension of contracts and transition grants £251,679*
- Total contribution to financial plan for 2020/21 = <u>£1,446,338</u>

Finances

Financial Savings

The total carers budget for 2020/21 is £4.1m, plus a sum towards purchasing. The current budget and associated financial plan is laid out below, with the impact of the proposed savings for each step indicated in the following tables:

Step 1

Budget for 2020/21	4,100,208
Spend for 2020/21	2,753,870
Savings/Pressure Breakdown	
Savings	**Apr-Mar**
Identified slippage (already inc within proposed 20/21 EIJB Financial Plan)	780,000
Identified slippage (already inc within proposed 20/21 EIJB Financial Plan) - Contingency	120,000
Estimated Carer Payments generated following completion of ACSP [2]	228,438
Older Peoples Day Opportunities	42,839
Delay to contract start to January 21	426,740
Subtotal Savings/Pressure	**1,598,017**
Additional spend - extension of existing contracts	251,679
Total Savings	**£1,346,338**

Step 2

Budget for 2020/21	4,100,208
Spend for 2020/21	2,653,870
Savings/Pressure Breakdown	
Savings	**Apr-Mar**
Identified slippage (already inc within proposed 20/21 EIJB Financial Plan)	780,000
Identified slippage (already inc within proposed 20/21 EIJB Financial Plan) - Contingency	120,000
Estimated Carer Payments generated following completion of ACSP [2]	228,438
Older Peoples Day Opportunities	42,839
Innovation Fund	100,000
Delay to contract start to January 21	426,740
Subtotal Savings/Pressure	**1,698,017**
Additional spend - extension of existing contracts	251,679
Total Savings	**£1,446,338**

The anticipated financial savings are laid out below:

Step	**Full year target 2020/21 (£k)**	**Forecast 2020/21 In Year Savings (£k)**	**Delivery Investment** *Additional spend for extension of contracts and transition grants*
1	£1,598,017	£1346,338	£251,679
OR			
2.	£1,698,017	£1446,338	£251,679

Risk

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
Step 1: Progress with proposed investment in contracted carer supports as close to original timescales as possible, reducing some investment activity and Step 2: Progress with proposed investments in contracted services, with a delay, and reduce further investment activity				
1.	Providers being unable to fully deliver contracts	All providers have participated in two stage negotiated tender evaluation process and financial assessment as part of procurement process.	Amber	Green
2.	Replacement care options for carers and cared for person are limited owed to contribution to financial plan.	Carer payments resulting from Adult carer support plans could be used to fund replacement care for carers who have eligible needs, continued access for cared for person to respite supports either day or residential. Expected increased funding from Scottish Government could be directed towards replacement care if supported by performance and evaluation outputs	Amber	Amber
3.	Ability of providers and newly formed provider partnerships to continue if contract awards are delayed	Providers have been informed of initial delay, ongoing communication with providers to further understand any impacts of delays	Amber	Green
4.	Impact on young adult carers who may be transitioning from young carers services.	Continue to work closely with Communities and Families and Young carer support providers and existing Young Adult Carer provider to minimise disruption and ensure Young adult carers are support at point of transition	Amber	Green

High Level Project Brief: 16. *Bed Based Review*

Introduction

The bed base review (BBR) project forms part of the Edinburgh Integration Joint Board's (EIJB) Transformation programme. It sits within Programme 3 which is aligned to Conversation 3, Build a Good Life. The project's objectives are to transform and redesign a broad range of bed-based services across all delegated services, taking into consideration demand and capacity and, will design and implement the optimum model for the provision of sustainable bed-based care services. This is a significant ongoing piece of work that will be implemented in phases. However, it is recognised that there is an opportunity to accelerate 2 key component of the BBR as part of the Savings Programme namely:

a. ***Review hospital bed base***
b. ***Review care home provision***

Background

The City of Edinburgh is expanding considerably with one of the highest percentage growth rates in Scotland. This increase creates a larger population with a greater proportion depending on care for multiple complex care needs. The current model of health and social care service provision is not sustainable and must evolve to meet the future challenges and anticipated demand. The Bed Based Review project aims to transform how bed-based services are delivered across the city and examine how the EIJB can create a sustainable delivery model for future generations.

Prior to the COVID-19 pandemic, work had begun on scoping and initiating the Bed Based Review project. The project team had identified the current bed base across the city and a workshop was planned to develop the short, medium and long term actions required to transform the future bed-based provision. Unfortunately, this workshop was cancelled due to the lock down measures that were introduced in March 2020.

Currently delayed discharges are at historically low levels, the roll out of Home First at pace has been widely adopted and there is capacity within our care home system. This offers us an exclusive window, allowing us to proactively redesign our bed base in line with the 3 Conversation ethos adopted by the EIJB. The evolving bed based model for older people is one which looks to reduce acute care bed usage and increase community-based health and social care support, enabling people to remain independent at home, or in a homely setting for as long as possible.

The landscape of the existing EIJB older people's bed base is complex and outdated. Beds are spread across the city in both acute and community settings. There are numerous pathways that refer into these beds and the criteria used to determine where someone should be cared for is applied inconsistently or inappropriately to ensure flow through the system. The environment is also challenging with a number of premises not fit for purpose and due to be decommissioned, increasing the need to move towards a community-based model, where acute services are only used when there is no alternative option.

Project Brief

There are 2 proposals within scope, both of which require further work before a decision can be made:

a. Review hospital bed base

As highlighted above the Bed Based Review is a key project as part of the Transformation Programme. This work will articulate our target bed-based model and provide a detailed plan for moving toward this. This work has been started but is not yet complete.

However, recognising that shorter term, tactical changes are needed, we have, and will continue to progress initiatives including: Home First Edinburgh; the establishment of Integrated Care Facilities; reviewing the use of HBCCC beds; and relevant beds in acute hospitals. Each of these workstreams are being carefully reviewed to ensure they align with our strategic intent.

b. Review care home provision

The Partnership manages nine care homes across the city providing high standards of care to those who are most vulnerable in our society. At present there are c.90 vacancies within the system and, due to COVID-19, admissions have been paused.

From data taken from 2016, the Partnership had a 16% market share of care home capacity. The private and independent sector made up 84% (4% of which was purchased using block contracts). It is recognised that, as the proposal evolves, vacancies may be reconfigured to either HBCCC or IC functions, and that further vacancies could be filled once admissions recommence.

We currently have an opportunity to influence and make changes to our approach more immediately than under normal circumstances. These changes must take the following into consideration:

- There are four care homes within our estate that are not fit for purpose, they have surpassed their design life expectancy and do not meet Care Inspectorate design guidance for building better homes.
- Capital funding needs secured in line with plan for reprovision.
- The need to address the gaps in specialist dementia care and in care provision for those with challenging behaviours

In recognition of the above (and the wider bed based review it is proposed that further work is completed to quickly enable informed, sustainable decisions to be made about the number of care home beds needed and any necessary actions expedited. Therefore, ensuring the most effective and efficient use of resources.

In the longer term these decisions must inform and shape the longer term delivery model of our internal care home provision.

Constraints and Assumptions

Constraints:

The delivery of both proposals outlined above are linked and must be planned for and delivered in a joined up manner.

High level constraints include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual. This will include colleagues in acute settings.

- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.
- Ability to continue to iteratively redesign and deliver services within the context of Scottish Government Guidelines in response to COVID-19 (e.g. physical distancing)]
- Capital resources to support any required reprovision

Assumptions:

High level assumptions include:

- Capacity of people to engage fully with the project, whilst also responding to the consequences of the first wave, and any future waves of COVID-19
- Programme management support will continue to be available via the new transformation

Dependencies

High level dependencies include:

- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19

Impact

Implementation of the changes to the Bed Based Review contributes to the following Strategic priorities:

- Person Centred Care
- Managing our resources effectively
- Making best use of capacity across the system
- Right care, right place, right time

To ensure the appropriate levels of due diligence have been taken across the project, Integrated Impact Assessments would be completed as the proposal are developed. However, at this initial stage, high levels impacts have been identified below

High level impacts;

People (citizens)

Positive

- Reduced length of stay and reduce time spent in hospital based setting
- People supported to live at home or in a homely setting
- Person centred , strengths based approach to their care

Negative

- Change in approach may be anxiety provoking for some

People (staff)

Positive

- Empowered staff
- Cultural change

Negative

- Change in approach may be anxiety provoking for some

System

Positive

- Approach is aligned with Home First a key strategic priority for EHSCP
- More effective service
- More efficient service

Benefits

Citizen Benefit

- Appropriate level of support when required, including bed based care
- Discharge facilitated in a timely manner
- Remaining at home enabled
- Independence maximised

Staff Benefits

- Staff empowered and supported to make decisions in the best interest of the people being supported
- Clearer processes

System Benefit

- In line with strategic objectives – Community based Home First approach;
- Improved flow
- Improved systems and processes
- Appropriate use of beds

Financial Benefit

- Improved overall value
- Spend incurred in the most appropriate setting
- Reduced spend

Finances

Financial Savings

The anticipated financial savings are laid out below:

Proposal	**Full year target 2020/21 (£k)**	**Forecast 2020/21 In Year Savings (£k)**	**Delivery Investment**
a. Review Hospital Bed Base	TBC	TBC	
b. Phase 1 review of Care Home Capacity	£500	£500	To be identified
TOTAL	£500	£500	

Non-Financial

- Right sizing of our bed base will provide an appropriate level of bed based capacity for those who need it but the default being that people are supported to live at home or in a homely setting.

Risk

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
Cross cutting risks				
13.1	**People:** confusion or misunderstanding of how and why new model is being implemented	Clear and appropriate engagement and communication with people and carers	Amber	Green
13.2	**Reputational damage:** service model does not meet existing expectations and perceptions	Ensure appropriate linkages are made with Edinburgh Pact Workstream and equivalent work streams across Lothian	Amber	Green
13.3	**Resistance to change:** by workforce/ stakeholders/ people	Clear and appropriate engagement and communication	Amber	Amber
13.4	**Change management**: pressures on staff from involvement and supporting change whilst delivering business as usual	Staff support through change management	Amber	Green
13.5	**Transition challenges**: ensuing that if appropriate affected people can access suitable alternatives that meet their needs	Clear and appropriate engagement and communication, to ensure those who do not have the means are supported	Amber	Green
13.6	**Financial risk:** that the planned efficiencies are not achieved	Effective planning and monitoring process implemented	Red	Amber
13.7	**COVID-19:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months	Red	Amber

High Level Project Brief: 17. *Additional Purchasing*

Project Brief

To ensure the best use of the purchasing budget and to maximise the benefit to eligible individuals in the most fair and equitable manner possible, within available resources, it is necessary to review and implement appropriate changes.

The key changes to support the proposed Grip and Control, redesign and transformation of the Purchasing Budget are outlined in Appendix 4 of the Savings Programme report, under Project Brief 9: Purchasing Savings. Through the implementation of these proposed changes it is identified that £4.1m could be saved.

However, based on initial data, it is anticipated that there is an opportunity to identify an additional saving within the purchasing budget to contribute to the EIJBS Savings Programme and address the remaining financial gap (currently £3.09m assuming all proposals are agreed and meet their current targets). However, at this point in the year, we do not currently have sufficient data to confirm the current trajectory of the purchasing budget (previously estimated to grow by £8m in year due to demography, but now likely to be less). Therefore, it is proposed that the purchasing target is reviewed at the end of July when the data is available to ensure that this saving continues to be accurate, with an update brought back to the next EIJB meeting.

Constraints and Assumptions

Constraints:

High level constraints include:

- Availability of accurate data to inform the decision making process
- Savings can only be attributed to this additional purchasing proposal once the original £4.1m purchasing target has been achieved
- Capacity of people to engage fully with the project and appropriate changes, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.

Assumptions:

High level assumptions include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual may constrain the benefits realisation of the project, however, this may be mitigated by the identification of appropriate project support
- It is assumed that the purchasing project proposal will be able to deliver its target of £4.1m alongside the delivery of the £3.09m identified within this proposal

Dependencies

- Delivery of the £4.1m purchasing savings proposal alongside the delivery of the £3.09m identified within this proposal
- Future peaks of COVID-19

Impact

Strategic Links

Implementation of the changes to Purchasing contributes to the following Strategic priorities:

- Prevention and early intervention
- Person Centred Care
- Managing our resources effectively
- Making best use of capacity across the system
- Right care, right place, right time

High Level Impact

People (citizens)

Positive

- Best use of purchasing budget to maximise the benefit to eligible individuals
- Provision of care and services in the most fair and equitable manner possible, within available resources.
- Improved consistency and equity in practice
- Person centred care using a collaborative approach which promotes choice and control

Negative

- Increase in the number of challenging and complex conversations
- Period of inconsistency as new systems and processes are implemented, mitigated by communication
- Some people may no longer receive the same level of funding to access the same level of care and support previously provided to them

People (staff)

Positive

- Clarity, support and consistency of practice
- Investment in staff via training, reflective practices and peer support and time to support this
- Cultural change

Negative

- Change in approach may be anxiety provoking for some, mitigated by communication and training
- Period of inconsistency as new systems and processes are implemented, mitigated by communication
- Increase in the number of challenging and complex conversations

System

Positive

- New and improved mechanism
- Resources are allocated fairly across the system
- Move towards Three Conversations as the new norm is aligned with EHSCP strategic intent and the principles of Self Directed Support (SDS)

Negative

- Period of inconsistency as new systems and processes are implemented, mitigated by communication
- Possible increase in delays

Reputation

Positive

- Services are delivered which ensure legal compliance, application of best practice, alignment of delivery with that seen across the country

Negative

- Perception that a selective and inequitable service is delivered, mitigation: communication about implementation of mechanisms

Benefits

Citizen Benefit

- Consistency in assessment and provision of care
- Improved communication
- Appropriate level of support when required
- Person centred and collaborative approach adopted
- Discharge facilitated in a timely manner
- Remaining at home enabled
- Reduced waiting lists

System Benefit

- Improved practice, systems and processes
- Consistency of decision making
- Reduced waiting lists
- Improved accountability and transparency of processes including decision making
- Improved audit trails
- Shift to a prevention approach

Staff Benefits

- Clarity of purpose through the provision of a position statement
- Improved communication
- Increased training
- Increased job satisfaction
- Cultural change

Financial Benefit

- Improved budget grip and control
- Improved accountability for spend
- Reduced spend

Finances

Financial Savings

The anticipated financial savings are laid out below:

Full year target 2020/21 (£k)	Forecast 2020/21 In Year Savings (£k)	Delivery Investment
	£3,090	• Dedicated time from senior managers, budget holders etc • Learning and development programme • Time from people to commit to developing and implementing processes • Finance support • Strategy and Insight support Delivery of other co-dependent work streams

Risk

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
15.1	**People:** confusion or misunderstanding of how and why new model is being implemented	Clear and appropriate engagement and communication with people and carers	Amber	Green
15.2	**Reputational damage:** new service model does not meet existing expectations leading to increased complaints	Ensure appropriate linkages are made with Edinburgh Pact Workstream	Red	Amber
15.3	**Skill and knowledge gap**: inconsistency in the skills, knowledge and confidence of current decision makers and assessors	Staff supported and provided appropriate training and peer support	Amber	Green
15.4	**Resistance to change:** by workforce/ stakeholders/ people	Clear and appropriate engagement and communication	Amber	Amber
15.5	**Change management**: pressures on staff from involvement and supporting change whilst delivering business as usual	Staff supported and provided appropriate training including being supported t through change management	Amber	Green
15.6	**Scale**: the work required does not match the capacity of staff to undertake	Effective planning, allocation and monitoring process developed and implemented	Red	Amber
15.7	**Volatility of the market:** challenges with managing purchasing spend due to the volatility and nature of the market	Consistent, effective planning and monitoring process implemented	Amber	Amber
15.8	**Financial risk:** that we do not achieve the planned efficiencies	Effective planning and monitoring process implemented	Red	Amber
15.9	**Clear vision and leadership**: Inconsistent understanding of the situation and what we are trying to achieve	Consistent, positive messaging and communication. With proactive engagement across all stakeholders Ensure appropriate linkages are made with Edinburgh Pact Workstream	Red	Amber
15.10	**COVID:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months	Red	Amber
15.11	**Inclusive involvement**: purchasing leads are not involved in major strategic workstreams that change the way EHSCP conducts its business, which impact on the purchasing budget and ability to achieve savings target	Purchasing Leads must be involved in all EHSCP major strategic workstreams	Red	Amber

High Level Project Brief: 18.Thrive - *Mental Health & Wellbeing*

Project Brief

The Thrive Edinburgh Adult Health and Social Care Commissioning Plan has 6 commissioning work streams:

1. Building Resilient Communities
2. A Place to Live
3. Get Help When Needed
4. Closing the Inequalities Gap
5. Rights in Mind
6. Meeting Treatment Gaps

This plan identifies the changes we can bring about within this partnership, but recognising the breadth and complexity of factors influencing our mental health. Within each work stream we have set out: our aspirations, what is happening now and what needs to happen in the future to achieve these aspirations.

The mental health service delivery landscape in Edinburgh is complex with a number of delegated services operationally managed (including budgets) by different partners:

- The Royal Edinburgh hospital and Associated Services manage the Mental Health Assessment Service, the Intensive Home Treatment Team, Consultant Psychiatrists (Clinical Psychology and Psychological Therapies), inpatient services, Older People's Rapid Response and Treatment team, the Rivers Centre, Cullen centre and Psychodynamic Psychotherapy.
- Locality Managers are responsible for Community services and their associated budgets, which include Community Mental health teams and Mental Health Officer/ Social Work services.
- EHSCP Strategic leads commission third sector providers across the city to deliver Support at home, supported accommodation and wellbeing services.
- Income generation through external funding agencies for specific programmes.

Efficiencies will be derived from multiple sources, including embedding working practices and specific targeted projects. Generating these efficiencies requires multidisciplinary and cross organisational working between senior operational managers, clinical and professional leads. There are a number of developing spend to save proposals which may require resource transfer from inpatient services and /or across workstreams.

There are 35 Change Programmes within the 6 Workstreams:

	Building Resilient Communities	A Place to Live	Get Help When Needed	Closing the Inequalities Gap	Rights in Mind	Meeting Treatment Gaps
Change Programmes	1 to 3	4 to 9	10 to 16	17 to 21	22 to 26	27 to 35
included in the efficiency programme		4,5,6,7	10,11,12			30,31,32, 33,34

The following **Change Programmes** will feed into the 2021/2 efficiencies target:

- Change Programme 4 - Provide a framework agreement for Wayfinder supported accommodation and support at home services which:
  - increases the ability of providers to respond flexibly to fluctuating levels of need,
  - enables providers to carry out reviews and assessments in defined circumstances where longer term adjustments to the levels of support are required,
  - increases level of flexible and collaborative working between providers and health and social care staff around clusters and localities.

- Change Programme 5 - Technology enabled care service has a major role to play across the Wayfinder model. We need to accelerate our efforts, making maximum use of the opportunities afforded by Digital Health Scotland.

- Change Programme 6 - Provide additional Wayfinder Grade 5 intensive rehabilitation in community settings for women with multiple and complex needs.

- Change Programme 7 - Provide Wayfinder Grade 5 facility for people who require high level support and treatment on a long term basis in an environment which provides support for meaningful days and person centered choices

- Change Programme 10 - Introduction of open access "Thrive" centres across the city with multi agency and multi professional team input, offering brief assessment and formulation leading to a jointly agreed plan with the client regarding next steps.

- Change Programme 11 - Refreshed DCAQ Improvement and investment plans to improve access to psychological therapies, this links to the development of Thrive Centres.

- Change Programme 12 - Build on the model established by Street Assist with our partners in Police Scotland, NHS Unscheduled Care Services, the Scottish Ambulance Service, NHS 24, Social Care Direct, Community Safety Partnership and the Chamber of Commerce to create a safe out of hours place where people who are intoxicated or vulnerable can be kept safe and if appropriate linked into support and services.

- Change Programme 30 - Integrate Positive Steps and Edinburgh IHTT to increase capacity to respond to people, enabling earlier discharge and reducing the number of unplanned admissions and length of stay in acute settings.

- Change Programme 31 - Open in spring 2020, a Grade 5 step up/step down resource for people who require short term stay to avoid admission to hospital setting or to facilitate earlier discharge from acute care.

- Change Programme 32 - Commission and implement the matched care model for women with multiple and complex needs, building on the successful Willow informed model, increasing day place, residential places and training and support and case management across community and inpatient settings.

- Change Programme 33 - Edinburgh will require 15 inpatient beds for people requiring low secure provision and 18 inpatient beds for people requiring rehabilitation to be reprovided in fit for purpose accommodation as part of the Business Case for Royal Edinburgh Hospital Redesign Phase 2. Hospital beds are essential for people for whom the process of assessment, treatment or risk management cannot be safely or effectively be delivered in any other setting.

- Change Programme 34 - Continue to commission 64 acute admission and 7 intensive psychiatric care beds at the Royal Edinburgh Hospital.

- Change Programme 35 - Ensure that young people receiving support for their mental health experience a smooth transition to adult services if this is required. The transition should be considered as part of the individual's person centered outcomes and care plan rather than solely based on calendar age.

