East Lothian
Integration Joint Board

# MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

## THURSDAY 16th SEPTEMBER 2021
## VIA DIGITAL MEETINGS SYSTEM

**1**

**Voting Members Present:**
Mr P Murray (Chair)
Councillor S Akhtar
Dr P Donald
Councillor N Gilbert
Councillor S Kempson
Dr R Williams
Councillor F O'Donnell (Items 5 – 9)

**Non-voting Members Present:**
Ms L Cowan
Mr D King
Ms J Tait
Dr C Mackintosh
Mr I Gorman
Mr T Miller
Dr J Turvill

**Officers Present from NHS Lothian/East Lothian Council:**
Mr P Currie
Ms C Johnston
Ms L Kerr
Ms J Ogden-Smith
Ms C Goodwin
Mr M Kennedy
Ms G Neil

**Others Present:**
Ms E Scoburgh, Audit Scotland

**Clerk:**
Ms F Currie

**Apologies:**
Ms F Ireland
Ms A MacDonald
Ms M McNeill

**Declarations of Interest:**
None

The members agreed to a change in Agenda order; Item 3 was taken first.

## 3. CHAIR'S REPORT

Peter Murray informed members of a communication with stakeholders on 1st September 2021 notifying them of the relocation of staff from the Edington Hospital in North Berwick to the East Lothian Community Hospital (ELCH) in Haddington. This action was in response to specific and significant pressures and was designed to ensure the continuity of services within the county. The position was to be reviewed after 12 weeks.

Mr Murray said that he had received a number of communications from individuals regarding the lack of consultation prior to this decision being taken. His response had been that this was a highly unusual set of circumstances which had required urgent action to avoid the situation worsening. This had limited the opportunity for and type of consultation with stakeholders. He said that the subsequent social media response had been concerning and disappointing, as well as being unhelpful to colleagues who were taking difficult decisions to ensure continuity of services and staff safety. He referred in particular to a petition which had been raised suggesting that the Edington Hospital was in line for closure. He assured IJB members that the Edington Hospital was not being closed. He encouraged members to support health and social care staff by countering any inaccurate comments or reports.

The Chair invited Iain Gorman to outline the reasons behind the decision to relocate staff. Mr Gorman provided details of some of the key challenges which had been facing the Health & Social Care Partnership (HSCP) and warned that these challenges were becoming more acute. He referred to increasing COVID-19 cases and the associated pressures on frontline services and the long-term impact on staff who had been dealing with the pandemic for over 18 months. Although the HSCP was working with partners across the sector, it was struggling to manage the pressure and the need to keep key services running. The decision to relocate staff had come from a need to consolidate staffing and maintain services in as safe as way as possible.

Mr Gorman also outlined the pressures facing the Care at Home service and the additional implications for the HSCP and individual care packages if external care providers struggled to deliver their contracted hours. He praised the work of staff to implement the COVID-19 vaccination programme but highlighted proposals to begin vaccinating 12-15 year olds, as well as delivering booster jabs and the winter flu jab programme, as further challenges to resources over the coming months. He advised members that the HSCP had alerted the Scottish Government to their current situation and that they would continue to manage current and future pressures as well as possible.

The Chair asked members to contact Mr Gorman if they had any questions on this issue. He added that it was important to present the decision relating to Edington Hospital within a broader context. He acknowledged the strength of feeling to maintain local services and also the need for Edington Hospital to be part of a broader analysis of care services. However, he wanted to emphasise that the current crisis, and the subsequent decision to relocate staff from Edington Hospital, was separate to that discussion.

## 1. MINUTES OF THE MEETING OF THE EAST LOTHIAN IJB ON 24th JUNE 2021 (FOR APPROVAL)

The minutes of the meeting on 24th June 2021 were approved.

## 2. MATTERS ARISING FROM THE MINUTES OF 24th JUNE 2021

The following matters were raised:

**Item 8:** Dr Richard Williams said he had raised a question regarding his membership of the Change Board and sought advice as to whether his participation was as a GP was appropriate, or whether he was there as a member of the IJB. Mr Murray agreed to seek advice and respond to Dr Williams directly.

*Sederunt: Dr Jon Turvill and Mr Thomas Miller left the meeting.*

## 4. CHANGES TO THE MEMBERSHIP OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

The Chief Officer had submitted a report seeking the Integration Joint Board's (IJB) agreement to changes in its non-voting membership.

The Clerk presented the report outlining the background and recommendations.

The Chair asked that a letter of thanks be sent to Paul White expressing the IJB's appreciation for his contributions during his tenure as Third Sector representative. He welcomed the new members and offered his thanks to those members continuing for a further term of office.

The vote was taken by roll call and all of the recommendations were approved unanimously.

**Decision**

The IJB agreed:

(i) that, with effect from September 2021, Maureen Allan would replace Paul White as a non-voting member and Third Sector representative on the IJB.

(ii) the re-appointment of Dr Jon Turvill and Thomas Miller as non-voting members of the IJB for a further term of office; and

(iii) the appointment of Dr Claire Mackintosh as a non-voting member, to replace Prof. Emma Reynish, effective from August 2021.

*Sederunt: Dr Turvill and Mr Miller re-joined the meeting. Mr David King left the meeting.*

## 5. INTERIM APPOINTMENT OF CHIEF FINANCE OFFICER

The Chief Officer had submitted a report updating the IJB on the proposals for the recruitment of the Chief Finance Officer/Section 95 Officer to cover a period of maternity leave.

The Clerk presented the update which followed on from the report considered at the IJB's meeting on 24th June 2021. The recommendation of this report was that the IJB approve the appointment of David King as Interim Chief Finance Officer.

The vote was taken by roll call and the recommendation was approved unanimously.

**Decision**

The IJB approved the appointment of David King as Interim Chief Finance Officer for the period of Claire Flanagan's maternity leave.

*Sederunt: Mr King re-joined the meeting.*

## 6. EAST LOTHIAN IJB 2020/21 ANNUAL AUDIT REPORT

Esther Scoburgh presented the 2020/21 ELIJB Annual Audit Report.

Ms Scoburgh advised members that the report and the ISA 260 (Report Charged to Those with Governance) had been presented to the IJB's Audit & Risk Committee on 14th September and had been agreed and recommended to the IJB. She outlined the content of the audit report which included reviews of the annual accounts; financial management and sustainability; governance transparency and Best Value; as well as the 2020/21 action plan and significant audit risks. The auditors proposed an unmodified opinion meaning that the accounts presented were true and fair and that there were no material misstatements noted in 2020/21. The report also recommended that the medium term financial plan and budgets were revisited to factor in the increased COVID-19 costs and funding and its impact.

She indicated that, as a result of rapid changes in the financial position at year end, a further updated report would be provided showing the finalised position. This would not alter the content of the message but rather provide improved clarity/transparency in the auditors' reporting. She drew members' attention to examples of good practice highlighted in the report and advised that these had been shared with the Audit Scotland national NHS overview team.

Ms Scoburgh referred members to the recommendations contained in the 2020/21 action plan and confirmed that the auditors were satisfied with management responses. She highlighted the key risks identified and the national reports which may be of relevance to IJB members. Finally, she thanked officers for their assistance during the year and in the preparation of this report.

Mr King welcomed the report noting in particular the comments regarding medium term financial planning. He said he was currently working on a post-COVID version of the IJB's 5 year financial plan and this would be brought to the IJB's October meeting along with a report on how to deliver a balanced financial plan.

Dr Richard Williams observed that the audit report was very clearly set out and understandable. He viewed the 'unqualified' audit opinion as meaning that the financial information provided to the IJB during the year was both robust and timely. He thanked the Chief Finance Officer and colleagues for their diligence.

Dr Patricia Donald stated that as chair of the Audit & Risk Committee she was always very impressed by the quality of reporting and level of assurance given, as well as the work done by officers. She also offered her thanks.

The Chair said he would pass on these comments to Ms Flanagan, who was currently on maternity leave, but who had been instrumental in preparing the 2020/21 accounts. He also welcomed the report and noted that the examples of good practice being shared nationally were a further testament to the work of local colleagues. He commented on the challenges of financial planning and said that change would be essential if the IJB was to balance its budget in the medium term.

## 7. 2020/21 AUDITED ANNUAL ACCOUNTS

The Chief Finance Officer had submitted a report presenting the IJB's annual accounts for 2020/21.

Mr King presented the report advising members that the accounts had been considered and recommended for approval by the IJB's Audit & Risk Committee at its meeting on 14th September. He also advised that the accounts would be signed by Councillor Shamin Akhtar, who latterly held the post of Chair in 2020/21, as the current Chair had been appointed from 1st April 2021.

In response to a question from Councillor Akhtar, Mr King indicated that during the pandemic there were a number of services which were postponed and which had resulted in cost savings. Following remobilisation, these services had restarted and the associated savings were no longer being achieved. This had resulted in increased financial pressures which would be likely to continue in the current financial year. He agreed to provide Councillor Akhtar with a more detailed update following the meeting.

The Chair actively encouraged members to read the accounts, if they had not already done so, as they provided a very good summary of the IJB's work during the previous financial year. He referred in particular to the management commentary which included a thank you to staff across services for their hard work and dedication during such a challenging period. He echoed those thanks resoundingly, on behalf of all IJB members.

