Edinburgh Integration Joint Board

REPORT

Bed Based Care – Phase 1 Strategy

Edinburgh Integration Joint Board

28th September 2021

Executive Summary	The purpose of this report is to provide the Edinburgh Integration Joint Board (EIJB) with the requested information required to inform decision making for the bed based care (phase 1) proposals

Recommendations	It is recommended that the **Edinburgh Integration Joint Board:** a. Decommission the residential care model provided at Drumbrae Care Home and direct the re-provisioning of Hospital Based Complex Clinical Care (HBCCC) services within that facility b. Decommission intermediate care beds currently provided at the remaining wards at Liberton Hospital and to direct the re-provisioning of these within a reconfigured number of beds within the remaining HBCCC estate. c. Decommission HBCCC beds provided at Findlay House and Ellen's Glen House and direct the re-provisioning of these within the former residential care home facility in Drumbrae d. Commission Intermediate Care beds within the bed base remaining at Ellen's Glen House and Findlay House e. Decommission the HBCCC beds provided at Ferryfield House, noting this will enable a withdrawal from the lease at intended break point and decommission the service provided there by October 2023

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 other groups or committees

DIRECTIONS FROM THE EDINBURGH INTEGRATION JOINT BOARD

Reference number	TBC
Does this direction supersede, vary or revoke an existing direction? If yes, please provide reference number of existing direction	N/A
Approval date	
Services / functions covered	Intermediate care, Hospital Based Complex Clinical Care (HBCCC) and Care Homes
Full text of direction	a. Decommission the residential care model provided at Drumbrae Care Home and direct the re-provisioning of Hospital Based Complex Clinical Care (HBCCC) services within that facility b. Decommission intermediate care beds currently provided at the remaining wards at Liberton Hospita direct the re-provisioning of these within a reconfigured number of beds within the remaining HBCCC estate c. Decommission HBCCC beds provided at Findlay House and Ellen's Glen House and direct the re-provisioning of these within the former residential care home facility in Drumbrae d. Commission Intermediate Care beds within the bed base remaining at Ellen's Glen House and Findlay House e. Decommission the HBCCC beds provided at Ferryfield House, noting this will enable a withdrawal from the lease at intended break point and decommission the service provided there by October 2023
Direction to	City of Edinburgh Council (a) NHS Lothian (b-e);

Link to relevant EIJB report / reports				
Budget / finances allocated to carry out the detail		NHS Lothian	City of Edinburgh Council	
		£15.4	£7.7	
Performance measures	Monitoring and reporting on delayed discharges; waiting list monitoring for each bed type considered; length of stay data; care home delays; occupancy rates across bed types; care at home / homecare demand			
Date direction will be reviewed				

Main Report

1. At its meeting on the 22nd June, the EIJB noted the recommendations set out in the bed based care – phase 1 strategy. The EIJB also noted that the bed based care proposals are designed to meet the strategic intention of the EIJB to deliver the right care, in the right place, at the right time, which the EIJB supports.

2. The EIJB noted that the four care homes proposed for decommissioning care, no longer meet Care Inspectorate standards and that the consequences of a reduction in care home beds in the city needs to be connected to a commensurate reinvestment in wider care provision.

3. The EIJB agreed to delay making a final decision, with the exception of the preparation towards the time critical elements of recommendations 2.a. Liberton Hospital, 2.d. Ferryfield House lease withdrawal and 3.b. the change in use of Drumbrae Care Home to provide Hospital Based Complex Clinical Care (HBCCC), until the following actions have been completed or progressed and reported for consideration to a future board meeting. An initial target date of 17 August was agreed and a special Board meeting to be arranged to consider this, if required, after this date. The required actions agreed were:

    a. Completion of a final Integrated Impact Assessment (IIA);
    b. Engagement with Trade Unions regarding the impact on Council Health and Social Care staff;
    c. Consultation with key stakeholders including the City of Edinburgh Council about the decommissioning of four care homes;
    d. A plan detailing what investment will be required to ensure people are supported to live independently in their own homes for as long as possible, including home care, community infrastructure and primary care services; and
    e. An update on workforce planning for each type of care and location and the measures to be taken to support the recruitment, retention and development of key staff.

4. A progress report was presented to the EIJB on the 17th August and can be accessed here.

Integrated Impact Assessments (IIAs)

5. The Integrated Impact Assessment is a process which enables partners to systematically consider and understand how a proposal may impact on people, the environment and the economy and includes consideration of human rights.

6. Integrated Impact Assessments were completed on the 18th and 19th August via MS Teams. The session on the 18th aimed to focus on the proposals set out in the bed based care (phase 1) strategy with the exception of the Drumbrae care home proposal, which was considered separately at the session on the 19th.

7. The representatives at the session on the 18th felt the remit was too broad and predominately wished to focus on the proposals to decommission the four older care homes. It was therefore, agreed to hold a separate IIA on the proposals relating to intermediate and hospital based complex clinical care (HBCCC).

8. Both sessions were well attended and included representatives from service areas, staff, trade unions, relatives, family members and community representation. The attendee list for each IIA is included in the reports (appendices 1 & 2)

9. The sessions were chaired independently, the chair has a background in Social Work and has 5 years of experience as an Independent Chair of Child Protection and Adult Protection Committees and, has led inquiries and investigations into practice concerns. The biography of the chair can be found in the IIA reports (appendices 1 & 2)

CARE HOME IIA – 18th AUGUST 2021

10. The session that focused on the decommissioning of the older care homes held on the 18th August 2021, highlighted that additional information was required to complete the final IIA. It was agreed by the group that this session would be documented as interim to allow further information to be collected.

11. A total of 14 actions were identified during the session, these are recorded in the IIA report (appendix 1)

12. Following the outcome of the IIA and considering the information required to fully complete this process, we propose that a decision on the four older care homes is taken following the public consultation process which will help to inform decision making.

13. An amended narrative, timeline and financial model has been developed that extends the decision on the care home proposals until completion of the public consultation. The updated information has been included in appendix 3

DRUMBRAE IIA – 19th AUGUST 2021

14. This session was held on the 19th August and focused on the change of function of Drumbrae care home, this was also recorded as interim at that point.

15. A total of 5 actions were identified during the session, these are recorded in the IIA report (appendix 2)

16. Four of these actions have been completed and information is included in this submission as follows:

    1. **Evidence of increased community capacity:** Included within the community infrastructure and investment plan
    2. **Population and demographic data required relating to an ageing population:** Included within the demand profile, modelling and projections
    3. **Evidence for balance of care required across different sectors to reflect projected need and demand:** Included within the demand profile, modelling and projections
    4. **Travel assessment and traffic and environmental impact on surrounding area:** Included as appendix 4.

The final action identified is:

    5. **Engagement with Drumbrae community:** This will be planned as part of the wider public consultation activity

17. As we have completed the majority of actions identified in the IIA and have plans in place to complete the final action, this report can now be finalised and published.

18. We recommend that the proposal for the re-provisioning of Drumbrae care home to a Complex Care Assessment unit is approved by the Board at the meeting on the 28th September.

Engagement with Trade Unions regarding the impact on Council Health and Social Care staff

19. Regular weekly meetings have continued between Trade Unions related to Council employees, the project team and CEC HR.

20. These meetings provide the opportunity to discuss the proposals and progress with Trade Union colleagues and, provide a forum to escalate any concerns.

21. As the proposals within the Bed Based Care (Phase 1) Strategy are only proposals at this point, formal consultation activity has not been initiated. Formal consultation can only begin following a decision by the Board.

22. Regular meetings with Trade Union colleagues will continue, if the proposals are approved, consultation and engagement will continue through the initiation of formal staff consultation and workforce organisational change.

Consultation with key stakeholders including the City of Edinburgh Council on the decommissioning of four care homes

23. A short life working group has been established with relevant stakeholders from both the City of Edinburgh Council and NHS Lothian on the property aspects of the proposals.

24. The group held the initial meeting w/c 2nd August and have continued to meet regularly.

25. The key focus of the group is to discuss and agree all issues relating to buildings. The main focus of the group to date is the requirements for the change in function of Drumbrae care home and the lease agreement for Ferryfield House. Going forward the group will consider the requirements and implications of decommissioning the four older care homes.

26. Although ownership of the buildings will stay as they are, the group will agree any contractual agreements that need to be in place to support a change in function and clear roles and responsibilities for the day to day operation and management of the buildings.

27. Assessments have been completed on the suitability of Drumbrae care home as a Complex Care Assessment unit. The building has been assessed as suitable with minor adaptations required, these adaptations predominately relate to infection, prevention and control (IP&C) measures with no structural or mechanical and engineering work required. A breakdown of the adaptations needed can be found in appendix 5. Costs are being sought for these adaptations and will be supplied when available, an estimate of £1m has been included in the financial modelling for this purpose.

28. A physical condition survey has been completed for Drumbrae care home which highlighted some minor repairs are required mainly to aesthetics that are required immediately equating to £9,500. Further physical condition maintenance costs have been estimated over a ten year period and equate to £30,092. The physical condition survey summary is included in appendix 6.

A plan detailing the investment required to ensure people are supported to live independently in their own homes for as long as possible, including home care, community infrastructure and primary care services

29. The community infrastructure and investment plan can be found in appendix 7.

30. There are many contributing factors to enable people to be supported to live independently in their own home.

31. It is an extremely complex landscape and activities and initiatives cannot be seen in isolation. There are a number of interdependencies that will support our redesigned bed base but it will require a range of initiatives to work together in a system wide delivery model to be successful.

Demand Profiling, Modelling and Projections

32. Following the EIJB meeting on 22nd June, a wider data set has been identified and analysed for all bed types considered in the phase 1 proposals. The Local Intelligence Support Team (LIST) have been supporting the project to validate the projections used in the Bed Based Care (phase 1) strategy.

33. The demand profiling, modelling and projection report (appendix 8) provides additional detail on population and demographic trends, trend analysis of care home demand, projected bed numbers including uplifts and demand relating to residential, nursing and dementia care from hospital.

An update on workforce planning for each type of care and location and the measures to be taken to support the recruitment, retention and development of key staff

34. Indicative workforce plans have been developed for all services affected by the proposals and can be found in appendix 9.

35. The existing and actual staffing numbers have been compared with the new staffing establishments for each service.

36. Formal staff consultation cannot begin until a decision has been reached. If a decision is reached, staff will be provided with a range of options for their onward employment depending on the service they work within. At this point, we will be able to fully develop the workforce plans for each service which will be informed by individual preferences;

37. There is a no redundancy policy within NHS Lothian and a no compulsory redundancy policy within the City of Edinburgh Council. The EHSCP fully support this and wish to retain the skilled workforce within these services.

38. The Partnership are looking to recruit to the new model of care within the 60 bed care homes which will see the introduction of registered nurses to complement the existing staffing establishment. These roles will provide further opportunities to our Health and Social care staff and will widen the options available to staff in the service areas that are impacted by the redesign proposals;

39. The increase in intermediate care capacity may also create additional jobs and will offer additional opportunities to staff affected by the redesign proposals;

Public Consultation requirements

40. Public consultation is planned on the future provision of health and social care in Edinburgh for older people.

41. Independent legal advice was sought on the process specifically relating to the EIJB undertaking public engagement and consultation on the proposals.

42. The Partnership have commissioned the Consultation Institute to support the consultation activity. The Consultation Institute are a well-established not for profit best practice institute, promoting high quality public and stakeholder consultation in the public, private and voluntary sectors.

43. There remains a lack of clarity about the IJBs requirement for public involvement, engagement and consultation, as legislation that established Integration Boards does not provide clear guidance or confirmation that they must meet the same duties as Health Boards or Local Authorities, in this regard, or have their own specific duties.

44. The Consultation Institute will undertake an analysis of the statutory and non-statutory requirements, scrutinising legislation, statutory guidance and case law to advise the Partnership on the process and procedures to follow to ensure the EIJB fulfils its obligations for consultation and engagement.

45. The Consultation Institute have been commissioned to undertake this work imminently and will summarise their findings in a report to the Partnership.

Report Author

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Background Reports

1. https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 – item 7.1

2. https://democracy.edinburgh.gov.uk/mgIssueHistoryHome.aspx?IId=17945

Appendices

Appendix 1: Care Homes IIA Report

Appendix 2: Drumbrae IIA Report

Appendix 3: Updated Narrative, Timeline and Financial Model

Appendix 4: Drumbrae Traffic Survey

Appendix 5: Infection, Prevention and Control Requirements

Appendix 6: Drumbrae Physical Condition Survey summary

Appendix 7: Community Infrastructure and Investment Plan

Appendix 8: Demand Profiling, Modelling and Projections

Appendix 9: Workforce

Edinburgh Integration Joint Board

Appendix 1

INTEGRATED IMPACT ASSESSMENT REPORT – CARE HOMES

Section 4 Integrated Impact Assessment

Summary Report Template

Each of the numbered sections below must be completed

Interim report	X	Final report	

(Tick as appropriate)

1. Title of proposal
Bed Based Review – Care Homes

2. What will change as a result of this proposal?

This proposal recommends the decommissioning of four older care homes operated by the Edinburgh Health and Social Care Partnership (EHSCP). The EHSCP cannot provide the kind of care that is required to meet the needs of the population who require more complex care usually with nursing input. These four buildings no longer meet modern day building design standards for their function and it would not be value for money to renovate or upgrade them for continued use. It is important to say that the level of care provided in these homes by our hard working care staff is not in question and they continue to deliver high standards of care, despite the environmental challenges of caring for residents in these buildings. There is an increased demand for nursing care within care homes, which the Partnership does not provide at present. The Partnership is looking to change the model of care provided in the newer care homes within the estate to include nursing provision, which would allow the Partnership to discharge people from hospital beds into a more appropriate environment to meet their needs. The intention of these proposals is to support more people to live independently in their own homes for as long as possible, ensuring bed based services are only utilised when care needs cannot be met in any other environment.

Intermediate Care and Hospital Based Complex Clinical Care (HBCCC) were to form part of this IIA however, the care home proposals became the focus and therefore a further

internal IIA for HBCCC and intermediate care will be completed. The group agreed that the remit was too broad and were supportive of separating the IIAs.

3. Briefly describe public involvement in this proposal to date and planned

The proposals have been discussed at the Edinburgh Integration Joint Board (EIJB), the Bed Based Care Project Board, subsequent working groups and the EHSCP Executive Management Team (EMT). There has been limited public involvement to date but a full public consultation is planned on the wider context of how we deliver care for our older population in the future.

It was clear throughout the IIA process that there was a perception of mishandling the approach to these proposals. The proposals are very emotive and it was felt that due consideration had not been given to the consultation process and, that further engagement was required. The timing of the proposals is also an issue as we are still in the midst of a pandemic, approaching a challenging winter, staff are fatigued and it was felt that these proposals added a layer of unnecessary stress and anxiety to an already challenging period.

Furthermore, there were strong feelings on the way the communications had been handled, with the misconception that the media received information prior to staff, residents and families. The Partnership did apologise to those present in the IIA for not getting the approach right but emphasised that the aim was to ensure staff, residents and family members were informed of the proposals before they became public knowledge and before the media reported on them.