It is important to note that the Change Programmes are interconnected and there may be redeployment of resource from one programme to another.

Due to the impact of the COVID-19 pandemic a number of workstreams have been paused/ delayed, specifically:

- Change Programme 12 – due to lockdown and the shutdown of the night-time economy
- Change Programme 30, 31 and 32 – Social distancing and prioritising staff for essential service provision has impacted on the ability to engage with the necessary wide range of stakeholders.

Moving into phase 2 of COVID-19 response will enable engagement to resume.

Constraints and Assumptions

Constraints:

High level constraints include:

- Capacity of people to engage fully with the change programmes as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst still delivering business as usual
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.

Assumptions:

High level assumptions include:

- Strategic programme budget approach is taken and there is potential to shift resource between organisations and programmes

Dependencies

Funding awards from the Scottish Government are made to previously stated levels.

Impact & Benefits

Strategic Links

Delivering efficiencies within mental health and wellbeing programme contributes to the following Strategic priorities:

- Making best use of capacity across the system
- Managing our resources effectively
- Right care, right place, right time
- Person Centred Care

High level impacts:

In line with the Thrive values:

- We make shared decisions and value peoples skills and experiences
- We always work collaboratively with a flattened hierarchy
- We always build trust and foster empathetic and honest relationships
- We are always person centred
- We show kindness and compassion and treat people with respect and dignity
- We always start with people's strengths and build on these
- We always engage people as citizens in their community and embrace the whole person
- We give permission to try new things, adapt, and learn
- We deeply believe our people are our greatest assets
- We always treat people as equal partners

An Integrated Impact Assessment (IIA) will be completed for each Change Programme.

Programmes are underpinned by robust evidence and research with the voices of people with lived experiences at the centre of change programme.

Thrive has a clear outcomes – key performance indicators for each change programme will be delivered in line with the 6 person outcomes and 3 system wide outcomes.

Citizen Benefit – Thrive Outcomes

- People have choice and control
- People are recovering, staying well and can live the life they want to lead
- People feel connected and have positive relationships
- People are living in settled accommodation of their choice where they feel safe and secure
- People have opportunities to learn, work and volunteer
- People receive good quality, person-centred help, care and support.

System Benefit – Thrive Outcomes

- Timely access to high quality person centred help and support when and where it is needed
- Reduced levels of mental and emotional distress
- Reduction in unplanned and crisis health and social care utilisation, including emergency response as well as institutional placements.

Financial Benefit

- Efficient use of resources
- Reduced spend

Finances

Financial Savings

The anticipated financial savings are laid out below:

Full year target 2020/21 (£k)	Forecast 2020/21 In Year Savings (£k)	Recurring £k (from 21/22)	Delivery Investment
	£300	TBC	

Risk

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
14.1	**Recruitment:** challenges with recruiting and retaining practitioners to roles due to a shortage of available and appropriately trained workforce in the area	Ongoing recruitment and investment in training for staff.	Amber	Amber
14.2	**People:** There will be an increase in the number of roles and changes in the skill mix of the team during 2020/21. The induction and training of these staff will require flexibility from the existing team and increase their workload potentially impacting on the ability to deliver the efficiencies plan.	Ongoing recruitment and investment in training for staff.	Amber	Amber
14.3	**Resistance to change:** as we are considering whole system change in a number of the programmes this may present challenges on many different levels.	There has been widespread engagement in the development of Thrive.	Amber	Amber
14.4	**Financial risk:** The Partnership does not have operational and financial responsibility for all of the budgets included within this programme	There has been widespread engagement in the development of Thrive. This and regular communication with all stakeholders will continue during implementation.	Amber	Amber
14.5	**Financial risk:** Difficulty in reaching agreement to shift resources both from hospital to community settings and across organisational boundaries	Demonstrate intended impact of change. Mandate and support for change from wide group of stakeholders in line with strategic commissioning plan.	Red	Amber
14.6	**COVID:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes and engage as comprehensively with stakeholders	Close monitoring throughout the coming months and employ different mean and approached s to ensure engagement.	Red	Amber

High Level Project Brief: *19. Medical Day Hospital Review*

Project Brief

Undertake a review of Medical Day Hospitals:

- Identify and determine the future function, demand and capacity required for medical day hospitals. This will include developing a consistent and fair framework for how day hospitals services will function.
- Within this context we will then be able to determine the unique role, and proportionate demand for day, given the associated growing re-enablement and rehabilitation support in the wider community.

Appropriate learning gained from the response to the COVID-19 pandemic, when some services had to be paused and others reduced or adapted, will be used to inform and shape how the service can sustainably be delivered in the longer term.

Constraints and Assumptions

Constraints:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.
- Delays in ability to engage, and achieve the data required to confirm baseline activity, owing to COVID-19
- The shielding list has grown in the Lothians. In Edinburgh the list started at c7,500, and at the end of May was just under 13,000. The majority of growth being added is to group 7 - anyone leaving hospital where there is a clinical view that they are at higher clinical risk, or a GP thinks that they are at higher clinical risk and should be added to the list. Depending how significantly this list increases, there could be a proportionate implication for the demand on MDH services, and what alternative care provision is available for this cohort of people, particularly if physical distancing restrictions remain in place.
- The role of the Royal Victoria facility has been utilised as a COVID-19 triage Hub, and may continue to play an ongoing role, outwith Medical Day hospital function
- Delays in ability to engage, and achieve the data required to confirm baseline activity, owing to COVID-19. The proposals developed will be subject to the evolving landscape of both clinical and political guidance from Health Protection Scotland and the Scottish Government respectively
- Co-dependent work streams in the wider transformation programme that may impact on timings for change to occur

Assumptions:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- Project and programme management support will continue to be available via the transformation team
- Digital/Automation solution to be applied where possible

- The decisions made are dependent on evidence gathered to analyse the current state of medical day hospital delivery
- There is a desire, and opportunity to resume Medical Day Hospitals to the new service model, rather than reverting service provision back to pre-COVID-19 state. In light of this, the project needs to be conducted in a more fluid way to ensure decision making is accelerated whilst ensuring there is an ongoing continuous improvement and refinement approach
- The decisions made are dependent on evidence gathered to analyse the current state of medical day hospital delivery
- Recognition the growing population of older people with in Edinburgh and will have greater complexity of need in the future.

Dependencies

- Successful roll out and implementation of this project will rely on clear and consistent support with and from other Savings Governance and Transformation projects, mainly
- Successful roll out and implementation of this project will rely on appropriate linkages being made and consistent support with and from key workstreams within the Transformation Programme and Savings Governance projects. In particular integrated working with the development and implementation of:
    - C1.1 Community Investment & Prevention,
    - C1.3 Community Frailty Services,
    - C1.5 Three conversations,
    - C2.1 Home First.
    - C3.4 The Edinburgh Pact
- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19
- The availability of medical day hospital facilities to resume care provision for frail and elderly patients. The ARC has currently (June 2020) been repurposed as a community hub during the COVID-19.
- Digital capacity capability, (e.g. band width for reliability of Near Me utilisation)
- Availability of diagnostics for ambulatory care functions
- The overall falls pathway featured in the chat as a key dependency to get people to the right place for the right intervention. There are a number of pathways that will spur off this work, this being one of them.
- There is a co-dependency with aligning the outputs of this project with the outcomes of the tech-enabled care and Scottish Route map project where relevant.

Impact & Benefits

Strategic Links

Implementation of a review of Medical Day Hospitals contributes to the following Strategic priorities:

- Prevention and early intervention
- Person Centred Care
- Managing our resources effectively
- Making best use of capacity across the system
- Right care right place right time

High Level Impacts

- Day hospitals will be used for the identified and agreed functions
- Opportunity to create a fair and consistent framework for day hospital service delivery, including standard operational procedures (SOP) across locations

- Reframe and reshape people's expectations about what day hospital services can provide through the central framework (where appropriate links will be made to align this work with the Edinburgh Pact)
- Develop more meaningful relationships with the people who use day hospitals and the wider community they interact with
- Fair and consistent accessibility and referral criteria
- Support people to access the right services in the right place at the right time

People (citizens) Impact

Positive

- Fair and proportionate service
- There will be the opportunity for people to become more aware of what community support is available in their local area
- Opportunity for closer conversations with individuals to find more personalised options for ongoing rehabilitation support, where this is the identified need
- There may be scope that alternative support services may be available closer to home
- Opportunity to increase promotion and access to physical activity and life skills through the promotion of the most appropriate community services

Adverse

- There could be some anxiety or fear associated with change as the service provision is adapted. This will be mitigated by understanding citizen's needs and using this information as evidence for any new model as well as relevant engagement.

People (staff)

Positive

- staff will have an opportunity to inform and shape the new services
- There will be the opportunity for people to become more aware of what community support is available in their local area
- Opportunity for closer conversations with individuals to find more personalised options for ongoing rehabilitation support, where this is the identified need
- Develop more meaningful relationships with the people who use day hospitals and the wider community they interact with
- Reframe and reshape people's expectations about what day hospital services can provide through an agreed consistent framework

Adverse

- There could be some anxiety or fear associated with change as the service provision is adapted. This will be mitigated by understanding staff's roles and involving them in the process of defining what a new model could look like.

System

Positive

- The approach is aligned with Home First a key strategic priority for EHSCP
- Identify the unique function of the medical day hospital, and its relationship with the acute experience, and wider community supports
- Develop and determine a consistent and fair approach for medical day hospitals across the City of Edinburgh
- Reduce variation of operational, management and specialist function services, where possible
- Resources are allocated fairly across the system
- Increased connections across sectors and increased awareness of community services that are available

Reputation

Positive

- Develop and determine a consistent and fair approach for medical day hospitals across the City of Edinburgh
- Reduce variation of operational, management and specialist function services, where possible

Adverse

- Perception that a selective and inequitable service is delivered, mitigation communication of service redesign (Ensure appropriate linkages are made with Edinburgh Pact Workstream)

Benefits

Citizen Benefit

- There will be a consistent and fair approach for medical day hospitals across the City of Edinburgh
- Clarity on, and improved experiences available to meet different levels of need, with least intensive options being promoted
- Promotion of Home First principles will allow people to be cared for in the most appropriate environment
- Access to the right support, in the right place at the right time to prevent or delay the need for admission to hospital or care home by offering proportionate, personalised medical, rehabilitation and re-ablement support

System Benefit

- Identify the unique function of the medical day hospital, and its relationship with the acute experience, and wider community supports
- Overall clarity on when and how to access these functions for person centred care
- Reduction in variation of operational, management and specialist function services, where possible and the opportunity to create internal mechanisms for greater quality assurance

Staff Benefits

- Opportunity to change the culture internally and staff to learn more about additional and alternative support services within their local area
- Potential to develop more meaningful relationships with the people who use day hospitals and the wider community they interact with

Financial Benefit

- Anticipated reduced spend

Finances

Financial Savings

The anticipated financial savings are laid out below:

Full year target (£k)	Forecast 2020/21 In Year Savings (£k)	Recurring £k (from 21/22)	Delivery Investment
£200	£0	TBC	Not yet determined. Potential for investment in wider community rehabilitation and reablement supports

It is recognised that the alterations in place for delivery of day hospital functions as a result of COVID-19, provides an opportunity to more clearly understand the alternatives across the wider community that are providing support for people during this crisis situation. This learning needs to be captured and fed into the options appraisal process going forward.

The ability to engage with the various professions, who provide the medical day hospital function and interventions, is reduced during COVID-19, owing to people responding to the acute hospital demand.

Risks

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	**Inherent RAG**	Residual RAG
4.1	**People:** ensuring people's needs are met on an ongoing basis in the right place by the right people	Clear and appropriate engagement and communication Once determined, communicate aims, objectives and expected impact on outcomes of Medical Day Hospital provision clear	Amber	Green
4.2	**Reputational damage:** associated with the potential perception of 'loss' of service	Ensure there is a clear communication strategy about the variety of wider community supports that will met a variety of rehabilitation and re-ablement needs Ensure appropriate linkages are made with Edinburgh Pact Workstream	Amber	Green
4.3	**Resistance to change:** by workforce/ stakeholders/ people	Clear and appropriate engagement, involvement, and communication	Amber	Amber
4.4	**Change management:** potential impact on workforce from involvement and supporting change whilst delivering business as usual	Staff support through change management	Amber	Green
4.5	**Transition challenges:** ensuing that affected people can move to the suitable alternatives that meets their needs	Clear and appropriate engagement and communication	Amber	Green
4.6	**Financial risk:** that we do not achieve the planned efficiencies, particularly if community investments in rehabilitation and reablement are required	Effective planning and monitoring process implemented	Red	Amber
4.7	**COVID-19:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months	Red	Amber
4.8	**Community capacity:** should the service model focus more towards community care there is a potential risk that community and outreach services could be overwhelmed due to increase in demand	Clear and appropriate engagement and communication with community and outreach services to understand how an increase in demand could sustainably be accommodated	Red	Amber
4.9	**COVID-19:** Medical Day Hospital environments as they are currently configured are not able to support physical distancing whilst responding to the service demand as services resume	Consideration and planning in line with Scottish Government guidelines to ensure any physical facilities are safe for those who use them	Amber	Green

High Level Project Brief: 20. *EADP – Social Care Investment Fund*

Project Brief

Following the increased investment by the Scottish Government in ADPs referred to as the "Seek, Keep and Treat", £1.4m of which was provided to Edinburgh, it is intended to recover the £420k Social Care Funding Investment agreed by the IJB in March 2017, provided at a point at which the Scottish Government had reduced funding to Alcohol and Drugs Partnerships (ADPs).

EADP considered the request with an understanding of the current pressures on core services and their targets/performance, as well as the expectation to deliver enhanced and assertive outreach with new monies.

Because of the need to protect SKT investment, this project seeks to complete a review of the provision of counselling and residential rehabilitation services, to identify and understand the implications and associated risk. Young people's services are not being considered due to the level of investment, giving the redesign proposals time to deliver.

Constraints and Assumptions

Constraints:

High level constraints include:

- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- COVID 19 has resulted in digital only, or no service in terms of counselling and residential rehabilitation
- COVID-19 has created unknown service demand for ADP services, therefore current needs analysis on which planning and strategic decisions are based may no longer be accurate
- Risks associated with proposed changes (see Section 4: Risk & Impact) regarding staff, services provided and the people who use these services.

Assumptions:

High level assumptions include:

- Recent additions of the EADP commissioning team will be able to support this work
- Capacity of people to engage fully with the project, as well as responding to the consequences of the first wave, and any future waves of COVID-19, whilst also delivering business as usual
- Programme management support will continue to be available via the new transformation team
- Staff are able to adapt to new ways of working (e.g. utilising and embedding technology into practice)
- Stakeholder buy in to support change
- The broader system is able to flex and adapt to respond to the demand for services

Dependencies

- Stakeholder buy in to support change
- Scottish Government guidance on managing COVID-19
- Future peaks of COVID-19
- The implementation of Edinburgh Pact will be progressed to ensure clarity of services understanding and capacity to manage expectations

Impacts

Strategic Links

Implementation of a review of EADP services has the potential to contribute to the following Strategic priorities:

- Managing our resources effectively
- Making best use of capacity across the system

High level impacts:

The high-level impacts include:

People (citizens)

Negative

- Reduced choice for people about the services that they can access e.g. no or limited access to single gender placements
- Increased risk to those most vulnerable to the greater harm
- Increased number of families living with people with active addiction
- Increased stress, strain and anxiety on carers and families
- Further work will need to be done to explore any impact of these savings on drug related deaths

People (staff)

Negative

- Uncertainty of future roles for staff that deliver residential rehabilitation and counselling services, which will cause stress and anxiety (at this stage it would be hard to predict the full impact)

System

Positive

- Support opportunities to look at how counselling services could work more closely together

Negative

- Reduction in service delivery (up to 50%)
- Increased pressure on other areas of the system (including a likely increase on emergency hospital admissions)
- Reduced vitality and therefore impact of the recovery community

Reputation

Positive

- Best value principles applied

Negative

- A risk that national drive to increase capacity and outreach is not matched locally
- Recovery community affected in terms of payback and motivation to recover
- Volunteer counsellors demoralised by disinvestment

Benefits

System Benefit

- Consideration will be given to ensuring that resources and services across the system are available and where appropriate utilised to support people

Financial Benefit

- Anticipated reduced spend

Finances

Financial Savings

The anticipated financial savings are laid out below:

Full year target 2020/21 (£k)	Forecast 2020/21 In Year Savings (£k)	Recurring £k (from 21/22)	Delivery Investment
£420	£105	£420	None identified

Risks

Risk ID	Description of Risk/ Issue	Summary of Action taken to Mitigate	Inherent RAG	Residual RAG
7.1	**People:** Removal of preventative and harm reduction interventions negatively impacting on individuals and family's health and wellbeing across Edinburgh communities and those in custody	Service priorities will be reviewed and will be based on greatest health risks and need Recognise and utilise whole system services	Red	Amber
7.2	**People:** Limited/ reduction of support for carers	Carers assessments utilised to prioritise interventions	Amber	Amber
7.3	**Financial risk**: Value for money interventions using volunteer counsellors de-invested in.	Understanding and taking a whole system approach that enable volunteers' counsellors to continue to deliver through other parts of the system	Amber	Amber
7.4	**Reputational damage**: new service model does not meet existing expectations	Ensure appropriate linkages are made with Edinburgh Pact Workstream	Red	Amber
7.5	**Reputational risk:** lack of political support for proposed changes	Clear and appropriate engagement and communication	Red	Green
7.6	**Resistance to change**: by workforce/ stakeholders/ people	Clear and appropriate engagement and communication	Red	Green
7.7	**Service risk:** Pressures not removed, but placed on other parts of the system	Review will include detail of the consequence and management of these risks on other parts of the system	Red	Amber
7.8	**Financial risk:** that we do not achieve the planned efficiencies	Effective planning and monitoring process implemented	Red	Amber
7.9	**COVID:** Operational priorities due to COVD-19 mean that it is not possible to implement the service changes	Close monitoring throughout the coming months	Red	Amber

Appendix 6: Savings Programme IIA

Section 4 Integrated Impact Assessment

Summary Report Template

Each of the numbered sections below must be completed

Interim report	✔	Final report		(Tick as appropriate)

1. Title of plan, policy or strategy being assessed

Edinburgh Health and Social Care Partnership (EHSCP) Savings Programme 2020/21

2. What will change as a result of this proposal?

To support the delivery of a balanced budget for the 2020/21 financial year the EHSCP has developed a comprehensive Savings Programme. Included within the programme are twelve different proposals.

These proposals are being developed to help:

- Achieve a balanced budget
- Improve efficiencies in service delivery
- Allow for continuous improvement of services
- Move forward and support the principles of the Strategic Plan
- More effectively target resources

All changes are ultimately driven by the strategic plan, which aims to support the sustainable delivery of services for all in our communities, now and in the future. Through the most efficient and effective use of resources it is anticipated that financial benefits and savings will be realised and an equalisation of services seen.

The Savings Programme and the proposals that sit within it will take on board national guidance as well as feedback from people themselves

This Cumulative IIA provides an opportunity to review collectively, the equality impact of the proposals on the population of Edinburgh. It provides a level of assurance that a robust, interactive consideration of potential impacts has taken place. As well as providing an overarching strategic perspective of how projects link together, this process is helping to ensure that work is not progressing in silos. The IIA also highlights any interdependencies between projects and work streams, within the savings programme and the EHSCPs wider transformation schemes of work.

3. Briefly describe public involvement in this proposal to date and planned

The proposals align with the intentions and intended strategic direction laid out within the EIJB Strategic Plan 2019-22. Extensive engagement was integral to the Plan's development, including significant public and stakeholder engagement, consultation and feedback.

There has been no overarching public engagement around budget proposals although several budget proposal workshops involving IJB members, including elected members and non-executive NHS Board members have taken place. Some proposals are in the early stage of development and any project specific engagement which has taken place to date is noted in each IIA report. Proposed future engagement is noted within each IIA and an overarching communication plan will be developed.

4. Date of IIA: 8th April 2020

Following the cumulative IIA meeting on the 8th April, additional IIAs for savings proposal have been completed and relevant information included in the report below.