The vote was taken by roll call and all of the recommendation was approved unanimously.

**Decision**

The IJB, having noted the report of the independent auditor, agreed that the annual accounts for 2020/21 could be signed electronically on behalf of the IJB by the Chair, the Chief Officer and the Interim Chief Finance Officer, following approval of the accounts at the IJB's Audit & Risk Committee meeting on 14th September 2021.

*Sederunt: David King left the meeting.*

## 8. NATIONAL CARE SERVICE CONSULTATION

The Chief Officer had submitted a SBAR report updating members on the national consultation underway concerning the establishment of a National Care Service and inviting members to consider how to formulate the IJB's response to the consultation.

Paul Currie presented the report outlining the background to the consultation exercise, its scope and some issues of particular interest to IJB members. He referred to the previous request for members' comments and said that 2 responses had been received initially and that he was now seeking approval to set up a development session in early

October. This event would allow members to consider the consultation and what is happening more widely and to formulate the IJB's response. He added that some IJBs had not put forward a response to the consultation as they could not reach a consensus. However, in his opinion, a range of views should not preclude the IJB from providing a constructive response to the consultation.

Dr Donald supported the opportunity to have further discussion on the issues and to formulate a response. She said that the IJBs and HSCPs both had relevant expertise in integration and it was right that they should be participating in this consultation.

The Chair expressed concern about the lack of recognition of the previous 5 years of endeavour on the part of IJBs. He said it would be important to highlight and reflect on good practice as well as responding to the current proposals. He also encouraged members to attend one of the information sessions being held by the Scottish Government as these provided useful background on the consultation.

Councillor Fiona O'Donnell said she was happy to support the recommendations in the report but queried the best way to respond to wider issues such as community justice and children's' services.

Judith Tait advised that that East Lothian Council was preparing its own response to the consultation which would cover these areas. It was undertaking a range of meetings with key services in order to prepare a draft response and there would be a briefing session for Councillors on 12th October to discuss this document. She added that the message from the Scottish Government was that they wanted to hear from as many people as possible. Responses were being encouraged in a range of formats and need not necessarily follow the consultation response proforma.

Councillor Akhtar also welcomed the recommendations in the report and the work to extend the deadline to the consultation. She said that everyone had the same aim – to improve outcomes for health and social care – and she encouraged as many people as possible to comment on the sections of the consultation which were relevant to them.

The vote was taken by roll call and all of the recommendations were approved unanimously.

**Decision**

The IJB agreed:

i. That a development session would be arranged in late September/early October to provide IJB members with an opportunity to discuss the implications of the NCS consultation for health and social care services in East Lothian and more widely; and
ii. That the outputs of any development session should be used to prepare an East Lothian IJB response to the consultation on the establishment of a National Care Service.

## 9. COMMUNITY TRANSFORMATION PROGRAMME, ADULTS WITH COMPLEX NEEDS OVER 65

The Chief Officer had submitted a report updating the IJB on the progress of the Community Transformation Programme for over 65s and seeking approval for the recommendations set out in the report; which were agreed at the Strategic Planning Group meeting on 8th September 2021.

Christine Johnston presented the report reminding members of the actions agreed by the IJB at its June meeting. She advised that discussions had subsequently taken place with Older People's Day Centres and additional new investment had been agreed to develop outreach support until 2023. However, in considering the longer term 4 year public contract framework, a number of risks and issues had been highlighted and, as a result, it was recommended that the existing funding for the centres should be continued until 31st March 2023. She added that additional actions had been recommended to mitigate any risks and to address the concerns of colleagues in procurement and legal services. Ms Johnston also updated the members on the proposals for a Meeting Centre in Musselburgh.

Ms Johnston responded to questions from members on demonstrating Best Value and the implications of a light touch application process.

Councillor Akhtar said she had been meeting with the Association of Day Centres and she felt that they would welcome this report. She referred to the range of work being done to support carers and service users and said she had agreed to circulate examples of good practice to IJB members. Ms Johnston offered to help collate some examples for circulation.

The Chair said that the report demonstrated a constructive response to the concerns raised and comments made by stakeholders during the engagement process. He felt that the proposals were being taken forward in a very measured way.

The vote was taken by roll call and all of the recommendations were approved unanimously.

**Decision**

The IJB agreed to:

i. Note the background;
ii. Note the risks and issues in commissioning Older People's Day Centres and approve the proposed approach set out in the report;
iii. Approve the mitigating actions set out in the report; and
iv. Note the update on the Meeting Centre proposal and approve the further development of the Public Social Partnerships approach set out in the report.

Signed .....

Mr Peter Murray
Chair of the East Lothian Integration Joint Board

East Lothian
Integration Joint Board

**REPORT TO:** East Lothian Integration Joint Board

**MEETING DATE:** 28 October 2021

**BY:** Chief Officer of the IJB

**4**

**SUBJECT:** Initial Agreements for the Next Stages of the REH Campus Re-development.

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## 1 PURPOSE

1..1 This report seeks support from East Lothian IJB to take forward the Initial Agreements (IA) for the next stages of the REH Campus re-development, which have been developed in partnership with East Lothian HSCP. This includes an IA for:

1. Inpatient Intellectual Disabilities and the National Intellectual Disability Adolescent Inpatient Unit (NIDAIPU)

2. Inpatient Mental Health Rehabilitation and Inpatient Low Secure Services

These services are delegated functions and East Lothian and other partnerships have worked closely with the REH project Board to develop the IA's on a pan- Lothian basis.

## 2 RECOMMENDATIONS

2.1 The IJB is asked to:

- Note the strategic case outlined in the Initial Agreement (IA), and how this links to the East Lothian vision for future care in this area
- Note the reduction in LD beds from 3 to 2
- Approve the IA's (prior to submission to Scottish Government)
- Acknowledge the continued involvement of ELHSCP officers in the development of the business case.

## 3 BACKGROUND

3.1 NHS Lothian provides assessment and treatment inpatient provision for adults with a Learning Disability and adults with complex Mental Health needs at the Royal Edinburgh Hospital (REH) campus in Morningside. The overall campus site has been the focus of a programme of modernisation, with Phase 1 completed in 2016/17. Phase

2 aims to build on the knowledge gained from the first phase to develop LD and MH inpatient facilities.

3.2 The development of a NIDAIPU on the REH site as described in appendix 1 would deliver high quality care for those requiring inpatient treatment as well as being a hub for training, learning and development in the area of managing patients with an intellectual disability with complex behavioural and mental health needs both within and out with hospital.

The campus will include 17 beds for the Lothian's and Borders Intellectual Disability patients, 2 of which would be commissioned by the ELIJB. This reflects a reduction of 1 bed from the original submission to the IJB in April 2018. The campus will also include 4 beds for the national IDAIPU, as specified by National Services Scotland (NSS) and the Scottish Government.

3.3 The development of an Integrated Mental Health Rehabilitation and Low Secure Service on the REH site is described in Appendix 2. This service will provide 60 beds, made up of 23 low secure and 37 rehabilitation beds.

When the paper was submitted to the IJB in April 2018, Mental Health Rehabilitation beds were split across the new Royal Edinburgh Building (phase 1 of the Royal Edinburgh redevelopment) and in the old part of the hospital.

The initial phase 2 redevelopment that was proposed at that time focused on the re-provision of the beds in the old hospital (45 beds in total; 4.5 beds for East Lothian) with the beds in the new building remaining as is (15 beds in total; 1.5 beds for East Lothian).

| **East Lothian** | September 2018 | October 2021 |
|---|---|---|
| Rehab beds in new building (15) | 1.5 | 0 |
| Rehab beds in old building (45) | 4.5 | 6 |
| Rehab beds in scope for phase 2 | 4.5 | 6 |
| Rehab beds commissioned phase 2 | 2 | 3.5 |
| **Total rehab beds after phase 2** | **3.5** | **3.5** |

Due to pressures on Adult Acute Mental Health beds the 15 existing Rehabilitation beds were moved into the old hospital in September 2020 so that that ward could be converted to Adult Acute Mental Health.

East Lothian has since commissioned a reduction of 2.5 beds due to the re-provision of Cameron Cottage, which will provide an increase in community rehabilitation placements. This will give East Lothian 3.5 in-patient rehabilitation beds.

Within Lothian, low secure has always been provided out of area, however following the 'Independent Review into the Delivery of Forensic Mental health Services, it advised that Low secure care should be provided locally and this IA seeks to deliver this recommendation.

East Lothian has also commissioned a reduction of 1 bed for low secure, providing East Lothian with 1 low secure inpatient bed in phase 2.

Therefore for the revised initial agreements are being taken forward to reflect that all the rehabilitation/low secure beds need to be provided in a new, fit for purpose facility.

3.4 ELHSCP Officers are members of the REH Project Board. Once agreed by the four IJB's the IA's will then progress through the NHS Lothian governance processes for submission to the Scottish Government. Once approved this will lead to the development of a business case.

## 4. RESOURCE IMPLICATIONS

4.1 The financial model that underpins both IAs has been developed on a pan-Lothian basis. As such, it focuses on the overall affordability of community and inpatient developments necessary to provide person centred case for people in Lothian, shifting the balance from hospital to community. All four IJBs have indicated they will commission a reduction in NIDAIPU and MH rehabilitation inpatient beds from current levels.