4. Is the proposal considered strategic under the Fairer Scotland Duty?

Yes

5. Date of IIA

18th August 2021

6. 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	Job Title	Date of IIA training
Liz Taylor (Biography)	Independent Chair	
Hazel Stewart	Programme Manager, EHSCP	**Feb 2020**
Jacqui Macrae	Senior Responsible Officer and Chief Nurse, EHSCP	
Elisa Giannulli	Project Manager (report writer), EHSCP	

Sara MacDonald	Senior Accountant, CEC	
Deborah Mackle	EHSCP Locality Manager, South West	
Jane Brown	Acting Senior Care Home Manager, EHSCP	
Shona McGregor	Ford's Road Care Home Manager, EHSCP	
Beverley Bowmaker	Business Support Manager, Ferrylee care home, EHSCP	
Mark Denholm	Business Support Officer, Jewel House care home, EHSCP	
Siobhan Murtagh	HR Consultant, CEC	
Helen Fitzgerald	Partnership Representative, NHS Lothian	
Billie Flynn	Deputy Chief Nurse, EHSCP	
Jenny Mackenzie	Delayed Discharge Manager, AAH Discharge hub, EHSCP	
Jane Shiels	Physiotherapy rehabilitation service lead, EHSCP	
Kirsty Macfarlane	Charge Nurse	
Emma Barnes	Occupational therapy rehabilitation service lead	
Mandy Bisset	Senior Charge Nurse, Findlay House	
Samantha Wight	Senior Charge Nurse, Medicine of the Elderly	
Hugh Campbell	Relative of resident	
Rhona Douglas	Relative of resident	
Conor McCleary	Relative of resident	
Ray Whittingham	Relative of resident	
Alison Anderson	Relative of resident	
Trisha Henderson	Relative of resident	
Graeme Smith	Unite The Union	
Gerry Stovin	Unison	
Brian Robertson	Unite The Union	

7. Evidence available at the time of the IIA

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected?
Data on populations in need	*NRS Population projections for Scottish Areas (2018)* *Joint strategic needs assessment – March 2021*	• The population in Edinburgh will continue to rise with the biggest increase projected in the 75-84 age group. • The overall population is expected to rise by 7.7% between 2018 - 2030 15.1% of the Edinburgh population are over 65
Data on service uptake/access	*Public Health Scotland acute hospital activity and NHS Board information (Quarterly) ending 31 December 2020* https://www.isdscotland.org/Health-topics/Health-and-social-community-care/Care-Homes/Census/index.asp?Co=Y Discharge hub data on IC referrals/admissions and discharges Discharge hub data on HBCCC referrals/admissions and discharges https://www.isdscotland.org/health-topics/health-and-social-community-care/nhs-continuing-care/ https://www.gov.scot/publications/inpatient-census-2019-hospital-based-complex-clinical-care-long-stay/pages/5/ http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf CEC Residential report NES TURAS Care Management Home First intermediate care dashboard *National Audit of Intermediate care (NAIC) England and Wales* ISD Delayed Discharge data – Occupied bed days Delayed Discharge in NHSScotland – Annual report https://www.gov.scot/publications/coronavirus-covid-19-care-home-oversight/ https://www.gov.scot/publications/transforming-specialist-dementia-hospital-care/pages/7/ https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/social-and-community-care/care-home-census-for-adults-in-scotland/	Detailed information on the demand and modelling can be found in the Bed Based Care strategy: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 (item 7.1) Intermediate care: • Modelling suggests that Edinburgh doesn't have enough intermediate care beds (currently 64) • Applying uplifts for various projections suggests approximately 130 beds are required • Due to bed numbers and existing demand patients can have an extended stay in a Hospital setting as there are no intermediate care beds available HBCCC: • Modelling suggests that Edinburgh has too many HBCCC beds (currently 144) • Applying uplifts for various projections suggests approximately 85 beds are required • Approximately 40% of patients within HBCCC could have their care needs met in an alternative setting such as a care home with nursing provision • Edinburgh internal care home estate cannot support these patients with existing infrastructure and staffing models Care Homes:

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected?
		• Edinburgh has eight EHSCP managed care homes • Four of these care homes have surpassed their design life expectancy • All EHSCP managed care homes offer residential care The introduction of registered nurses would enable the EHSCP to enhance the existing model of care to support people with more complex care requirements
Data on socio-economic disadvantage e.g. low income, low wealth, material deprivation, area deprivation.	*NRS Population projections for Scottish Areas (2018)* *Joint strategic needs assessment – March 2021* https://apps.esriuk.com/app/MyNearest/29/view/5face59295c042f1b1320816cec9c412/index.html	• The North West is the largest locality in Edinburgh accounting for 28.5% of the population • The largest growth is expected in the North East locality • The largest growth for older people aged 65+ is expected in the North East locality (33.4%) • The largest growth for older people aged 90+ is expected in the South West locality (57.7%) Approximately 36% of people aged over 65 are living in single person households
Data on equality outcomes	https://www.gov.uk/guidance/equality-act-2010-guidance https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2018/03/fairer-scotland-duty-interim-guidance-public-bodies/documents/00533417-pdf/00533417-pdf/govscot%3Adocument/00533417.pdf	The Integrated Impact Assessment was designed to consider the impact of any strategic decision in relation to equality; socio-economic disadvantage; climate change; sustainability; the environment and human rights
Research/literature evidence	https://www.careinspectorate.com/images/documents/4293/Building%20better%20care%20homes%20for%20adults%202017.pdf https://www.isdscotland.org/Health-topics/Health-and-social-community-care/Care-Homes/Census/index.asp?Co=Y *National Audit of Intermediate care (NAIC) England and Wales* https://www.gov.scot/publications/coronavirus-covid-19-care-home-oversight/ https://www.gov.scot/publications/transforming-specialist-dementia-hospital-care/pages/7/ https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/social-and-community-care/care-home-census-for-adults-in-scotland/	Detailed information and references to the literature evidence can be found in the Bed Based Care strategy: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 (Item 7.1)

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected?
	https://www.gov.scot/policies/independent-living/intermediate-care/ https://www.gov.scot/publications/maximising-recovery-promoting-independence-intermediate-care-framework-scotland/ https://www.isdscotland.org/health-topics/health-and-social-community-care/nhs-continuing-care/ http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf	
Public/patient/client experience information		Some of this information has been gathered within services. Further public/patient and client experience information will be gathered through engagement activities
Evidence of inclusive engagement of people who use the service and involvement findings		As above, as these are proposals at this point and as they are sensitive wide spread inclusive engagement has not taken place yet. Public consultation is being investigated and will begin once preparatory work has been completed – expected to begin in September for 12 weeks.
Evidence of unmet need		The evidence of unmet need can be found within the Bed Based Care strategy: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 (Item 7.1) For each bed type considered within the strategy, the waiting lists were taken into account and included in the modelling and projections
Good practice guidelines	https://www.careinspectorate.com/images/documents/4293/Building%20better%20care%20homes%20for%20adults%202017.pdf *National Audit of Intermediate care (NAIC) England and Wales* https://www.gov.scot/publications/coronavirus-covid-19-care-home-oversight/ https://www.gov.scot/publications/transforming-specialist-dementia-hospital-care/pages/7/ https://www.gov.scot/policies/independent-living/intermediate-care/ https://www.gov.scot/publications/maximising-recovery-promoting-independence-intermediate-care-framework-scotland/	

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected?
	https://www.isdscotland.org/health-topics/health-and-social-community-care/nhs-continuing-care/ http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf	
Carbon emissions generated/reduced data	https://www.gov.scot/collections/environment-statistics/ https://www.gov.scot/publications/cmo-annual-report-2020-21/pages/6/	Some evidence of carbon emissions relating to buildings can be found within the Bed Based Care strategy appendices relating to building condition reports: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 (Item 7.1)
Environmental data	https://www.gov.scot/collections/environment-statistics/ https://www.gov.scot/publications/cmo-annual-report-2020-21/pages/6/	As above
Risk from cumulative impacts		https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 The bed based care strategy (item 7.1) includes within the appendices an options appraisal which assesses the risk associated with the recommendations
Other (please specify)		
Additional evidence required		

8. In summary, what impacts were identified and which groups will they affect?

Equality, Health and Wellbeing and Human Rights	Affected populations
Positive People who did not need to be in an acute setting could be cared for in a community setting with nurse led care or could be supported to live at home; Increasing Intermediate Care capacity will enable more people to be rehabilitated and will improve outcomes;	Current residents in four older care homes (over 65s); Current and future over 65s who require bed based care; families and friends of people requiring bed based care; Staff – both NHS & CEC

Introducing nursing provision into care homes will enable the EHSCP to provide complex care to meet the needs of the most frail and vulnerable in our society, supporting hospital discharges for those delayed due to lack of nursing home provision; The new model of care allows the EHSCP to have the right skill mix in the right environment to meet the needs of those with complex care requirements; Modern care home environments which meet modern day design standards enable care delivery to those with complex care requirements and supports better outcomes; Efficiencies of care on newer buildings will allow reinvestment. New model of care gives staff the opportunity to train and learn new skills. The introduction of the Care Academy (separate initiative) will provide additional opportunities to staff working in this area; Assurance was provided that if a decision is reached on the proposals, full staff consultation would follow. This is a defined process in both the NHS and CEC, staff will be consulted on a 1-2-1 basis and will receive support throughout the transition period should the proposals be approved; Care home staff are doing the best they can in a challenging environment. This proposal doesn't / shouldn't detract from the excellent care that is provided however, our residents and our staff deserve a better living and working environment. **Negative** Letter received about proposed closures "took the feet from under relatives and staff" (relative). Residents moved to care home believing this to be a home for life. Family members feel a move would not be in their relatives' best interests, for residents currently accommodated in one of the older care homes. They held strong views that people were not being put at the centre of decisions, rather budgets were driving. Concerns were raised on the choices available to residents should they have to move, what other options there are in the same area and would these have a financial impact. Information on the other providers / care homes in each of the affected areas should have been made available to allow the group to fully assess the impact of the proposals.	

Uncertainty around job security for staff in our care homes is affecting morale, particularly after the hard work and sacrifices made during the COVID-19 pandemic. Timing is not great. Some people in protected characteristic groups could be more disadvantaged if asked to move home / workplace. Due to issues with acceptance, it could mean people in this category are more disadvantaged by the proposals; Impact is on staff and family members due to the potential of increased travel time and cost. Potential impact may be greater on BAME staff - need to understand the current proportion of BAME staff within the affected care homes and remove any barriers faced through redeployment. Concerns raised around future provision of residential care and potential costs to residents. Removing local authority residential care means this option would only be available through the private sector and could discriminate against people without the means to fund their own care. Inequity for care home staff relating to pay and conditions, with the private sector mostly offering less than local authorities, could impact on employment and living standards. The older care homes are located in areas of deprivation and decommissioning them could impact on local communities. Closures will create situations of discrimination with loss of local employment, loss of local authority provision and impact on costs of care for individuals. The existing environmental challenges relating to the four older care homes means that difficult decisions have to be made when admitting residents. Due to environmental limitations the care homes already discriminate against some potential residents (for example, residents with reduced mobility that require equipment). If a resident's mobility deteriorates over the course of their stay, alternative care homes need to be considered as the environment does not support residents with these care requirements. Concerns were raised about the significant reduction in care home places when the older population in the City is increasing and whether future demand can be met.	

Some of the group felt there was not enough data on accessibility and equality impacts to fully assess the impact of the proposals – would have expected consultation to have taken place before the IIA to inform the assessment. The alternative of upgrading homes in cost-benefit terms was not known.	

Environment and Sustainability including climate change emissions and impacts **Positive** A reduction in our care home estate has a positive impact on our carbon footprint; Fewer buildings means we would be more carbon efficient and sustainable going forward; The newer care homes in our estate are more energy efficient as they meet modern day building standards; Our newer homes all have good environmental ratings; A reduction of buildings mean less individual building based procurement; Newer care homes that meet modern building design standards for their function support better infection, prevention and control measures; The barriers to discharging our older population from hospital are access to nursing care that is affordable and care in the right environment. The new model of care will mitigate some of these issues and impact on people who are delayed in hospital; Need to consider the wider impact of the range of activities underway across the EHSCP as they are all interconnected: the introduction of 3 Conversations, working to a Home First model, reviewing Self Directed Support (SDS), more community investment initiatives and a redesign of existing Home Care services all need to work together at Locality, Community and City level; **Negative** Some of the group felt there was not enough data to fully assess the impact. Very little environmental and carbon data provided to allow for appropriate assessment;	**Affected populations** Citizens of Edinburgh

It was raised that moving to a Home First approach would mean increased car journeys by care at home staff, increasing emissions and congestion in the City. This is partially mitigated as the majority of our home care staff travel on foot with very few registered as car users. Staff and families may have to travel further depending on their own/their relatives' onward location which could increase emissions and congestion in the city. The care homes that are proposed to be decommissioned are all smaller and the Care Inspectorate suggest that better care can be provided in smaller environments. People delayed in hospital waiting for affordable nursing care cannot access suitable accommodation within the EHSCP existing care home estate, with a knock on effect in both acute and community settings; The timescales set out in the redesign proposal are concerning and not realistic. Noted – these were indicative and no decisions have been taken by EIJB.	

Economic including socio-economic disadvantage	**Affected populations**
Positive The EHSCP does not provide nursing care within care homes at present. By changing the model of care the EHSCP can provide nursing care to those who need it at local authority funded rates, creating a more equitable landscape to that which is currently provided; By introducing a new model of care with nursing provision we will create opportunities for staff to learn and develop new skills. By reducing the number of care homes in the estate, the model is more economically viable than the existing model. **Negative** The proposals were perceived as financially driven in order to make savings even though the strategy clearly states there will be reinvestment in new models of care. Further work is needed to clarify the intention; People who are socio-economically disadvantaged are less likely to be able to afford private care and are therefore going to be dependent on what is provided by the city. There was concerns that these proposals	Staff, Residents and families, Citizens of Edinburgh

disadvantage a large proportion of the population by removing the provision of local authority residential care; People with protected characteristics could also be disadvantaged socio-economically and the EHSCP have a responsibility to ensure their specific needs are considered in these proposals; Consideration should be given to the communities in which these older homes are located - the community need to be given the opportunity to provide their opinion on the proposals; There could be negative impacts relating to the removal of care provision from areas of deprivation; The potential for additional travel time and costs could negatively impact on staff and residents' relatives	

9. **Is any part of this policy/ service to be carried out wholly or partly by contractors and if so how will equality, human rights including children's rights, environmental and sustainability issues be addressed?**
   N/A

10. **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.**
    Extract from communications plan available (appendix 2)

11. **Is the policy likely to result in significant environmental effects, either positive or negative**? If yes, it is likely that a Strategic Environmental Assessment (SEA) will be required and the impacts identified in the IIA should be included in this.

    There is more work to be done on the environmental impact, understanding the additional travel times (or reduced travel time in some cases) needs to be worked through however, the information required to complete this would normally become available through formal consultation. The Partnership cannot start formal consultation without a decision so this is a challenge. Additionally, it is difficult to predict the impact on care at home workers to understand the environmental impact this would have, unlikely to increase car journeys but could require additional capacity. Further work is needed to understand the environmental factors in decommissioning four homes, reducing the overall care home estate and the impact of more people remaining in their own homes for longer.

12. 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.

More data is to be gathered on the different workforce groups and particularly those with protected characteristics.

The number of residents without representation, either by family members or those with Power of Attorney (POA) arrangements in place, and how their views may be sought needs addressing. Recent assessments were completed of our care home population by the Residential Review Team and a request has been made to obtain this information.

Carbon Emissions – related to increase in care at home and additional journeys and increase in travel times for staff and members of family. Socio economic impact, workforce and population.