5. Who was present at the IIA? Identify facilitator, Lead Officer, report writer and any partnership representative present and main stakeholder (e.g. NHS, Council)

Name	IIA role	Job Title	Date of IIA training
Moira Pringle	Lead Officer	Chief Finance Officer	
Katie McWilliam	Savings Proposal Lead Rep	Strategic Planning & Quality Manager - Older People & Carers	2009
Jenny McCann	Facilitator & Report writer	Programme Manager – Savings	16/03/20
Rachael Docking	Note taker	Programme Manager – Transformation	30/01/20
Sarah Bryson	Note taker	Strategic Planning & Commissioning Officer	Nov 2017

6. Evidence available at the time of the IIA

Evidence	Available?	Comments: what does the evidence tell you?
Data on populations in need: *Strategic needs Assessment City of Edinburgh HSCP (2015)* *Edinburgh HSCP Joint Strategic Needs Assessment: Health and Care Needs of People from Minority Ethnic Communities (April 2018)* https://www.edinburghhsc.scot/wp-content/uploads/2020/03/JSNA-Health-Needs-of-Minority-Ethnic-Communities-Edinburgh-April-2018.pdf *Edinburgh Integration Joint Board Strategic Plan (2019-2022)*	Yes	Provides supporting information for understanding the demographics of the wider population in the City of Edinburgh (*https://www.edinburghhsc.scot/wp-content/uploads/2020/01/Joint_Strategic_Needs_Assessment.pdf* Provides an understanding of what contributes to poor health and wellbeing and the barriers and challenges to seeking and obtaining support (many being interrelated). The report includes an overview of the main contributors, from the perspective of people in minority groups and people involved in supporting them. These include: • The impact of discrimination and racism • Language barriers and literacy issues - affecting access and engagement • Poverty and low socio-economic status • Social isolation • Culture and religion-specific issues which impact on health-seeking behaviours • Stigma e.g. of mental health issues • Impact of trauma and crisis in home country e.g. asylum seeks • Interaction with the health care system – expectations versus reality. Actions highlighted as needed to address these include: • Staff training including cultural sensitivity • Recognition of the role of the Third Sector • Effective community engagement • Developing effective approaches to prevention including overcoming isolation. Details the Strategic direction of the EHSCP https://www.edinburghhsc.scot/wp-content/uploads/2020/01/Strategic-Plan-2019-2022-1.pdf
Data on service uptake/access	No	

Evidence	Available?	Comments: what does the evidence tell you?
Data on equality outcomes: *Individual Savings Proposals IIAs*	Yes	Completed/Interim IIAs for the following savings proposals (will be available here: https://www.edinburghhsc.scot/the-ijb/integrated-impact-assessments/) provide details of identified impacts that may come from the implementation of the proposed changes: 1. Home First 2. Community Equipment 3. Day Services and Be Able 4. Learning Disability Savings (a, b & d) 5. External Housing Support – Older People 6. Purchasing 7. Prescribing 8. Hospital based Rehabilitation Services 9. Sexual Health Services 10. Carers Contracts
Research/literature evidence	No	
Public/patient/client experience information	No	
Evidence of inclusive engagement of service users and involvement findings *Edinburgh Integration Joint Board Strategic Plan (2019-2022)*	Yes	Details consultation completed with stakeholders about the EIJB Strategic Plan: https://www.edinburghhsc.scot/wp-content/uploads/2020/01/Strategic-Plan-2019-2022-1.pdf
Evidence of unmet need *Edinburgh Integration Joint Board Strategic Plan (2019-2022)*	Yes	Details the health needs and priorities for the people of Edinburgh https://www.edinburghhsc.scot/wp-content/uploads/2020/01/Strategic-Plan-2019-2022-1.pdf

Evidence	Available?	Comments: what does the evidence tell you?
Good practice guidelines	No	
Environmental data	No	
Risk from cumulative impacts *Savings Programme Cumulative IIA Evidence Document*	Yes	Document presents all identified impacts (positive and negative) for all the IIAs together, providing a cumulative overview of the impacts across all the proposals. Highlights that particular attention should be given to the impact on older people, those with a disability and carers.
Other (please specify)	N/A	
Additional evidence required	N/A	

7. In summary, what impacts were identified and which groups will they affect?

Equality, Health and Wellbeing and Human Rights	Affected populations
An overview of the individual IIAs highlights that the main groups of people who may be impacted by the proposals, both positively and negatively, are older people and people with disabilities.	Older people and people with disabilities
Focus of the proposals are on providing alternative ways in which people's needs can be met to help ensure services are provided in the right place, at the right time and in the right way	All those that receive services, but in particular Older people and people with disabilities
Positive Opportunities for improvement in services which will focus on better outcomes for people and take a person-centred approach to delivery	All those that receive services, but in particular Older people and people with disabilities
Move to alternative arrangements/model which may include; encouragement of SDS for example and encouragement of a person-centred approach	All those that receive services, but in particular Older people and people with disabilities
More equitable and increased fairness across system which is the correct principal e.g. moving to a mechanism for older people which is already applied to those with mental health issues and those with disabilities (Housing Support and Intensive Housing Management)	All those that receive services

Changes will provide a level of support which we can afford and so increase sustainability	All those that receive services
Opportunities for greater choice and independence in-line with policy through increased use of SDS, personalised service and individual approach	All those that receive services
Opportunities that actively promote life skills and physical activity, which will likely positively impact on individuals independence and confidence	All those that receive services
Build family support networks, resilience and community capacity	All those that receive services, but in particular Older people and people with disabilities
Supports the adoption of a whole system approach wherever possible, enabling professionals to indentify the breadth of services that may support someone and discouraging silo working facilitating better outcomes for people	All those that receive services, but in particular Older people and people with disabilities
There may be opportunities for more flexibility of working hours in some settings and skills development/career development opportunities.	Staff
There is an opportunity to incorporate technological solutions to aid and provide flexible access to service delivery	All those that access services
Clarity of way forward	Staff
Improved consistency and equity in practice and application of existing policy	Staff
Negative	
Perceived loss as a result of change to services, despite many transitioning to different model/approach or provider, for instance, day services for older people being re provided by the third sector.	All those that receive services, but in particular Older people and people with disabilities
Transitional arrangements have been identified to mitigate any potential negative impact as a result of service changes, however the disruption and change, still have the potential to be anxiety provoking,	All those that receive services, but in particular Older people and people with disabilities
Potential increase burden place on carers/women(higher proportion of carers are women)	Women and carers
Consultation about changes and or information provided about the changes to services is either not clear to all individuals, is not fully understood or does not reach them	Staff, those with learning disabilities, those with literacy issues and those for whom English is a second language
People may have to pay for service that previously they did not have to	Older people, people with disabilities, those at risk of

	falling into poverty or those in poorly paid jobs
Those with poor health literacy skills, language difficulties and those with limited or no digital skills or with less online access will be considered whilst developing any technology enabled services or any move to a more self-managed care approach.	Those with poor literacy skills; those for whom English is not as a first language, and those with less access to digital technology
Consideration of digital first approach (in line with Health and Social Care strategic intent Nationally, regionally and locally) may create anxiety for staff for whom this will be a new approach and may not be confident and comfortable with utilising technology within their practice.	Staff
Changes in approach and an increase in the number of challenging and complex conversations which may provoke increased levels of stress and anxiety and lead to a potential decrease in moral	Staff

Environment and Sustainability	**Affected populations**
The Strategic Plan 2019-22 commits EHSCP to working with its partners to support the development of the city's new sustainability strategy for 2030 – pg 21 - https://www.edinburghhsc.scot/wp-content/uploads/2020/01/Strategic-Plan-2019-2022-1.pdf **Positive** None **Negative** None	

Economic	**Affected populations**
Positive Improved quality and access to services: by implementing efficiencies, service improvements and savings, we are ensuring that those who really need services can continue to access them	All those that access services
Changes ensure the long term sustainability of services. By prioritising resources and maintaining our focus on better outcomes for people, we can ensure we deliver effective and efficient services for all	All those that access services
Negative None	

8. Is any part of this policy/ service to be carried out wholly or partly by contractors and how will equality, human rights including children's rights , environmental and sustainability issues be addressed?

Yes, a number of the proposals cover services that will be delivered by contractors. In line with procurement regulations, the formal contracts detail the requirements to comply and adhere to equality, human rights, environmental and sustainability issues. Further detail can be found in the individual IIAs.

9. **Consider how you will communicate information about this policy/ service change to children and young people and those affected by sensory impairment, speech impairment, low level literacy or numeracy, learning difficulties or English as a second language? Please provide a summary of the communications plan.**

A robust overarching communication strategy will be developed and implemented as well as individualised communication plans for each proposal. All communications plans/ strategies will include specific information for patients, unpaid carers, staff and wider stakeholders and will include consideration of easy read and dementia friendly versions, BSL, Braille, hearing loop, information on screens, audio signage, and use of Happy to Translate. Consideration will also be given to health literacy and the use of different mediums and channels for sharing information.

Feedback from ongoing communication with stakeholders will inform the wider Savings Programme as well as the transformation programme (in particular the Edinburgh Pact).

10. **Does the policy concern agriculture, forestry, fisheries, energy, industry, transport, waste management, water management, telecommunications, tourism, town and country planning or land use?** If yes, an SEA should be completed, and the impacts identified in the IIA should be included in this.

No

11. Additional Information and Evidence Required

If further evidence is required, please note how it will be gathered. If appropriate, mark this report as interim and submit updated final report once further evidence has been gathered.

None noted

12. Recommendations (these should be drawn from 6 – 11 above)

Develop and implement:

- A robust overarching communication strategy for the whole programme*
- Individualised detailed & comprehensive communication plans for each*

  * *Both to include clear briefings for councillors and broader stakeholders (link with Edinburgh Pact)*

Support and manage public expectations through the emerging Edinburgh Pact, encouraging people to help themselves where possible and ensuring there are feedback mechanisms in place for people to inform how things might improve further Appropriate engagement, involvement, appropriate consultation and feedback processes should be considered and applied prior to any changes being implemented

Ensure appropriate processes, procedures, support, and where appropriate training are in place to support EHSCP staff, wider staff groups and providers, when they are informed of any decisions or changes

Support the change, and continuous improvement culture change via:

- Strong leadership
- Supportive, but robust management
- Ensuring consistent approaches to promote the changes and improvement

Ensure training and or communication to staff about support available to people to maximise their income/benefits e.g. welfare rights or citizens advice for support, and where relevant provide details of referral processes

Monitor expansion of support for carers via the Carers Strategy Implementation Plan, and Performance Framework

In line with the ongoing work of partnership and as a strategic priority identified within the EHSCP Strategic Plan, more robust consideration must be given to reducing health inequalities

Ensure ongoing monitoring of the impact of the changes on the market, ensuring two way communication, whilst being cognisant that we are operating in an ever changing environment and that we cannot anticipate the landscape post COVID-19 nor any changes that may be necessary.

Without progressing with these proposals we will not be able to ensure sustainable, effective and efficient delivery of services for all, nor ensure that better outcomes for people will consistently be achieved.

That a digital first approach is considered and implemented where appropriate but that appropriate mitigations are considered to avoid any negative impact for:

- *People*: via the continuation of face to face services where appropriate
- *Staff*: ensure appropriate communication, training, peer support (within and beyond service) and ongoing feedback opportunities are implemented alongside any moves towards a digital first approach

13. Specific to this IIA only, what actions have been, or will be, undertaken and by when? Please complete:

Specific actions (as a result of the IIA which may include financial implications, mitigating actions and risks of cumulative impacts)	**Who will take them forward (name and contact details)**	**Deadline for progressing**	**Review date**
Develop and implement a robust overarching communication strategy for the whole programme (including stakeholder briefings where appropriate)	Jenny McCann	July 2020	September 2020
Develop and implement a Individualised detailed & comprehensive communication plans for each proposal. Ensure consultation processes and support during transition and included (including stakeholder briefing)	Savings proposal leads	August 2020	October 2020
Overarching report delivery of the programme to be provided to Savings and Governance Board (SGB) monthly	Jenny McCann	Monthly	July 2020
Ongoing reporting to EIJB bi-monthly	Moira Pringle (with support from Jenny McCann)	Bi-monthly	September 2020

14. How will you monitor how this policy, plan or strategy affects different groups, including people with protected characteristics?

An overarching view on delivery of the savings programme, including monitoring of activity and spend, will be provided at the monthly Savings Governance Board, chaired by EHSCP's Chief Officer. Bi-monthly reports will also be provided to the EIJB.

Existing NHS Lothian & CEC finance reporting processes will also be utilised as appropriate.

Where appropriate there will be ongoing engagement, involvement and appropriate consultation with staff, patients, and carers about any changes, allowing for feedback

It is currently uncertain what longer term impact COVID-19 will have on the programme and what contingencies may be required to address. It may be that changes are required which are not currently quantifiable. This will be monitored closely throughout the coming months.

15. Sign off by Head of Service/ Project Lead

Name: 

Date: 2nd July 2020

16. Publication:

Send completed IIA for publication on the relevant website for your organisation. See Section 5 for contacts.

Section 5 Contacts

- **East Lothian Council**

Please send a completed copy of the IIA to equalities@eastlothian.gov.uk and it will be published on the Council website shortly afterwards. Copies of previous assessments are available via http://www.eastlothian.gov.uk/info/751/equality_diversity_and_citizenship/835/equality_and_diversity

- **Midlothian Council**

Please send a completed copy of the IIA to zoe.graham@midlothian.gov.uk and it will be published on the Council website shortly afterwards. Copies of previous assessments are available via http://www.midlothian.gov.uk/downloads/751/equality_and_diversity

- **NHS Lothian**

Completed IIAs should be forwarded to impactassessments@nhslothian.scot.nhs.uk to be published on the NHS Lothian website and available for auditing purposes. Copies of previous impact assessments are available on the NHS Lothian website under Equality and Diversity.

- **The City of Edinburgh Council**

Completed impact assessments should be forwarded to Strategyandbusinessplanning@edinburgh.gov.uk to be published on the Council website.

- **City of Edinburgh Health and Social Care Partnership**

Completed and signed IIAs should be sent to Sarah Bryson at sarah.bryson@edinburgh.gov.uk

- **Edinburgh Integration Joint Board**

Completed and signed IIAs should be sent to Sarah Bryson at sarah.bryson@edinburgh.gov.uk

- **West Lothian Council**

Complete impact assessments should be forwarded to the Equalities Officer.

Edinburgh Integration Joint Board

REPORT

2020/21 Financial Plan

Edinburgh Integration Joint Board

21st July 2020

Executive Summary	The purpose of this report is to present the 2020/21 financial plan and provide an update on the potential financial implications of COVID-19.

Recommendations	It is recommended that the Board: a. Agree the 2020/21 financial plan as presented in this paper; b. Note that, whilst financial balance can be achieved in year, this relies heavily on one off measures; c. Agree to receive a first draft of the 2021/22 budget in line with our partners financial planning timescales; d. Note that both partners have commissioned work to further understand the financial impact of COVID-19.

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 presented elsewhere.

Main Report

Background

2. Work on the Integration Joint Board's (IJB) 2020/21 budget and associated savings and recovery plan started in late summer of 2019. The original timetable was impacted, firstly, by delays in the UK and Scottish Government budgets and, secondly, by the emergence of COVID-19. The latter diverted management resource as well as introducing significant turbulence into the system. This has a consequent impact on our ability to model the associated costs, particularly as we ease out of lockdown and services transform and adapt.

3. In April 2020 the IJB discussed the draft financial plan, recognising the need to balance the governance requirements of scrutinising the financial plan at a time of great uncertainty and, in the knowledge that the plan presented does not address the financial challenge of the pandemic, against the risk of deferring to a time when greater assurance will be possible. At this point the plan showed a potential in year deficit of £5.2m and the board requested updates and further work in 3 specific areas:

   - Potential financial consequences of COVID-19;
   - On the assumption that the proposed savings and recovery programme is agreed what the realistic level of in year delivery would be; and
   - Identification of additional proposals to address the remaining financial plan deficit.

4. This paper focuses on the 20/21 financial plan and the associated deficit. A separate paper to this meeting presents the savings and recovery plan which outlines how financial balance could be achieved, effectively addressing points b and c above.

Funding - IJB delegated budget 2020/21

5. The Scottish Government's budget for 2020/21 was approved by the Scottish Parliament on the 5th March 2020. In line with this, the baseline budget set for the IJB from its 2 partners, the City of Edinburgh Council (the Council) and NHS Lothian, was increased as follows:

   - *NHS Lothian* uplifted the recurring baseline budget by the 3% uplift received by all territorial Health Boards. This equated to £12.2m (excluding General Medical Services, the allocation for which will confirmed in due course);
   - *The Council* passed on in full the health and social care monies received via the Scottish Government's (SG) budget. Nationally this amounted to

£100m, Edinburgh's share of which was £8m, representing an increase of 3.8% over the 2019/20 budget. It should be noted that, whilst this increase provided additional funds as a contribution to meeting living wage requirements, free personal and nursing care and implementation of the carers act, no allowance was made for the other pressures facing us. Accordingly, the IJB may wish to redirect elements of this funding to address other priorities; and

- Following the initial budget announcement, a further £95m across Scotland was identified for local authorities. On 30th June the Council decided that £2m of its £7.4m share would be allocated to the IJB.

6. The final element of the funding picture relates to the communication from the Cabinet Secretary for Health and Sport which indicated that funding would flow through to Integration Authorities to meet the full cost of the 3.3% living wage increase. For Edinburgh, the difference between our planning assumption and the cost of the associated contractual uplift is £4.7m. Funding of £1.2m has subsequently been confirmed, a shortfall of £3.5m. This gap has been the subject of ongoing discussion with SG officials which started when the original announcement was made. As part of this dialogue the Chief Officer has reiterated the IJB's commitment to reward the social care workforce, but cannot sanction this without the agreement of the Board if the associated contract uplift is not fully funded. Reflecting this (i.e. the IJB should not be faced with having to find additional offsetting savings) the financial plan presented assumes that the funding position will be resolved positively. Accordingly, table 1 below assumes the full £4.7m.

7. The combination of both budget offers would give the IJB a delegated budget of £684.6m at the beginning of financial year 2020/21 as shown below in table 1:

	Council £m	NHS Lothian £m	Total £m
2019/20 baseline budget	217.7	439.8	657.5
Uplift	15.0	12.1	27.1
Total budget 2020/21	**232.7**	**451.9**	**684.6**

Table 1: Delegated budget 2020/21

Costs – 2020/21 expenditure forecast for delegated services

8. In conjunction with the City of Edinburgh Council and NHS Lothian finance teams the projected costs on delegated services for the coming financial year have been modelled. The underpinning assumptions were set out in the April 20 report on the financial plan which can be found here

9. Purchasing inflation and national care home inflation cost estimates have been provided by the Council finance and contracting teams and reflect national agreements where in place. As discussed above, this includes the Scotland

wide 3.3% contract uplift to reflect living wage increases. It is also assumed that this initiative is fully funded.

10. The impact of these assumptions on projected expenditure for the IJB is that 20/21 costs will rise to £706.4m, a breakdown of this increase is shown below in table 2:

	£m
Baseline expenditure	663.5
Projected expenditure increases	
Loss of income	5.7
Full year effect of 2019/20 pressures	6.0
Pay awards	10.4
Contract and non pay inflation	8.6
Growth and capacity	12.2
Total Projected Expenditure 2020/21	**706.4**

Table 2: projected delegated expenditure 2020/21

11. Taking the indicative budget offers from the Council and NHS Lothian and the projected costs for delegated services generates a £23.9m savings requirement going into 2020/21 as shown in table 3 below:

	CEC £m	NHSL £m	IJB* £m	Total £m
Indicative delegated budgets	232.7	451.9		684.6
Projected delegated costs	251.7	458.4	(3.7)	706.4
Savings requirement	**19.0**	**6.5**	**(3.7)**	**21.9**

Table 3: projected IJB savings requirement 2020/21

* full year effect of savings from Gylemuir closure

12. It should be noted that the position set out in table 11 could be further impacted by the outcome of the discussions on contractual uplifts referenced above.

Financial impact of COVID-19

13. Assessing the financial implications of the pandemic is not a straightforward exercise. At its simplest there are 2 elements to this: the net additional cost of the immediate and ongoing response to COVID-19; and the medium to longer term cost associated with reconfigured services. The following section of this report considers these 2 factors in turn.

14. At the outset of the pandemic NHS boards were required to submit mobilisation plans which outlined their response to the pandemic, with a particular focus on reducing delayed discharges, thereby increasing hospital capacity to deal with COVID-19. These mobilisation plans were developed on a system wide basis and high level estimates of the anticipated additional costs were included in the

initial submission. At that stage many of these costs were speculative, relying on a high level of estimation whilst awaiting actual costs and an increased understanding of the reshaping and rescaling of different services across the city.

15. Subsequently, Health and Social Care Partnerships (Partnerships) have been required to submit regular updates to these preliminary estimates to the Scottish Government (SG). This happened via NHS Boards who were charged by the Cabinet Secretary with coordinating the mobilisation planning efforts. Initially weekly submissions were made, as plans were firmed up and implemented. The frequency has since reduced, and returns now include a combination of actual costs and estimates of future expenditure. The latest return is summarised in table 4. A comparison between this and the original mobilisation plan is given in appendix 2:

	£k
Additional capacity	11,103
One Edinburgh	5,313
Provider sustainability	25,188
PPE	999
Miscellaneous	1,170
GPs & prescribing	3,737
Slippage on savings	6,609
Living wage uplift shortfall	4,700
Total	**58,819**

Table 4: mobilisation plan costs as reported to SG

16. Both the UK and Scottish Governments have recognised that the response to the pandemic will require a range of additional funding to be made available. The Scottish Government (SG) published an exceptional summer budget revision which was laid before parliament on 27th May 2020. This detailed additional spending across the 8 SG portfolios, with an additional £620m allocated for health and sport. This has since risen to c£780m, the total funding currently available to support both the range of national initiatives (e.g. the creation of the Louisa Jordon hospital) and to fund the mobilisation plans.