4.2 The financial model takes this in to account, but also includes the cost of commissioning additional community capacity for LD and MH clients in order for the planned beds reductions to be sustainable.

4.3 At this stage, the model is affordable overall and it has been agreed previously with all CFO's that the model and costs are feasible. If and when the IAs are approved by the Scottish Government, an outlined business case will be produced, which will allow further discussion with each partnership.

## 5. INTEGRATED IMPACT ASSESSMENT

5.1 Integrated Impact Assessments (IIA) will be carried out for each client group as business cases are developed through the REH programme Board.

## 6. RISKS

6.1 The reduced bed base is predicted on robust community developments, which requires whole system planning with client pathways to ensure that community supports are accessible, robust and sustainable.

6.2 As the individuals planned to leave hospital are complex, recruiting training and retaining a workforce will present an on-going challenge.

| | |
|---|---|
| **AUTHOR'S NAME** | Gillian Neil |
| **DESIGNATION** | General Manager |
| **CONTACT INFORMATION** | gneil@eastlothian.gov.uk |
| **DATE** | 18/10/2021 |

# Intellectual Disability and National Intellectual Disability Adolescent Inpatient Unit (NIDAIPU)

## NHS Lothian

## Initial Agreement

**Project Owner:** Nickola Jones

**Project Sponsor:** Alex McMahon

**Date:** 14/05/2021

**Version:** 1.13

## Version History

| Version | Date | Author(s) | Comments |
|---|---|---|---|
| 1.0 | 13/05/2021 | Nickola Jones | Initial draft, pulling together progress to date |
| 1.1 | 25/05/2021 | Nickola Jones | Updating IA Title, developing case |
| 1.2 | 27/05/2021 | Nickola Jones | Updating Case based on service discussions and options appraisal |
| 1.3 | 28/05/2021 | Nickola Jones | Review and update of case |
| 1.4 | 04/06/2021 | Scott Taylor | Review and update of case |
| 1.5 | 10/06/2021 | Nickola Jones | Review and update of case |
| 1.6 | 14/06/2021 | Nickola Jones | Review and update of case |
| 1.7 | 15/06/2021 | Nickola Jones and Steve Shon | Review and update of case |
| 1.8 | 16/06/2021 | Nickola Jones | Review and update of case |
| 1.9 | 16/06/2021 | Laura Smith/Hamish Hamilton | Updates to Economic Case & Financial Case |
| 1.10 | 20/07/2021 | Laura Smith | Review and update of Financial Case |
| 1.11 | 22/07/2021 | Nickola Jones | Review and update of case |
| 1.12 | 26/07/2021 | Nickola Jones | Review and update of case |
| 1.13 | 27/07/2021 | Nickola Jones | Review and update of case |

## Contents

# 1. Executive Summary

## 1.1 Purpose

Intellectual Disability services are currently delivered on the Royal Edinburgh Hospital (REH) site from outdated, clinically challenging accommodation. As described in the Initial Agreement (IA) for an initial 2 bedded facility for the NIDAIPU, currently there is no inpatient intellectual disability facility in Scotland for young people over the age of 12 with mental health needs.

This IA makes the case for the development of an intellectual disability campus on the Royal Edinburgh Hospital Site. The campus would deliver high quality care for those requiring inpatient treatment as well as being a hub for training, learning and development in the area of managing patients with an intellectual disability with complex behavioural and mental health needs both within and out with hospital.

The campus will include 17 beds for the Lothian's and Borders Intellectual Disability patients and 4 beds for the national IDAIPU, as specified by National Services Scotland (NSS) and the Scottish Government.

## 1.2 Background and Strategic Context

This IA follows on from the implementation of Phase 1 of the Royal Edinburgh Hospital campus re-development. It seeks to build on knowledge gained from the first phase and to provide high quality facilities for those with an intellectual disability receiving inpatient care for their mental health. This case also incorporates 4 beds to implement the Scottish Government's ambition to provide inpatient care in Scotland for adolescents with mental health needs and an intellectual disability.

The case aligns with all current Scottish Government and local strategies and has been included in the four Lothian IJB Strategic Plans for 2019-2022.

Inpatient care for those with an intellectual disability is a delegated function in Lothian, which means that the four Lothian IJBs are responsible for setting the direction for the future. Therefore, the Royal Edinburgh Project Board has worked closely with colleagues from across the four Lothian IJBs to create a joined up plan for Adults with intellectual disability.

The IJBs have agreed on a reduced bed number for adults with intellectual disability from a current funded capacity of 37 to 17 beds. This includes 2 beds for NHS Borders. The breakdown across the IJBs is as follows:

| IJB | New Bed No: |
|---|---|
| Edinburgh | 10 |
| West | 2 |
| East | 2 |
| Midlothian | 1 |
| **Lothian** | **15** |
| NHS Borders | 2 |
| **TOTAL** | **17** |

## 1.3 Need for Change

The current accommodation in Lothian for patients with intellectual disability requiring inpatient admission is not fit for purpose. The ward environment does not meet care standards such as providing en-suite facilities, and sharing bathrooms presents particular problems with regards to dignity for this patient group. The ward environment makes it challenging for staff to safely manage patients, which has an impact on both patient's recovery and staff morale and wellbeing. There is a lack of therapeutic space for patients, making it difficult for them to practice the life skills required to go home, and to receive 1:1 therapies in a private environment. The need for change is further described throughout this case, supported by direct feedback from patients receiving treatment within the wards in June 2021.

The impact of not having access to dedicated assessment and treatment inpatient facilities for adolescents with intellectual disability and mental health needs in Scotland are:

- Children and young people remained in distress and under-treated at home or in unsuitable units, sometimes with high use of sedative medication and restraint
- Due to delays in admission and not admitting, families were highly stressed, managing severe self-injury, aggression and destructive behaviours in their children. Families managing changes in medication and other treatments in crisis stages at home.
- Dislocation from family and local services due to distance when admitted to specialist units in England (however it was noted that better clinical outcomes were achieved).
- Additional costs, nursing costs and ward environmental adaptations to safeguard and manage young people in adult and paediatric ward settings.

## 1.4 Investment Objectives

The investment objectives for this case are to:

- Shift the balance of care by reducing inpatient beds and developing pathways to support people with long term needs relating to their intellectual disability in residential settings
- Provide adequate space for the delivery of therapeutic activities and spending time with family
- Establish a high quality, safe and robust inpatient services which meet care standards such as providing en-suite bathrooms
- Establish an inpatient environment which provides adequate space for care which enables staff to deliver care in the least restrictive way possible
- Have a facility which meets the current standards for energy efficiency and sustainability
- Embed a realistic and sustainable workforce model using the whole multidisciplinary team (MDT)

## 1.5 The Preferred Option(s)

The preferred solution was identified as Option 4: New Build for Both Services on REH Site. This was identified as the preferred option because it ranked the highest it both the Non-Financial and the Economic Assessment. Option 4 delivers a greater number of the benefits that have been set out as the criteria for achievement from this project.

6

It is recommended that NHS Lothian proceeds with this option to Outline Business stage where the implementation of the solution shall be further developed and tested for value for money.

## 1.6 Readiness to proceed

A benefits register and initial high level risk register for the project are included in Appendix 2: Benefits Register and Appendix **3:** Risk Register. Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

NHS Lothian is ready to proceed with this proposal and is committed to ensure the necessary resources are in place to manage it. Section 6.2 outlines the governance support and reporting structure for the proposal and section 6.3 details the project management arrangements.

## 1.7 Conclusion

This case clearly describes the need for improved accommodation for those with intellectual disability and mental health needs in NHS Lothian, it also describes the case for providing a bespoke 4 bedded facility for adolescents with these needs across Scotland, as requested by the Scottish Government and supported nationally.

The case presents first hand feedback from those receiving care in the current facilities in NHS Lothian which provides a clear indication of the failings of the current environment. The Scottish Government and IJBs have a strategic direction to care for people in an inpatient setting only when that is the only possible solution. Therefore, when someone does require a hospital admission, it will be because they have a high level of need. The best quality environment is required to ensure those admitted receive the highest quality care, in an appropriate environment and supported by staff who feel valued and well equipped.

Co-locating the national unit with the local unit will create a centre of excellence for supporting people with intellectual disability both in hospital and in the community. It will become more attractive for staff to work in the units because there will be a variety of learning and training opportunities. The environment would be bespoke and fit for purpose and provide dignity to those requiring a hospital admission.

This case is supported by the 4 Lothian IJBs, NHS Borders and Borders IJB and is driven by a genuine desire to provide care for vulnerable patients in the best possible environment to give people the greatest chance of getting better and being able to go home. It is aligned with the ambition to shift the balance of care from hospital to community settings and exhibits NHS Lothian's commitment to this agenda.

# 2. The Strategic Case

## 2.1 Existing Arrangements

### *Intellectual Disability Wards*

#### What is a Learning Disability?

The term learning disability is commonly used in the UK and is synonymous with intellectual disabilities, which is used currently internationally (These are not the same as learning difficulties which is a term that, in the UK, refers to a separate group of specific reading and writing disorders).