13. Specific to this IIA only, what recommended actions have been, or will be, undertaken and by when? (these should be drawn from 7 – 11 above) 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 job title**	**Deadline for progressing**	**Review date**
Data required on alternative care homes in the localities of the four older homes to show the options available to residents and their families – to include weekly bed cost to understand financial implications	Project team	ASAP	
No. of BAME staff in the affected care homes to be clarified	Project team	ASAP	
List all care homes in Edinburgh that offer residential care and include specific details on care homes that offer LA funded placements	Project team and contracts	ASAP	
Consultation required on future provision of care for older people	EIJB led	ASAP	

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 job title**	**Deadline for progressing**	**Review date**
A wider context is required to show all the initiatives underway that support a redesigned bed base and enable more people to be cared for at home;	Project team	21st September	
Additional environmental and carbon data required to fully assess the impact of the proposals	Project team	ASAP	
Data required on the ratio of home care staff that are car users	Project team	ASAP	
Data required on the potential impact of more people being cared for at home	Project team	ASAP	
Further data needed on the impact of people being delayed in hospital awaiting nursing care, what is the impact on hospital and community services	Project team	ASAP	
Proposals are seen as financially driven, need to clarify the intention and clearly show the financial impact of the proposals	Project team/finance	ASAP	
Engagement with the communities in which these care homes are located to ensure the community has the opportunity to provide their opinions on the proposals	Project team	ASAP	
Need to understand the existing residents who don't have POA or relatives to support them with the transition	Project team / RRT	ASAP	
Ageing population and future demand, additional data needed to ensure demand can be met	Project team		
Cost v benefit analysis of alternative option to upgrade the older homes	Project team		

14. Are there any negative impacts in section 8 for which there are no identified mitigating actions?

Further data is required to mitigate some of the potential negative impacts identified. Once this has been gathered and presented, we will know if any of the negative impacts require mitigating actions.

15. How will you monitor how this proposal affects different groups, including people with protected characteristics?

We need to look closer at the groups impacted in the workforce and in particular identify those with protected characteristics. It would be the intention that 1-2-1 meetings would be held with impacted staff as part of the formal consultation process, to understand their personal circumstances and preferences for ongoing employment. Through this process we would aim to mitigate any negative impact for all staff but particularly those with protected characteristics. With regard to residents and their families, they would each have their own RRT (Residential Review Team) member to support them through the transition process, and we would make every effort to move people in their friendship groups with familiar staff wherever possible to help them to settle into their new home. The RRT would support the resident and family members at every stage of the move.

16. Sign off by Head of Service/ NHS Project Lead

Name

Date

17. Publication

Completed and signed IIAs should be sent to

strategyandbusinessplanning@edinburgh.gov.uk to be published on the IIA directory on the Council website www.edinburgh.gov.uk/impactassessments

Edinburgh Integration Joint Board/Health and Social Care sarah.bryson@edinburgh.gov.uk to be published on the www.edinburghhsc.scot/the-ijb/integrated-impact-assessments/

Appendix 1

Biography – Liz Taylor

Liz Taylor is a qualified social worker who has held senior positions in adult services, children's services and criminal justice in several local authorities, to Director and Chief Social Work Officer level. Liz has worked also for central government and other national bodies, in policy and practice development, education, inspection and audit. She has 5 years of experience latterly as an Independent Chair of Child Protection and Adult Protection Committees and has led inquiries and investigations into practice concerns. Collaborative working across agencies and co-production to make best use of resources in meeting needs have always been areas of particular interest for Liz. She has an MSc in management in community care and an MBA.

Appendix 1

EXTRACT FROM COMMUNICATIONS PLAN

Audiences and audience-specific objectives	
Audience group	**Audience-specific objective**
EIJB members	To have confidence about the programme of change.
Colleagues	To understand that this exercise is about better outcomes and isn't about 'cuts' To feel secure, well informed and looked after throughout the change process. To feel excitement, energy and pride in what we are all trying to achieve together. To feel that we recognise their skills and expertise and that we want to help them be their best selves and help even more people stay cared for, healthy and safe.
Other external stakeholders / interested parties	To have confidence about the programme and its impacts. To have the information they need to work with us and make the programme a success. To be assured that the programme is in line with our strategic objectives and focused on better outcomes for residents, families and colleagues. To provide CEC and NHSL partners with assurance, information, and opportunities to contribute.
Media	To have confidence and understanding about the programme. To have the information they need to promote the programme with positive sentiment.

Communications approach				
Audience group	**Proposed communications channels**	**Responsible**	**Communications assets to be produced to support activity**	**Proposed frequency**
EIJB	Development session with the EIJB	Programme team	Communications plan (working draft) Draft reactive lines ahead of 18 May EIJB Development session	TBC
	Board meeting updates	Programme team	Reactive lines to anticipate media interest Internal communications following the meeting, closely aligned to strategic objectives	June 2021 October 2021 and as requested
Colleagues	Colleague News	Communications team	Regular briefings in newsletter to update colleagues on consultation, key decisions, programme purpose etc	Monthly (minimum) and also as required following key milestones
	Project specific detailed engagement and consultation with staff	Programme team	NA	As required
	Webpage updates	Comms team	Regular updates on progress – such as key dates/decisions / activity	Bi-monthly

Other external stakeholders	Formal meetings	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Board attendance	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Formal reports and returns	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Attendance at CEC and NHSL corporate management team	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Attendance and information reports fed to council and NHS committees	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Resident, family and patient updates	Programme team / RRT / CH managers	Media channels, webpage, direct contact (generic email address for enquiries)	As required
	Care Inspectorate updates	Programme team / RRT /	Slide packs and reports as required Attendance at forums on request Direct contact	As required
Media	Reactive media response	Communications team	Lines prepared in advance of key milestones (e.g. 22 June 2021 board / October board)	As required depending on programme deliverables
	Key message lines	Communications team	Lines to take prepared to cover key messages	As required depending on programme deliverables
	FAQ document	Programme team (with C&E team acting as a consultant)	FAQ to cover anticipated questions	As required depending on programme deliverables
	Social media response	Communications team	Reactive social media response prepared to enable EHSCP and CEC to respond to any noise on owned social media channels	As required depending on programme deliverables

Edinburgh Integration Joint Board

Appendix 2

INTEGRATED IMPACT ASSESSMENT REPORT – DRUMBRAE

Section 4 Integrated Impact Assessment

Summary Report Template

Each of the numbered sections below must be completed

Interim report	X	Final report	

(Tick as appropriate)

1. Title of proposal

Bed Based Review: The re-provision of Drumbrae Care Home from residential Care Home to a Complex Care Assessment unit, part of the Hospital Based Complex Clinical Care (HBCCC) service

2. What will change as a result of this proposal?

Drumbrae would cease to operate as a care home and change function to a Complex Care Assessment (CCA) unit, part of the HBCCC service allowing existing service to reduce bed numbers in line with benchmarking and modelling projections.

3. Briefly describe public involvement in this proposal to date and planned

The proposals have been discussed at the Edinburgh Integration Joint Board (EIJB), the bed based care project board, subsequent working groups and the EHSCP Executive Management Team (EMT). There has been limited public involvement to date but a full public consultation is planned on the wider context of how we deliver care for our older population in the future.

4. Is the proposal considered strategic under the Fairer Scotland Duty?

Yes

5. Date of IIA

19th August 2021

6. 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	Job Title	Date of IIA training
Liz Taylor (Biography)	Independent Chair	
Hazel Stewart	Programme Manager, EHSCP	Feb 2020
Jacqui Macrae	Senior Responsible Officer (SRO) and Chief Nurse, EHSCP	
Elisa Giannulli	Project Manager (report writer), EHSCP	
Jane Brown	Acting Senior Care Home Manager, EHSCP	
Jackie Reid	Drumbrae Care Home Manager, EHSCP	
Lorraine Lockhart	Drumbrae Care Worker, EHSCP	
Debbie Finch	HR Consultant, CEC	
Billie Flynn	Deputy Chief Nurse, EHSCP	
Sheena Muir	Hospital & Hosted Services Manager, EHSCP	
Emma Barnes	Occupational Therapy Rehabilitation Service Lead	
Jane Shiels	Physiotherapy Rehabilitation Service Lead	
Helen Fitzgerald	Partnership Representative, NHS Lothian	
Mike Massaro-Mallinson	North West locality manager and Multi Agency Quality Assurance (MAQA) Chair, EHSCP	
Liam Stewart	Drumbrae Community representative	
Gordon Milne	Relative of Drumbrae Resident	
Brian Robertson	Unite the Union	

7. Evidence available at the time of the IIA

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected?
Data on populations in need	*NRS Population projections for Scottish Areas (2018)* *Joint strategic needs assessment – March 2021*	• The population in Edinburgh will continue to rise with the biggest increase projected in the 75-84 age group. • The overall population is expected to rise by 7.7% between 2018 - 2030 15.1% of the Edinburgh population are over 65
Data on service uptake/access	*Public Health Scotland acute hospital activity and NHS Board information (Quarterly) ending 31 December 2020* https://www.isdscotland.org/Health-topics/Health-and-social-community-care/Care-Homes/Census/index.asp?Co=Y Discharge hub data on HBCCC referrals/admissions and discharges https://www.isdscotland.org/health-topics/health-and-social-community-care/nhs-continuing-care/ https://www.gov.scot/publications/inpatient-census-2019-hospital-based-complex-clinical-care-long-stay/pages/5/ http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf CEC Residential report NES TURAS Care Management ISD Delayed Discharge data – Occupied bed days Delayed Discharge in NHSScotland – Annual report https://www.gov.scot/publications/coronavirus-covid-19-care-home-oversight/ https://www.gov.scot/publications/transforming-specialist-dementia-hospital-care/pages/7/ https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/social-and-community-care/care-home-census-for-adults-in-scotland/ https://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=307039	Detailed information on the demand and modelling can be found in the Bed Based Care strategy: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 (item 7.1) HBCCC: • Modelling suggests that Edinburgh has too many HBCCC beds (currently 144) • Applying uplifts for various projections suggests approximately 56 beds are required • Approximately 40% of patients within HBCCC could have their care needs met in an alternative setting such as a care home with nursing provision • Edinburgh internal care home estate cannot support these patients with existing infrastructure and staffing models Care Homes: • Edinburgh has eight EHSCP managed care homes • Four of these care homes have surpassed their design life expectancy • All EHSCP managed care homes offer residential care The introduction of registered nurses would enable the EHSCP to enhance the existing model of care to support people with more complex care requirements

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected?
Data on socio-economic disadvantage e.g. low income, low wealth, material deprivation, area deprivation.	*NRS Population projections for Scottish Areas (2018)* *Joint strategic needs assessment – March 2021* https://apps.esriuk.com/app/MyNearest/29/view/5face59295c042f1b1320816cec9c412/index.html	• The North West is the largest locality in Edinburgh accounting for 28.5% of the population • The largest growth is expected in the North East locality • The largest growth for older people aged 65+ is expected in the North East locality (33.4%) • The largest growth for older people aged 90+ is expected in the South West locality (57.7%) Approximately 36% of people aged over 65 are living in single person households
Data on equality outcomes	https://www.gov.uk/guidance/equality-act-2010-guidance https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2018/03/fairer-scotland-duty-interim-guidance-public-bodies/documents/00533417-pdf/00533417-pdf/govscot%3Adocument/00533417.pdf	The Integrated Impact Assessment was designed to consider the impact of any strategic decision in relation to equality; socio-economic disadvantage; climate change; sustainability; the environment and human rights
Research/ literature evidence	https://www.careinspectorate.com/images/documents/4293/Building%20better%20care%20homes%20for%20adults%202017.pdf https://www.isdscotland.org/Health-topics/Health-and-social-community-care/Care-Homes/Census/index.asp?Co=Y https://www.gov.scot/publications/coronavirus-covid-19-care-home-oversight/ https://www.gov.scot/publications/transforming-specialist-dementia-hospital-care/pages/7/ https://www.isdscotland.org/health-topics/health-and-social-community-care/nhs-continuing-care/ http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf https://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=307039	Detailed information and references to the literature evidence can be found in the Bed Based Care strategy: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 (Item 7.1)
Public/patient/client experience information	https://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=307039	Some of this information has been gathered within services. Further public/patient and client experience information will be gathered through engagement activities
Evidence of inclusive engagement of		As above, as these are proposals at this point and as they are sensitive wide spread inclusive engagement has not taken place yet. Public consultation is being investigated and will begin once preparatory

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected?
people who use the service and involvement findings		work has been completed – expected to begin in September for 12 weeks.
Evidence of unmet need		The evidence of unmet need can be found within the Bed Based Care strategy: https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 (Item 7.1) For each bed type considered within the strategy, the waiting lists were taken into account and included in the modelling and projections
Good practice guidelines	https://www.careinspectorate.com/images/documents/4293/Building%20better%20care%20homes%20for%20adults%202017.pdf https://www.gov.scot/publications/coronavirus-covid-19-care-home-oversight/ https://www.gov.scot/publications/transforming-specialist-dementia-hospital-care/pages/7/ https://www.isdscotland.org/health-topics/health-and-social-community-care/nhs-continuing-care/ http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf https://www.careinspectorate.com/berengCareservices/html/reports/getPdfBlob.php?id=307039	
Carbon emissions generated /reduced data	https://www.gov.scot/collections/environment-statistics/ https://www.gov.scot/publications/cmo-annual-report-2020-21/pages/6/	
Environmental data	https://www.gov.scot/collections/environment-statistics/ https://www.gov.scot/publications/cmo-annual-report-2020-21/pages/6/	
Risk from cumulative impacts		https://democracy.edinburgh.gov.uk/ieListDocuments.aspx?CId=160&MId=5571&Ver=4 The bed based care strategy (item 7.1) includes within the appendices an options appraisal which assesses the risk associated with the recommendations

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected?
Other (please specify)		
Additional evidence required		

8. In summary, what impacts were identified and which groups will they affect?

Equality, Health and Wellbeing and Human Rights	Affected populations
Positive Those requiring HBCCC would be cared for in one location with the specialist staff required to deliver that care; This change of function could provide development opportunities for staff; The EHSCP have successfully moved people from care homes previously with good outcomes 1-2-1 meetings with staff would take place if proposals are approved to understand their needs and preferences regarding ongoing employment opportunities; The Residential Review Team (RRT) would assist each family throughout any planned move; There is enough capacity in our other care homes to accommodate residents in friendship groups with familiar staff should they choose to move together; Strategically, there is no HBCCC service in the North West meaning people requiring this service do have to travel currently. There are other care homes in the North West of the city so how can we manage the existing residents but enhance the service offering available. A new service in a good facility could be seen as a gain for the North West;	Residents and Families Staff (NHS & CEC) Local community Citizens of Edinburgh

Current links to local schools where students can come to the care home and learn from residents. This relationship could continue even if the function of Drumbrae changes. **Negative** Moving the current residents into other care homes and the associated risks with moving elderly and or frail people; Concerns surrounding the psychological impact of moving frail and vulnerable residents; Resident's choose a home for life and changing the function of Drumbrae does mean the existing residents will lose their home; Current residents' families local to the Drumbrae area and would have difficulties in travelling further to be able to visit, many are elderly themselves; Potential for impact on residents' families, particularly if they have a disability, could lead to isolation of residents if their family are unable to visit them regularly; Impact of uncertainty for staff currently working in Drumbrae; Staff are a surrogate family for resident's, particularly during the pandemic when visiting was suspended. Resident's, especially those with dementia need consistency and moving them without the staff could have a negative impact on wellbeing; Significant number of BAME staff in employment and an analysis of needs is required to ensure these staff members are supported through any transition and not disadvantaged. 23/73 staff have protected characteristics and if a decision is reached, 1-2-1 discussions will take place with them to identify their preferences, a matching process is undertaken and every effort made to support staff in their onward choices; Low staff morale is evidenced and concern regarding existing residents is causing anxiety among staff at Drumbrae; Communication has not been open with Drumbrae care home staff. Disparity in the communications provided to CEC and NHS staff, inconsistent leading to anxiety Change brings uncertainty and this will affect morale and retention rates, losing staff means loss of experience and skills;	

Data suggests a rising population of BAME in the community and moving these staff will dilute the culture; Population of Drumbrae feeling disregarded and need an opportunity to engage; Staff have worked hard to improve standards of care and practice at Drumbrae care home and there have been many requests for the brochure which suggests this is a valuable resource. Interest has increased recently with family members returning to work who now need to source care for their relative.	