17. To bolster the monies available for the COVID-19 response, the SG has indicated that they will also take account of: redirection of resources within boards to address COVID-19; and wider spending reprioritisation across the Scottish Government and NHS Boards. In this context it has been made clear to both Health Boards and Integration Authorities that only net additional costs will be met. In other words, any underspends attributable to COVID-19 will be redirected to offset additional costs. Making this distinction requires a degree of judgement and will be closely scrutinised by SG colleagues.

18. An early assessment of the mobilisation plan financial returns highlighted that, across Scotland, the funding available was some distance short of the total estimated costs. Although the SG has not confirmed the magnitude of the

shortfall it is understood to be significant, thus increasing the risk that additional costs will not be met in full.

19. As the mobilisation planning process developed, differences in approach across the country became evident. In response, a significant amount of work has been done through national finance networks to ensure that financial submissions to the SG are as clear and consistent as possible. A 'peer review' process has been established for Health Boards and a benchmarking group set up for Partnerships. It is intended that these mechanisms will ensure robustness and consistency of costs set out in mobilisation plans and provide the necessary assurance for funding to be allocated. Health boards have been asked to undertake a detailed quarter 1 review with an emphasis on quantifying the actual costs associated with COVID-19. This will provide greater certainty over the actual implications as opposed to earlier estimates. As part of the process, the SG will undertake some further detailed scrutiny of areas where there are significant differences in approach reflected in local mobilisation plan submissions. This includes unachieved savings and areas such as IT/Telephony costs. Using this information they will then further consider the most appropriate next steps in addressing financial implications.

20. To date only limited funding has been agreed. An initial allocation of £50m to Integration Authorities was confirmed by the SG on 12th May 2020. Edinburgh's share of this allocation is £4.1m. Although the SG has provided assurance that this is an initial advance only whilst further work to ensure the robustness of costs is undertaken, this assurance needs to be considered in the context of the overall shortfall in resources available.

21. The ongoing financial implications of COVID-19 are far less clear. The impact will crystallise as we progress our 'route map planning' and consider the joint impact of transformation and what we have learned during the pandemic. This work is being led by the Head of Strategy and any associated financial consequences will be captured as part of the decision making processes.

22. Based on the conclusions derived from the information set out in paragraphs 13 to 21 above, the financial plan has been prepared on the basis of no net impact from COVID-19 i.e. assuming that any additional costs will either be funded or otherwise mitigated. Although NHS Lothian has now produced its financial results for April, the Director of Finance has advised the board that further work is required to accurately determine the financial impact of the pandemic. The Council will produce its first monitoring information (based on the first quarter) in July. Both organisations are in the process of updating their financial projections for the year. In the absence of further clarity in this area it is anticipated that the costs incurred as a result of mobilisation activities will be met in full. Further work is required on the ongoing financial implications and this cannot be quantified until our commissioning intent is clearer.

23. Whilst it is recognised there is risk inherent in this approach, it is a necessary one given the prevailing level of complexity and turbulence caused by COVID-19 on financial performance and the further work being undertaken by our partners and colleagues at the SG. Working through this detail required will

take some time but and will require a degree of interpretation. However the outcome of this exercise will be needed in order to provide the IJB with an appropriate degree of assurance on the financial plan.

Achieving financial balance

24. We continue to face unprecedented challenges to the sustainability of our health and care system; an ageing population; an increase in the number of people living with long term condition; a reduction in the working age population which compounds the challenge in workforce supply and fundamentally resource availability cannot continue to match levels of demand. As highlighted in the discussions above, and notwithstanding COVID-19, these factors influence our ability to set a balanced budget. Each year we face a discrepancy between the level of funding available and the projected costs of delivering the IJB's delegated services.

25. A separate paper to this meeting sets out the proposed savings and recovery programme. However this paper does cover some additional mitigating actions to achieve financial balance. These are set out in table 5 below:

	£m
Financial plan gap	21.9
Potential actions	
Phase community investment strategy	2.0
Older peoples reserve	1.0
Total potential actions	**3.0**
Potential additional contributions	
NHSL (set aside deficit)	3.0
In year savings requirement	**15.9**

Table 5: projected in year savings requirement

26. The financial position described above indicates a remaining gap of £21.9m for this financial year, with the potential to further reduce this to £15.9m. This includes:

- For a number of years now the financial plan has included provision for a £2m investment in community capacity. Work on the underpinning strategy, led by the Head of Operations and supported by the third sector, is a key component of our transformation programme. As we reflect upon the recent mobilisation of communities we've seen during the COVID-19 pandemic, we can see the enormous benefit of a community based infrastructure to support and promote independence. The strategy (as was being developed prior to COVID-19) was scheduled to come to the Board in April 2020 for implementation from April 2021. Understandably, it was postponed and will be rescheduled for the board at a later date taking on-board lessons learned from this last period. In view of this current review of the direction of the investment to take account of the

lessons, it is unlikely that any meaningful spending plans will be in place for this financial year. Accordingly it is proposed that the 20/21 investment is used, on a one off basis, to support the overall in year financial position;

- An older peoples reserve was established some years ago, funded from the social care fund. Recognising that demographic related increases in costs feature prominently in the £21.9m gap (table 5), it is proposed to offset this on a recurring basis with the £1m provision; and
- NHS Lothian's Director of Finance has indicated that, as in previous years, an agreement on set aside pressures is a reasonable planning assumption. This will be monitored as the year progresses in conjunction with health colleagues.

27. A separate paper to this meeting sets out the associated savings and recovery programme. This proposes a number of elements or 'phases' and, if agreed in full, will allow the IJB to set a balanced budget for the 20/21.

28. The resultant budget is set out in Appendix 2, which will accompanies direction EIJB-22/10/2019-1. This schedule sets out the initial allocation for all delegated services.

29. As in previous years, this position relies heavily on one off or non recurring measures. Like many other public sector organisations, we face significant financial challenges and, due to the continuing difficult national economic outlook, further uncertainty in the light of COVID-19 and increasing demand for services, will need to operate within tight fiscal constraints. Whilst many things are uncertain, it is clear that achieving recurring financial balance will require major redesign of services, radical changes in thinking and approach, and the involvement of all partners and stakeholders. To address this we are developing our financial strategy. This will build on the financial framework and be closely aligned to the strategic plan. Progress with this strategy has stalled as we have redirected our energies to dealing with COVID-19. This work is now being reinvigorated and prioritised and we are aiming to present it by the end of the financial year. We would also intend to present an early draft of the budget for 2021/22 by this autumn.

Implications for Edinburgh Integration Joint Board

Financial

30. Financial impacts are outlined in the main body of this report.

Legal/risk implications

31. Legal / risk implications are outlined in the main body of this report.

32. The financial plan set out in this paper assumes that all COVID-19 costs will be met by the Scottish Government through the mobilisation planning process and the regular financial returns associated with this.

Equality and integrated impact assessment

33. There are no specific implications arising from this report. Integrated impact assessments have been undertaken for all savings and recovery proposals being presented for approval.

Environment and sustainability impacts

34. There are no specific implications arising from this report.

Quality of care

35. There are no specific implications arising from this report.

Consultation

36. This report has been prepared with the support of the finance teams in the City of Edinburgh Council and NHS Lothian.

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Appendices

Appendix 1	Comparison of original mobilisation plan with original submission
Appendix 2	Financial schedule to accompany direction

Appendix 1

Comparison of original mobilisation plan with original submission

Cost heading	Description	Cost per mob'n plan £k	Update per latest submission £k
Additional bed capacity	Purchase of 'safehaven' care home beds	5,822	5,861
Additional care at home capacity	Planned increase in capacity	5,242	5,242
One Edinburgh	Scheduling software for care at home under a 'One Edinburgh' approach	5,100	5,313
Home First		200	200
Provider sustainability	Payments to reflect additional COVID-19 costs incurred by providers in line with the	0	25,188
PPE	Personal protective equipment	200	999
Miscellaneous		45	291
Sub total		**16,609**	**43,094**
Included on pan Lothian basis in original submission			
Ophthalmology	Payments to opticians		28
GPs & prescribing	Payments to GPs (for example Easter opening) and projected increase in prescribing costs		3,737
Community hubs	Centres set up to deal with COVID-19 related issues from members of the public		652
Slippage on savings	Potential shortfall on delivery as management resource diverted		6,609
Now being dealt with separately by SG			
Living wage uplift shortfall	3.3% contract uplift to reflect the living wage	5,000	4,700
Grand total		**21,609**	**58,819**

As can be seen from table 4, the variation in estimates is significant, however it should be noted that the material differences reflect changes in reporting format and approaches as opposed to changes in costs.

We already know that we have not needed to action all the activities set out in our mobilisation plans. Other projects (for example provider sustainability payments) are

in the early stages of implementation and it is not possible to accurately estimate the costs at this point

Appendix 2

Direction from Edinburgh Integration Joint Board
Financial Schedule 2020/21
Direction ref: EIJB-22/10/2019-1

	Delegated budget £k
CEC Delegated Budget 2019/20	
External Services	
Assessment and Care Management	539
Care at Home	35,082
Care and Support	56,398
Day Services	13,094
Direct Payments & Individual Service Fund	34,860
Other Services	11,680
Residential Services	73,320
Total External Services	**224,972**
Internal Services	
Assessment and Care Management	13,408
Care at Home	25,120
Care and Support	8,161
Day Services	10,785
Equipment Services	8,481
Management	3,169
Other Services	6,747
Residential Services	27,802
Strategy / Contract / Support Services	2,904
Therapy Services	3,502
Pension Costs	450
Total Internal Services	**110,529**
Gross Expenditure	**335,502**
Income and Funding	
Customer and Client Receipts	(20,576)
Cost Recovery	(20,595)
Funding (SCF / ICF / RT / NHS Recharges)	(51,725)
Total Income and Funding	**(92,896)**
Net Delegated Budget - CEC	**242,606**

	Delegated budget £k
NHSL Delegated Budget 2019/20	
Delegated - Core	
Community Hospitals	12,895
District Nursing	12,024
Geriatric Medicine	4,081
GMS	70,912
Learning Disabilities	1,165
Mental Health	10,766
Other core	687
Management and RT	33,901
PC Services	10,659
Prescribing	80,317
Resource Transfer	24,106
Substance Misuse	1,809
Therapy Services	6,702
Total Delegated - Core	**270,024**
Delegated - Hosted	
Community Equipment	1,830
Complex Care	1,250
Hospices & Palliative Care	2,369
Learning Disabilities	8,033
LUCS	6,273
Mental Health	28,607
Oral Health Services	6,627
Other hosted	1,596
Psychology Services	3,954
Public Health	1,193
Rehabilitation Medicine	4,555
Sexual Health	3,725
Substance Misuse	2,903
Therapy Services	6,507
UNPAC	3,317
Total Delegated - Hosted	**82,740**
Set Aside - Acute	
Acute Management	3,310
Cardiology	4,136
Diabetes & Endocrinology	2,278
ED & Minor Injuries	9,773
Gastroenterology	3,323
General Medicine	25,353
General Surgery	5,413
Geriatric Medicine	14,098
Infectious Disease	5,884
Other set aside	1,234
Rehabilitation Medicine	2,487
Respiratory Medicine	6,058
Therapy Services	5,805
Total Set Aside - Acute	**89,154**
Net Delegated Budget - NHSL	**441,917**
Total Net Delegated Budget (CEC + NHSL)	**684,524**

Edinburgh Integration Joint Board

REFERRAL REPORT

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

Edinburgh Integration Joint Board

28 April 2020

Executive Summary	The purpose of this report is to refer the attached report on Mental Health Services (including Substance Misuse): Quality Assurance from the Clinical and Care Governance Committee to the Edinburgh Integration Joint Board for approval/consideration with the Committee's recommendations detailed below.

Recommendations	The Clinical and Care Governance Committee recommends that the Edinburgh Integration Joint Board**:** 1. Supports the proposal that the Edinburgh Health and Social Care Partnership join the Royal College of Psychiatrists (RCoP) Accreditation Scheme for adult in-patient and community mental health teams.

Terms of Referral

1. The Clinical and Care Governance Committee on 17 February 2020 considered a report on Mental Health Services Quality Assurance, which provided an overview of mental health and substance misuse services and the scrutiny that sought to provide assurance of quality of care and clinical practice.

2. During consideration of the report, the Committee discussed the following:

- The complexity of mental health and substance misuse service structures, including lines of responsibility across different services and the number of partners involved in delivering services;
- The tools, networking and learning that could be gained from the RCoP Accreditation Scheme would help staff to consider ways to improve the quality and efficiency of their work and the care that they provided;
- Recognition that not all of the targets required to achieve accreditation from the RCoP Accreditation Scheme would be appropriate for Edinburgh, but that despite this there were a number of benefits to adopting these, in particular the learning to be gained from self-assessment and peer review exercises;
- The benefits of other Lothian IJBs also joining the RCoP Accreditation Scheme;
- The importance of ensuring members understood clearly which services were within the remit of the HSCP and the IJB and where responsibility lay for each; and
- The development of the new quality hub to bring together improvement teams to share best practice, provide support and deliver on initiatives.

The Committee also noted the financial implications for the IJB as there was a cost of £2,250 per year per team to join the Accreditation Scheme. The annual cost would be £9,000 to cover the four community mental health teams.

3. The Committee agreed:

3.1 To note the national quality indicators for mental health and their alignment to wider system outcomes.

3.2 To recognise the progress made in relation to the whole system approach in response to NHS Lothian escalation.

3.3 To acknowledge the significant change agenda for mental health and substance misuse services.

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

3.5 To support the proposal that mental health and substance misuse services were part of the Quality Hub which would ensure a consistent and constant focus on quality assurance.

3.6 To take significant assurance that monitoring and evaluation frameworks were in place to measure the impact of Action 15 and Seek, Keep, Treat funding allocations.

3.7 To request a report within 6 months' time providing information on mental health services, where responsibility was held for each area, the assurance monitoring processes in place, risk identification and mitigation processes, and how targets and outcomes were set and measured in order that the Committee could take assurance that processes were in place in these areas.

4. The Integration Joint Board is asked to consider the recommendations of the Clinical and Care Governance Committee, particularly in relation to 3.4 above, to support the proposal that the Health and Social Care Partnership join the Royal College of Psychiatrists Accreditation Scheme for adult in-patient and community mental health teams.

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Appendices

Appendix 1	Mental Health Services (including Substance Misuse): Quality Assurance – report by Head of Operations, Edinburgh Health and Social Care Partnership

Edinburgh Integration Joint Board

REPORT

Mental Health Services (including Substance Misuse): Quality Assurance

Clinical and Care Governance Committee

17 February 2020

Executive Summary	The purpose of this report is to provide the Clinical and Care Governance with an overview of Mental Health and Substance Misuse Services and the scrutiny that seeks to provide assurance of quality of care and clinical practice. The report also recommends that the Committee support the Health and Social Care Partnership's aspiration to join the Royal College of Psychiatrists Centre for Quality Improvement accreditation programme which would contribute to our local assurance system. The report also recommends that Mental Health Quality Assurance is a key component of the recently established Health and Social Care Partnership Quality Hub.

Recommendations	It is recommended that the Clinical Governance and Care Committee: 1. Note the national quality indicators for mental health and their alignment to wider system outcomes. 2. Recognise the progress made in progress whole system approach in response to NHS Lothian escalation 3. Acknowledge the significant change agenda for mental health and substance misuse services. 4. Are assured that monitoring and evaluation frameworks are in place to measure the impact of Action 15 and Seek, Keep Treat funding allocations. 5. Support the proposal that the Health and Social Care Partnership join the Royal College of Psychiatrists Accreditation Scheme commencing with community mental health teams.

	6.	Support the proposal that of mental health and substance misuse services are part of the Quality Hub which will ensure a consistent and constant focus on quality assurance.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations		✓
	CCGC may consider the need to recommend a direction to EIJB for consideration/implementation	

Report Circulation

1. Members of the Clinical and Care Governance Committee.
2. Members of the Edinburgh Health and Social Care Partnership Executive Management Team
3. Members of the Royal Edinburgh Hospital and Associated Service Executive Management Team

Main Report

4. Action 38 of the Mental Health Strategy 2017-20271 committed to and published a Quality Indicator (QI) profile in mental health (September 2018) which includes measures across six quality dimensions – person-centred, safe, effective, efficient, equitable and timely.

5. It also committed to measuring progress towards parity by introducing a measurement framework similar to those used in physical health, which will draw on a range of information to understand the differences that are being made to, for example, premature mortality, what money is being spent, how long people wait to access services, rates of employment, and poverty levels. The quality profile did not set new targets but was built predominantly build on data that is already available.

6. The delivery of the QI profile requires actions by:

Scottish Government – national analysis of aggregated reports will allow consideration of improvement action. The Annual Report to Parliament on progress in relation to the Mental Health Strategy will use selected data to illustrate progress.

Information Services Division, NHS NSS – collection, analysing and reporting data.

Healthcare Improvement Scotland (HIS) – whilst working with Boards through the Mental Health Access Improvement Support Team (MHAIST), HIS will encourage Boards to generate data required by ISD for collection, analysis and reporting of data.

Health Boards – aligning data collection and systems to permit data gathering and reporting to ISD. Agreeing local clinical and personal outcome measures. Local analysis of reports with improvement actions.

Integration Authorities - aligning data collection and systems to permit data gathering and reporting to ISD. Agreeing local clinical and personal outcome measures. Local analysis of reports with improvement actions.

7. The detailed list of QIs provides secondary definitions for each QI, and maps them against:

- the six Quality Outcomes (Timely, Safe, Person Centred, Effective, Efficient and Equitable)
- the nine Health and Wellbeing Outcomes
- relevant actions set out in the Mental Health Strategy.

Appendix 1 sets out the national QIs and the publication schedule.

8. NHS Lothian was escalated to level 3 of NHS Scotland's escalation process due to a number of concerns some of which related to services and functions delegated to the 4 Lothian Integration Joint Boards (IJBs). A 'whole system approach' was supported by NHS Lothian and the 4 Lothian IJBs to address those areas. The recovery plan developed spans the entirety of those areas for which NHS Lothian is responsible. This includes Mental Health and Learning Disabilities for Adults – including Psychological Waiting Times. Recovery and improvement Boards have been established and in terms of the delegated functions; the Mental Health and Learning Disabilities Board is chaired by the EIJB Chief Officer.

9. The plan sets out the additional capacity being put in place funded by NHS Lothian to deliver sustainable improvement including the role of Director of Improvement, with Programme Director posts also being secured to support the individual Recovery and Improvement Boards in developing and delivering their action plans. Initial reporting to Scottish Government on actions towards improvement was undertaken on a fortnightly basis until 5 November 2019. Thereafter a single integrated Recovery Plan was submitted to the Scottish Government on the 29 November 2019. The Scottish Government are currently considering the appropriate level of escalation for NHS Lothian given the progress made in a number of areas.

10. In terms of mental health, one of the significant challenges relating to escalation was the availability of beds for acute admissions. The action taken to date has supported a reduction from around 106% occupancy to between 85- 90% at the time of reporting which is positive in ensuring bed availability.

11. Performance in relation to Psychological Therapies 18-week target has steadily deteriorated over the past few months with the adult treatment list increasing by 30-40 patients per month. The number of people waiting on this list was 2,743 at the end of November 2019 with performance against the 18-week standard currently at 79.9%. To address these issues, the Lothian system is investing in additional short-term capacity to tackle the longest waits, is implementing a number of changes in Standard Operating Policies (SOPs) and is taking part in a number of initiatives to extend the use of a computer based Cognitive Behavioural Therapy (CBT) and other CBT digital services.

12. While further improvement is both necessary and possible, it is recognised that the whole system approach has started to demonstrate a positive impact in a number of areas and that trajectories for improvement for areas not currently demonstrating improvement have been set. The EIJB received a formal update on progress on 4 February 2010.

13. Following widespread concerns raised in the Scottish Parliament in May 2018 about the provision of mental health services in Tayside, NHS Tayside commissioned an Independent Inquiry to examine the accessibility, safety, quality and standards of care provided by all mental health services in Tayside. The Independent Inquiry published an interim report in May 2019, which identified six key themes emerging from the evidence it had received[1]. These themes were:

[1] The Independent Inquiry into Mental Health Services in Tayside. (2019). Interim report: inquiry update and emergent themes. https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf

- Patient access to mental health services,
- Patient sense of safety
- Quality of care
- Organisational learning
- Leadership
- Governance

14. The final report of the Independent Inquiry, *Trust and Respect*, was published on 5 February 2020[2] and was been shaped by the voices of people who have provided evidence, many of whom had felt that their voices were not being heard. Over 1,500 people contributed evidence to the Independent Inquiry, including patients, families, carers, staff, partner organisations, professional bodies, third sector organisations and community representatives.

15. The report sets out 51 recommendations framed within 5 cross cutting themes:

- Strategic Service Design
- Clarity of Governance and Leadership responsibility
- Engaging with people
- Learning Culture
- Communication

16. The recently established Healthcare Improvement Scotland (ihub) "Mental health Inpatients – Designing the future Model Project" will be focusing on these recommendations as part for the progression of this workstream. The pan-Lothian Mental Health and Recovery Board will consider these recommendations as part of their improvement and redesign work.

17. The Thrive Edinburgh Adult Health and Social Care Commissioning plan details 6 workstreams which are incorporated into the Strategic Plan 2019-2022. The 6 commissioning work streams:

Building Resilient Communities	A Place to Live
Get Help When Needed	Closing the Inequalities Gap
Rights in Mind	Meeting Treatment Gaps

detail aspirations, what is happening now and what needs to happen in the future to achieve these aspirations.