Following the recent revisions of international mental health diagnostic classification systems (ICD-11 and DSM-5), the terms Disorders of Intellectual Development or Intellectual Development Disorder are likely to be more widely used in the years ahead. Therefore, this case will use the term 'intellectual disability' or 'ID' throughout.

In Scotland, within the Keys to Life strategy (Scottish Government, 2013), people with learning (intellectual) disabilities are described as having a significant, lifelong, condition that started before adulthood, which affected their development and which means they need help to:

- understand information;
- learn skills; and
- cope independently.

#### How many people have an intellectual disability?

About 16,000 school children and young people in Scotland have an intellectual disability. About 26,000 adults in Scotland have an intellectual disability and need support. Around 3,900 (15%) of these adults live in Lothian (Scottish Learning Disabilities Observatory 2021). For any of these needs the level of support will vary. A person with learning disabilities may need:

- occasional or short-term support;
- limited support, for example, only during periods of change or crisis;
- regular long-term support, perhaps every day; or
- constant and highly intensive support if they have complex or other needs which are related.

#### What does the existing inpatient service do?

The NHS Lothian Intellectual Disability Inpatient Service is designed to accommodate adults (18 years or over) across NHS Lothian with an intellectual disability, presenting with a range of mental health, forensic or behavioural support needs. The principle function of the service is to provide a period of systemic assessment of intense, severe, enduring or unpredictable high-risk behaviours, and
8

subsequently provide treatment and behavioural support plans to enable patients to live safely within their local community.

There are distinct pathways of assessment and treatment depending upon patient needs. These could be behaviours that challenge, those determined as forensic, or those with mental ill-health concerns which cannot be met within adult mental health services. It is also expected that the service should anticipate the needs of those with dementia.

People with an intellectual disability, with and without co-morbidities, can experience a range of physical disorders, which can add complexity to their presentation. They may require continuous observation, physical intervention and pharmaceutical interventions. Medical and psychiatric expertise is required for accurate diagnoses and effective treatment.

People with ID have higher incidence of preventable disease, divergent disease profile and lower life expectancy than the general population. Generally this can be attributed to lifestyle factors, ability to identify early signs and manage symptoms of disease, along with chronic conditions that are associated with genetic and congenital disorders. It is also well recognised that people with ID experience a diverse and systemic range of health inequalities, and diagnostic overshadowing with symptoms of preventable disease attributed to their ID.

The intellectual disability service is specialist by nature, operating on a pan-Lothian basis for a specific cohort of patients, addressing specialist needs of the most acute individuals. It is the only NHS Lothian inpatient service of its type.

## Model of Care

NHS Lothian provides the inpatient element of care for people with an intellectual disability, and has strong links and interdependencies across primary and community care colleagues and intermediate care teams.

GPs, community service providers and intermediate care teams work with individuals in the community to support them at home wherever possible, and if an inpatient stay is required, that they are supported to be discharged home as soon as they can be.

Primary reasons for admission are a) deterioration in mental health state, b) medication review c) increased risk associated with forensic or distressed behaviour. Those receiving care can be described as belonging to three categories:

- Mental Health – presenting needs will be related to new emerging or chronic symptoms associated with schizo-affective disorders or depressive and anxiety disorders. Along with the secondary symptoms of self neglect and poor physical health and psycho-social status.
- Forensic – presenting needs will be related to high risk behaviours which would attract the attention of the criminal justice system such as violence, sexual assault or arson
- Distress behaviours – often associated with autism or other neurodiverse disorders with associate communication concerns and behaviours that challenge

In general, unless the individual has the ability to consent to a voluntary period as an inpatient, all patients must meet the psychiatric criteria to require a period of detention under the Mental Health (Care

and Treatment) (Scotland) Act 2003. All patients who are detained have an allocated Mental Health Officer (MHO), and all patients have access to NHS Lothian funded Advocacy.

The model of care relies on close partnership working with the centrally funded Intermediate Tier of services: Mental Health Intensive Support Team (MHIST) and the Forensic Assessment and Support Team (FAST), along with the locality-based Integrated Community Learning Disability Teams to ensure appropriate patient progression and flow, supportive of their needs as they change.

The key functions that the intermediate teams provide are:

1) to work with community partners to step up care for a time limited period with additional intensive and assertive interventions to maintain people within their community, and mitigate against admission
2) when an admission to an adult mental health bed is required provide the additional ID expertise and support to enable positive outcome and experiences
3) support discharge planning and to work with community partners to step up for a time limited period with additional intensive and assertive interventions to maintain people within their community

Currently, the model of access to the service is as follows;

- Patients are admitted following community crises by Community Learning Disability Teams (CLDTs) or out of hours by GPs
- They are seen by MIHST, FAST, SBPST if time allows
- Patient flow involves appropriate, timely admission by the current clinical team to the appropriate inpatient area according to clinical need for assessment (forensic, mental illness, challenging behaviour)
- Following assessment and treatment the person should then progress to discharge home in a timely manner


The current model is one of “admit to assess”, described above.

## Current Ward Establishment

There are currently 38 patients receiving care within the Intellectual Disability service which include patients within the core Royal Edinburgh Hospital site facilities including the William Fraser Centre (WFC) and Islay Centre. Off-site services include Primrose Lodge, Camus Tigh, and Glenlomond. The geographical locations are shown on the map below:


Current capacity is as follows:

| Ward | Location | Current Funded Capacity | Current Use |
|---|---|---|---|
| Islay | REH Site | 10 | 11 |
| William Fraser | REH Site | 12 | 13 |
| Carnethy | REH Site | 0 | 2 |
| Primrose Lodge | Midlothian | 3 | 1 |
| Camus Tigh | West Lothian | 6 | 6 |
| Glenlomond | Edinburgh City | 5 | 5 |

Glenlomond, Camus Tigh, Primrose Lodge and WFC are all congregate living spaces – each patient has their own bedroom, but living areas and bathrooms are shared. All services have varying levels of security and all are locked using keys.

The Service also has patients currently placed in the REH, St John's Hospital, Midlothian Community Hospital in addition to Regional and National Hospitals. There are currently 7 people receiving care out of area.

Length of Stay

Lengths of stay in the Intellectual disability service are often measured in years, rather than days or months, with low turnover of patients in units, small numbers of admissions and discharges annually through a small number of beds. These long lengths of stay mean that the inpatient units are “home” for patients for several years. The lengths of stay range from 6 months to 10 years.

Currently the service is operating at 130% occupancy and experiencing 30% delayed discharges.

### *Services for Young People Aged 12-18 with Intellectual Disability and Inpatient Mental Health Needs*

Currently there is no NIDAIPU in Scotland for young people over the age of 12. If a young person requires admission to hospital they have to travel to England for treatment or are cared for in an adapted setting which is designed for adults.

Following the completion of the 5 Year Survey of Need for Mental Health Inpatient Care for Children and Young People in Scotland with a Learning Disability and/or Autism, published by Scottish Government (2017), a Short Life Working Group (SLWG) was established to review access to mental health inpatient care for young people in Scotland with learning disability. The group aimed to address three distinct areas:

- To benchmark bed numbers and specification with NHS England
- To identify current expenditure in Scotland and revenue for proposed facility
- To develop a high level service specification for a Learning Disability Child and Adolescent Mental Health Inpatient Service.

The SLWG concluded that a specialist inpatient unit was required for Scotland. The Directors of Planning asked NSD to undertake an options appraisal exercise to assess and identify the most effective, sustainable and person-centred model of delivery for specialist inpatient mental health care for children and young people with learning disability. The appraisal concluded that a 4 bedded facility was required. Boards were asked to express an interest to host the new facility.

Following a successful bidding process, NHS Lothian is the preferred host for the service. This unit would be located on the Royal Edinburgh Hospital campus alongside new facilities for adult learning disability services.

## 2.2 Drivers for Change

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

## *Intellectual Disability Wards*

The following paragraphs are supported by pictures included in Appendix 6.

### Inappropriate Physical Environment

The Austin Smith Lord report describes that the buildings in which LD services are currently situated are not fit for purpose. The following paragraphs describe what that means in practice, both for patients receiving care and staff delivering it.

The buildings have shower rooms and toilets located on corridors, which means that if a patient requires support when using these facilities, the door has to be left wide open to enable staff to enter and support that patient, and other staff are required to make sure that no one else currently receiving care within the unit can see them. Due to the nature of this patient group there can be low impulse control and difficulty in communicating which may lead to patients leaving the bathroom in a state of undress, and because the shower opens into a public corridor, there is no privacy for that patient to walk to their room without clothes on. This situation represents a complete lack of dignity for those receiving care and a highly challenging situation for staff to manage, which also means higher levels of staffing. It also represents a lack of freedom for patients to be in a state of undress if they want to be in the privacy of the place in which they are receiving care. The location of the shower rooms and toilets also do not comply with Healthcare Acquired Infection (HAI) standards, which is even more pressing given current requirements to prevent the spread of COVID-19. One patient who did have access to their own shower room (due to their being fewer patients in the ward) said 'I like the shower room and not having to share'. Other patients said:

- 'I can't always use the bathroom when I want to'
- 'I'd like to have my own toilet and shower'
- 'I'd like to have my own bathroom and shower, not having to wait to go to the toilet or shower. It's bad if you have an appointment and you can't get in the shower – it makes you late'
- 'It's not fair that we have to share showers and toilets and you can't always get it when you want it'

The rooms in a large proportion of the LD estate are not wheelchair accessible and there is insufficient room to use hoists and stand aids if patients have physical disability requirements. Additionally, there are risks associated with ligature points due to standard doors being in place. In a new unit there would be doors with sensors which would alert staff if any weight was put on the door.