Environment and Sustainability including climate change emissions and impacts	**Affected populations**
Positive A change in function is unlikely to alter the environmental impact of the building; HBCCC is not a high traffic service, therefore expected admissions and associated transport will be low; The change in function of Drumbrae supports wider system redesign and would allow for an increase in intermediate care capacity for recovery and rehabilitation and also the withdrawal from the Liberton hospital site which has been sold for redevelopment. The change in function of Drumbrae would allow for the HBCCC service to reduce bed numbers in line with benchmarking and modelling projections. Drumbrae would be a suitable facility to accommodate HBCCC and would allow for units to be split into male and female which is not available at present A change in function doesn't remove the facility from the community; it would still be a community asset and would create job opportunities; The building is very energy efficient, rated A; **Negative**	Residents and families, Staff, local community & Citizens of Edinburgh

Currently the home is operating with only 11 residents which is not sustainable or viable long term; Roads and parking in the area need assessed, Drumbrae is in a residential area and access can be challenging especially if increased traffic flow and more ambulances City planners should be involved in assessing traffic and environmental impact. If the four older homes are to be decommissioned, has consideration been given to the potential of utilising the buildings differently therefore, negating the need to use Drumbrae? How does a reduction in care home capacity support projections of an ageing population? Additional information needed to evidence an increase in community capacity; Drumbrae has a range of services and facilities in the community and would removing the care home causing a negative impact to the community. Although the care home would cease to function it would be replaced by a similar facility in terms of scale and size, it would be staffed to support full occupancy and would bring new workers into the area. Drumbrae provided day care services and the kitchen provided the lunches for those services (day care services are currently suspended) The timescales set out in the redesign proposal are concerning and not realistic. Noted – these were indicative and no decisions have been taken by EIJB.	

Economic including socio-economic disadvantage **Positive** There would be an HBCCC NHS led facility in the community providing care to the most frail and vulnerable citizens Any impact on staff of moving to a different location in terms of time and also cost would need to be assessed through 1-to-1 consultation, paying particular attention to those with protected characteristics;	**Affected populations** **Residents & their families** **Staff** **Community**

The Residential Review Team (RRT) would work closely with residents and their families to understand any socio economic challenges a move to another care home could cause; By introducing nursing provision into the remaining larger care homes, the EHSCP can reduce unnecessary hospital admissions, enable discharge from HBCCC units and provide local authority funded nursing care which is not provided currently; Potential positive impact for staff who could be better trained and if better trained, they could be better paid; Staff may have less travel to their place of work, decreasing travel costs; **Negative** Taking a residential care home out of the local community where there is a diverse mix of people from different socio economic backgrounds and the impact on future demand for this type of care in that area; Concerns were raised that the occupancy at Drumbrae had been deliberately run down. In 2020, the care home was under an Improvement Notice from the care inspectorate which means admissions were suspended, during that time the impact of COVID was felt and due to outbreaks admissions could not take place. Demand overall for residential level care is also decreasing with increased demand for nursing provision; Drumbrae has been testing the model of care with nursing proposed for all homes so it should be leading the way on redesign. The skills and practice that have been developed at Drumbrae care home could be lost when the staff team is broken up. Staff are already leaving or looking for other jobs. Staff may have to travel further to their place of employment, increasing travel costs; Trade unions represent a lot of low paid workers, if workers were paid better, local economies could grow; If unable to provide a suitable role for existing Drumbrae staff this could lead to unemployment; There are 66.3 FTE in Drumbrae at present and there are adequate vacancies across the city. The EHSCP are committed to	

retaining the workforce and there is a no compulsory redundancy policy in CEC; NHS staff are also involved in these proposals who have different T&Cs and different policies relating to organisational change; Trade Union colleagues felt the no compulsory redundancy policy won't be in place next summer due to the political landscape; The overall impact on jobs of closing Drumbrae and 4 other homes needs to be known. Retrofitting or rebuilding properties could create new jobs, there is no economic benefit from private organisations. Sixty pence of every pound us spent in local communities, if the private sector operates these establishments the money goes into their profits. There is no private sector organisation involved in these proposals; Concerns were raised on the economic impact of reducing care home capacity and the potential reliance on the private market. Work needs to be done to evidence the balance of care needed for the city and the kind of care we want for people.	

9. Is any part of this policy/ service to be carried out wholly or partly by contractors and if so how will equality, human rights including children's rights, environmental and sustainability issues be addressed?

N/A

10. 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.

Extract from communications plan included in appendix 2

11. Is the policy likely to result in significant environmental effects, either positive or negative? If yes, it is likely that a Strategic Environmental Assessment (SEA) will be required and the impacts identified in the IIA should be included in this.

No

12. 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.
Workforce analysis, Drumbrae survey to ensure suitability for change of function, environmental impact

13. Specific to this IIA only, what recommended actions have been, or will be, undertaken and by when? (these should be drawn from 7 – 11 above) 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 job title)**	**Deadline for progressing**	**Review date**
Source travel assessment and traffic and environmental impact on surrounding area.	Project team	Sept 2021	
Evidence of increased community capacity	Project team	Sept 2021	
Population and demographic data required relating to an ageing population	Project team	Sept 2021	
Evidence for balance of care required across different sectors to reflect projected need and demand.	Project team	Sept 2021	
Engagement with the Drumbrae local community	Project team	Oct 2021	

14. Are there any negative impacts in section 8 for which there are no identified mitigating actions?

No

15. How will you monitor how this proposal affects different groups, including people with protected characteristics?

Through engagement and consultation with all affected staff should proposals be approved. Resident and family engagement supported by the residential review team to fully assess residents and understand their preferences and needs**.**

16. Sign off by Head of Service/ NHS Project Lead

Name

Date

17. Publication

Completed and signed IIAs should be sent to

strategyandbusinessplanning@edinburgh.gov.uk to be published on the IIA directory on the Council website www.edinburgh.gov.uk/impactassessments

Edinburgh Integration Joint Board/Health and Social Care sarah.bryson@edinburgh.gov.uk to be published on the www.edinburghhsc.scot/the-ijb/integrated-impact-assessments/

Appendix 2

BIOGRAPHY – LIZ TAYLOR

Liz Taylor is a qualified social worker who has held senior positions in adult services, children's services and criminal justice in several local authorities, to Director and Chief Social Work Officer level. Liz has worked also for central government and other national bodies, in policy and practice development, education, inspection and audit. She has 5 years of experience latterly as an Independent Chair of Child Protection and Adult Protection Committees and has led inquiries and investigations into practice concerns. Collaborative working across agencies and co-production to make best use of resources in meeting needs have always been areas of particular interest for Liz. She has an MSc in management in community care and an MBA.

Appendix 2

EXTRACT FROM COMMUNICATIONS PLAN

Audiences and audience-specific objectives	
Audience group	**Audience-specific objective**
EIJB members	To have confidence about the programme of change.
Colleagues	To understand that this exercise is about better outcomes and isn't about 'cuts' To feel secure, well informed and looked after throughout the change process. To feel excitement, energy and pride in what we are all trying to achieve together. To feel that we recognise their skills and expertise and that we want to help them be their best selves and help even more people stay cared for, healthy and safe.
Other external stakeholders / interested parties	To have confidence about the programme and its impacts. To have the information they need to work with us and make the programme a success. To be assured that the programme is in line with our strategic objectives and focused on better outcomes for residents, families and colleagues. To provide CEC and NHSL partners with assurance, information, and opportunities to contribute.
Media	To have confidence and understanding about the programme. To have the information they need to promote the programme with positive sentiment.

Communications approach				
Audience group	**Proposed communications channels**	**Responsible**	**Communications assets to be produced to support activity**	**Proposed frequency**
EIJB	Development session with the EIJB	Programme team	Communications plan (working draft) Draft reactive lines ahead of 18 May EIJB Development session	TBC
	Board meeting updates	Programme team	Reactive lines to anticipate media interest Internal communications following the meeting, closely aligned to strategic objectives	June 2021 October 2021 and as requested
Colleagues	Colleague News	Communications team	Regular briefings in newsletter to update colleagues on consultation, key decisions, programme purpose etc	Monthly (minimum) and also as required following key milestones
	Project specific detailed engagement and consultation with staff	Programme team	NA	As required
	Webpage updates	Comms team	Regular updates on progress – such as key dates/decisions / activity	Bi-monthly

Other external stakeholders	Formal meetings	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Board attendance	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Formal reports and returns	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Attendance at CEC and NHSL corporate management team	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Attendance and information reports fed to council and NHS committees	Programme team	Slide packs and reports as required Attendance at forums on request	As required
	Resident, family and patient updates	Programme team / RRT / CH managers	Media channels, webpage, direct contact (generic email address for enquiries)	As required
	Care Inspectorate updates	Programme team / RRT /	Slide packs and reports as required Attendance at forums on request Direct contact	As required
Media	Reactive media response	Communications team	Lines prepared in advance of key milestones (e.g. 22 June 2021 board / October board)	As required depending on programme deliverables
	Key message lines	Communications team	Lines to take prepared to cover key messages	As required depending on programme deliverables
	FAQ document	Programme team (with C&E team acting as a consultant)	FAQ to cover anticipated questions	As required depending on programme deliverables
	Social media response	Communications team	Reactive social media response prepared to enable EHSCP and CEC to respond to any noise on owned social media channels	As required depending on programme deliverables

Appendix 3

BED BASED CARE REVIEW – UPDATED NARRATIVE, TIMELINE AND FINANCIAL MODEL

In Edinburgh, there is an imbalance within bed based services which means the Partnership has the incorrect types of beds, in disproportionate numbers across the city. Due to this imbalance, our elderly citizens are unable to access the services they need, when they need them leading to unnecessary hospital admissions, delays whilst in hospital and bed based services, and inappropriate admissions to care homes.

The Partnership is seeking to rebalance its bed base to ensure there are the right number of beds, in the right locations, providing the right type of care to meet the needs of our population.

The Partnership does not have enough intermediate care capacity to meet existing demand. This service provides 24 hour, intense and frequent bed based rehabilitation for up to six weeks to enable people to return home following a hospital admission. At present our intermediate care provision is at capacity which is resulting in people who need this level of rehabilitation being delayed in an acute hospital bed. During this time, they are not receiving the intense and frequent rehabilitation they need to regain independence and return home. Delays in hospital are debilitating and often patients become deconditioned meaning further interventions are required during their recovery and reablement.

The Partnership has the highest number of Hospital Based Complex Clinical Care (HBCCC) beds per head of population nationally. This service provides very complex clinical care to our frail and elderly population when the level of care cannot be provided in any other setting. A high proportion of patients currently receiving this level of care could have their care needs met in the community however, as the EHSCP doesn't have nursing provision within its care homes it cannot offer this level of care at present. There is very limited capacity in the independent and third sector offering this type of care and therefore, people who could be cared for in the community are in a hospital based environment because the existing models of care cannot support them.

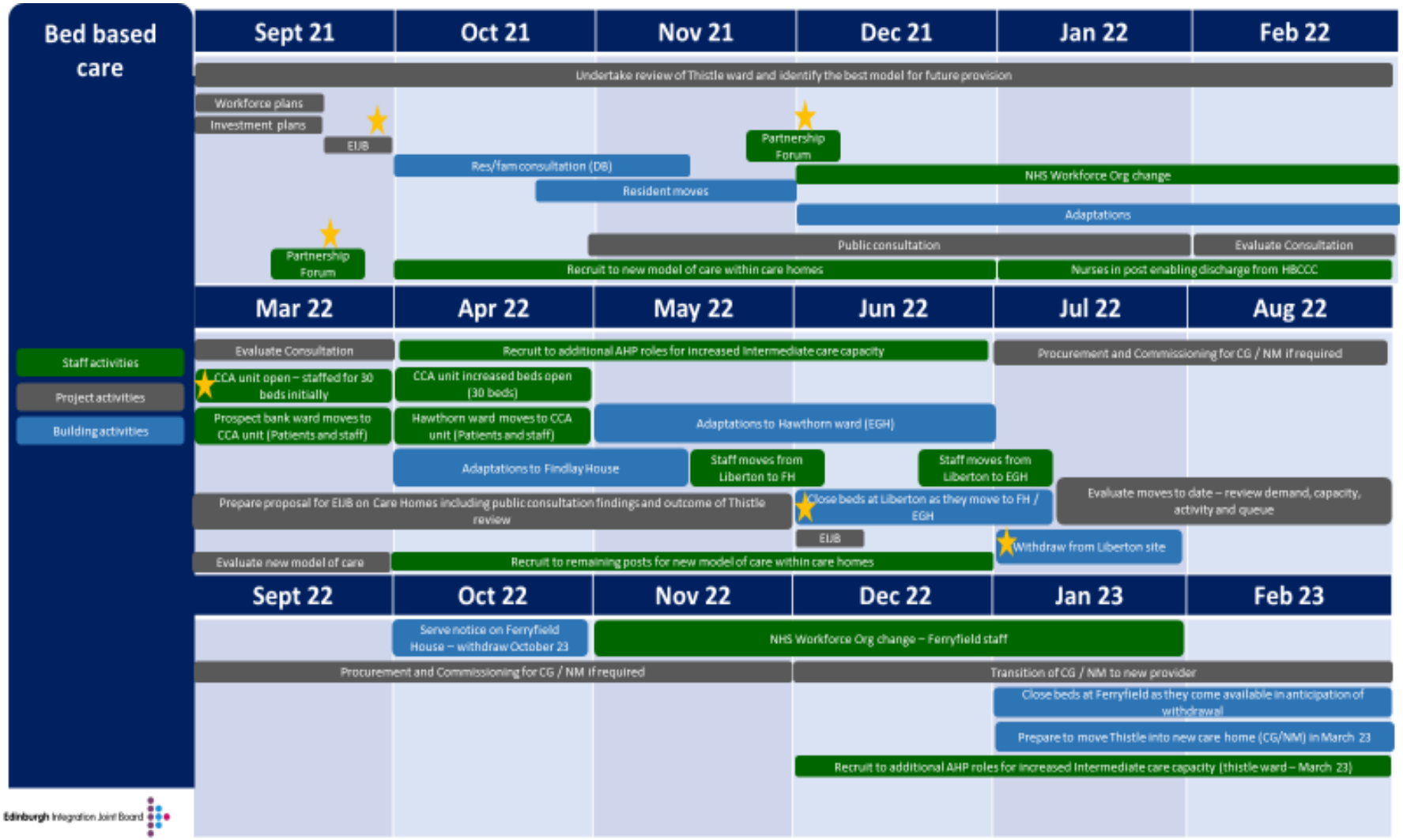
The Partnership will introduce registered nurses into care homes in the estate that can support this level of care. Complex care cannot be provided in care homes with environmental limitations and therefore, only the newer homes could introduce this model. By having nursing provision on site, the Partnership can provide complex care in the most appropriate setting, to those who need it most. This would enable people to access and receive the care they need, when they need it, in the right setting.