18. Several change programmes are being progressed through "business as usual" and within the Transformation Programme. As we progress with whole systems change

[2] https://independentinquiry.org/wp-content/uploads/2020/02/Final-Report-of-the-Independent-Inquiry-into-Mental-Health-Services-in-Tayside.pdf

implementation it is essential that due cognisance is taken in relation to quality assurance and governance across commissioning, planning, delivery and quality assurance structures. A schematic diagram included in Appendix 2 sets out the range of services and commissioning and operational management arrangements.

19. The following paragraphs (20 to 46) in this report briefly summarise the change programmes with each workstreams which are informed by data and evidence, and current quality assurance systems in place. Paragraphs 47 to 52 detail the recommended the additional quality assurance components that the Committee are invited to consider.

20. The Manchester Study of Suicides in Scotland[3] found that 80% of people who end their life are not known to mental health services at the time of death. "Building Resilient Communities" and "Addressing Inequalities" work streams will encompass work to prevent suicides focusing on the actions detailed in the national "Every Life Counts" Suicide prevention action plan,[4] paying particular attention to high risk groups in Edinburgh and support for those impacted upon by suicide. For those that are known to mental health services there is a learning review process ensuring that lessons learned are fed into service improvement and delivery. Appendix Three includes the recent "lessons learnt" themes from Community Mental Health SAERs.

21. The National Records of Scotland produce an annual report in relation to drug-related deaths in Scotland. Edinburgh and Alcohol Drug Partnership (EADP) provide the EIJB and Edinburgh Chief Officers Group with an update on the national information and Edinburgh specifically.

22. The city has a rigorous review system to make analysis of all the circumstances at the time of death and this informs an action plan to improve the level of engagement and support for people who are vulnerable to overdose or drug-related death. The new Scottish Government Strategy Alcohol and Drug Strategy for Scotland has a focus on how Alcohol and Drug Partnerships will innovate and invest in services aimed at reducing drug and alcohol related deaths in Scotland.

23. Four locality-based Drug Related Deaths Review Groups work to learn lessons from individual drug related deaths. These groups are attended by local professionals who are responsible for local service delivery. Key issues and lessons are fed into the Pan Lothian Strategy Group to develop a strategic response across organisations. Appendix 4 sets out more detail in relation to drug related deaths.

[3] http://documents.manchester.ac.uk/display.aspx?DocID=37591

[4] https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters

24. "A Place to Live" workstream focuses on ensuring that people with mental health problems have a safe place to call home in which they feel safe, receive the support they need and are able to connect to and be part of their local community. This work is closely aligned to the strategic principles of Home First and seeks to minimise institutionalisation, maximise community provision and ensure that when hospital care is required, it is a safe and therapeutic experience which reflects the person's needs, levels of acuity and functioning.

25. EHSCP spends approximately £14 million per annum through purchasing a range of services to support people at home. Throughout the year the Care Inspectorate carry out a series of announced and unannounced visits to assess the quality of care, leadership, environment and service user and carer feedback. Appendix 2 provides an overview of the gradings awarded to these services.

26. A number of 'A Place to Live' change programmes are underway focusing on current community capacity (256 supported places) by increasing choice and control for clients and improving throughput. The Care Inspectorate have a year long announced and unannounced visiting programme. The findings from these visits are included in Appendix 5.

27. This workstream includes the development of a new framework agreement for supported accommodation and support at home services which will increase the ability for providers to respond flexibly to fluctuating levels of need, enable providers to carry out reviews and assessments in defined circumstances where longer term adjustments to the levels of support are required. This will increase the level of flexible and collaborative working between providers and health and social care staff around clusters and localities.

28. Acceleration of Technology enabled care service has a major role to play across the mental health model and work set to commence in February 2020 as part of the EHSCP Transformation programme will accelerate our Change Programme around this, making maximum use of the opportunities afforded by Digital Health Scotland.

29. The introduction of an innovation test site for 3 Conversations across statutory and third sector providers which will allocate resources based on a single shared care and treatment plan will further increase client choice and control and collaborative working across statutory and 3rd sector services.

30. "Get Help When Needed" workstream is focused on ensuring that when people need help they are able to access the support they need in a timely manner, for both planned and unplanned care. The introduction of "Thrive Welcome Teams and the

Thrive Collective will reduce barriers to access and ensure that there is clear assessment and formulation which in turn leads to care, support and treatment being matched to the individual's needs. This co-produced redesign is supported by the UK Living Well Programme (funded by the Big Lottery) to implement the lessons learnt from the Lambeth programme across four sites in the UK.

31. In recent years there has been a consistent increase in the demand for psychological therapies and significant numbers of people are waiting over the recommended Government standard of 18 weeks to receive the treatment they have been assessed as requiring. An Improvement Plan (which forms part of the Lothian Recovery Plan) is in place focusing on those who have waited longest, this is supported by additional investment over an 18 month period. Performance on improving access to psychological therapies forms part of the EHSCP performance report which is reported to the Performance and Review Committee.

32. Substance misuse services provide a range of early intervention, prevention of harm, access to treatment interventions and programmes to different populations including children and young people, people who are in contact with community justice system and initiatives to reduce substance misuse related offending. A quarterly report is produced and submitted to Edinburgh Chief Officers Group (COG). The Scottish Government recently announced that further targets will be issued in response to the new strategy Rights, Respect and Recovery.

29. Two additional funding streams Seek, Keep, Treat and Action 15 Funding have supported a number of new developments. The impact and outcomes of these new developments will be measured using agreed key performance indicators specific to the development / intervention.

33. The Seek, Keep, Treat comprehensive plan builds on long established Edinburgh recovery orientated services and support for people with substance misuse problems. The plan has 8 domains:

- Local needs assessment ensuring we are responding to issues that are specific for Edinburgh's population;
- Increased involvement of those with lived experience of addiction and recovery in the evaluation, design and delivery of services;
- Reduced waiting times for treatment and support services, particularly waits for opioid substitution therapy (OST);
- Improved retention in treatment particularly for those detoxed from alcohol and those accessing OST;
- Development of advocacy services;

- Improved access to drug/alcohol treatment services amongst those accessing inpatient hospital services;
- Whole family approaches to supporting those affected by problem drug/alcohol use;
- Continued development of recovery communities.

34. The Action 15 commitment aims to deliver on the national strategy for mental health commitment to support the employment of 800 additional mental health workers to improve access in key settings such as Accident and Emergency departments, GP practices, police station custody suites and prisons was confirmed by the Scottish Government to Chief Officers. In Edinburgh this includes:

- **Thrive Centres/ Networks -** Allocation to Edinburgh's four wellbeing locality partnerships to build on the robust partnerships comprising of third and statutory sectors which will support the creation of wellbeing open access Thrive Centres with statutory and third sector contribution across a range of community settings.
- **Adult A & E at Royal Infirmary Edinburgh (RIE)** 3.00 WTE Additional nurses to deliver evidenced based intervention (IPT- Acute Crisis) for people who have attempted to commit suicide.
- **Children and Young People, A & E, New Sick Children's Hospital at** RIE - 3.00 WTE nurses to deliver evidenced based interventions to children and young people who have presented with serious self harm and suicidal ideation.
- **Edinburgh Prison (Males):** Maximize the opportunities for meaningful activities within prison and enhance psychological interventions in prison setting through the employment of 5.5 WTE Occupational therapists and clinical psychologists.
- **Edinburgh Prison (Females**) to provide evidence based psychological therapies to women in community and prison settings; enhance capacity of prison staff to work in psychologically informed way through the employment of 3.00 WTE staff members
- **Court diversion and custody settings** - to provide specialist mental health assessment (2.2 WTE) in partnership with Court Diversion Service
- **Clinical Psychology Pilot** (1.5 WTE) in North East GP Cluster: test of concept to explore the role of clinical psychology as first line responder using a 20 minute formulation model in GP settings
- **Enhance capacity for the training and delivery of the Prospect Model interventions** - adapted evidence-based interventions which can be delivered by a range of staff across agencies and settings. (1.00 WTE Principal Psychologist)

35. The "Rights in Mind" workstream is committed to ensuring that people understand their overarching human and legal rights and that staff working in mental health statuary and voluntary sector services ensure that their clients, along with their families, friends and carers, are afforded their rights. The PANEL principles - Participation, Accountability, Non-discrimination and equality, Empowerment, and Legality need to be embedded in all our Thrive Edinburgh commitments.

36. John Scott QC is the government lead for the review of Adults with Incapacity, Mental Health Care and Treatment, and Adult Support and Protection legislation. We are currently exploring with John Scott QC the potential for Edinburgh to be a test site for innovative practice in rights-based care which will help inform the legislative review and future practice. We are also planning to host an Edinburgh Summit on Human Rights and Care chaired by Professor Jill Stavert from Napier University.

37. The Mental Welfare Commission (MWC) regularly visits hospitals providing psychiatric care. The Commission carry out local visits to look at the experiences of people receiving treatment in these wards and publish these local visit reports. Their annual reports focus on the use of detention highlighting differences in practice across Board and Local Authorities. The recent Chief Social Work Officer's report highlighted a sharp increase in the use of Emergency Detention Orders and a steady increase in all compulsion orders.

38. The MWC also undertake themed visits, where they visit people using similar services across a short period of time, with key questions for patients, staff and visitors. In their most recent themed visit they focused specifically on NHS in-patients in rehabilitation services.[5] The function of a specialist inpatient rehabilitation service is to help patients gain or regain the skills and confidence needed to progress their recovery. Inpatients in rehabilitation services are likely to have severe and complex mental health needs and will often have spent months or years in hospital which significantly affects their skills and abilities needed to live back in the community.

39. This themed visit was arranged as the Commission recognised it was some time since they looked at rehabilitation. In comparison with acute inpatient services where the length of stay is short (averaging 40 days in the inpatient census for Scotland) the length of stay for people in rehabilitation services is much longer (582 days) and a higher percentage are likely to be detained under the mental health act (73% of patients in rehabilitation wards compared with 43% in acute psychiatry wards. [6]

40. Given these differences and the impact on people of being in hospital for a prolonged length of time, the Commission wanted to visit all rehabilitation services to review the

[5] https://www.mwcscot.org.uk/sites/default/files/2020-01/20200130_ScotlandsMHRehabWards_ThemedVisitReport_1.pdf
[6] Scottish Government Annual Inpatient Census 2019 https://www.gov.scot/publications/inpatient-census-2019-part-1-mental-health-learning-disabilityinpatient-bed-census-part-2-out-scotland-nhs-placements/pages/5/

standard of care in these wards and to hear from patients about their experience of being treated in a rehabilitation service.

41. They visited 22 wards in 15 hospitals between June and September 2018 and met every patient who was able and willing to talk to them. They also spoke with staff, and reviewed case files and drug prescription sheets, including those of patients we had not been able to talk with. In addition, they also spoke to 26 family members to find out their experiences of the care and treatment of their relative.

42. The report was published on 30 January 2020 and set out a number of recommendations:

- NHS Boards should consider seeking accreditation under the AIMS standards for inpatient mental health rehabilitation services, or benchmark their service against these standards, with particular attention to factors such as delivery of physical healthcare, participation in purposeful and meaningful therapies and activities which reflect the preferences of patients and evaluation of outcomes using structured measurement tools.
- NHS Boards should ensure that no-smoking perimeters they have set around hospital buildings are clear to patients and staff, and that patients are supported to comply with no smoking policies.
- NHS Boards should ensure that processes are in place at ward level to audit the prescription of medication for detained patients and the certification of this under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003, to ensure that all such treatment is properly authorised.
- NHS Boards should develop plans to promote the knowledge and use of advance statements in rehabilitation services.
- Integrated Joint Boards should review on an individual basis, rehabilitation patients whose discharges have been delayed by over 3 months in order to develop a clear plan for discharge within an acceptable timescale.

43. The Place to Live Commissioning and Review group will prepare a formal response to these recommendations which will highlight work underway to address them. This includes a quantitative investigation of the association between social and physical features of the environment and participation in meaningful activity for individuals with complex mental health difficulties living in supported accommodation and the use of standardised assessment tools including the Residential Environment Impact Scale, Model of Human Occupation Screening Tool and Camberwell Assessment of Need Short Appraisal Scale In rehabilitation settings in hospital and community.

44. The ”Meeting Treatment Gaps” work stream is focused on working effectively to integrate service provision in localities and across the city to further develop and enhance person, carer and family support to maximise the life opportunities for people with mental health problems and mental illness and to reduce the requirement

for acute and long-term care. This clearly links with the "Rights in Mind" work stream and the MWC report on Rehabilitation is a good example of how attention to rights needs to be embedded in care planning and service delivery.

45. This work stream will also focus on Integrated Care and Support Pathways for severe mental illness including Bipolar, Schizophrenia, Eating disorders, Personality Disorder, Perinatal Mental Health and Depression to ensure that our services are rights based, provide evidenced based clinical treatment as defined by SIGN and NICE[7], and there is a comprehensive focus on meaningful days.

46. There are well established multi-professional Community Mental Health Teams, Social Work Teams, Mental Health Officer Service, and a wide range of third sector agencies, providing a range of biopsychosocial interventions. Over the last few years these services have experienced increasing demand set against a reduced workforce. The introduction of open access services will change the demand on these services, and it is important that we have a refreshed and up to date understanding of the current secondary mental health care provision across the city.

47. To assist with this, it is recommended that the EHSCP sign up to the Royal College of Psychiatrists Standards for Adult Community Mental Health Services (ACOMHS)[8] . This is an accreditation programme which works with staff to assure and improve the quality of community mental health services for people with mental health problems, and their carers. Accreditation assures staff, service users and cares, commissioners and regulators of the quality of the service being provided. It engages staff in a comprehensive process of review, through which good practice and high-quality care are recognized, and teams receive support to identify and address areas for improvement. The programme has involved service users and carers as a priority, and people with firsthand experience of using community mental health services have been encouraged to get involved in all stages of the development process. The standards are set out in Appendix 6.

48. Standards used within the network are designed specifically for community mental health services. They are developed in consultation with frontline staff, managers, patients and carers and are aligned with NICE guidelines. Participating members are able to demonstrate that they are working towards and achieving these measures, as well as our wider standards, while showing their commitment to quality improvement. The backbone of the network is peer review and accreditation but member services

[7] SIGN: Scottish Intercollegiate Guidelines Network: NICE – National Institute for Health and Care Excellence https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/adult-community-teams-(acomhs)/acomhs-standards-first-edition-2016.pdf?sfvrsn=4dcf4a70_2

[8] https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/adult-community-teams-(acomhs)/acomhs-standards-first-edition-2016.pdf?sfvrsn=4dcf4a70_2

are also able to benefit from specialist events, publications, and the knowledge and experience of peers.

49. There are good opportunities for networking, tools for self -assessment and peer review visits are facilitated between member services. These visits are a key element of both developmental and accreditation processes. A peer-review team review evidence provided by the service to assess whether they meet the standards. Those meeting the required level are accredited by the Royal College of Psychiatrists.

50. The network allows services to create a learning community, where they share and benefit from best practice and updates in the field. It enables staff to regularly consider ways to improve the quality and efficiency of their work and the care that they provide.

51. The EHSCP **Quality Hub** led by the Chief Nurse has been established. It is recommended that there is further discussion to ensure that the Hub can support the quality improvement and assurance functions that are critical to ensure that we continue to use data, evidence and research to drive practice change and redesign. Having a recognised single point is crucial to ensure that we continue to develop and embed a culture of learning and reflection that drives service improvement and delivery. This will also provide a single point where the Care Inspectorate and MWC reports can be reviewed and any subsequent action and improvement plans developed and monitored.

Implications for Edinburgh Integration Joint Board

Financial

52. There is an annual charge of £2,250 per year per team to join the Adult Community Mental Health Services Accreditation Scheme. The annual cost would be £9,000 to cover the four community mental health teams.

Legal / risk implications

53. There are several pieces of law that ensure people with mental illness, learning disabilities, dementia and related conditions get appropriate treatment and have their rights respected. The Mental Health (Care and Treatment) (Scotland) Act 2003 applies to people who have a mental illness, learning disability, or related condition. The Act calls this mental disorder. The Adults with Incapacity (Scotland) Act 2000 provides a framework for safeguarding the welfare and managing the finances of adults (people aged 16 or over) who lack capacity due to mental illness, learning disability, dementia or a related condition, or an inability to communicate. The Criminal Procedure Act includes provisions for people who are accused of a criminal act and who may have a mental disorder. The Adult Support and Protection Act protects people - “adults at

risk" - who may find it more difficult to stop harm happening to them. The Act calls people in this situation 'adults at risk'

54. The MWC has duties under the Mental Health (Care & Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000. The Commission monitors the Acts to see how the law is being used. Every year the MWC produce an independent overview of the operation of the Mental Health (Care & Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

Equality and integrated impact assessment

55. Service users, carers and third sector partners are involved in any proposal for investment or disinvestment and proposals would be subject of an Impact assessment.

Environment and sustainability impacts

56. None noted.

Quality of care

57. The recommendations within this report will improve the governance and assurance of mental health services across the city.

Consultation

58. Thrive Edinburgh has full participation of all stakeholders in all work streams which are focussed on in terms of service development and delivery.

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Background Reports

National Mental Health Strategy
Thrive Edinburgh Adult Health and Social Care Commissioning Plan
Every Life Matters – Scotland' Suicide Action Plan
Rights, respect and recovery – Scotland's drug strategy

Appendices

Appendix 1	National Quality Improvement indicators and the publication schedule.
Appendix 2	Schematic diagram -Mental Health Services
Appendix 3	Learning from Experience: Themes from Community Mental Health SAERs
Appendix 4	Drug related deaths
Appendix 5	Mental Health Services: Quality Assurance Summary
Appendix 6	Standards for Adult Community Mental Health Services

Appendix One: All mental health related publications for November 2019 to December 2020

Topic		Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
Mental Health Inpatient Activity												A			
Scottish Suicide Information Database (ScotSID)					Q							Q			
Suicide - ScotPHO									A						
Dementia (Dates To be confirmed)															
Mental Health Quality Indicators Profile						Q						Q			
Medicines for Mental Health													A		
Outpatient Activity (Psychiatrist)		Q			Q			Q						Q	
Child and Adolescent (CAMHS) Waiting Times			Q			Q			Q			Q			Q
Psychological Therapies Waiting Times			Q			Q			Q			Q			Q
Electroconvulsive Therapy(To be confirmed)															
Learning Disability Inpatient Activity															A
Alcohol related discharges from Psychiatric Hospitals		A												A	

Key: A : Annual Publication Q : Quarterly publication

Mental Health Quality Indicators Profile

The Mental Health Quality Indicators profile provides information about quality outcomes for services for people with mental health problems located within the context of Integrated Authority provision.

Website: Mental Health Quality Indicator Profile

Most recent publication: Adult Mental Health Benchmarking Toolkit [1.4Mb]

Medicines for Mental Health

ISD maintains a detailed database of details of NHS prescriptions dispensed in the community in NHS Scotland that is augmented by information on prescriptions that originate in NHS Scotland but dispensed elsewhere in the United Kingdom. The publication shows medicines and prescriptions used in mental health, specifically Insomnia & Anxiety, Psychoses & related disorders, Depression, Attention Deficit Hyperactivity Disorder (ADHD) and Dementia.

Annually published in October.

Website: Prescribing and Medicines

Most recent publication: Medicines using in Mental Health 22 October 2019 [1.4 Mb]

Mental Health Inpatient Activity

Mental health inpatient activity trend data until March 2019 has now been published.

Website: Mental Health

Most recent publication: Mental Health Inpatient Activity, 2019 release 10 September 2019

Outpatient Activity (Psychiatrist)

An outpatient is a patient who attends (outpatient attendance) a consultant or other medical clinic or has an arranged meeting with a consultant or a senior member of their team out with a clinic session. Outpatients are not admitted to a hospital and do not use a hospital bed. The tables on the link below include information on outpatient attendances with consultant psychiatrists.

Quarterly published in November 2019, February 2020, May 2020 and November 2020.

Website: Outpatient Activity

Most recent publication: the Outpatient Activity section provides some data on psychiatic outpatient activity in its annual figures.

Scottish Suicide Information Database (ScotSID)

The overall aim of the ScotSID is to provide a central repository for information on all probable suicide deaths in Scotland, in order to support epidemiology, preventive activity, and policy making.

The database covers demographic information, contact with health services and related health data, and will eventually provide details relating to the suicide event and individuals' wider social circumstances.

Annually, most recent publication in December 2018:

Website: Mental Health

Most recent publication: A profile of deaths by suicides in Scotland 2011-2017: A report from the Scottish Suicide Information Database (ScotSID) 4 December 2018 [2.3Mb]
Data tables: View Data Tables

Advice on how to access ScotSID data [109kb]

Suicide - Scottish Public Health Observatory (ScotPHO)

Annual update of suicide information in Scotland including numbers and rates of suicide at Scotland, NHS board and LA level and by deprivation decile at Scotland level.

Published annually.