Supported by the Learning Disability Managed Clinical Network the current services based at REH Campus have been pursuing accreditation with the RCPsych standards[1]. There are fundamental limitations with achieving accreditation related to environmental, deficits and facilities available to patients, families and staff within the current services. only with systemic redesign and direct repurposing of environments will enable successful accreditation.

[1] RCPsych Standard - https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/qnld-fourth-edition-standards.pdf?sfvrsn=5fce5d7f_2

Patients within intellectual disability wards can also be hyper aware of any flaws associated with their living environment. There have been numerous incidents where there have been small holes in walls which patients have become very interested in and possibly want to try to fix or find out what is behind the wall, they therefore exhibit compulsive behaviours which lead to them picking at the wall and creating further damage to the environment. There are also instances where walls are punched and kicked. With a more robust unit, these issues would not arise as often as the walls would be robust enough to withstand damage.

The Islay Centre presents a challenge for staffing because it has three different front doors to enter different parts of the unit. In order to ensure safe staffing levels at night there has to be 3 staff nurses to cover each area of the unit as well as two nursing assistants to support each. This means there are 9 staff on each night for 11 patients. A smarter building design would reduce the need for additional staff.

Additionally, there are considerable safety implications of the current ward environment. Due to a lack of flexibility in the clinical space, there are instances where patients who have low inhibition and may remove clothing may also be sharing communal spaces with someone who has been admitted due to forensic reasons such as sexual inappropriateness. This means that there is limited access to shared spaces for some patients and these risks need to be managed by having high staffing numbers who can ensure each patient is safe. Additionally, there are a limited number of exits from the wards meaning that patients have to pass the doors of other patients' bedrooms to leave the building. Again, due to the nature of this patient group, there are instances where one patient is unable to leave the building due to another patient requiring support from staff outside of their bedroom door and whereby it could be dangerous for that other patient to pass by. In other instances, it can be challenging for patients to re-enter the ward because the doors into the ward open straight onto the corridor with the doors of the other patients' bedrooms. Again, if there is an event happening for another patient in front of that door, other patients are unable to enter.

## Lack of Therapeutic/General Space

Not only is the current accommodation physically challenging for staff to deliver care from, there is a lack of space available to deliver therapeutic activities which will support patients to be able to go home.

There are significant restrictions with regards to therapeutic space available in the wards. Patients are admitted to the LD wards due to significant challenging behaviours which require an intensive period of assessment and therapeutic intervention to enable them to go home and live as independent a life as is possible. It is therefore vitally important that they have access to their usual type of environment in an inpatient setting to practice key skills.

There is currently no therapeutic kitchen where patients can practice skills to support them to go home or for patients to use who are able to prepare their own food. There is no space to do art therapy activities and other OT activities. There is also no indoor space for any physical activity, which can be an important element of a patient's normal day which is currently denied to them in the current inpatient unit. Access to space for physical activity would have a positive impact on the mental and physical health of inpatients with an intellectual disability. Currently, the outdoor space available is situated next to a school playground, so there is a lack of privacy and can be distracting. Patients said:

- 'A kitchen I could use myself would be good for making snacks and meals'
- 'I'd like to be able to make some of my own food. I'd like to have more things to do'

- ‘I think a kitchen for patients to use would be good – to keep up your skills and learning new ones making snacks and drinks and meals. I’d like more opportunities to keep active and fit and looking after myself’
- ‘I’d like to have a kitchen that I could use to learn how to cook and make meals’

It is extremely challenging to do 1:1 interventions with patients as it is usually inappropriate to conduct therapeutic interventions within a patient bedroom, and the other spaces are communal and therefore not private. Often this means that OT and Psychological interventions do not happen. Additionally, being able to associate certain spaces with certain activities is often important when supporting people with learning disabilities due to the nature of their condition. There is a requirement for certain sensory elements to be associated with a certain room, for example their being a bed and dark curtains in the place you go to sleep. This room being used for a purpose other than sleeping can be damaging to patients’ understanding of what activity happens where, which can lead to further distress. Additionally, another challenge is access to washing machines. Generally, patients are supported to do their own washing if they are able to as this is an activity they will be doing when they go home, however, some people with an intellectual disability have specific preferences relating to their clothes, and some like to wash clothes every night to be ready to wear again the next morning. There is currently no access to washing machines on the wards. These factors in combination make the lack of therapeutic space detrimental to patient care and increases their length of stay due to an inability to practice skills required for going home.

Feedback from some of the patient’s currently receiving inpatient care support this description:

- ‘I have used the sitting room for therapy sessions- it’s OK. I’d like a better place to meet with visitors’
- ‘A big open space for therapy  and some more private spaces for meetings with visitors, doctors or lawyers’
- ‘There should be an art room and activity room, it would be more peaceful and quieter. I would be able to do my therapy better without people shouting and that’
- ‘I mostly use my own sitting room for working with therapists and my support workers and social workers. It would be bad if I didn’t have it. It might be good to have a therapy room where you could do groups and that with other people not just on your ward’

There is no private space outwith bedrooms for patients to meet with family members and friends. This means that there can be disengagement with the community in which patient’s will be discharged to. This further impedes timely discharge. Patients commented:

- ‘Can’t watch TV in the sitting room because other patients talk over it so I have to watch in my own room so it can be quite lonely here’
- ‘The sitting room is good when people I don’t get on with are not around, but mostly I just use my own space’

Patients and staff see the value of being based on the REH site as there are opportunities to practice skills across the site. For example, patients can do garden related activities at the Cyrenians garden and they can practice selecting and purchasing items at the Royal Voluntary Service shop, both of which are safe and understanding environments.

Further to this, the current rooms are not large enough to enable NHS staff to work alongside third sector or private provider staff to train them on how to care for individuals. This is a critical part of the process for discharging people from hospital to home as often people within this patient group have very specific needs and preferences, and it takes time to build knowledge and trust with a new staff team before a patient is able to be discharged from hospital and for the teams to be confident that the community placement will be successful.

## Lack of Storage

There is a lack of storage space in the wards, both for patient belongings and for equipment such as hoists and stand aids. People with an intellectual disability sometimes require there to be very few and specific things in their room and there is currently very little storage space for people's personal belongings to be able to rotate items such as books to ensure they are not all out at once. One patient stated 'There's not much space for anything here, just your own room'.

## Staff Morale and Development

The current environment is damaging to staff morale and wellbeing. Staff often feel that they are managing the environment rather than supporting patients. The requirement for additional staff due to space challenges means that there is less to do for staff on shift and it can feel like they are just trying to keep someone safe rather than delivering treatment and support. It is disheartening for staff to be so restricted in the care they can provide and they do not feel they are providing the best care possible for their patients. This results in low staff morale which can lead to increased rates of sickness absence and higher staff turnover.

Additionally, there is no space for staff to de-brief together about their approach to patient care. There is a high level of distress for this inpatient group which can often be communicated through self injury or injury to others. This means that it is essential that staff have space to speak to one another about what has happened and how they might approach patient care differently going forwards. For example, a Speech and Language Therapist or Occupational Therapist may be able to work with nursing staff to analyse a situation and formulate an understanding of what may have caused a certain behaviour in order to prevent it from happening again. Without space for this Multidisciplinary Team (MDT) discussion, often these discussions do not happen and therefore the number of instances of violence in the unit is higher than it could be.

The needs for change are summarised as follows:

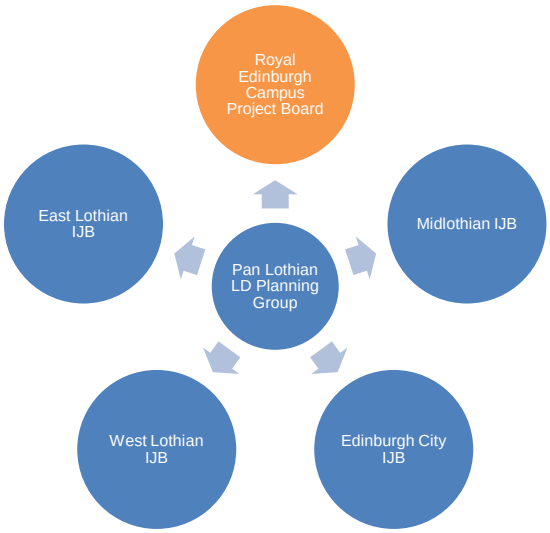
- The Austin Smith Lord report describes that the buildings in which LD services are currently situated are not fit for purpose. Of particular importance for LD patients is robustness and space, a lack of which can lead to a higher level of restrictions for patients and a lack of dignity. Despite multiple upgrades to current accommodation, they continue to fall short of the needs of service users

- The shift in resource stated in this proposal will mean that those with longer term needs will be cared for in the community, however, those who will require hospital based care will therefore have more challenging needs and will require a robust, high quality, safe inpatient environment, which is also safe for staff to deliver care from

- NHS Lothian's Property and Asset Management Strategy states that the Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant
- There is likely to be increased demand for the service alongside population growth. This service development, alongside the development of sufficient community services, will support a high quality inpatient service for this population
- Current LD accommodation is located across multiple sites meaning service delivery is more fragmented and high numbers of staff are required
- People want a safe place to live that is a 'home' rather than a hospital. There is currently not enough funding to provide alternative care in a community setting. Reducing the inpatient beds will release funding to enable people with LD currently living in hospital to move back to a community setting

## A Joint Vision for the Future

Strategic Planning for LD is delegated to the four Lothian IJBs and over the last 5 years, colleagues from across the four IJBs have worked closely with the inpatient intellectual disability service to establish a joint plan for the future of LD inpatient services. This joint planning was conducted formally through the 'Pan Lothian LD Planning Group' which had a revolving chair across the Lothian IJBs and reported through members to their respective IJBs as well as to the Royal Edinburgh Campus Project Board.