The four older care homes in the estate have surpassed their design life expectancy and are not sustainable for future use. They are restricted when admitting residents because of the level of need they can accept and have to admit carefully due to the environmental limitations. These buildings cannot continue to be used as care homes as they simply cannot meet the needs of the population who now present and require residential bed based care. The integrated impact assessment (IIA) completed on the 18th August highlighted that additional information is needed before the assessment can be completed, a total of 14 actions were identified during the IIA which need addressed. Furthermore, listening to the feedback received on these proposal's we recommend

extending the timescales for a decision on the four older care homes until after the public consultation process. From the feedback received through Elected Members, Scottish Ministers, Trade Unions, staff, relatives of residents and members of the public, a full public consultation on the future provision of care for older people in Edinburgh was repeatedly requested. Although, it was always the intention to undertake a public consultation we feel that this process needs to be completed to inform decision making. Therefore, we have amended the timescales accordingly and updated the financial modelling to reflect the extended time for a decision, both the timeline and financial model can be found below.

These proposals are a step towards modernising our bed base to meet existing and future demand. We need to rebalance our bed base to ensure we can provide accessible care and support to our older population that is outcomes based and person centred. We must increase our intermediate care provision to ensure people can access this service in a timely manner without a lengthy delay in an acute bed, we must increase our nursing provision within our care homes to enable us to provide complex care, by doing so we will be able to discharge patients from the HBCCC service into a better, homely environment that is resourced appropriately to provide their care. We need to reduce the overall number of HBCCC beds and increase our community complex care capacity. We need to replace residential care within our care homes to complex nursing and dementia care to meet the needs of our older population. We need to provide care in the most appropriate environment and that cannot be in buildings that have surpassed their life expectancy. We agree with the Independent Review of Adult Social Care[1], whereby we do not believe that building more care homes is the answer. Traditional models of care no longer meet the needs of our older population and our bed base must adapt to demand, to ensure we can continue to offer care and support to our citizen's both now and in the future.

[1] *Chapter 8: Models of care: Independent review of Adult Social Care*


Bed based care
Sept 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Undertake review of Thistle ward and identify the best model for future provision
Workforce plans
Investment plans
EIJB
Partnership Forum
Res/fam consultation (DB)
Resident moves
NHS Workforce Org change
Adaptations
Public consultation
Evaluate Consultation
Partnership Forum
Recruit to new model of care within care homes
Nurses in post enabling discharge from HBCCC
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Evaluate Consultation
Recruit to additional AHP roles for increased intermediate care capacity
Procurement and Commissioning for CG / NM if required
CCA unit open – staffed for 30 beds initially
CCA unit increased beds open (30 beds)
Prospect bank ward moves to CCA unit (Patients and staff)
Hawthorn ward moves to CCA unit (Patients and staff)
Adaptations to Hawthorn ward (EGH)
Adaptations to Findlay House
Staff moves from Liberton to FH
Staff moves from Liberton to EGH
Prepare proposal for EIJB on Care Homes including public consultation findings and outcome of Thistle review
Close beds at Liberton as they move to FH / EGH
Evaluate moves to date – review demand, capacity, activity and queue
EIJB
Withdraw from Liberton site
Evaluate new model of care
Recruit to remaining posts for new model of care within care homes
Sept 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Serve notice on Ferryfield House – withdraw October 23
NHS Workforce Org change – Ferryfield staff
Procurement and Commissioning for CG / NM if required
Transition of CG / NM to new provider
Close beds at Ferryfield as they come available in anticipation of withdrawal
Prepare to move Thistle into new care home (CG/NM) in March 23
Recruit to additional AHP roles for increased Intermediate care capacity (thistle ward – March 23)
Staff activities
Project activities
Building activities
Edinburgh Integration Joint Board

The timeline above has been amended to reflect the recommendation to delay a decision on the four older care homes until after the public consultation has been completed.

There are a number of caveats with the proposed timeline as follows:

1. The timeline is indicative and is wholly reliant on a decision being reached at the IJB meeting on 28th September
2. Any delay to a decision on the future use of Drumbrae beyond the 28th September pushes the whole timeline out. The proposals for intermediate care and HBCCC could not progress without a decision on Drumbrae and if delayed, any redesign can't begin until after winter. This impacts on the timescale to withdraw from Liberton hospital, which has already been delayed until spring / summer 2022. As the site has been sold for redevelopment, any delay could impact on external timescales related to the redevelopment
3. The timeframe for adaptations to all properties are estimated at present. Adaptations for Drumbrae are being costed and associated timescales developed. The PFI buildings have a different arrangement for adaptations which could involve procurement and commissioning.
4. The adaptations already underway in Findlay House should be completed this calendar year however, with the increase in intermediate care beds further adaptations may be required.
5. Recruitment to the nursing provision must begin as soon as possible to allow the EHSCP to meet existing demand, delays for nursing home places in hospital settings are growing and this needs to be addressed urgently.
6. Recruitment to AHP roles may not be required depending on the choices of staff when considering their options as part of workforce organisational change, timescales included should recruitment be necessary
7. Walkers Healthcare who own Ferryfield House have offered to extend the break point in the lease by one calendar year to October 2022. This offer was accepted to build in assurance within the transition timescales however, it is the Partnership's intention to work to the existing timescales.
8. The contract for the care provision at Castlegreen and North Merchiston care homes (CEC owned) comes to an end in March 2023 and a procurement and commissioning exercise is planned for next summer. Alongside this, at that point, we will fully cost and assess the option of bringing both these homes in house.
9. There is a financial impact relating to the delay in decision making, a savings target was identified and attributed to the overall bed based care programme however, this target will no longer be achieved in this financial year adding to the budget pressures overall.

Bed based care – Financial model

The financial implications of the updated proposals have been modelled with the support of the City of Edinburgh Council (CEC) and NHS Lothian finance teams and are summarised in the table below:

	£m
Council run homes with new model	9.2
HBCCC @ Drumbrae	4.5
Intermediate care facilities	9.4
Total projected running costs	**23.1**
Available budgets	**25.2**
Projected saving	**2.1**

To support this modelling a number of assumptions have been agreed, the main ones being:

- The new staffing model is implemented in the 3 newer Council run care homes (Inchview, Marionville and Royston);
- A 10% contingency has been included to reflect the fact that this model will require to be tested;
- Expenditure relating to the other Council owned care homes do not change;
- Any costs required to bring existing facilities up to appropriate standards will be funded from the surplus; and
- Further work is required on how these costs will be phased, particularly the impact of any double running required as new models are implemented.

Appendix 4

BED BASED CARE REVIEW – TRAFFIC SURVEY DRUMBRAE

CITY DEVELOPMENT

TRANSPORT PLANNING (DEVELOPMENT CONTROL)

To: John Bury
Head of Planning
FAO David McFarlane

MEMORANDUM

From: Marshall Poulton
Head of Transport

Our Ref: T/TP/DC38236/ACB

Date: 06 July 2011

Your Ref: 11 / 01814 / FUL

TOWN AND COUNTRY PLANNING (SCOTLAND) ACT 1997

PLANNING APPLICATION No: 11 / 01814 / FUL

FOR: ERECTION OF 60 BED RESIDENTIAL CARE HOME

AT: DRUMBRAE PRIMARY SCHOOL, ARDSHIEL AVENUE, EDINBURGH

I have no objections to the application subject to the following conditions being added to any permission:-

a) The new footway link between Drum Brae Avenue and Durar Drive to be increased to

3 metres in width.

(Reason:- To accommodate cyclists)

Prior to the issuing of the consent the developer to enter into a suitable legal agreement to make provision for the following:-

a) The developer to fund all the costs in relation to providing new waiting and loading restrictions within the proximity of the proposed home and remove any existing restrictions with regard to the Drum Brae Primary school. (£3,000)

(Reason:- To provide a safe road network and prevent indiscriminate parking)

b) Contribute the sum of £7,000 towards the improvement to the Public Transport Infrastructure.

(Reason:-Projected increase in pedestrian movements and public transport demand.

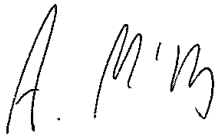
The sum will be used to part finance a Real Time Information Sign on the Drum Brae North Bus Corridor.)

Informatives

1) The new footpath/cycleway and road which are outwith the planning boundary will be subject to a Road Construction Consent under Section 21 of the Roads (Scotland) Act 1984. This will include street lighting.
2) The footpath/cycleway link between Drum Brae Avenue and the development site is not a public road therefore this section will be required to be brought up to an adoptable standard under Section 16 of the Roads (Scotland) Act 1984.
3) The section of footpath / cycleway between Durar Drive and the development site is a public road but is not lit therefore the street lighting will need to be designed and installed.

Enquiries and applications regarding the above matters can be made to the Director of City Development at Waverley Court, 4 East Market Street, Edinburgh EH8 8BG

If you have any queries, please call Mr Andrew C Bogle on 0131 529 3926 (Direct Dial).



Andrew McBride

Development Control Manager

Transport Planning

Appendix 5

BED BASED CARE REVIEW – INFECTION, PREVENTION AND CONTROL REQUIREMENTS

The infection, prevention and control (IP&C) team undertook an inspection of Drumbrae care home on 4th September 2021 to identify any adaptations required in relation to IP&C should the facility change function to become a Complex Care Assessment unit.

The team praised the buildings position and noted the cleanliness and maintenance of the building was to a high standard. The points to note from an IP&C perspective were:

1. Non-compliant sinks and taps in prep and medical areas: These would need replaced
2. Bedrooms and en-suites have vinyl flooring which is recommended however, the communal areas were carpeted. Although not essential to the building becoming an CCA unit we would recommend replacing these at the designated point in the maintenance cycle. Replacement flooring should be vinyl or lino for ease of cleaning.
3. There are no sinks in the bedrooms themselves however, there are sinks in the ensuites which the staff could use if required alongside surgical hand rub.
4. Showers: The shower hoses need to be shortened to ensure they do not fall into the drain when not hung up.
5. We would not recommend the use of heated/self-cleaning toilets and recommend these are replaced.
6. There is laundry facilities on site and the machines are monitored and on a maintenance programme.
7. We would also advise that any furnishings within the unit is wipeable and can withstand up to 10,00ppm of chlorine.

The required adaptations are being costed at present.

Appendix 6

BED BASED CARE REVIEW: PHYSICAL CONDITION SURVEY – DRUMBRAE CARE HOME

Physical Condition		
	Net Costs	Costs Including Uplift
Total costs Years 0-10	£30,092	£30,092
Total Cost to B - Immediate Backlog (Year 0)	£9,500	£0

Costs by risk - Total Cost to B - Immediate Backlog (Year 0)										
Facet	Total Cost to B Immediate Backlog (Year 0)		Cost to B- Immediate Backlog (Year 0)							
			Low		Moderate		Significant		High	
	Net	Including Uplift	Net	Including Uplift	Net	Including Uplift	Net	Including Uplift	Net	Including Uplift
Physical Condition	£9,500	£9,500	£9,500	£9,500	£0	£0	£0	£0	£0	£0

Physical Condition - Cost Breakdown by Year													
Costs By Year		Cost to B Immediate Backlog (Year 0)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Physical Condition	Net	£9,500	£0	£0	£0	£0	£0	£11,320	£0	£9,272	£0	£0	£30,092
	Including Uplift	£9,500	£0	£0	£0	£0	£0	£11,320	£0	£9,272	£0	£0	£30,092

Appendix 7

BED BASED CARE REVIEW – COMMUNITY INFRASTRUCTURE AND INVESTMENT PLAN

We know that most people wish to remain in their own home, as part of their communities for as long as they can and we know that sometimes, in order to do so, as they grow older, they may need care and support in their day to day activities. Traditional methods of supporting people to remain at home are debilitating, intrusive and restrictive. There is a perceived culture of "do for" rather than "support to do" in home care, with visits planned for prescriptive times throughout the day it is a restrictive service that is inflexible. It is also perceived to be more costly than traditional residential services and often people would end up in a care home when they could have remained at home.

This has been identified within the Independent Review of Adult Social Care and alternative options to the traditional choice of care home/care at home have been presented.

Extract from Chapter 8: Models of care: Independent review of Adult Social Care

Reducing use of institutional/residential care

"Given the demographic trends, including the projected growth in diagnoses of dementia, this needs urgent attention. We do not believe that the answer to those demographic challenges lies in building additional care homes. Most people say they would like to live in their own homes for as long as possible. Nonetheless, people told us that there is still an almost automatic default to care home care in some areas, particularly for frail older people. This observation is especially striking in light of our human-rights based approach: moving into a care home must always be the informed choice of the person requiring care and support. We are concerned that at times the emphasis on residential care for older people is counter to that fundamental right to choose and is sometimes suggested because care at home can be more expensive. Alternatives exist beyond the traditional choice of care home/care at home"

In Edinburgh, through strategic planning, wide scale redesign and collaborative working with our partners we are embarking on a journey that puts citizens and communities at the heart of all we do. We have a number of large scale redesign projects underway that follow our Three Conversation ethos. We will Listen and Connect, with citizen's, partner organisations and community networks. When people are approaching or are in a crisis situation, we will work with them intensively to support them with what they need, we will ensure consistency during this time of instability by connecting people to the support and services required to get out of crisis and back to normal. When in life, longer term support arrangements are needed, we will work with our citizen's and their families to enable people living with support needs to build their best life. We will listen and match people to the services they want and we won't prescribe to people just because that was the traditional way. We will be person centred and outcome focused and we strive to continuously improve.

This is a big culture and practice shift from the way services have historically been delivered and also a shift in the perception of expectation among our citizens. It will not happen instantaneously and will require drive and determination to implement successfully. Many different services will enable

this shift to modernise our health and social care offer in Edinburgh and bed based services are part of the solution. In the covering report we have outlined our approach to our public consultation where we will ask the citizens of Edinburgh their thoughts on how they would like their care provided when they can no longer live independently at home. Where would they like to live and what services and activities would they want to access? Through this process we hope to identify what matters to our citizens and then we can build our health and social care service to respond.

That being said, there is an immediate issue, where Edinburgh has a disproportionate number of beds to meet existing demand. We are already experiencing the population increases in our older people, we are already supporting people with multi morbidities and chronic conditions however, our services have never evolved on the scale in which they need to, to ensure the very best outcomes for people. Through an imbalance in our bed based services and through lack of investment in social care over an increasing number of years, we find ourselves in a critical situation where people are delayed in hospital unnecessarily, due to lack of suitable, safe and appropriate onward care provision. We do not have enough intermediate care beds, therefore delaying people in acute hospital sites. We do not offer nursing care in our care homes, especially dementia care and therefore cannot admit anyone with this level of need. However, on occasion where people had to be admitted in emergency circumstances, we have neither trained nor developed our staff to the level required to provide the care and support needed to care for these people, often resulting in admission or readmission to hospital because the community infrastructure cannot support these citizens in its current form.

We need to redesign our bed base to continue to deliver care and support to the people who need it, we have a duty to ensure the right care is delivered, in the right place at the right time, the first time.

There are a number of investments that could sustain and enhance the existing delivery model of health and social care however, to transform services with people at the heart, we have to listen. People do not want to be institutionalised unless it is absolutely necessary, they want a human rights based approach that allows them choice.

To offer the care and support needed to our existing service users but also, to our service users of the future we must invest in people. Buildings and spaces are just that, they are inanimate, sterile places that enable the delivery of services by and for people. Our people, our citizens, our staff and our partners, are the only mechanism to make a difference to providing the right care in the right place. Social care has been regarded as the poor distant cousin of the NHS It is an under resourced, undervalued and demotivated sector, as recognised by the recent Independent Review of Adult Social Care (IRASC)however there is also much to celebrate. The staff working in Social Care bring skills, experience, and ultimately care and contact to the people they support.