Website: ScotPHO website, Suicide: key points

Most recent publication: Suicide Statistics for Scotland - Update of trends to 2017 27 June 2018 [193 Kb]

Psychological Therapies Waiting Times

The Scottish Government has set a target for NHS Boards to deliver a 18 week referral to treatment for Psychological Therapies by December 14. This publication shows the Psychological Therapies Waiting Times in Scotland.

Quarterly published in March, June, September and December. First published in August 13.

Website: Psychological Therapies Waiting Times

Most recent publication: Psychological Therapies Waiting Times in NHSScotland 3 December 2019 [1011 Kb]

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Psychology Workforce

NHS Scotland Psychology workforce statistics.

Published annually in March.

Website: Psychology Workforce Planning Project

For new publications visit: www.isdscotland.org/Health-Topics/Workforce/NES-Publication/

Electroconvulsive Therapy (ECT)

ECT, a treatment reserved for people with serious mental illness, still attracts polarised views with respect to acceptability in contemporary practice. The formation of the Scottish ECT Accreditation Service (SEAN) with its focus on audit and adherence to nationally agreed standards and guidelines provides assurance about practice within Scotland. Publication is an annual report on the work of the SEAN.

Annually published in October.

Website: The Scottish Electroconvulsive Therapy (ECT) Accreditation Network (SEAN)

Most recent publication: Scottish ECT Accreditation Network Annual Report 2016

Alcohol related discharges from Psychiatric Hospitals

Alcohol-related hospital discharge statistics are published annually by ISD in two different publications, which are released in alternate years. They are included in this Alcohol-related Hospital Statistics report, which is published every two years. They also form part of the Alcohol Statistics Scotland release, which is also published every two years (in alternate years to the Alcohol Hospital Statistics publication). This publication includes data on alcohol-related psychiatric discharges (from SMR04). These are presented by age, gender, deprivation and Health Board area.

Annually published in November.

Website: Drugs and Alcohol Misuse

Most recent publication: Alcohol-related Hospital Statistics Scotland 2018/19 19 November 2019 [150 kb]

Quality Indicators

Timely

T1
Psych access
% of people who commence psychological therapy based treatment within 18 weeks of referral

T2 CAMH access
% of young people who commence treatment by specialist Child and Adolescent Mental Health services within 18 weeks of referral

T3 Sub misuse access
% of people who wait less than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

T 4 4 hour Emergency Assess.
% of unscheduled presentations referred to specialist mental health services, who have had direct assessment by MH specialists within 4 hours

T5 First present. psychosis
% of first presentation psychosis patients that start SIGN or NICE guideline evidence based treatment within 14 calendar days of referral to specialist mental health services

Safe

S1 Suicide rates
Suicide rates per 100,000 population

S2 Discharge FU
% of all discharged psychiatric inpatients followed-up by community mental health services within 7 calendar days

S3 Emerg. Self harm
% of all unscheduled care presentations where self-harm is a presenting feature

S4 Medication safety
% of people prescribed lithium who experienced lithium toxicity in the last 12 months

S5 Inpatient Safety
Incidents of physical violence per 1000 occupied psychiatric bed days

Person-Centred

P1 Caring support
% of carers for people with mental health problems who feel supported to continue in their caring role (Integration indicator 8)

P2 Quality of life
% of adults with mental health problems supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (Integration indicator 7)

P3 Matters to me
% of replies for people with mental health problem that agree with statement “people took account of the things that
mattered to me” in Health and Social Care Experience Survey

P4 Advance statements
Number of people with advanced statements registered per year with the Mental Welfare Commission for Scotland

P5 Personal outcomes
% of people in mental health services seen for at least 1 month that show improvement in any personal outcome measurement over the previous month

Effective

E1 Delayed discharge
Number of days people spend in hospital when they are ready to be discharged per 1,000 population (Integration indicator 19)

E2 Antipsychotics
% people prescribed antipsychotics for reasons other than psychoses and bipolar disorder treatment

E3 BMI
% people with severe and enduring mental illness and / or learning disability who have had their BMI measured and recorded in the last 12 months
.
E4 functioning
% of people seen for at least 1 month that show improvement in functioning using any clinical outcome measurement over the previous month

E5 symptoms
% of people seen for at least 1 month that show improvement in symptom severity using any clinical outcome measurement over the previous month

Efficient

Ef1 Emergency bed days
Rate of emergency bed days for adults (Integration indicator 13)
services.

Ef2 readmission
% Readmissions to hospital within 28 days of discharge (Integration indicator 14)
Ef3 beds
Total psychiatric inpatient beds per 100,000 population (NRAC adjusted)

Ef4
Mental health spend
Total mental health spend as a % of total spend.

Ef5 DNAs
% of did not attend appointments for community based services of people with mental health problems

Equitable

Eq1 Mortality rate
Premature mortality rate (Integration indicator 11) = Standardised mortality rate for persons in contact with mental health services

Eq2 CTOs
Number of emergency detention certificates (EDCs) per 100,000 population
.
Eq3
LD health checks
% of people with severe and enduring mental illness and/ or learning disability who have had an annual health check within previous 12 months

Eq4
CAMH admissions
% of under 18 psychiatric admissions admitted outwith NHS specialist CAMH wards

Eq5 ACPs
% of caseload with an active anticipatory care plan

Appendix Two- Mental Health Services Schema

Key

Operationally Managed by Health and Social Care Partnership

Operationally Managed by REAS

Operationally Managed by 3rd Sector Services

North West Locality
Primary Care Liaison Team
Community Mental Health Team
Older People's CMHT
Commissioned 3rd Sector Services[1]
Pilton Community Health, Health in Mind

North East Locality
Primary Care Liaison Team
Community Mental Health Team
Older People's CMHT
Commissioned 3rd Sector Services[1]
The Stafford Centre, NE Counselling Services

Statutory City Wide
Intensive Home Treatment Team
Rapid Response Team
Psychological Therapies Team
Mental Health Assessment Service (REH and RIE (24/7)
Behaviour Support Service
Lothian Older People's Psychology Service
Rivers Centre; Cullen Centre; Lothian V1P

Commissioned Services (3rd Sector/ City Wide)
Edinburgh Crisis Centre[2]
Stafford Centre[1]
Barony Contact Point
256 Supported accommodation places[3]
Plan to Change- Peer Workers[1]
Individual and Collective Advocacy

Royal Edinburgh Campus
Acute Admission Wards
Intensive Psychiatric Care
Rehabilitation
Older People's Wards
Community HPCCC
Ferryfield
Ellen's Glenn
Finlay House

Royal Edinburgh Campus (regional and national)
Medium Secure Unit
Brain Injury Unit
CAMHS Unit
St John's - regional
Mother and Baby Unit
Eating Disorder Unit

South West Locality
Primary Care Liaison Team
Community Mental Health Team
Older People's CMHT
Commissioned 3rd Sector Services[1]
Redhall - SAMH, Cyrenians, Broomhouse Space, health in mind

Notes
1. Services in place until 31 July 2020. New service being commissioned in line with Thrive Open Access Model.
2. Service in place until 31 July 2020- redesign of out of hours and crisis provision underway
3. Framework agreement being developed which will increase capacity and flexibility of support

South East Locality
Primary Care Liaison Team
Community Mental Health Team
Older People's CMHT
Commissioned 3rd Sector Services[1]
Barony Contact Point, health in mind

Appendix 3: Learning from Experience: Themes from Community Mental Health SAERs

March 2018; Updated May 2019 and Jan 2020

Pathways Into and Through Services

Quicker access to mental health care or treatment was identified as being needed, and this should be monitored and improved to ensure people can get help when they need it.

This must include much easier ways for primary care, or other agencies, to discuss people they are seeing with psychiatrists or other members of the mental health team and to seek advice when needed

Teams should carefully consider the ways they engage people into the service and adopt assertive approaches where there are high levels of risk accompanied by a low likelihood of people engaging with services through their own volition.

Where referrals are not accepted there should be clear feedback loops to referring teams and an opportunity to challenge that decision

Discharge protocols/SOP's should be reviewed, with a particular focus on ensuring plans for post discharge review of all patients discharged from hospital within a maximum of 7 days. Further consideration should be given to reduce this target to 3 days. When there are transitions between teams there are clear strategies to ensuring the person's care moves safely over from one team to the other and that they and their family, friends or carers are kept informed throughout

Where third or independent sector services are part of someone's agreed plan then workers must share as much information with them as the client will allow, particularly around risk and they must be as involved as much as possible in overall care planning.

Localities to develop robust ways to routinely share adult concern forms and other risk information across the locality.

Some reviews noted that conventional clinic settings were not suitable to some people who struggled to attend them. They recommended that localities use their outward focus to identify suicide hotspots or potential areas of risk and develop ways to work with the local community and carry out suicide prevention work.

Assessment and Decision Making

Opportunities to improve assessment and care planning were identified in many SAERs. This included:

- Where referrals are made which are considered urgent by the referrer, but not felt to be urgent by the receiving team and downgraded, that this decision is communicated to the referrer to allow alternative arrangement to be made or a further discussion carried out. To ensure that such referrals are seen within a reasonable timescale, not exceeding 8 weeks, and their progress monitored.
- That the routine timescale to initial assessment is monitored and does not exceed 12 weeks

- Much greater involvement of family, friends or carers in assessment and planning whenever it is possible to do so
- Using all agreed tools in the Mental Health ICP documentation to come to a clear view of the person's difficulties, shared with them, but acknowledging that at times the worker and the person may not agree.
- Taking a longitudinal view of someone's needs or appropriate treatment not just relying on brief one-off assessments – particularly where the person has emotional instability or who may have attachment difficulties and so present very differently in different settings or times.
- Using agreed treatment guidance such as SIGN and NICE to make evidence based but individualised treatment decisions and documenting the rationale for doing so – particularly around treatment for depression (NICE CG90)
- Ensuring that if someone is declining treatment or support without which they are at risk of serious harm that an assessment of capacity to make that decision is made and documented

Complex Difficulties

Not surprisingly, many recommendations focused on how to ensure good care when the person faced complex difficulties. Many of these overlap with other issues, for example, assessment, treatment, drug use and so on, but the key recommendations included:

- Ensuring that risk assessment and safety planning takes into account all factors in the person's life. Assessment should not be based on narrow or one off assessments but take into account all the information available, including past history, views of others including family, friends or carers and other agencies and consider the way the person is likely to relate to services, considering, for example, their attachment style.
- On occasion, staff needed to improve the way they understood and related to people with relational difficulties or personality disorder, particularly in the assessment of risk.
- Where there is longstanding ongoing risk to self or others CMHTs should keep an open mind about the need for their involvement and avoid therapeutic nihilism

To help improve these aspects of care some organisational strategies should be put into place:

- Developing a common language for talking about complex difficulties particularly relational difficulties using a common model of care
- That all teams have the ability to support practitioners to work with people to develop psychological or psycho-social formulations of their difficulties and strengths developed with the person, with their wider teams and , whenever possible, with family, friends or carers.
- Ensuring that the Care Programme Approach (CPA) is considered and applied consistently whenever it is likely to be helpful to keep someone safe and well
- Ensure that Adult Support and Protection measures (ASP) are considered and applied consistently whenever it is considered that criteria for ASP may be met
- Consider the use of GIRFE meetings where CPA or ASP meetings are not appropriate but that a wider view of professionals with the ability to escalate issues that appear intractable might be helpful.
- Developing use of Anticipatory Care Plans (ACPs) to ensure all members of extended out of hours care team understand the person's needs and their care plan

- Developing close links and ways of communicating freely with GPs and other primary care workers to be able to quickly share information. In particular to offer opportunities for general practice to consult mental health or substance misuse services in complex cases, for example, where someone is at significant risk of harm, but is not engaging with services.

Drugs and Alcohol

Drugs and alcohol played a role in a number of SAEs, both in terms of their effects and of the impact of withdrawing from them on people's mental state.

Specific recommendations included:

- Teams should ensure they routinely identify all prescribed medication of people who use substances, in case those medications potentiate the effect of drug use and increase risk of death
- The risk of patients resuming drug use after a period of abstinence should be considered in care plans, for example, on discharge from hospital
- Developing improved pathways between substance misuse and mental health. In particular being able to consult with substance misuse teams to gain advice and recommendations or to co-work if that is required.
- To seek advice as to how to encourage and support pole into substance misuse treatment
- Specifically to consider the risks of poly-pharmacy of drugs such as opiate replacement drugs, painkillers including gabapentinoids, or benzodiazepines

Family, Friends and Carers

Perhaps the most common learning was the need to involve family, friends or carers in all aspects of care wherever it is possible to do so, from initial assessment right through to support if someone takes their life.

Several recommendations suggested we need to go much farther than we currently do into obtaining the views of family, friends or carers in making assessments. It was acknowledged that this sometimes runs counter to our desire to put clients at the centre of assessment and may require a significant change in the way we help identify people's problems and make plans.

As a result of recommendations Guidance for Involving Family, Friends and Carers was developed and this for should be revised for EHSCP and made available to all staff.

- Teams were encouraged to develop some means by which carers can keep in touch with teams during or after their treatment to communicate increased risk and to provide support for carers
- If a discharge plan relies on family friends or carers, they must be fully aware of the risks and the plan and how to seek help if the person deteriorates
- After death or other traumatic incident teams should identify a senior single point of contact for families and follow the Being Open approach to support them

Physical Healthcare

We know there is hugely increased mortality for people with severe mental illness, and this was reflected in some of the learning.

- Teams must consistently and systematically deliver physical healthcare checks for those with severe mental illness.
- Teams should develop systems and strategies to support intervention where there are identified physical health problems or where factors may increase risk of physical illness, for example, cardio-vascular events. This may include supporting the person to receive treatment in general practice or to third sector organisations supporting healthier lifestyles
- Where someone is identified as being potentially acutely physically unwell, assertive efforts must be made to connect them with the right physical healthcare

People receiving Clozapine were particularly at risk of death due to their medication and special care is prescribed for them: Learning included

- Annual Clozapine levels being taken as a minimum as directed by the Clozapine Handbook June 2017
- The physical healthcare of people, receiving Clozapine is governed by SGHD/CM(207)4 and teams must adhere to that standard as well as being able to demonstrate they are doing so by audit
- If a Red result is identified teams must be aware of the need to stop Clozapine immediately and to communicate to patients or carers to stop taking their medication

Documentation

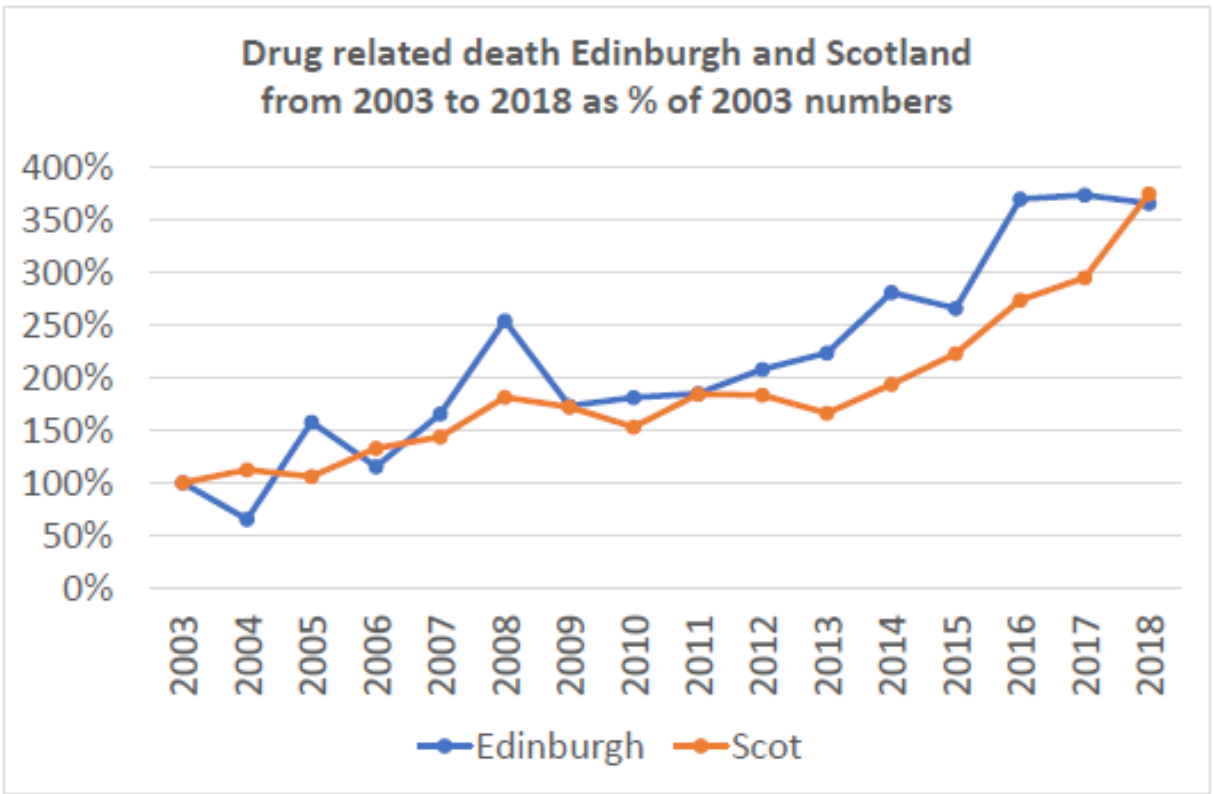
Unfortunately documentation continued to need some improvement in particular reminding all staff that records ***must be contemporaneous*** i.e. written on the day of the contact and that this includes TRAK entries. If it is impossible to write on the day it must be written by 12.00 the following day.

Decision making, particularly where there is high risk or complex presentations needed to be better documented. Where there are complex decisions made or positive risk taking (where a more risky course of action is taken in the person's best interest), a clear rationale for those decisions must be clear in the documentation. Where patients are declining treatment or are not engaging with offered treatment or support special care must be made to ensure that there is clear documentation of risk and plans with a clear rationale for this. Team discussions should be documented and communicated. Where someone is declining treatment which is potentially lifesaving then their capacity to make that decision should be documented at the time and at appropriate points thereafter.

Mike Reid, Mental Health and Substance Misuse Manager.

Appendix 4: Drug related Deaths in Edinburgh 2018: Issues and responses

There were 95 drug related deaths in Edinburgh in 2018. As the chart below shows, there has been a steady increase in Drug- related deaths in Edinburgh since 2003. Between 2015 and 2016 the numbers had a significant upturn and since that time have plateaued over the last three years. In 2017 Edinburgh recorded that 97-people died from a Drug-related death and in 2018 this number reduced to 95.



Drug related Deaths figures

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Edin	26	17	41	30	43	66	45	47	48	54	58	73	69	96	97	95
Scot	317	356	336	421	455	574	545	485	584	581	526	613	706	867	934	1187

2 The number of drug related deaths recorded in NHS Lothian in 2018 was 151.

The number of drug related deaths recorded in NHS Lothian in 2018 was 151. This compares with 161 in 2017.

Drug related deaths in the City of Edinburgh have been steady for the past three years. Whilst this is better than many other areas in Scotland, this is a plateau at a maximum level. The aim for EIJB and EADP is to commission services that will reduce the number of people who die from a drug overdose and alcohol related death.

The median number of drugs implicated in death was 4 with an interquartile range of 3 to 6. Poly-drug use is the norm in drug related deaths and may be a significant factor in the ongoing high numbers. Of significance is the prevalence, potency, and affordability of substances such as “street Valium”.

The median age at death in drug related deaths has not changed over the period of 2014 to 2018. It is the same for men and women and has roughly the same interquartile range over that period.

Whilst heroin use has declined in relative terms, opioids are implicated in the majority of drug related deaths in Edinburgh and usually with at least one other drug group. Benzodiazepine and gabapentinoids also implicated in a majority of deaths although not always in combination.

Of the benzodiazepines, diazepam is still the most frequently implicated but etizolam is emerging as a particular local concern.

Whilst the majority of people who had drug related deaths were not currently engaged with specialist services, many had been up until around a year before death. Around 50% had no engagement with services within the previous year and that includes a group of people who had no history of drug misuse. Engagement with specialist treatment services reduces the risk of death significantly

Comparison with drug related deaths recorded in 2014, the number of drugs taken together has doubled and the drugs taken have changed markedly in only 4 years.

Actions and responses:
The National Records of Scotland produce an annual report in relation to Drug- related deaths in Scotland. Edinburgh and Alcohol Drug Partnership (EADP) provide the EIJB and Edinburgh Chief Officers Group with an update on the national information and Edinburgh specifically.

The city has a rigorous review system to make analysis of all the circumstances at the time of death and this informs an action plan to improve the level of engagement and support for people who are vulnerable to overdose or Drug- related death. The new Scottish Government Strategy Alcohol and Drug Strategy for Scotland has a focus on how Alcohol and Drug Partnerships will innovate and invest in services aimed at reducing drug and alcohol related deaths in Scotland.

Four locality-based Drug Related Deaths Review Groups work to learn lessons from individual drug related deaths. These groups are attended by local professionals who are responsible for local service delivery. Key issues and lessons are fed into the Pan Lothian Strategy Group to develop a strategic response across organisations.