The group has based the future proposals on the outcomes of extensive feedback from people from across Lothian with learning disabilities using inpatient and community services. This is summarised in the Edinburgh IJB Strategic Plan 2018-2021 –

*"People with a learning disability continue to seek access to independent lives and to be accepted in their communities. We have taken positive steps towards achieving this, but we need to reshape how we provide support at different levels of engagement... We need to stop people 'living' in hospital and commission housing that can support people in the community. We intend to reshape how people interact with all our partners to better enable them to gain the independence they are entitled to and reinforce the commitment to on-going engagement"*

The group has proposed a smaller inpatient intellectual disability service, commissioned by each of the IJBs, supported by robust community alternatives for those with an intellectual disability who have long term and complex needs. The group has worked extensively to assess the needs of those patients currently in hospital who have been there for a long time and have commissioned bespoke services to meet their needs. This proposal has been supported by all of the Lothian IJBs and the NHS Lothian Board.

The majority of current inpatients are residents of Edinburgh and West Lothian. Both Health and Social Care partnerships (H&SCPs) have plans in place to provide a suitable Community response for those people who do not require to be in an inpatient beds and would not meet the criteria for admission if the legislation is to change. Timescales for discharge are as shown below:

| Integration Authority | Current IP | Planned Discharges | | Future IP or OOA | Planned beds |
|---|---|---|---|---|---|
| | | 2021 | 2022 | | |
| East Lothian | 2 | 0 | 1 | 1 | 2 |
| Edinburgh | 33 | 20 | 2 | 11 | 10 |
| Midlothian | 1 | 0 | 0 | 1 | 1 |
| West Lothian | 10 | 1 | 9 | 0 | 2 |
| **Totals** | **46** | **21** | **12** | **13** | **15** |

*Table 1: Planned LD Discharges*

In addition, H&SCPS are putting in place a number of developments to strengthen Community support for this population. All H&SCPs have invested in Positive Behaviour Support training and it is anticipated the continuing focus on developing this across social work, community learning disability teams and commissioned services will impact upon planning to support adults to sustain community placements. Specifically, within each area the following developments are underway:

## Edinburgh

- Edinburgh City are working to reduce reliance on the Voluntary Sector to provide community based packages of care and instead recruit staff with additional training in place to help minimise situations whereby packages of care break down with the default position being a hospital admission as a result.
- They have commissioned bespoke community packages of care and accomodation to facilitate discharges for patients currently in hospital to enable the reduction in bed numbers

## East Lothian

- Within East Lothian, a new short break provision at Hardgate Court has been developed to support those with more complex needs. This includes an adjoining flat/safe space which can be

used in crisis/emergency situations where 24 hours care can be provided utilising internal day services staff in an outreach role.

- In addition, East Lothian are currently developing an Autism Hub in Musselburgh which will provide care at home and housing support for individuals with Autism. The aim of the hub is to offer a community based accommodation whilst developing a hub of support, information and advice to other providers, professionals and unpaid carers.
- East Lothian are also in the process of developing an enhanced LD service bringing together the ELCLDT and SW staff in to one team to provide specialist health and social care support to adults with Learning Disabilities.

## West Lothian

- West Lothian HSCP is taking forward a number of actions to strengthen community based support. This includes ongoing review and development of community resources such as the development of 16 tenancies to support individuals with complex care needs. The care delivered within the resource will be commissioned on the basis that POCs can flex as required dependent upon individual need.
- This is complemented by the development of additional core & cluster sites across the authority. The specialist disability framework for commissioned services has been refreshed to bring greater focus on developing Packages of Care that are response to changing need other than defined hours of service delivery.

## Midlothian

- There has and continues to be low usage of hospital beds by Midlothian HSCP. Development of Teviot Court complex care service has supported this position. The release of funding will allow Midlothian to further strengthen the community provision to minimise the use of hospital beds.

NHS Borders currently have no adult LD beds and have advised commissioning intent for two in the new facility.

The overall total beds to be commissioned by the 5 IJBs and delivered by NHS Lothian is 17 as outlined in Table 1 below:

| IJB | New Bed No |
|---|---|
| Edinburgh | 10 |
| West | 2 |
| East | 2 |
| Midlothian | 1 |
| **Lothian** | **15** |
| NHS Borders | 2 |
| **TOTAL** | **17** |

Core to the plan is the centralising inpatient LD services on the Royal Edinburgh Campus. This impacts on 3 buildings currently owned by NHS Lothian as follows:

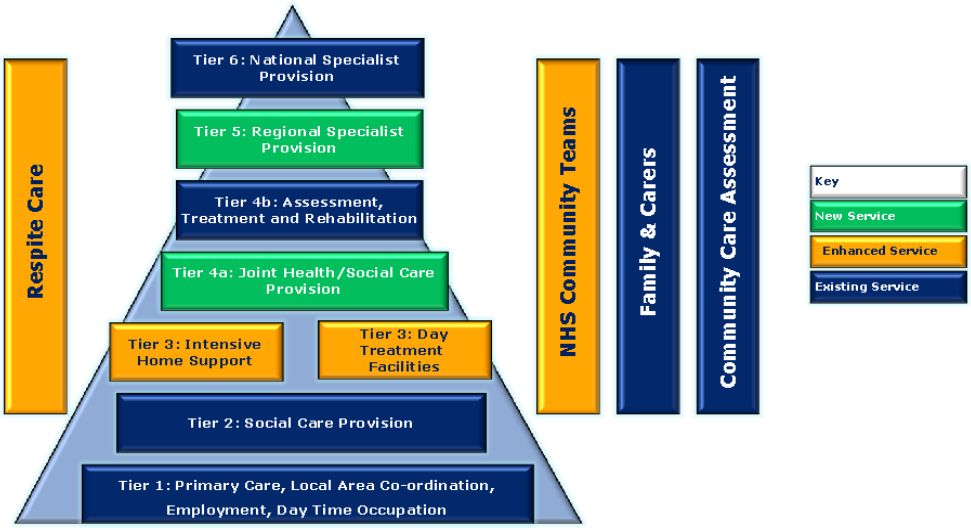
- Primrose Lodge – will be taken over by Midlothian for conversion to a 4 bedded complex physical health facility
- Glenlomond – located directly on the outskirts of the main Royal Edinburgh Campus, potential for future use is being considered by current REAS services
- Camus Tigh – located in Broxburn there maybe opportunities to support with the overall plan for Complex Care provision by West Lothian H&SCP

## Future Model of Care

The current model of care and bed base does not align with the strategic direction of IJB's and does not provide fit for purpose inpatient accommodation for people with learning disabilities when they need it. The reduced bed base means that only those with the highest level of need will be admitted to hospital, which creates a further need for the environment to be as safe and supportive as possible, and for staff to feel valued and equipped to deliver care. A new facility would provide the clinical space required to deliver the highest quality of care possible, including multidisciplinary therapeutic interventions and activities to support daily living.

The dependencies between GPs and other teams referring into the service, intermediate care teams supporting individuals at home and community teams caring for people at home or in residential settings have been the focus of the work with the five IJB areas; to ensure that the reduction in bed numbers in the inpatient facility is supported by enhanced community provision. This enhanced provision is described in Chart 1 below and is made up of intensive home support, which involves tenancy based high volume packages of care as well as day treatment facilities.

**Chart 1: LD Service Tiers**



The ambition of the new units will be to enable flexibility for patients to progress from different levels/ models/ types/ spaces of care to facilitate their treatment and progression towards discharge. It aims to use flexibility of staffing across LD disciplines to support key activities and enable continued care from community partners involved with patients who come for admission, involving them in interventions throughout the duration of inpatient admissions.

Establishing a high quality facility which uses the model of assess to admit will mean that only those with identified, specific needs level of need will be admitted. This will be a benefit to patients, staff, family members and many other stakeholders because inpatient care will only be delivered to those who's needs can only be met within an inpatient setting.

To support this model the community LD teams, intermediate care teams and inpatient teams will work together to undertake initial assessments and formulation to identify and agree achievable outcomes with an admission. Intermediate care teams would be co-located with LD.