The Independent Review of Adult Social Care was completed and reported earlier this year. It's recommendations were approved in full by the then Scottish Government and its implementation is a commitment of the current Scottish Government with a consultation on the development a National Care Service currently underway. The recommendations set out in the IRASC sought to address issues of ethical commissioning, fair work and a person centred and human rights based approach and clear alignments can be seen between its principles and those set out in the EIJB Strategic Plan and transformation programme.

COMMUNITY INVESTMENT

The Community Mobilisation project, the project that will enact the Edinburgh Wellbeing pact is undertaking an exercise to identify and map community investment across the Partnership. The aim of this exercise is to understand the totality of community investment across third sector and community organisations and to provide insight into the areas the Partnership supports. The key performance and outcome data available from funded services, alongside the composite financial overview will inform the community mobilisation plan and future allocation of resources through community commissioning.

This work is ongoing at present and not complete however, findings to date show that across all funds from grants and contracts the Partnership invests the highest amount of funding on care at home support, day care opportunities, support to unpaid carers, support to those struggling with alcohol and drug related challenges and mental health support. The prevalent themes identified so far are Prevention and Early Intervention, Health Inequalities and Wellbeing.

Work is underway to analyse the totality of the financial investment across grants and contracts. The funded programmes included in the analysis are those provided by third sector organisations in the community, excluding bed based or residential support contracts.

Ultimately, this exercise will measure the impact of funded programmes across the Partnership and will identify and evidence areas where community investment can support people to remain independent in their communities as active members of society for as long as possible, improving outcomes, building community resilience and supporting local organisations.

HOME FIRST

The Partnership is taking a strategic approach to ensure that all flow in and out of the acute hospital system is optimised, while balancing those demands for care and support in the community, keeping people safe at home and, where possible, preventing admissions to hospital. The teams that operate under the Home First umbrella are pivotal to this approach through prevention and by supporting discharge from hospital.

To date the Partnership has increased Hospital at Home (H@H) capacity, introduced new pathways to prevent unnecessary hospital admissions, introduced additional social work capacity to support hospital discharges, enhanced existing services to provide more capacity and enhanced multidisciplinary team working to plan for discharge.

These initiatives proactively look to prevent people going to hospital when they don't need to and support people to get home from hospital following an admission however, they are usually funded short term to support busy periods such as winter. Short term initiatives are challenging to recruit to due to the length of the employment opportunity. Additionally, they do not allow for enough time for services to adapt and embed. Investment is needed to permanently increase capacity in these services to enable them to operate optimally all year round.

The Home First project team has identified areas of improvement in the Discharge to Assess (D2A) pathway and would like to enhance the service to offer care. At present, this cannot be introduced

as there is not enough capacity within the Reablement team to support this. There are plans to move towards are larger Reablement team within the Partnership but this will take time to implement.

HOMECARE, REABLEMENT AND CARE AT HOME

In order for Home First to be successful, there needs to be appropriate Homecare, Reablement and Care at Home capacity to support people to live independently at home. Any delay in accessing care and support in the community can lead unnecessary hospital admissions, people being delayed in hospital or inappropriate care home admissions.

The Partnership has an internal homecare and reablement service primarily focusing the majority of the provision on homecare with a smaller proportion providing reablement. The strategic vision is to move toward a reablement model of care and support, which maximises independence for individuals, helping them to achieve quality outcomes and live good lives, reducing dependency in the long term. Modern, digital solutions and improved processes are essential to ensure that the Partnership can optimise existing staffing capacity, evidence best value in service delivery and provide quality care and support going forward.

Our internal home care staff are predominately “walkers” meaning they walk between their visits, they do not have the appropriate tools to undertake their job, they don’t have appropriate or effective communication devices, they have no access to email and they cannot access learning, training or development opportunities with the technology provided to them.

They, on average, provide 38% contact time when delivering care, representing just under 4 hours of a full time 10.25 hour working day. That, plus inconsistent runs that can see homecare workers, especially during lockdown periods, waiting for long periods of time outdoors before going to their next appointment means the service is grossly inefficient. This is no reflection on the workers themselves, more the system for the management of logistics and co-ordination. We are pleased to note the recent approval by the IJB in August to procure the Mobile Workforce Solution by TotalMobile which will see improved technology for our homecare and reablement workforce. The solution will allow runs to be scheduled in advance, making optimum use of workers’ time and will offer security to them when lone working. Workers will be equipped with appropriate mobile devices with internet access to ensure they aren’t disadvantaged in learning, development and employment opportunities. By moving to a reablement model of care and introducing the Mobile Workforce Solution the Partnership will be able to provide an additional 2,856 hours per week of care, the equivalent of 80 FTE in our social care workforce. The investment in this solution goes some way to showing we value this staff group but it will take time to change perceptions about the sector and make it an attractive career choice.

Caring is not always seen an attractive career path, especially for younger people, there appears to be little in the way of progression opportunities but there is a lot of responsibility delegated to the workers. The sector is perceived to be underpaid and undervalued. Radical investment is needed to raise the profile of social care and make it an attractive career choice, but this will take time, political backing, commitment and drive.

The Home Based Care project team have recognised the issues faced by care providers, especially during this extremely challenging time approaching the winter period. Both the EU Exit and the pandemic are having an impact on staff absence and the workforce pressure this causes translates to issues with recruitment and retention. Providers have reported that staff are leaving the sector completely as the economy reopens, with a high percentage returning to previous roles in hospitality as the sector returns to normal. Although providers are actively recruiting there is a notable drop in interest and a slowdown in activity compared with 2020. Some providers have noted a drop in the overall staff available but an increase in care provision required, meaning they are asked to do more with less.

Providers have been proactive to address these issues and have introduced staff retention bonuses, introduction incentives and have invested heavily in recruitment advertising. Some providers have had to use agency staff but have found shortage in available agency provision.

Providers have also noted escalated recruitment costs due to introduction and retention incentives. One provider has shown an increased monthly spend of 42% on recruitment and a cost of hire increase of 520% cause by a reduction of applicants and increased overheads.

The current method of recruitment advertises social care roles on sites like Indeed and Total which means the vacancies are competing against opportunities from other sectors which often pay more and are perceived as more attractive employment options.

Although this is a national / UK wide problem affecting multiple parts of society which will require significant change to address the long term impact there are steps we can take to help mitigate the impacts at a local level in the care at home service. We need to reinforce our “One Edinburgh” partnership approach and take proactive steps to support our providers with the challenges they are experiencing to prevent a loss in capacity at a later date. By developing a targeted marketing campaign to raise awareness of the opportunities in the sector, signposting people to vacancies and engaging with 3rd party organisations to distribute information to a wider audience, we can support our providers in their recruitment challenges. By offering this support now, we have an excellent opportunity to show a partnership model can help to resolve some of the issues by taking a collaborative approach. We hope that this approach will increase trust between our providers and the EHSCP and will increase collaboration between providers, it will provide a better understanding of the issues which will help to design a more efficient service and a more informed commissioning structure ultimately benefiting service users and carers.

PRIMARY CARE

There is ongoing improvement initiatives under way in Primary Care as part of the Primary Care Improvement Plan (PCIP). A number of new ways of working have been introduced within Primary Care settings due to the pandemic and some are set to continue such as virtual clinics. These initiatives are aimed at maximising the use of capacity across the system and enable a flexible approach to a traditional delivery model.

Primary care receive investment annually for each resident they support within care homes. A GP practice could have all residents of a particular care home registered to them however, some

residents choose to remain with their family GP and therefore it is not as simple as an entire care home registered to one practice. Any proposal to decommission care homes could impact on the GP practices that support them however as residents could choose to remain with their GP, the impact would not be known until residents have chosen their onward accommodation and GP practice.

Primary Care colleagues are assessing the impact on each GP practice affected by the bed based proposals and will report back their findings in due course.

The introduction of registered nurses into care homes would be welcomed by Primary Care. Nurses can appropriately deliver a lot of the skilled care that GPs are usually called upon to provide. Having nursing provision within care homes provides residents with the care and support they need as well as ensuring the Primary Care / GP input is targeted and appropriate to each residents' medical needs. In doing so the model will potentially free up resources.

Appendix 8

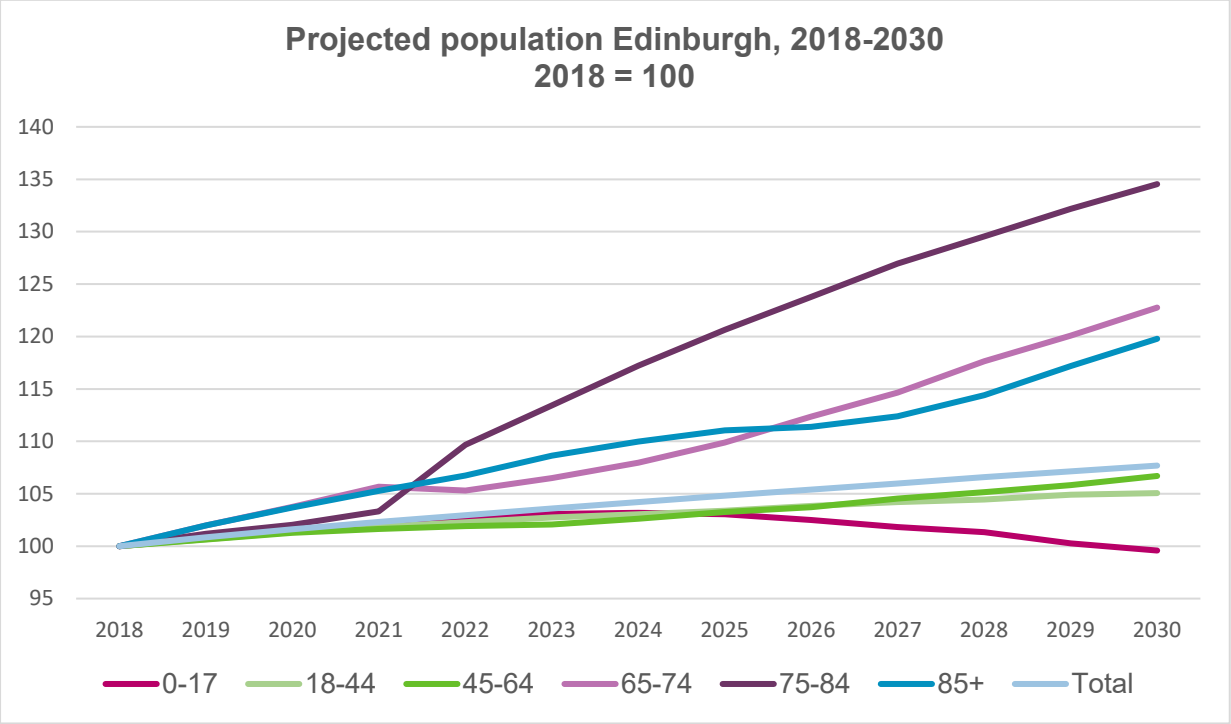
BED BASED CARE REVIEW – DEMAND PROFILING, MODELLING AND PROJECTIONS

POPULATION AND DEMOGRAPHICS

The population and demographic data provided in the Bed Based Care (Phase 1) Strategy remains valid and provides projections for the City of Edinburgh up to 2030. We know the population is expected to increase by 7.7% between 2018 and 2030 with the largest increase occurring in the age range 74 – 85.

Graph 1: Population projections, Edinburgh 2018-2030

Source: NRS Population projections for Scottish Areas (2018)



These projections see our older population increasing significantly and by 2030 each age category of older people (65+) is expected to increase by at least 20%.

As people age, their needs change and we are seeing increasing complexity of need and multimorbidity in older people. This is evident when we consider healthy life expectancy (years lived in good health) alongside overall life expectancy, with more than 20% of life lived in poor health for females. Females in Edinburgh experience fewer years of good health than males. In recent years, there is evidence of a widening gap between males and females which appears to be a combination of improvements in male HLE and a worsening of female HLE.

Table 1:

	Males			Females		
	Life expectancy (years)	Healthy life expectancy (years)	Percentage of life expectancy in good health	Life expectancy (years)	Healthy life expectancy (years)	Percentage of life expectancy in good health
2015-2017	78.0	65.0	83.4	82.3	65.1	79.1
2016-2018	78.1	65.4	83.8	82.3	63.9	77.6
2017-2019	78.4	66.3	84.6	82.5	65	78.8

Source: EIJB Joint Strategic Needs Assessment

While life expectancy is the average number of years those in a defined population are expected to live, healthy life expectancy (HLE) is the average number of years a person in a particular population is expected to live in a healthy state. People experiencing disabilities or limiting long term conditions tend to have poorer health overall. [2]

This data indicates that we are going to have a larger older people population in Edinburgh in the coming years with many people living with chronic conditions and multimorbidity. There is a large inequality in life expectancy rates between the most and least deprived areas equating to 14 years for males and 10 years for females.

Within Edinburgh HSCP, there is a higher proportion of areas of multiple deprivation within the North East locality and life expectancy is lowest in this community.

People from deprived communities are most likely to have unscheduled hospital admissions. Many of these hospital admissions are potentially preventable. Potentially preventable admissions are defined as conditions that can be managed with timely and effective treatment in the outpatient setting. There are 19 conditions defined as 'potentially preventable', such as COPD, angina and diabetes complications. There are more than 7,000 potentially preventable hospital admissions in Edinburgh annually. [3]

Health and social care services need to prepare now to be able to respond to the future increased pressure due to a growing and ageing population. It will also be critical to ensure that this response considers the geographical disparities between localities to ensure citizens receive the care and support they need as close to home as possible.

[2] *Extract taken from Joint Strategic Needs Assessment – Population and health inequalities*

[3] *Extract taken from Joint Strategic Needs Assessment – Population and health inequalities*

DEMAND PROFILE AND MODELLING

We have updated the modelling on our future need for IC and HBCCC beds to reflect the discussion with the EIJB in June. This work has been supported by the Local Intelligence Support Team (LIST) in Public Health Scotland (PHS).

a. Intermediate care

Our intermediate care service is experiencing increasing demand with waiting lists increasing. This means that more people are delayed in their discharge in an acute setting unable to access the intensity and frequency of rehabilitation required to enable them to return home. We are managing this through our Home First team, who are screening referrals however the table below, comparing the previous year in 6 month increments shows that there is a large proportion of inappropriate referrals. Patients admitted to bed based rehabilitation and to intermediate care has increased however, so has the length of stay from referral to admission. From the National Audit of Intermediate care (NAIC) England and Wales, we would expect the time between referral and admission to be no more than 72 hours, our data shows that we are well off achieving this. The proposed increase to intermediate care capacity should enable quicker admission from referral and stop patients waiting in an acute setting, deconditioning due to the inability to access to intense and frequent rehabilitation in the right setting.