The Take Home Naloxone Programme - Naloxone is an opioid antagonist, which can temporarily reverse the effect of an opioid overdose; this provides more time for emergency services to arrive and further treatment be given. Naloxone continues to be distributed within key settings: injecting equipment provision outlets, drug services, homeless services GP surgeries and pharmacies. Over 4000 kits have been distributed in the city at £18 per kit.

Responding to non-fatal overdose - A non-fatal overdose is the strongest indication that an individual is likely to die a drug related death in the near future and EADP has developed a number of interventions to prevent these deaths –the Scottish ambulance service notify drug services following an overdose. The locality service review and intensify support to the individual (if the person is already in treatment) and try to reach out to them if they are not.

A drug liaison nurse is employed at Edinburgh Royal Infirmary and works to reach those in the hospital who need to begin drug treatment while admitted and to have it continued discharge.

New government strategy - National and local drugs strategy is increasingly focussing on the needs of the highest risk and most vulnerable individuals and on the key life-saving measures needed to minimise harm and extend life. According to the Programme for Government, The new Scottish Government drugs policy will be "guided by a principle of ensuring the best health outcomes for people who are, or have been, drug users, our aim being to seek, keep and treat those who need our help". This determination is based on the increasing rates of drug related deaths and the recognised needs of an ageing drug using population.

Locally, a health needs assessment was initiated in 2016/17 to identify the needs of injecting drug users and the efficacy of the response provided by services. This was steered by a multi-agency group which included representatives from Police Scotland, NHS Lothian, City of Edinburgh Council and the third sector. The final needs assessment was published July 2017, and a summary infographic on its findings can be found here: https://www.nhslothian.scot.nhs.uk

At its meeting in June 2019 EIJB agreed to the proposed EADP investment plan amounting to £1.4 million. This money will fund services to respond to the priorities outlined below:

Priority population groups in need:
Currently / recently dependant, adult, high risk opiate / benzodiazepine / poly drug users in the community. Drinkers at high risk of/ experiencing alcohol related death, alcoholic liver disease, alcohol related brain disorder, or other severe alcohol-related physical and mental illness.

Priority unmet/under met need:
Speed of initiation of Opiate Substitute Therapy (OST) and titration in for those presenting at the hubs who were not on a script

Reaching hardly reached vulnerable groups by providing assertive outreach and accelerated treatment access for those at highest risk. Including more actively following up after: hospital contact; referral or attending drop in and whom we consider high risk; police custody and prison; vulnerable persons processes; those using pharmacy Injection Equipment Provision; those at risk of discharge from or disengaging from prescribing

More emphasis on evidence-based care in the prison which links with an effective transition of care at release

Reduce isolation by providing access to meaningful activity and social engagement, especially for those in medication assisted recovery and those who are not seeking abstinence

Improving the offer of psychosocial interventions for the primary care Opiate Substitution Therapy patients

Matching care to need, particularly those on OST (i.e. stepped care model)

Improving general medical care for those in substance use treatment via the hubs, primary care and pharmacy contacts. Identification and treatment of physical and mental co-morbidities, learning disabilities, polypharmacy and addiction to prescription drugs.

Developing psychologically informed environments, improving our response to trauma in the target groups and availability of high quality psychological therapies to people in all settings.

Access to effective alcohol treatment and alcohol related brain disorder interventions in line with national guidelines

Operation Threshold - Police Scotland worked closely with partners in EADP to engage those most at risk of overdose and death with the treatment system. This has been a programme of assertive outreach between police officers and Aid & Abet. This was followed up with a major exercise in June 2019 to address supply and those most at risk. Again, partners worked together to motivate and engage people seek support and treatment. The investment described above will build and continue the good work of operation Threshold.

• • Drinkers at high risk of/ experiencing alcohol related death, alcoholic liver disease, alcohol related brain disorder, or other severe alcohol-related physical and mental illness.

Priority unmet/under met need:

• • Speed of initiation of Opiate Substitute Therapy (OST) and titration in for those presenting at the hubs who were not on a script

• • Reaching hardly reached vulnerable groups by providing assertive outreach and accelerated treatment access for those at highest risk. Including more actively following up after: hospital contact; referral or attending drop in and whom we consider high risk; police custody and prison; vulnerable persons processes; those using pharmacy Injection Equipment Provision; those at risk of discharge from or disengaging from prescribing

• • More emphasis on evidence-based care in the prison which links with an effective transition of care at release

• • Reduce isolation by providing access to meaningful activity and social engagement, especially for those in medication assisted recovery and those who are not seeking abstinence

• • Improving the offer of psychosocial interventions for the primary care Opiate Substitution Therapy patients

• • Matching care to need, particularly those on OST (i.e. stepped care model)

• • Improving general medical care for those in substance use treatment via the hubs, primary care and pharmacy contacts. Identification and treatment of physical and mental co-morbidities, learning disabilities, polypharmacy and addiction to prescription drugs.

• • Developing psychologically informed environments, improving our response to trauma in the target groups and availability of high quality psychological therapies to people in all settings.

• • Access to effective alcohol treatment and alcohol related brain disorder interventions in line with national guidelines

• 18. **Operation Threshold -** Police Scotland worked closely with partners in EADP to engage those most at risk of overdose and death with the treatment system. This has been a programme of assertive outreach between police officers and Aid&abet. This was followed up with a major exercise in June 2019 to address supply and those most at risk. Again, partners worked together to motivate and engage people seek support and treatment. The investment described above will build and continue the good work of operation Threshold.

10

Recommendations

19. That the COG • Note the national increase of drug related deaths in Scotland.

• Note that Edinburgh drug related deaths have plateaued over the last few years and decreased slightly in 2018.

• Note the Edinburgh actions aimed at reducing future drug related deaths.

Appendix 5: Mental Health Services: Quality Assurance Summary

Introduction

This report provides a summary and overview in respect of independent voluntary and Council mental health services. The focus is placed upon the findings of inspections by the Care Inspectorate.

The Edinburgh Integration Joint Board (EIJB) and Edinburgh Health and Social Care Partnership (Partnership) has a minimum expectation of all service providers achieve Grades of 4 in all themed inspection areas. Where providers are not achieving this expectation, they are referred to the Multi Agency Quality Assurance Groups for Care and Home and Support Services.

During an inspection, the Care Inspectorate will select a number of themes to inspect which includes:

Previous Quality Inspection Framework	New Quality Inspection Evaluation Framework
Care and Support	How well do we support people's wellbeing?
Environment (for services with buildings only)	How good is our leadership?
Staffing	How good is our staff team?
Management and Leadership	How good is our setting?
-	How well is care and support planned?

Each theme inspected is awarded a grade using the following approach:

Grade	Description
6	Excellent
5	Very Good
4	Good
3	Adequate
2	Weak
1	Unsatisfactory

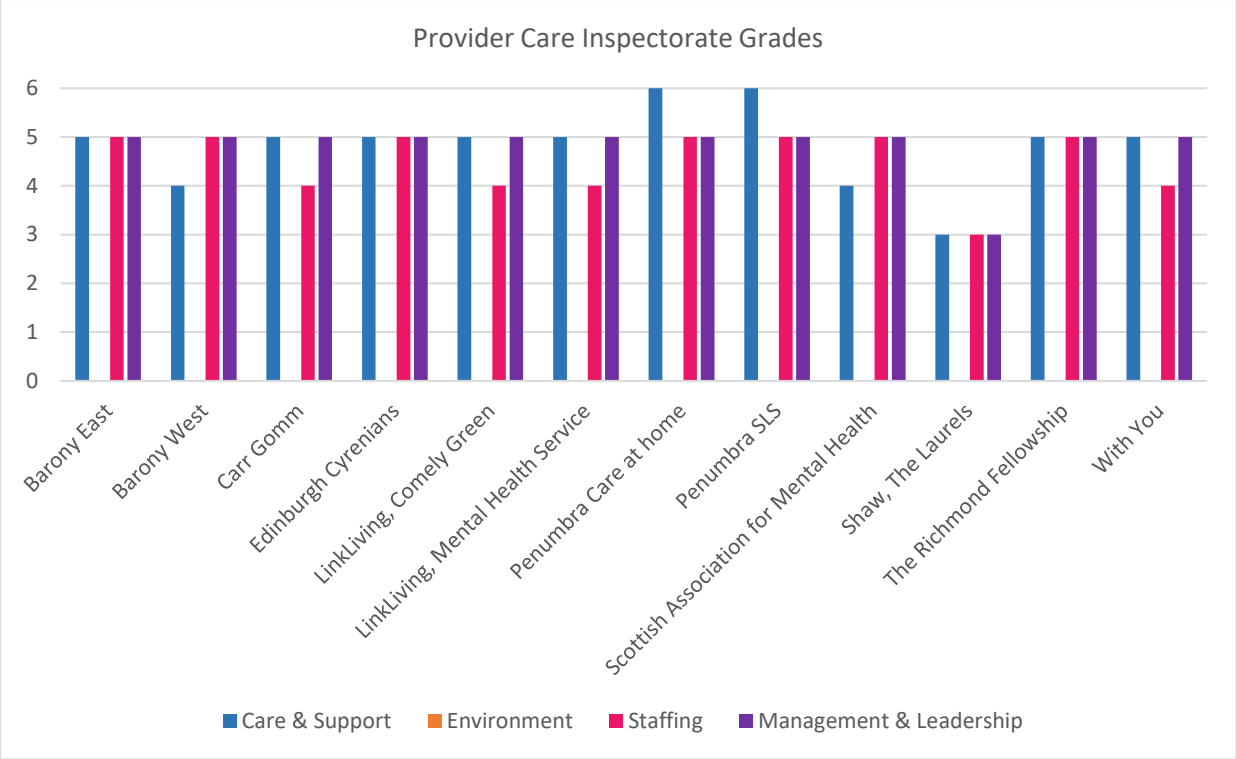
Edinburgh Registered Mental Health Services

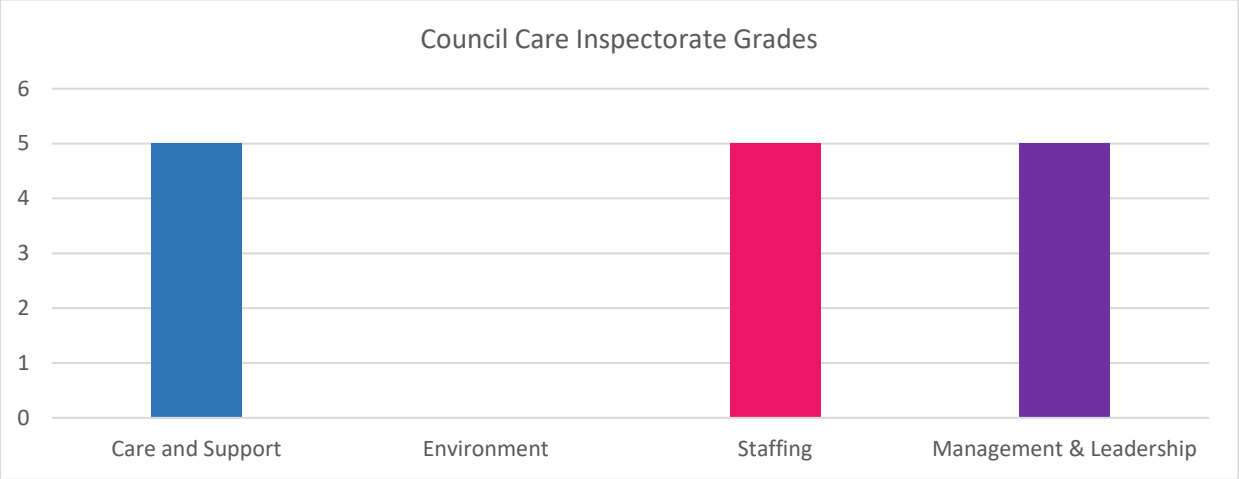
The tables below provide a summary of the Care Inspectorate grades for registered services as at 27 January 2020 for (a) Care and Support Services and (b) Other Registered Services.

(a) Care and Support Services – Mainly Adults Under 65 years of age

The Council contracts with 9 voluntary sector providers, with 12 services, which deliver care and support services, mainly to adults under the age of 65 years with mental health support needs. The Council operates one comparable registered service, Positive Steps.

The grades of these services range from 3 (adequate) to 6 (excellent). We do not have any contracts with services with grades of 1 or 2.

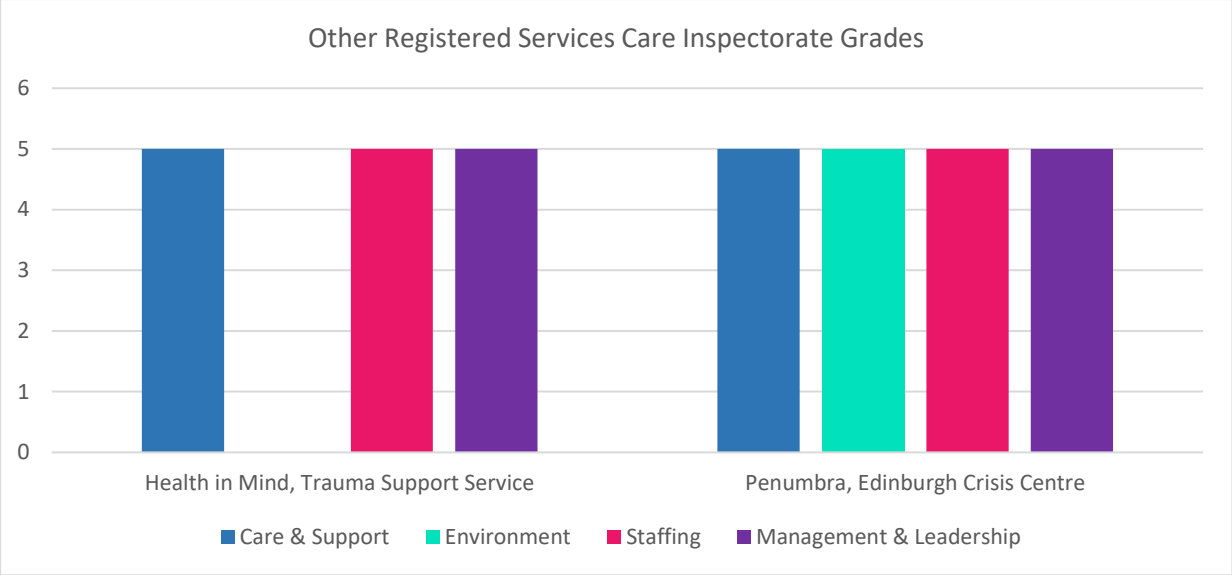




- 92% of our providers are achieving grades of 4 and above.
- 42% being graded at 5 and above.
- Providers with grades of 3 in one or more themed areas are the subject of contract monitoring activity and supportive challenge.

(b) Other Registered Services

The Council contracts with 2 voluntary sector providers of Other Registered Services for people with mental health support needs. There are no comparable Council services.



- Both of these services are achieving grades of 5 (very good) across all quality themes.
- Reviews of these inspection reports will be undertaken with a view to highlighting and sharing details of their very good practice in service delivery.

Services which are not Registered with the Care Inspectorate

The Partnership funds a further 16 wellbeing services which are not registered or regulated by the Care Inspectorate. These services will be subject to procurement and contract management arrangements.

Contract Management

The Partnership has adopted a risk-based approach to managing contract quality assurance arrangements and a new Contract Management Framework is being implemented. This framework involves an assessment of each provider on the basis on a number of risk factors which helps prioritise monitoring activity:

- infrastructure,
- management and staffing,
- annual spend,
- service specification and contract position,
- routine monitoring,
- external sources including Care Inspectorate,
- service type/client risk,
- strategic fit and financial assessment.

A key objective of service provider monitoring is for Partnership staff to gain insight into and understanding of the work service providers are doing on our behalf. This understanding can be best achieved through a balance of observation and formal processes.

All contracted providers will be asked to provide a summary report on a six-monthly basis which outlines the service and performance information, activities undertaken and share a small selection of Stories of Difference.

Appendix 6: Standards for Adult Community Mental Health Services – First Edition (September 2016)

1. Access, referral and waiting times

1.1 The service reviews access data at least annually about the people who use it. Data are compared with local population statistics and actions taken to address any inequalities of access where identified.

1.2 Clear information is made available, in paper and/or electronic format, to service users, carers and healthcare practitioners on:

- A simple description of the service and its purpose;
- Clear referral criteria;
- How to make a referral, including self-referral if the service allows;
- Clear clinical pathways describing access and discharge;
- Main interventions and treatments available;
- Contact details for the service, including emergency and out of hours details

1.3 A clinical member of staff is available to discuss emergency referrals during working hours.

1.4 Where referrals are made through a single point of access e.g. triage, these are passed on to the community team within one working day

1.5 The service provides information about how to make a referral and waiting times for assessment and treatment.

1.4 A clinical member of staff is available to discuss emergency referrals during working hours.

1.5 Outcomes of referrals are fed back to the referrer, service user and carer (with the service user's consent). If a referral is not accepted, the team advises the referrer, service user and carer on alternative options

1.6 Acceptance to the service is based on need and risk; the service does not use specific exclusion criteria
Guidance: Self-harm, substance misuse, social background, criminal history, learning disability or personality disorder are not barriers to acceptance by the service

1.7 There is sufficient car parking for visitors to the service

1.8 Everyone is able to access the service using public transport or transport provided by the service

2. Waiting Times

2.1 Service users receive an assessment within 3 weeks of referral

2.2 There are systems in place to monitor waiting times and ensure adherence to local and national waiting times standards
Guidance: There is accurate and accessible information for everyone on waiting times from referral to assessment and from assessment to treatment
Guidance: If the service sees people with suspected psychosis, they are assessed within 2 weeks of referral

2.3 The team provides service users with information about waiting times for assessment and treatment
Guidance: Service users on a waiting list are provided with updates of any changes to their appointment, as well as details of how they can access further support while waiting

2.4 Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes:

- Their rights regarding consent to treatment;
- Their rights under the Mental Health Act;
- How to access advocacy services;
- How to access a second opinion;
- Interpreting services;
- How to view their records;
- How to raise concerns, complaints and give compliments.

3. Preparing for the Assessment

3.1 For planned assessments the team sends letters in advance to service users that include:

- An explanation of the assessment process;
- Information on who can accompany them;
- How to contact the team if they have any queries, require support (e.g. an interpreter), need to change the appointment or have difficulty in getting there

3.2 Service users are provided with information and choice about their assessment and appointments
Guidance: This includes choice of time, day, venue, gender of staff or access in another language

3.3 The service has access to independent advocates to provide information, advice and support to service users, including assistance with assessment, advance statements and Care Programme Approach reviews

3.4 The assessing professional can easily access relevant clinical information (past and current) about the service user from primary and secondary care

3.5 Service users are given verbal and written information on their rights under the Mental Health Act if under a Community Treatment Order (or equivalent) and this is documented in their notes

4. Initial assessment

4.1 Service users have a comprehensive assessment which includes their:

- Mental health and medication;
- Psychosocial needs;
- Strengths and weaknesses

4.2 Immediate social stressors and social networks are identified and recorded, including financial, housing, employment, educational and vocational issues

4.3 A physical health review takes place as part of the initial assessment. The review includes but is not limited to:

- Details of past medical history;
- Current physical health medication, including side effects and compliance with medication regime;
- Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use;
- Consideration of risk of cardiovascular disease, metabolic disorders, and excessive weight gain

4.4 An assessment of practical problems of daily living is recorded

4.5 Service users have a risk assessment that is shared with relevant agencies (with consideration of confidentiality) and includes a comprehensive assessment of:

- Risk to self (including self-neglect);
- Risk to others;
- Risk from others

4.6 The team discusses the purpose and outcome of the risk assessment with the service user and a management plan is formulated jointly

4.7 The service user is asked if they have a carer, and if so, the carer's name is recorded

4.8 Any dependants are identified and recorded, including their wellbeing, needs, and any childcare issues
Guidance: This includes the names and dates of birth of any young people

4.9 Staff members are easily identifiable (for example, by wearing appropriate identification)

4.10 Staff members address service users using the name and title they prefer

5. Completing the initial assessment

5.1 All patients have a diagnosis and a clinical formulation
Guidance: The formulation includes presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation should be devised

5.2 The team sends a letter detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment

5.3 All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner

6. Following up service users who don't attend appointments

6.1 The team proactively follows up service users who have not attended an appointment/assessment or who are difficult to engage, with consideration of risk, in line with the service's engagement policy
Guidance: This could include visiting service users at home or another suitable venue, using text alerts, or engaging with their carers

6.2 If a service user does not attend for assessment, the team contacts the referrer
Guidance: If the service user is likely to be considered a risk to themselves or others, the team should contact the referrer immediately to discuss a risk action plan

6.3 Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may exist
Guidance: This should include monitoring a service user's failure to attend the initial appointment after referral and early disengagement from the service

7. Reviews and care planning

7.1 The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments, reviews and service users on the waiting list
Guidance: Referrals that are urgent or that do not require discussion can be allocated before the meeting

7.2 Every service user has a written care plan, reflecting their individual needs
Guidance: This clearly outlines:

- Agreed intervention strategies for physical and mental health;
- Measurable goals and outcomes;
- Strategies for self-management;
- Any advance decisions or stated wishes that the service user has made;
- Crisis and contingency plans;
- Review dates and discharge framework

7.3 The practitioner develops the care plan collaboratively the service user and their carer (with service user consent)

7.4 The service user and their carer (with service user consent) are offered a copy of the care plan and the opportunity to review this

7.5 The service uses the Care Programme Approach (CPA) framework (or equivalent) when necessary for the needs of the service user, which is applied in line with Trust/Social Services policy, based on effective care coordination in mental health services

7.6 Managers and practitioners conduct clinical review meetings at least annually, or according to clinical need (in line with the Care Programme Approach)

7.7 Risk assessments and management plans are updated at least annually, or according to clinical need (in line with the Care Programme Approach)

7.8 There is a single record for each service user and all contacts with the service user and their carers are recorded

8. Care and Treatment

8.1 **Therapies and activities**

8.1.1 Service users are offered evidence-based pharmacological and psychological interventions and any exceptions are documented in the case notes
Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base

8.1.2 Service users begin evidence-based pharmacological and psychological interventions within 18 weeks of accepting the intervention

8.1.3 Service users' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible

8.1.4 Service users have access to occupational therapy

8.1.5 Service users have access to art/creative therapies

8.1.6 The team signposts service users to structured activities such as work, education and volunteering

8.1.7 The team provides information, signposting and encouragement to service users to access local organisations for peer support and social engagement such as:

- Voluntary organisations;
- Community centres;
- Local religious/cultural groups;
- Peer support networks;
- Recovery Colleges

8.1.8 Service users and carers are offered written and verbal information about the service user's mental illness
Guidance: Verbal information could be provided in a 1:1 meeting with a staff member or in a psycho-education group. Written information could include leaflets, websites, etc.