## Alignment with National and Local Strategy

The Keys to Life is the Scottish Government's ten year learning disability strategy for 2013 – 2022. It takes a human rights approach to addressing inequalities experienced by many people with learning disabilities. The national 2018-2020 Implementation Framework presents four strategic objectives - A Healthy Life, Choice and Control, Independence and Active Citizenship - to support local partnerships frame priority areas for action. This proposal is aligned with the strategic ambition to: 'Support services that promote independent living, meet needs and work together to enable a life of choices, opportunities and participation. Health and social care support services are designed to meet - and do meet - the individual needs and outcomes of disabled people.' (The Keys for Life Implementation Framework 2019-2021). The Keys to Life states: '*The need for people with learning disabilities to live independently, having the same choice, control and protection as all other citizens of Scotland in terms of the age-appropriate support they receive, is more relevant than ever'.* This proposal supports the realisation of this strategy by shifting the balance of care away from hospital based services and towards community services. It does this by reducing bed numbers and transferring resources but also by proposing that a new facility is built to meet the specific needs of people with an intellectual disability when they are admitted to hospital. This will mean that people who are admitted receive the best possible care that enables them to be discharged home or to a homely setting as quickly as possible. This proposal has been developed in partnership with health and social care providers and is supported by extensive community plans.

The Scottish Government policy position set out within the Keys to Life[2] and more recently within the Coming Home Report[3] and the Independent Review of Adult Social Care[4] is clear that people with IOD should access care and treatment within their local community and any admission to hospital requires to be outcome focussed and within as local a hospital to the persons community as possible.

[2] https://keystolife.info/

[3] https://www.gov.scot/publications/coming-home-complex-care-needs-out-area-placements-report-2018/

[4] https://www.gov.scot/groups/independent-review-of-adult-social-care/

In the Scottish Government's 'Learning/intellectual disability and autism: transformation plan' published in March 2021, there is a commitment to digital inclusion for those with an intellectual disability[5]. The designs which will be developed following approval of this case will incorporate digital elements from the beginning of the design process, ensuring maximum use of technology within the facilities to ensure that when people are in hospital, they are able to communicate well with friends and family.

In addition to these national strategies, there is a pending legislative change which will mean that people with an intellectual disability will only be able to be legally detained in hospital if there is a mental health requirement for their admission. While the service currently focuses on those with mental health needs, there are instances where patients are admitted due to a break down in their packages of care. The shift in resource from hospital to community described in this case will enable NHS and social care services to support people within their own homes more responsively, which should result in more support early and decreased likelihood of a breakdown of support.

The Scottish Government and COSLA's 'Coming Home' Report states that 'The Scottish Government wants to support Health and Social Care Partnerships (HSCPs) to find alternatives to out-of-area placements, and to eradicate delayed discharge for people with learning disabilities'. This case would support the achievement of this goal by improving pathways across NHS Lothian for people with an intellectual disability. Improving the inpatient element of care will mean that there is more appropriate therapeutic and living space for those admitted to hospital, which will mean that they are able to practice and maintain their skills for going home rather than becoming de-skilled while in hospital. This will help to decrease delayed discharges.

The Lothian Hospitals Plan describes the Royal Edinburgh Hospital as one of the four key strategic planning priorities for NHS Lothian alongside the 4 Lothian IJB's and Borders IJB. The 4 Lothian IJB's strategic plans state the intention to support the re-design of the REH campus alongside the development of broader care pathways for people with an intellectual disability. This broader piece of work is focused on ensuring people have access to treatment outwith an acute hospital environment when possible, which requires reducing numbers of acute beds and increasing investment in community service. The reduction in bed numbers described in this IA aids the realisation of these local aims.

Austin Smith Lord, an architectural practice with extensive masterplanning experience, was commissioned to undertake a study of the REH campus prior to the publishing of the IA in 2011. Their study concluded that most of the existing buildings were not fit for purpose and the majority could not efficiently be converted into single bedroom ward accommodation.

A key part of NHS Lothian's service delivery is ensuring best use of estate in supporting operational and corporate delivery. To achieve this, the Board has in place a Property and Asset Management Strategy (PAMS). NHS Lothian's current strategy reflects its commitment to improving the healthcare environment whilst reducing the number of hospital and other sites it currently manages, to reduce property expenditure. The Royal Edinburgh Hospital site is a major part of this strategy and its retention has been predicated on the aim to maximise its development potential. This decision has been reviewed through various updates to the site masterplan (most recently in 2019) and it continues to be viable.

The Scottish Government's commitment to deliver a greener, zero carbon Scotland will be pursued through a focus on sustainability in this new development. In this way NHS Lothian will continue to maximise the sustainability of its estate.

[5] https://www.gov.scot/publications/learning-intellectual-disability-autism-towards-transformation/pages/11/

## *Services for Young People Aged 12-18 with Intellectual Disability and Inpatient Mental Health Needs*

Evidence for the 5 Year Survey identified that between 2010 and 2014, at least 45 children and young people with intellectual disability required specialist inpatient mental health treatment which was not available in Scotland and were admitted elsewhere as shown below:

- Adult Learning Disability Wards (including secure units) – 30%
- Adult Mental Health Units (including intensive care and secure units) – 28%
- Child and Adolescent Mental Health Units – 16%
- Paediatric Wards – 5%
- Not admitted – 8%
- Specialist Units in England: 13%. Reasons for cross border transfer not being used included distance, lack of bed availability, clinician awareness of option to transfer, cross-border Mental Health Act issues and family refusal.

Of the 45 young people who were admitted from across NHS Boards, 70% of these patients were male; 36 were aged 14-17 years and nine were 13 years or under.

The impact of not having access to dedicated assessment and treatment inpatient facilities in Scotland are:

- Children and young people remained in distress and under-treated at home or in unsuitable units, sometimes with high use of sedative medication and restraint
- Due to delays in admission and not admitting, families were highly stressed, managing severe self-injury, aggression and destructive behaviours in their children. Families managing changes in medication and other treatments in crisis stages at home.
- Dislocation from family and local services due to distance when admitted to specialist units in England (however it was noted that better clinical outcomes were achieved).
- Additional costs, nursing costs and ward environmental adaptations to safeguard and manage young people in adult and paediatric ward settings.

One specialist NIDAIPU for Scotland would provide rapid, planned, safe and effective specialist holistic assessment and treatment closer to home, whilst also acting as a focus to support and build up community learning disability support across Scotland.

The Scottish Government has tasked NHS Lothian with providing a 4 bedded national unit for young people aged 12-18 who have an intellectual disability and a significant mental health need. This has been supported by the national Chief Executives group and revenue funding on a national basis has been agreed through National Services Division (NSD). As a first step, NHS Lothian is providing a 2 bed facility by refurbishing one of its existing buildings and this case is for the next phase which is to provide a 4 bedded bespoke facility for this patient group. The 2 bed unit is an interim solution and will not provide the bespoke environment with sufficient therapeutic space and links to wider ID services in the way that the 4 bedded unit will.

The NIDAIPU 4 bedded unit is being included in the wider IA for Adult Intellectual disability wards in NHS Lothian because there are economies of scale by both commissioning the building services together and

also recruiting and retaining staff. There may also be opportunities for enhanced gym and outdoor space for the 4 bedded unit since it will be co-located with the adult unit. There would be careful consideration on how any shared space would be used given the vulnerability of the young people being cared for within the unit.

The table below summarises the need for change, the impact it is having on present service delivery and why this needs to be actioned now:

**Table 1: Summary of the Need for Change**

| What is the cause of the need for change? | What effect is it having, or likely to have, on the organisation? | Why action now? |
|---|---|---|
| Local and national strategies aim to ensure people have access to treatment out with an acute hospital environment when possible, which requires reducing numbers of acute beds and increasing investment in community service | The organisation is currently not meeting the strategic goals of the four Lothian IJBs. Therefore the proposal set out within this IA is to reduce the number of beds within the adult learning disabilities service and transfer investment into community services. | The intention to commission new facilities for people with learning disabilities on the REH campus is stated in the plans of the 4 Lothian IJBs. There is pan-Lothian agreement on this proposal. Reduction in acute hospital beds is required to transfer resource to community alternatives. |
| There is currently a lack of space for therapeutic activities, including therapeutic interventions, space to practice skills for discharge and space to spend time with family | Poorer outcomes for patients who are admitted to hospital because there is a lack of space to deliver therapeutic activities which would provide them with skills required to be discharged. Patients may also struggle to maintain good links with family and friends as there is no space in the inpatient unit to meet with them. | Patients continue to receive care in environments which do not enhance their treatment and recovery. They may lose some ability to maintain key relationships which may be important to their recovery. |
| Existing buildings are not fit for purpose and the majority cannot efficiently be converted into single bedroom/bathroom ward accommodation | The organisation is failing to meet requirements such as having single, en-suite rooms.<br><br>Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older. | The redevelopment is required now to provide a safe, financially sustainable and high quality environment to those requiring inpatient care for a long term mental health illness |
| The existing buildings are not safe for staff to deliver care from due to their size and configuration | The organisation is at risk of placing higher levels of restrictions on patients with an intellectual disability and of buildings being unsafe for staff to deliver care from | Staff are under continued pressure to deliver care in a challenging environment. This makes the work highly stressful, which can lead to higher rates of sickness absence and staff turnover |
| Existing buildings have poor energy efficiency | Current facilities incur high facilities costs and have poor energy efficiency | Spending on energy is higher than it could be because it is not efficient or sustainable |

| | | |
|---|---|---|
| | which is not aligned with the national aim to decrease carbon footprint | |
| There are significant workforce challenges, particularly within nursing | High vacancy rate across mental health services | The proposed bed reduction in Adult LD will enable the recruitment of staff for the new 4 bedded NIDAIPU facility. The LD campus will help to attract and retain staff |
| There is no NIDAIPU in Scotland | Young people over the age of 12 are inappropriately admitted to the wrong hospital settings. Historically they often travelled to England for treatment, however due to reduced capacity in England they stopped accepting referrals from Scotland therefore we no longer have access to these beds. | A SLWG have concluded that a specialist inpatient unit is required for Scotland and this should be located on the Royal Edinburgh Hospital Campus |