Table 2:

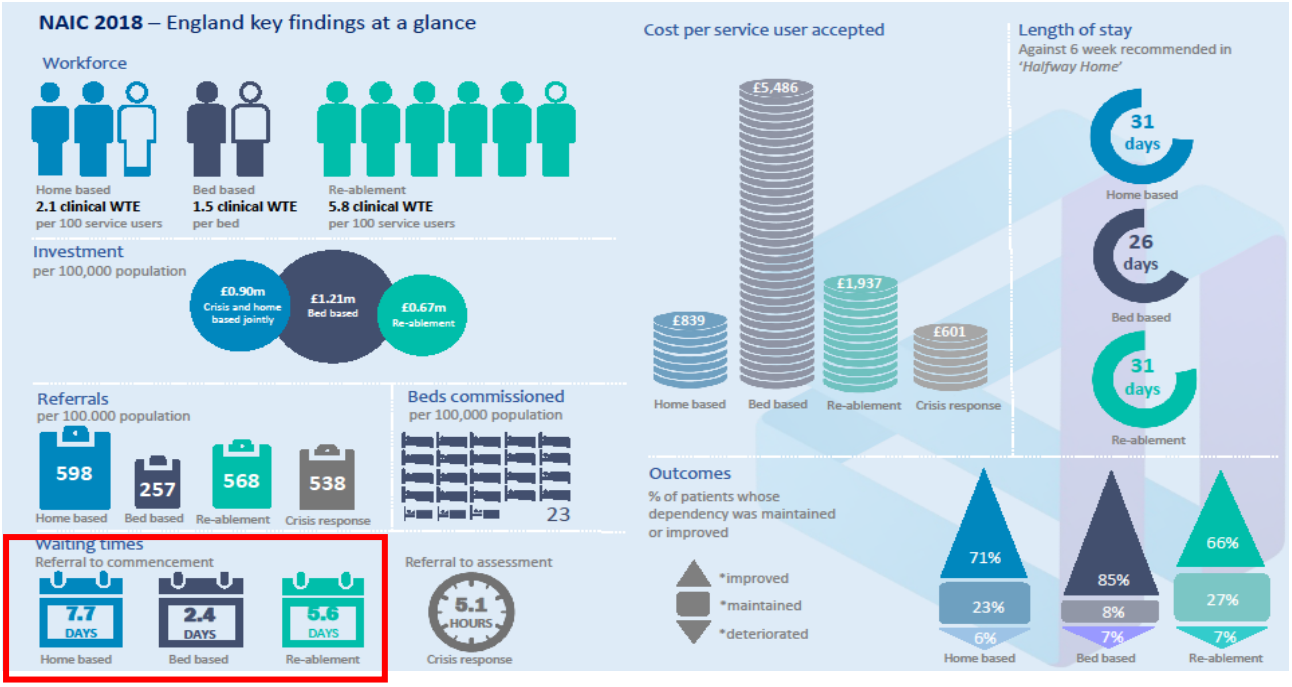
6 month comparison

ADMISSIONS TO BED BASED REHABILITATION	AUG 20 – JAN 21	FEB 21 – JUL21
No. of referrals	415	458
Patients admitted	231	261
Patients admitted to IC	200	225
LOS from referral to admission to IC	8	10
% D/C home following IC admission	56%	52%
% D/C to care home or HBCCC following IC admission	22%	17%

THOSE NOT ADMITTED TO BED BASED REHABILITATION	AUG 20 – JAN 21	FEB 21 – JUL21
Not admitted	183	197
% of those not admitted D/C home	68%	69%
LOS from referral to D/C home	20	16
% D/C to care home or HBCCC following IC referral	17%	17%

home first

Table 3: National audit of intermediate care (NAIC) England and Wales – Key findings at a glance (2018)
Source: National Audit of Intermediate care (NAIC) England and Wales



For the updated modelling, we have drawn on longer trend data to understand flows of patients into and out of intermediate care facilities. This is supplemented with an understanding of patients who have been unable to access intermediate care following their stay in hospital to ensure we have an accurate picture of demand.

As this modelling is reflecting our desired future state of intermediate care capacity, we have used a length of stay of 42 days, reflecting the role of intermediate care as intensive rehabilitation for a period of 6 weeks. We have also revised our future growth uplift to 13% (the projected growth rate for over 75s between 2021 and 2025) instead of 7% (the growth rate for over 65s) to reflect that almost 90% of referrals are for those aged over 75.

These minor revisions to the modelling result in very similar overall need for intermediate care beds as outlined initially in the Bed Based Care (Phase 1) Strategy.

	Total patients	Average LoS (days)	Bed days required overall	No of beds in use/required	Total beds required (currently)	inc 85% occupancy uplift	inc 13% for growth of over 75 population	inc 10% uplift for direct refs
Patients admitted to Liberton IC (Jan 2018 - Aug 21)	1,335	42	56,070	43	43	49	56	62
Patients admitted to Fillieside (2020-21)	121	42	5,082	14	57	65	74	82
Patients d/c Acute with between 7-13 days stay from ref (2020-21)	107	42	4,494	12	69	79	90	99
Patients d/c Acute with over 14 days stay from ref (2020-21)	159	42	6,678	18	75	86	98	108
Combined patients d/c Acute with over 7 days stay from ref (2020-21)	266	42	11,172	31	87	101	114	125

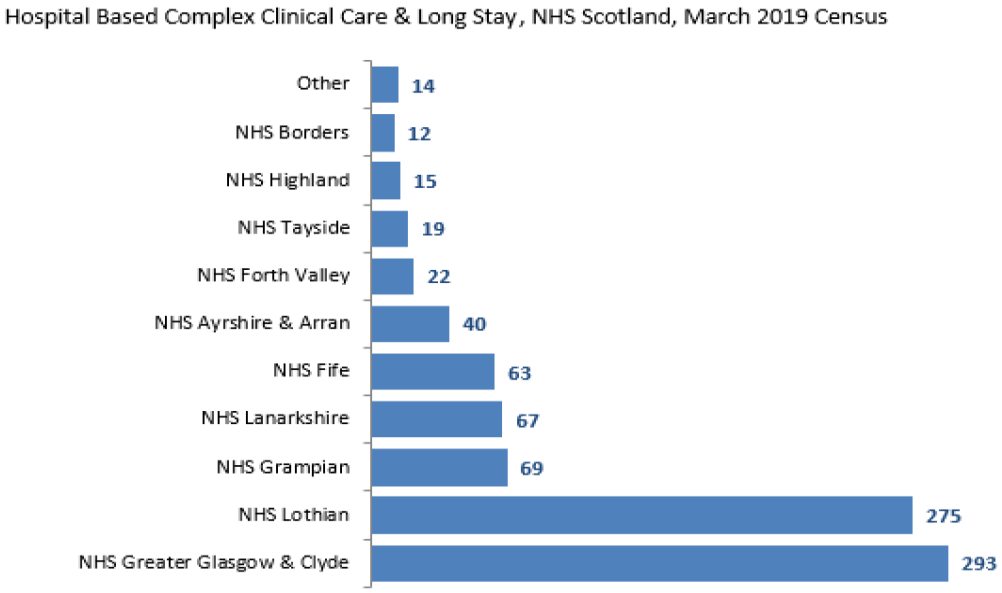
The table below illustrates our current provision, modelled future need (by 2025) and the gap that we hope to fill through the changes proposed in this strategy.

No of beds available currently	No beds required (2025)	Planned beds in this strategy
64	125	100

b. Hospital Based Complex Clinical Care (HBCCC)

As described in the Bed Based Care (Phase 1) Strategy, it is widely recognised, as far as possible, hospitals should not be places where people go to live - even people who have ongoing clinical needs. Hospitals are places to go for people who need specialist short-term or episodic care. The Partnership has the highest number of HBCCC beds in Scotland per head of population.

Table 4: Hospital Based Complex Clinical Care & Long Stay, NHS Scotland, March 2019 Census
Source: Scottish Government inpatient census 2019



Similar to the ICF modelling, we have applied a 13% uplift for future demand growth to the HBCCC beds as these are also predominantly occupied by those over 75.

We have also revised the average length of stay to reflect those currently residing in HBCCC beds.

	Patients on waiting list	Total patients	Average LoS (current - days)	Bed days required overall	No of beds in use/required	inc 85% occupancy uplift	inc 13% for growth
Thistle	8	34	278	9,464	26	30	34
Frail /Elderly	5	59	179	10,554	29	33	38
Old Age Psychiatry	1	39	268	10,441	29	33	38
Pentland*		6	322	1,931	5	6	7

This results in slightly higher projected need for HBCCC beds, but this remains below current provision, supporting the case for recommissioning some of the HBCCC bed base for additional intermediate care beds to support increased demand for these beds.

	No of beds available	No beds required	Planned beds
Thistle	27	34	27*
Frail /Elderly	54	38	30
Old Age Psychiatry	47	38	30
Pentland*	8	7	8**
Total	136	117	82

**TBC once review of Thistle ward is complete*
***Included in OAP bed numbers*

Although the modelling suggests more beds are required than are planned for, there are a large number of patients within HBCCC beds (frail/elderly and old age psychiatry) that do not meet the criteria for this level of care. The modelling was completed using data on current occupants and the waiting lists and did not remove the patients that did not meet the criteria.

A recent day of care survey completed on the 5th July identified that 54% of the beds surveyed (equating to 50 patients) had patients that did not meet the criteria for this level of care. The largest number of patients who did not meet the criteria (32 patients) were in the frail/elderly wards. 86% of the patients identified as not requiring this level of care had a length of stay in excess of 30 days.

Taking these findings into account validates the planned bed numbers. Ensuring the right staff mix within the EHSCP managed care homes is essential in reducing the number of HBCCC beds. Care homes need to provide complex nursing and dementia care to enable these patients to move on to a more appropriate, homely setting.

c. Care homes

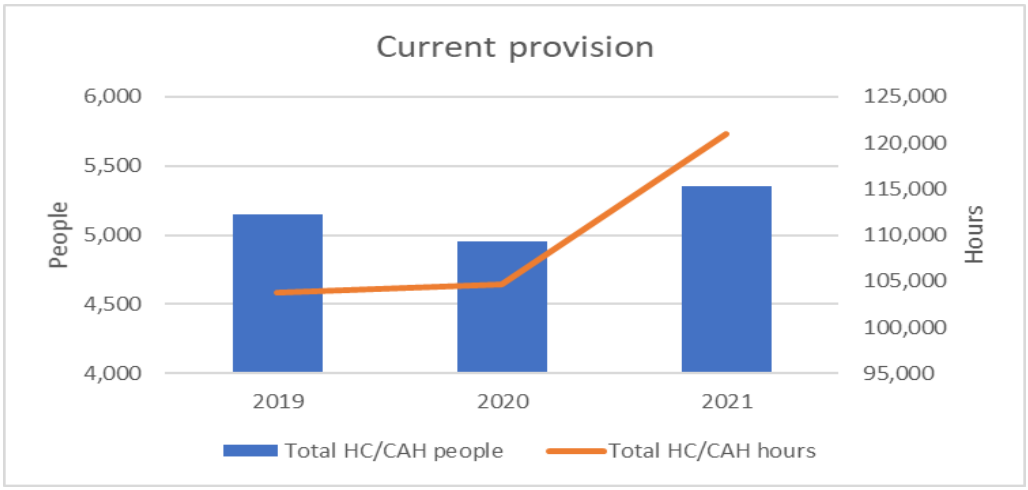
As described within the population and demographic section, we are seeing our older population growing at significant rates.

The increasing size of the older population will result in their care and support needs changing over time, with a proportion requiring more complex nursing-led care rather than the more general, low-level care that can be offered in the Partnership's existing care homes.

At the same time, there is a strategic move both within EIJB and nationally for people to live independently and in their own homes for as long as possible. This means that much of the low-level care provided in the Partnership's care homes is now being provided within individuals' own home through Home Care and Care at Home services.

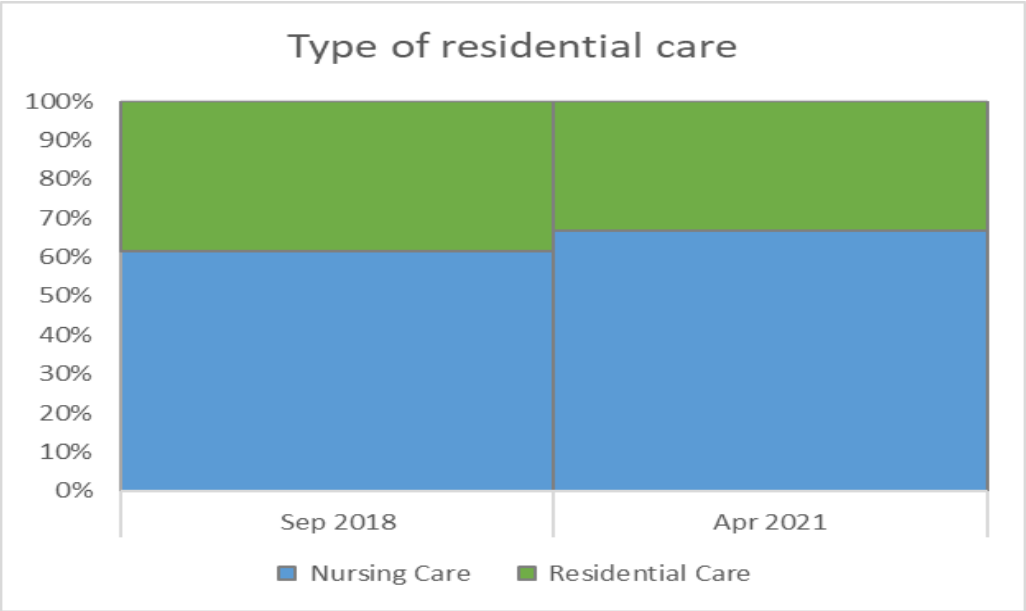
This shift can be seen both in the trends on number of people receiving social care services as well as the shift in residential care to nursing care.

Graph 2



Source: City of Edinburgh Council

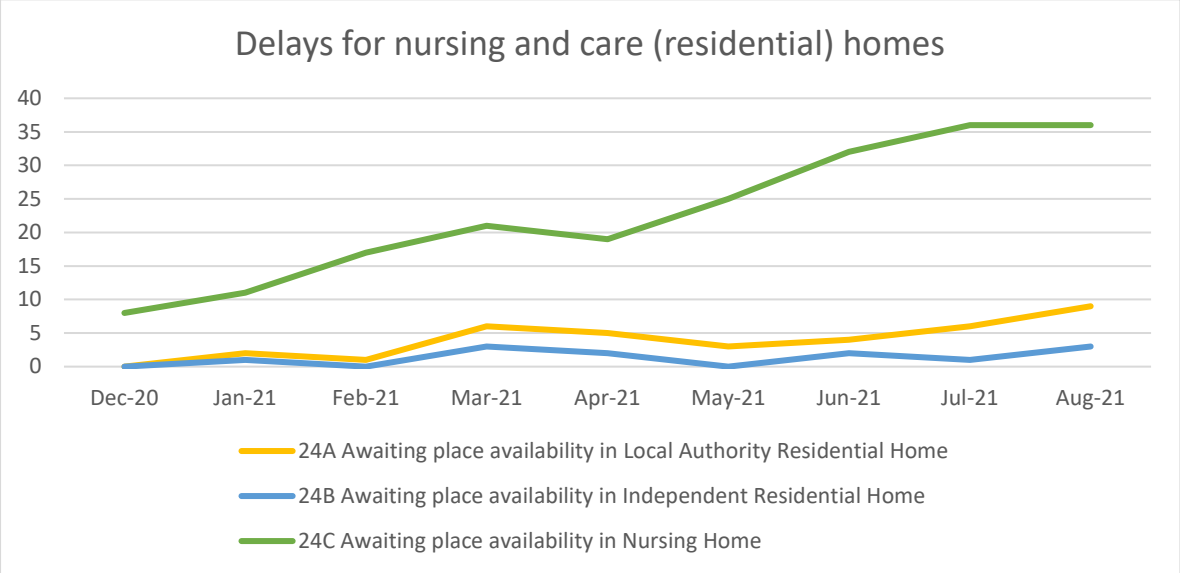
Graph 3



Source: City of Edinburgh Council

We can also see growing pressure on our nursing home provision in Edinburgh through our delayed discharges.