8.1.9 Carers are given information on mental health problems, what they can do to help, their rights as carers and an up to date directory of local services they can access

8.1.10 All healthcare professionals have received training and supervision in providing psychologically informed care, including evidence-based low-intensity talking therapies

8.1.11 All staff members who deliver therapies and activities are appropriately trained and supervised

8.1.12 The service is able to provide care to people with a personality disorder, or signpost/refer them on for care
Guidance: Care for service users with a personality disorder is provided in a team approach with a consistent clinical model and good understanding of this group

8.1.13 The service user and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis or treatment

8.2 Medication

8.2.1 When medication is prescribed, specific treatment targets are set for the service user, the risks and benefits are reviewed, a timescale for response is set and service user consent is recorded

8.2.2 Service users and their carers (with service user consent) are helped to understand the functions, expected outcomes, limitations and side effects of their medications, to enable them to make informed choices and to self-manage as far as possible

8.2.3 Service users have their medications reviewed at a frequency according to the evidence base and clinical need. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime
Guidance: Side effect monitoring tools can be used to support reviews. Long-term medication is reviewed by the prescribing clinician at least once a year as a minimum

8.2.4 The service has rapid access to medication during working hours

8.2.5 The service is able to use or access blood tests and other physical investigations to monitor outcomes and side effects of medications

8.2.6 When service users experience side effects from their medication, this is engaged with and there is a clear plan in place for managing this

8.2.7 The service has a shared care protocol with primary care which defines responsibility for prescription and administration of medication

8.2.8 The safe use of high risk medication is audited at a service level, at least annually
Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination and benzodiazepines

8.2.9 There is a written protocol governing the removal and gradual reintroduction of medicines in situations where there is an acute risk of suicide or self-harm, which includes the need to notify the GP

9. Physical healthcare

9.1 Physical healthcare and substance misuse

9.1.1 Where concerns about a service user's physical health are identified, the team arranges or signposts the service user to further assessment, investigations and management from primary or secondary healthcare services

9.1.2 The service gives targeted lifestyle advice to service users when appropriate. This includes:
- Smoking cessation advice;
- Healthy eating advice;
- Physical exercise advice

9.1.3 The service has a policy for the care of service users with dual diagnosis of mental health problems and alcohol or substance misuse that includes:
- Liaison and shared protocols between mental health and substance misuse services to enable joint working;
- Drug/alcohol screening to support decisions about care/treatment options;
- Liaison between mental health, statutory and voluntary agencies;

- Staff training;
- Access to evidence based treatments

9.1.4 The service has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes:
• Assessment;
• Care and treatment (particularly relating to prescribing psychotropic medication);
• Referral to a specialist perinatal team/unit unless there is a specific reason not to do so

9.1.5 The team understands and follows an agreed protocol for the management of an acute physical health emergency
Guidance: This includes guidance about when to call 999 and when to contact the duty doctor

9.2 Managing the physical health of service users on mood stabilisers or antipsychotics

9.2.1 Service users who are prescribed mood stabilisers or antipsychotics are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the service user:
- A personal/family history (at baseline and annual review);
- Lifestyle review (at every review);
- Weight (at every review);
- Waist circumference (at baseline and annual review);
- Blood pressure (at every review);
- Fasting plasma glucose/HbA1c (glycated haemoglobin) (at every review);
- Lipid profile (at every review);
- ECG (at baseline and annual review)

Guidance: Service users are advised to monitor their own weight every week for the first 6 weeks and to contact the service if they have concerns about weight gain

10. Risk and safeguarding

10.1 The team receives training, consistent with their roles, on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on:
- Safeguarding vulnerable adults and children including awareness of domestic violence;
- Assessing and managing suicide risk and self-harm;
- Prevention and management of aggression and violence

10.2 All staff have received training on personal safety issues

10.3 Staff members follow inter-agency protocols for the safeguarding of vulnerable adults, and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral

10.4 If a service user drives and their mental state or diagnosis indicates that there is a risk to their driving ability, they are informed of the necessity to report their mental state or diagnosis to the DVLA (or equivalent vehicle licensing authority)

11. Discharge planning and transfer of care

11.1 Discharge or onward care planning is discussed at the first and every subsequent care plan review

11.2 Service users and their carers (with service user consent) are involved in decisions about discharge or transfer plans
Guidance: This could be through a formal discharge meeting

11.3 There are agreements with other agencies for service users to re-access the service if needed, without following the initial referral pathway
Guidance: There may be exceptions where service users require a generic assessment and it may be appropriate to follow the initial referral pathway

11.4 A letter setting out a clear discharge plan is sent to the service user and all relevant parties within 10 days of discharge. The plan includes details of:

- On-going care in the community/aftercare arrangements;
- Crisis and contingency arrangements including details of who to contact;
- Medication;
- Details of when, where and who will follow up with the service user as appropriate

11.5 The team follows a protocol to manage service users who discharge themselves against medical advice. This includes:

- Recording the service user's capacity to understand the risks of self-discharge;
- Putting a crisis plan in place;
- Contacting the relevant agencies to notify them of the discharge

11.6 When a service user is admitted to a psychiatric hospital, a community team representative attends and contributes to ward rounds and discharge planning

11.7 Service users who are discharged from hospital to the care of the community team are followed up within one week of discharge, or within 48 hours of discharge if they are at risk
Guidance: This may be in coordination with the Crisis Resolution/Home Treatment Team

11.8 When service users are transferred between community services there is a handover which ensures that the new team have an up-to-date care plan and risk assessment

11.9 When service users are transferred between community services there is a meeting in which members of the two teams meet with the service user and carer to discuss transfer of care

11.10 There is active collaboration between Child and Adolescent Mental Health Services and Working Age Adult Services for service users who are approaching the age for transfer between services. This starts at least 6 months before the date of transfer

12. Interfaces with other services

12.1 The team follows a joint working protocol/care pathway with primary health care teams
Guidance: This includes the team informing the service user's GP of any significant changes to the service user's mental health or medication, or of their referral to other teams. It also includes teams following shared prescribing protocols with the GP

12.2 The service has a physical health care pathway with clearly identified and agreed responsibilities with primary care
Guidance: This could include the agreed use of the Lester UK Adaptation of the positive cardiometabolic health resource, Rethink integrated physical healthcare pathway and NICE guidelines on physical healthcare

12.3 There are regular clinical discussions between the community mental health service and the primary care team to:
• discuss service users with shared care arrangements;
• discuss service users known only to primary care;
• provide information and advice to primary care practitioners on managing common mental health conditions;
• seek advice from primary care on the management of physical health problems

12.4 The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution Team, in services that have access to one
Guidance: This includes joint care reviews and jointly organising admissions to hospital for service users in crisis

12.5 The service is able to signpost or refer service users on to:
- other health services;
- advocacy;
- peer support;
- employment services;
- voluntary sector services

12.6 The team supports service users to access organisations which offer:
- housing support;
- support with finances, benefits and debt management;
- social services

12.7 The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence

12.8 Health records can be easily accessed by other services who may be involved with the service user's care
Guidance: This could include psychiatric liaison teams, home treatment teams, acute inpatient wards, general wards, primary care and accident and emergency departments

12.9 There are arrangements in place to ensure that service users can access help, from mental health services, 24 hours a day, 7 days a week
Guidance: Joint protocols are agreed, for example, with commissioners, primary healthcare services, emergency medical departments and social services

12.10 The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice
Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as service user and carer representatives

13. Capacity and Consent

13.1 Capacity assessments are performed in accordance with current legislation

13.2 When service users lack capacity to consent to interventions, decisions are made in accordance with current legislation

13.3 There are systems in place to ensure that the service takes account of any advance decisions that the service user has made

14. Service user involvement

14.1 Service users and their carers are given the opportunity to feed back about their experiences of using the service, and their feedback has been used to improve the service
Guidance: This might include service user and carer surveys or focus groups

14.2 Service user and carer representatives attend and contribute to local and service level meetings and committees

15. Carer engagement and support

Note: Carer involvement is subject to the service user giving consent and / or carer involvement being in the best interests of the service user

15.1 Carers are involved in discussions about the service user's care, treatment and discharge planning

15.2 Carers are advised how to access a statutory carers' assessment, provided by an appropriate agency
Guidance: This advice is offered at the time of the service user's initial assessment, or at the first opportunity

15.3 Carers are offered individual time with staff to discuss concerns, family history and their own needs

15.4 The team provides each carer with a carer's information pack
Guidance: This includes the names and contact details of key staff members in the service. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities

15.5 Carers have access to a carer support network or group. This could be provided by the service, or the team could signpost carers to an existing network
Guidance: This could be a group/network which meets face-to-face or communicates electronically

15.6 The team follows a protocol for responding to carers when the service user does not consent to their involvement

15.7 The service has a designated staff member dedicated to carer support (carer lead)

15.8 The service ensures that children and other dependants are supported appropriately
Guidance: This could include offering appropriate written information to children, or supporting the service user to communicate with their children about their mental health

16. **Treating service users with dignity and respect**

16.1 Service users are treated with compassion, dignity and respect
Guidance: This includes respect of a service user's race, age, sex, gender reassignment, marital status, sexual orientation, pregnancy and maternity status, disability and religion/beliefs

16.2 Service users feel listened to and understood in consultations with staff members

16.3 The service can demonstrate that it promotes culturally and spiritually sensitive practice

17. Provision of information to service users and carers

17.1 Information, which is accessible and easy to understand, is provided to service users and carers
Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example; audio and video materials, using symbols and pictures and using plain English, communication passports and signers. Information is culturally relevant

17.2 The service has access to translators and interpreters and the service user's relatives are not used in this role unless there are exceptional circumstances
Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice

17.3 The service uses interpreters who are sufficiently knowledgeable to provide a full and accurate translation

17.4 When talking to service users and carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them

17.5 Service users are asked if they and their carers wish to have copies of letters about their health and treatment

17.6 Service users are given verbal and written information on:

- How to access advocacy services;
- How to access a second opinion;
- How to access interpreting services;
- How to raise concerns, complaints and compliments;
- How to access their own health records

17.7 How to make a crisis/contingency plan, or advance decision/statement if they wish

17.8 Managing their health and wellbeing
Guidance: This may include reference to '5 Ways to Wellbeing'

18. Service user confidentiality

18.1 Confidentiality and its limits are explained to the service user and carer at the first assessment, both verbally and in writing

Guidance: For carers this includes confidentiality in relation to third party information

18.2 The service has confidentiality policies which are regularly monitored and reviewed, and upheld at all times when exchanging information
Guidance: Policies include the provision of information release forms and advanced statements protocols and forms

18.3 All service user information is kept in accordance with current legislation
Guidance: Staff members ensure that no confidential data is visible beyond the service by locking cabinets and offices, using swipe cards and having password protected computer access

18.4 The service user's consent to the sharing of clinical information outside the team (including with carers) is recorded. If this is not obtained, the reasons for this are recorded
Guidance: If the service user does not wish any information to be shared with their carers, staff regularly check whether they are still happy with this decision. Information already known to carers is not considered to be confidential information

19. Service environment

19.1 The environment is comfortable, clean and warm, and areas of privacy are available in the waiting area

19.2 The service entrance and key clinical areas are clearly signposted

19.3 If teams see service users at their team base or other health-based community settings, entrances and exits are visibly monitored and/or access is restricted

19.4 Clinical rooms are private and conversations cannot be easily over-heard

19.5 There is easy access to suitable toilet facilities

19.6 The environment complies with current legislation on disabled access
Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence

19.7 Furniture is arranged so that doors, in rooms where consultations take place, are not obstructed

19.8 There is an alarm system in place (e.g. panic buttons) and this is easily accessible

19.9 There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information e.g. information about services, conditions and treatment, service user records, clinical outcome and service performance measurements

19.10 Staff members follow a lone working policy and feel safe when conducting home visits

19.11 An audit of environmental risk is conducted annually and a risk management strategy is agreed

19.12 A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least 6 monthly

19.13 Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available at the team's base within 3 minutes

19.14 The crash bag is maintained and checked weekly, and after each use

20. Leadership and culture

20.1 There are written documents that specify professional, organisational and line management responsibilities

20.2 Staff members can access leadership and management training appropriate to their role and specialty

20.3 Staff members have an understanding of group dynamics and of what makes a therapeutic environment

20.4 The organisation's leaders provide opportunities for positive relationships to develop between everyone
Guidance: This could include service users and staff members using shared facilities at the team base

20.5 Team managers and senior managers promote positive risk-taking to encourage service user recovery and personal development

20.6 Staff members and service users feel confident to contribute to, and safely challenge decisions
Guidance: This includes decisions about care, treatment and how the service operates

20.7 Staff members feel able to raise any concerns they may have about standards of care

21. Teamworking

21.1 Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises

21.2 The team has protected time for team-building and discussing service development at least once a year

22. Staffing levels and skill mix

The team has dedicated sessional time from:

22.1 A Service Lead
22.2 Registered Mental Health Nurse(s)
22.3 Social Worker(s)
22.4 Occupational Therapist(s)
22.5 Psychologist(s)
22.6 Support Worker(s)
Guidance: An unqualified professional, e.g. healthcare assistant, occupational therapy assistant, psychology assistant etc.
22.7 Consultant Psychiatrist (s)
22.8 GP Link Worker (s)

22.9 Independent Prescriber(s)

The team has dedicated sessional time from:

22.10 Pharmacist(s)
22.11 Employment Advisor(s)

The team has adequate access to:

22.12 Peer Support Worker(s)
Guidance: A service user or carer employed by the team to support other service users and/or carers
22.13 Approved Mental Health Professional(s) (AMHPs)

22.14 Welfare and Benefits Advisor(s)

22.15 Administrative assistance to meet the needs of the service

22.16 Full-time care co-ordinators have a caseload of no more than 35 (reduced pro-rata for part-time staff)

22.17 There is an identified duty doctor available at all times. They are able to attend the team base within 1 hour

22.18 There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service

22.19 The service has a nominated medicines management lead

22.20 The service includes individuals with special interests that cover a range of needs
Guidance: This includes physical health, substance or alcohol misuse, access to and engagement with psychological interventions

22.21 The service has a mechanism for responding to low staffing levels, including:
- A method for the team to report concerns about staffing levels;
- Access to additional staff members;
- An agreed contingency plan, such as the minor and temporary reduction of non-essential services

22.22 There are systems in place to ensure that staffing is sufficient, and caseloads are covered and monitored when members of the team are absent for planned or unplanned periods

23. Staff recruitment and induction

23.1 Service user or carer representatives are involved in interviewing potential staff members during the recruitment process

23.2 Staff members receive an induction programme specific to the service, which covers:
- The purpose of the service;
- The team's clinical approach;
- The roles and responsibilities of staff members;
- The importance of family and carers;
- Care pathways with other services

Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme

23.3 New staff members, including agency staff, receive an induction based on an agreed list of core competencies
Guidance: This should include arrangements for:
- Shadowing colleagues on the team;
- Jointly working with a more experienced colleague;
- Being observed and receiving enhanced supervision until core competencies have been assessed as met

23.4 All newly qualified staff members are allocated a preceptor to oversee their transition into the service
Guidance: This should be offered to recently graduated students, those returning to practice, those entering a new specialism and overseas-prepared practitioners who have satisfied the requirements of, and are registered with, their regulatory body

23.5 All new staff members are allocated a mentor to oversee their transition into the service

24. Appraisal, supervision and support

24.1 All staff members receive an annual appraisal and personal development planning (or equivalent)
Guidance: This contains clear objectives and identifies development needs

24.2 All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body
Guidance: Supervision should be profession-specific as per professional guidelines and be provided by someone with appropriate clinical experience and qualifications

24.3 All staff members receive monthly line management supervision

24.4 All supervisors have received specific training to provide supervision
Guidance: This training is refreshed in line with local guidance

24.5 Staff members in training and newly qualified staff members are offered weekly supervision

24.6 The quality and frequency of clinical supervision is monitored quarterly by the clinical director (or equivalent)

25. Staff Wellbeing

25.1 The service actively supports staff health and wellbeing
Guidance: For example, providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed

25.2 Staff members have access to reflective practice groups

25.3 There are systems in place to monitor individual caseloads of staff members

25.4 Staff members are able to take breaks during their shift that comply with the European Working Time Directive

26. Staff training and development

26.1 Clinical staff members have received formal training to perform as a competent practitioner, or, if still in training, are practising under the supervision of a senior qualified clinician

26.2 All staff have received training on medication as required by their role
Guidance: This includes storage, administration, legal issues, encouraging concordance and awareness of side effects

26.3 All practitioners who administer medications have been assessed as competent to do so. This is repeated on a yearly basis using a competency based tool

26.4 All staff have received training in reflective practice and debriefing

26.5 All staff have received training in the use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent)

26.6 All staff have received training in physical health assessment
Guidance: This could include training in understanding physical health problems, physical observations and when to refer the service user for specialist input

26.7 All staff have received statutory and mandatory training
Guidance: This includes equality and diversity and information governance

26.8 All staff have received training in carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality

26.9 All staff have received training in recognising and communicating with service users with special needs, e.g. cognitive impairment or learning disabilities

26.10 All staff have received training in recognising and communicating with service users with special needs, e.g. cognitive impairment or learning disabilities

26.11 Shared in-house multi-disciplinary team training, education and practice development activities occur in the service at least every 3 months

26.12 Service users, carers and staff are involved in devising and delivering training face-to-face

27. General Management

27.1 The service has an operational policy which covers the purpose and aims of the service, ways of working and defined catchment population

27.2 The team attends business meetings that are held at least monthly

27.3 The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy

27.4 Front-line staff members are involved in key decisions about the service provided

27.5 Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team finds accessible and easy to use

28. Clinical outcome measurement

28.1 Clinical outcome measurement data is collected at two time points (initial assessment and discharge) as a minimum, and at clinical reviews where possible

28.2 Outcome data is used as part of service management and development, staff supervision and caseload feedback
Guidance: This should be undertaken every 6 months as a minimum

28.3 Clinical outcome monitoring includes reviewing service user progress against service user-defined goals in collaboration with the service user

29. Audit and service evaluation

29.1 A range of local and multi-centre clinical audits is conducted which include the use of evidence-based treatments, as a minimum

29.2 The service has audited the provision of carer education and support programmes in the last 3 years

29.3 An assessment of the extent to which the service is recovery-focused has taken place, using an identified tool within the last 2 years
Guidance: e.g. Scottish Recovery Indicator, Developing Recovery Enhancing Environments Measure (DREEM) or Implementing Recovery through Organisational Change (IMROC)

29.4 The team reviews and updates care plans according to clinical need or at a minimum frequency that complies with College Centre for Quality Improvement specialist standards

29.5 An audit of adherence to Mental Health Act guidance has been undertaken in the last year

29.6 The team, service users and carers are involved in identifying audit topics in line with national and local priorities and service user feedback

29.7 Key information generated from service evaluations and key measure summary reports (e.g. reports on waiting times) are disseminated in a form that is accessible to all

30. The service learns from complaints and serious incidents

30.1 Staff members share information about any serious untoward incidents involving a service user with the service user themselves and their carer, in line with the Statutory Duty of Candour

30.2 Staff members, service users and carers who are affected by a serious incident are offered post-incident support

30.3 Systems are in place to enable staff members to quickly and effectively report incidents.
Managers encourage staff members to do this

30.4 Lessons learned from incidents are shared with the team and disseminated to the wider organisation

30.5 Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations and examples of innovative practice

31. Commissioning and financial management

31.1. The service is explicitly commissioned or contracted against agreed standards
Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders

31.2 Commissioners and service managers meet at least 6 monthly