Graph 4



Source: NHS Lothian

The Partnership's current internal provision is entirely residential level care within its care homes, which is not the type of care required to meet demand for the population's needs into the future.

Reviewing our weekly summary of care home demand from hospital for w/c 13/09, the following was noted:

Weekly Summary

		North West	North East	South West	South East	**TOTAL**
Nursing	Self Funder	8	5	2	1	**16**
	LA Funded	12	8	3	5	**28**
Residential	Self Funder	0	2	0	0	**2**
	LA Funded	1	1	0	4	**6**
Dementia	Self Funder	1	0	0	2	**3**
	LA Funded	1	2	3	2	**8**
YPU		1	1	1	1	**4**
TOTAL		**24**	**19**	**9**	**15**	**67**

Out of the 67 people delayed in hospital waiting on a care home place, only 6 were LA funded residential places. Although these patients are coded as requiring local authority funded places this does not necessarily equate to choosing a bed in the Partnership's care homes. From the 6 patients identified above:

- 1 was miscoded and should be under Adults with Incapacity (Code 9_51x)
- 2 have been discharged, 1 into EHSCP care home
- 1 patient has been delayed for 56 days, they were initially intended for supported accommodation however due to a deterioration in health, this option is no longer suitable. The patient is also listed as waiting list for a bed within North Merchiston care home which provides specialist dementia care, this suggests that our internal homes would not provide the right level of care to support this patient and is likely why they are still delayed in hospital
- 2 patients have chosen external providers for their care.

This suggests that from the patients identified as needing LA funded residential care, only 2 were suitable for the level of care provided in the Partnership's care homes.

The greatest demand is for nursing care with 44 people delayed in hospital waiting on a placement. As the Partnership do not offer this level of care at present, they cannot accept patients with this level of need into their care homes. By introducing nursing provision in the newer 60 bed care homes (the only homes that can support this level of care), the Partnership can begin to offer nursing provision and will increase capacity by 180 beds.

Similarly, demand for specialist dementia care is higher than residential care and is another type of care that is not offered by the Partnership at present. Through introducing nursing staff with the relevant skills and experience to deliver specialist dementia care, the Partnership can offer this service going forward enabling them to provide appropriate care and support to those who are the most vulnerable in our society in the most appropriate setting to meet their needs.

It is imperative that the Partnership rapidly change the model of care provided within its care homes to meeting existing and future demand. This type of care cannot be provided in the older homes due to environmental limitations and as the homes have surpassed their design life expectancy they must be decommissioned. They are not sustainable or viable for future use and do not support the best outcomes for people. Through the proposals within the bed base care (phase 1) strategy, the Partnership can begin to modernise its bed base to continue to provide care and support to the citizens of Edinburgh who need it most both now and in the future.

Appendix 9

BED BASED CARE REVIEW - WORKFORCE

Hospital Based Complex Clinical Care (HBCCC) and Intermediate Care

All staff working in HBCCC and Intermediate Care units are NHS Lothian employees so, once the proposed changes are approved, appropriate policies will be followed to manage the organisational process for staff impacted by the changes. This requires consultation with staff and the preparation of a Workforce Organisational Change Paper for approval by the EHSCP Partnership Forum and then by the NHS Lothian Workforce Organisational Change Group.

The following information provides a summary of the planned workforce changes for the new model of care delivery for HBCCC and Intermediate Care and the staff (by Whole Time Equivalent: WTE) who will be impacted by the change. The changes will ensure a safe, sustainable and deliverable workforce for care delivery.

The staff groups impacted by the change are nursing, medical, occupational therapy, physiotherapy and pharmacy. The following tables illustrate the current workforce and the proposed workforce when the changes are fully implemented. The impacts on staff will become effective in a phased way to reflect the staged approach to the implementation of the changes to HBCCC and IC units.

The current and proposed bed numbers / wards for when the proposal is fully implemented have influenced the changes to the workforce model. However, as there will be interim arrangements these have also been considered.

The proposed staffing has been calculated based on Liberton Hospital closing, the HBCCC dementia old age psychiatry wards being located in Drumbrae, HBCCC frail wards consolidated in Ferryfield, no change to the HBCCC functional psychiatry ward at Ellen's Glen and IC wards being Findlay House (2 wards) and Ellen's Glen (1 ward).

	ICF	HBCCC - frail	HBCCC - psychiatry	Total
Current bed numbers / wards	64	55	81 (includes 27 functional and 7 in Pentland)	200 (includes 27 functional and 7 in Pentland)
Proposed bed numbers / wards	75	50 interim 30 full implementation	57 (includes 27 functional)	182 interim 162 full implementation

Nursing staff

The current establishment for nursing staff is calculated from the existing staff workforce models for the HBCCC and IC units. The proposed staffing considers safe staffing levels, staff:patient ratios and skill mix between registered and non-registered nursing staff. It is expected that some of the reduction in nursing staff will be used to support the nurse practitioner increases to the medical model.

	ICF	HBCCC - frail	HBCCC - psychiatry	Total
Current establishment	107.08wte	87.50wte	130.14wte*	324.72wte
Proposed establishment	121.17wte	80.66wte	91.50wte	293.33wte

*does not include current Pentland establishment which is within REAS

AHPs

The proposed occupational therapy and physiotherapy workforce has taken into account a number of factors including skill mix, complexity of caseload (complexity weighting) and decision making, high rehabilitation criteria for ICF, multidisciplinary working, complex discharge planning, capacity, capability of the service to deliver the needs of the individuals and effective and safe care.

The current establishment staffing is for a Monday to Friday service. The proposed workforce model incorporates staffing to support an increased bed based, early supported discharge and skeleton weekend 7day therapy model for IC and support for the HBCCC bed based population. In addition, it is expected that the role of therapy rehabilitation support workers at band 4 and band 3 will evolve so that they can work seamlessly across both professions to support the rehabilitation service delivery model in a more global way. It is anticipated that these teams will work together to provide support across all services.

	Physiotherapy		Occupational Therapy		AHP		Total	
	ICF	*HBCCC - frail*	*ICF*	*HBCCC - frail*	*ICF*	*HBCCC - frail*	*ICF*	*HBCCC - frail*
****Current establishment**	11.63wte	0wte	11.96wte	1.00wte	1.00wte	0wte	24.59wte	1.00wte
****Proposed establishment**	10.00wte	1.00wte	10.00wte	1.00wte	12.00wte	1.00wte	32.00wte	3.00wte

**does not include detail on the current resource for the old age psychiatry HBCCC wards

Medical model (doctors and nurse practitioners)

The current establishment is calculated from the existing medical and nurse practitioner models for the HBCCC and IC wards. The proposed establishment takes into consideration the increase in IC beds, the expectation that specialty doctors will work between Ferryfield and Drumbrae with daily input from nurse practitioners on all 4 sites. It is also proposed that the specialty doctors could provide specialist advice into care homes accommodating those with higher needs supporting the care home support team (CHST).

Hospital at Night and Hospital at Home will continue to provide out of hours and weekend cover for all IC. It is proposed that Lothian Unscheduled Care Service (LUCS) will continue to provide out of hours cover for HBCCC.

		ICF	HBCCC	Total
Current establishment* **	Clinical lead	0.20wte		0.20wte
	Consultant	0.70wte	0.70wte	1.40wte
	Specialty doctors / clinical fellows	3.35wte (also provide cover to an HBCCC ward)	1.50wte	4.85wte
	NPs		1.22wte	1.22wte
			Total	7.67wte
Proposed establishment	Clinical lead	0.20wte		0.20wte
	Consultant	1.10wte	0.70wte	1.80wte
	Specialty doctors / clinical fellows	3.00wte	1.50wte	4.50wte
	NPs	2.44wte	2.44wte	4.88wte
			Total	11.38wte

***does not include 1PA consultant and junior doctor resource allocated to Pentland

Pharmacy

The current pharmacy has not been enhanced since Fillieside ward in Findlay House changed from HBCCC to IC in March 2020 which has created additional workload due to the higher patient turnover in an ICF ward compared to an HBCCC ward. Such an increase is required to ensure patients receive optimum pharmaceutical care. The proposed staffing establishment therefore takes this into consideration as well as these proposed changes to the HBCCC and IC arrangements.

	ICF	HBCCC	Total
Current establishment	1.60wte	0.50wte	2.10wte
Proposed establishment	2.60wte	0.90wte	3.50wte

Double running costs

There will be some double running costs associated with the operational implementation of the proposal as it will take time to move all the services to the interim and final destination. The likely impact of this will be between Drumbrae as it starts to open as an HBCCC unit

and Liberton Hospital as it gradually closes with the phased move of IC to Findlay House (Prospectbank ward) and Ellen's Glen (Hawthorn ward). The timescale of this is expected to be at least 6 months.

BED BASED CARE REVIEW – WORKFORCE

DRUMBRAE

All staff working in EHSCP managed care homes are City of Edinburgh Council (CEC) employees so, once the proposed changes are approved, appropriate policies will be followed to manage the organisational process for staff impacted by the changes. This requires consultation with staff and the preparation of an HR business case for approval by CEC HR, CEC Finance and the EHSCP Executive Management Team (EMT), then the EHSCP Partnership Forum.

The following information provides a summary of the planned workforce changes for the new model of care delivery for Care Homes and the staff (by Full Time Equivalent: FTE) who will be impacted by the change. The changes will ensure a safe, sustainable and deliverable workforce for care delivery.

The staff groups impacted by the change are managers and deputes, business support officers and assistants, team leaders, social care workers and assistants and ancillary staff.

The following tables illustrate the current workforce and the proposed workforce when the changes are fully implemented. The impacts on staff will become effective in a phased way to reflect the phased approach to the implementation of the changes to the care home estate.

The proposed staffing has been calculated based on Drumbrae changing function to HBCCC and the new model of care implemented in the remaining 60 bed care homes (Royston, Inch View and Marionville). The four older homes have been included in the vacancy numbers below however, a detailed workforce plan has not been completed at this stage due to the proposal to extend the timeframe for a decision on these homes until after the public consultation has concluded.

DRUMBRAE CARE HOME – STAFFING ESTABLISHMENT vs ACTUAL

	Grade	Current establishment	Current actual	Vacancies within remaining 60 bed care homes	Vacancies within four older care homes
Manager	Grade 9	1.00	1.00	0.00	0.00
Depute manager	Grade 7	1.00	1.00	1.00	0.00
Depute manager (NHS)	Band 7	0.00	0.00	2.00	0.00
Business support officer	Grade 6	1.00	1.00	1.00	0.00
Business support administrator	Grade 4	1.00	1.00	0.00	1.00
Team lead (D)	Grade 6	6.00	4.67	0.00	3.00
Team lead (N) **Employed on a temp basis*	Grade 6	0.50	1.00	0.00	0.00
Social care worker (D) **1xFTE on LT sickness* **1xFTE resigned 15/9* **1xFTE on temp transfer to Clovenstone*	Grade 4	12.89	11.00	9.00	3.00
Social care worker (N)	Grade 4	7.00	7.66	0.00	0.67
Activity co-ordinator	Grade 4	0.00	0.00	3.00	3.22
Social care assistant (D) **2.67xFTE on LT Sickness* **0.67xFTE resigned 1/9* **1xFTE on temp transfer to Marionville*	Grade 3	25.00	15.00	11.00	17.00
Social care assistant (N) **3.83xFTE on LT Sickness* **0.67xFTE on temp transfer to Clovenstone* **0.67xFTE employed until 9/11/21*	Grade 3	11.33	12.17	3.00	4.00
Senior cook **1xFTE on temp transfer to Royston*	Grade 4	1.00	1.00	1.00	1.00
Cook **1xFTE temporarily acting up*	Grade 3	1.50	1.00	0.00	0.00
Kitchen Assistant	Grade 2	3.00	3.00	1.50	0.69
Domestic	Grade 2	7.00	6.36	2.43	2.00
Laundry	Grade 2	2.00	1.83	0.00	0.00
Handyperson	Grade 3	2.00	2.00	0.50	1.50

There are a number of caveats with the establishment and vacancies shown above. The care home sector has a high staff turnover and a high level of agency staff spend. Even though there may be vacant positions in other care homes of a matching role and grade, staff must be given choice in their onward employment and that doesn't necessarily mean they will choose to continue to work in the care home sector. As CEC employees, all vacancies of similar role and grade can be considered and there are similar posts available in Education and Learning among other CEC services.

Consideration must also be given to the vacancies across the four older care homes. If we are to extend the timeframe for a decision on the decommissioning of these homes until after the public consultation (as set out in the covering report), likely well into 2022/23 then we must staff them to continue operating. Although positions may only be for a finite amount of time, staff have every right to choose one of these homes as there next place of employment.

NEW MODEL OF CARE FOR 60 BED HOMES

Comparison: existing staffing establishment vs new staffing establishment

Capacity 60	Grade	Current Establishment	Future Establishment
60 bed Care Home			
Manager	Grade 9	1.00	1.00
Depute Manager	Grade 7	1.00	1.00
Depute Manager NHS	Band 6	-	1.22
Business Support Officer	Grade 6	1.00	1.00
Business Support Administrator	Grade 4	1.00	1.00
Team Leader (D)	Grade 6	6.00	6.33
Nurse (D&N)	Band 5	-	8.20
Team Leader (N)	Grade 6	0.50	-
SCW (D)	Grade 4	12.89	11.33
SCW (N)	Grade 4	7.00	6.33
Activity co-Ordinator	Grade 4	-	1.00
SCA (D)	Grade 3	25.00	24.33
SCA (N)	Grade 3	11.33	18.33
Senior Cook	Grade 4	1.00	1.22
Cook	Grade 3	1.50	1.83
Kitchen Assistant	Grade 2	3.00	3.66
Domestic	Grade 2	7.00	8.54
Laundry	Grade 2	2.00	2.44
Handyman	Grade 3	2.00	2.44
		83.22	101.20

Recruitment to the new model of care will begin following approval at the EHSCP Partnership Forum in October. To allow time for the model to embed and to ensure consistent practice, it will be introduced gradually, one care home at a time. It is anticipated that nursing staff will be recruited and in post in Q4, 2021/22.

FOUR OLDER CARE HOMES

A detailed workforce plan has not been developed at this stage for the four older homes due to the high staff turnover and constantly changing vacancy position. Once a date has been agreed for consideration of the future of these care homes, a workforce plan will be developed and presented to the Board.

With regards to the number of staff in the four older homes based on establishment v actuals, the table below refers:

	Role	Grade	Est	Actual
Four old homes combined	Manager	Grade 9	4.00	4.00
	Depute Manager	Grade 7	4.00	4.00
	Business Support Officer	Grade 6	4.00	4.00
	Business Support Administrator	Grade 4	4.00	3.00
	Team Leader (D)	Grade 6	14.00	12.00
	Team Leader (N)	Grade 6	2.00	0.56
	SCW (D)	Grade 4	38.66	33.39
	SCW (N)	Grade 4	19.00	6.67
	SCA (D)	Grade 3	50.54	29.66
	SCA (N)	Grade 3	19.66	17.00
	Senior Cook	Grade 4	4.00	3.00
	Cook	Grade 3	4.00	3.00
	Kitchen Assistant	Grade 2	10.50	10.56
	Domestic	Grade 2	16.91	18.26
	Laundry	Grade 2	6.50	3.50
	Handyperson	Grade 3	4.00	3.00
			205.77	**155.60**

If a decision is reached to decommission the four older homes following the outcome of the public consultation, the withdrawal process would be phased over time as opposed to all at once, meaning positions would come available throughout the transition.