## 2.3 Investment Objectives

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

**Table 2: Investment Objectives**

| Effect of the need for change on the organisation | What has to be achieved to deliver the necessary change? (Investment Objectives) |
|---|---|
| Poorer outcomes for patients who are admitted to hospital because there is a lack of space to deliver therapeutic activities which would provide patients with skills required to be discharged. Patients may also struggle to maintain good links with family and friends as there is no space in the inpatient unit to meet with them. | Provide adequate space for the delivery of therapeutic activities and spending time with family |
| The organisation is failing to meet requirements such as having single, en-suite rooms. | Establish a high quality, safe and robust inpatient services which meet care standards such as providing en-suite bathrooms |
| Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older. | |
| The organisation is at risk of placing higher levels of restrictions on patients with an intellectual disability and of buildings being unsafe for staff to deliver care from | Establish an inpatient environment which provides adequate space for care which enables staff to deliver care in the least restrictive way possible |

| | |
|---|---|
| Current facilities incur high facilities costs and have poor energy efficiency which is not aligned with the national aim to decrease carbon footprint | Have a facility which meets the current standards for energy efficiency and sustainability |
| High vacancy rate across mental health services | Realistic and sustainable workforce model using the whole multidisciplinary team (MDT) |
| Young people and their families sometimes have to travel to England for treatment. This is both challenging for the young people and their families in terms of practicalities of visiting and support as well as being less clinically effective as the young person is further from home and therefore their day to day meaningful activities | Development of a dedicated inpatient unit in Scotland. |
| Young people are being cared for in inappropriate settings such as adult wards. This means that both the staff caring for them and the environment in which they are being cared for are not fit for purpose. | Development of an initial specialist inpatient unit of 4 beds on the Royal Edinburgh Hospital campus, negating the need to use adapted adult LD environments for this service user group. |
| Adult intellectual disability beds are being used to care for young people, reducing the capacity within the adult LD service which may lead to a delay in admission for an adult requiring hospital care. | |
| Young people with learning disabilities are being admitted to inappropriate environments which do not have the facilities to meet their educational needs. | Development of an appropriate educational space within the 4 bedded specialist unit, supported by the right educational support. |
| Young people are being admitted to facilities which are far from their parents and that have no facilities for parents to stay overnight. | Development of dedicated space for young people and their families, including provision for overnight stays for parents. |
| There is no dedicated centre for excellence for care of young people with learning disabilities in Scotland. This means that there are inconsistent pathways for this group when an inpatient admission is required. | Develop a centre for excellence on both community and inpatient care for young people with learning disabilities. This means that referral for admission to the national unit is only made when there is no other community based option. It will also be a consistent centre for advice and outreach to support community teams. |

## 2.4 Benefits

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

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

The above investment objectives and the Strategic Assessment (see Appendix 1) have informed the development of a Benefits Register (see Appendix 2). As per the draft Scottish Capital Investment Manual guidance on `Benefits Realisation`, this initial register is intended to record all the main benefits of the proposal. A full Benefits Realisation Plan will be developed at OBC stage.

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

1. Make the environment in which patients receive care more dignified and respectful of human rights by providing privacy en-suite bathrooms
2. Improve the environment in which patient receive care to reduce the need for restraint and requirement for 1:1 observations which should reduce reportable incidents
3. The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention
4. Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends
5. The creation of an LD campus on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments. This will make LD in NHS Lothian a more attractive place to work and will help to support the staff we already have to enjoy their roles and continue to work in Lothian
6. A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site
7. There will be a new, high quality, bespoke 4 bedded service for young people aged 12-18 with an intellectual disability with significant mental health needs which will serve the whole of Scotland

## 2.5 Strategic Risks

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

***Table 3: Strategic Risks***

- Unable to meet demand;
- Unable to recruit and retain staff;
- Unable to manage the needs of all patients' needs within the space available;
- Inappropriate level of restrictions due to building layout and configuration;
- Inability to meet needs of young adultsi.e. 16 to 18yrs old;

- Number and frequency of adverse events is unacceptable; and
- Lack of sufficient time and resource to plan for new model and redevelopment.

| Theme | Risk | Safeguard |
|---|---|---|
| Workforce | High level of staffing required for the NIDAIPU, recruitment to all posts, particularly nursing, will be challenging | The reduction in the bed numbers for Adult LD will release trained staff who will be able to work with adolescent patients |
| Funding - Capital | NHS Lothian is aware that there is a high level of demand for capital funds across Scotland, therefore there may be challenges securing capital funding | The project team have worked to ensure the proposal presents best value. |
| Funding - Revenue | IJBs will be required to issue directions to both reduce the bed base and transfer funds to community services | The project team has worked closely with IJB colleagues to ensure the proposal is supported by all four Lothian IJBs |
| Capacity | This proposal is for a reduced bed base for learning disabilities. The model of care and community provision to support this can be delivered out with this case, however, if not delivered, there is a risk that there will not be enough beds when the new facility is built | The four Lothian IJBs are already working to identify community alternatives for those with learning disabilities currently in hospital who could be cared for in the community. |
| Training | There is currently no facility for inpatient ID care for those aged 12-18, therefore, additional training will be required to meet the needs of this patient group | There is a well established Intellectual Disability community team within the CAMHS service, who will lead on the development of the NIDAIPU. They will ensure that staff are appropriately trained. |
| Green space assets on site | Green space is an important element of treatment for people receiving care on the site. There is a risk that this is compromised as development happens on the site. | The project team are working to ensure there is as minimal disruption as possible as works go forward. Green space is an important consideration within the design of the build and will be incorporated into any plans. |

A register of strategic risks is included in Appendix 3. The risk register was developed at a workshop of key stakeholders in July 2021. A full risk register will be developed for the project at the OBC stage.

## 2.6 Constraints and Dependencies

The key constraints to be considered are:

- Workforce availability is a key constraint for this case. The availability of sufficient multidisciplinary staff, particularly nursing, for the NIDAIPU is dependent on the reduction in bed numbers in Adult LD, which would release staff to be able to work within the national unit Capital availability may also be a constraint due to a high demand on Scottish Government Capital Finance

The key dependencies to be considered are:

- The proposal to reduce the bed numbers in Adult LD is dependent on community based developments as alternative places of care for those currently in hospital, these developments are described above
- The proposal is for the upgraded or new LD campus to be built on the site of the existing accommodation for Adult LD. Therefore, any building works may displace patients currently receiving care within the wards. The case is therefore dependent on the provision of alternative community accommodation being available to reduce the inpatient numbers sufficiently that patients can be moved around the existing accommodation as work is undertaken.

# 3. Economic Case

## 3.1 Do Minimum/baseline

The table below defines the 'Do Minimum' option, a 'Do Nothing' option is not feasible as the service would still be required and would require building maintenance, therefore the Do Minimum solution has been selected as a baseline. This is based on the existing arrangements as outlined in the Strategic Case.

**Table 4: Do Minimum**

| Strategic Scope of Option | Do Nothing |
|---|---|
| Service provision | Learning disabilities inpatient services would continue to be delivered from unsuitable accommodation as described in the 'Current Model of Care' section above |
| Service arrangements | Intellectual disability services would continue to be delivered by NHS Lothian from the REH and other sites across Lothian |
| Service provider and workforce arrangements | NHS Lothian would continue to provide staff and services at a higher staffing level than would be required in a bespoke facility |

| | |
|---|---|
| Supporting assets | Standard maintenance work as required to maintain existing standard (backlog maintenance on REH site is circa £16 million) |
| Public & service user expectations | People receiving care within the intellectual disability wards would continue to receive care in poor quality environments. They may experience a higher level of restriction as a result, leading to poorer clinical outcomes for them as well as having the potential to cause them more harm during their stay in hospital |

## 3.2 Engagement with Stakeholders

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

**Table 5: Engagement with Stakeholders**

| Stakeholder Group | Engagement that has taken place | Confirmed support for the proposal |
|---|---|---|
| Patients/service users | Patients and service users affected by this proposal include patients receiving care within intellectual disability wards. Their involvement in its development includes being involved with the development of the clinical model through the Patients Council and have provided direct feedback on the current environment through a supported interview conducted by a lead OT in May/June 2021. The impact that this has had on the proposal's development includes additional evidence to support a move towards en suite bathrooms to promote privacy. | Patient / service user groups were consulted on the final version of this Initial Agreement by [*method*], on [*date*]. Their feedback was [*outline*] which has been incorporated into this proposal by [*outline any direct changes*]. |
| General public | The general public will not be directly affected by this proposal. There has been public consultation around Phase 1 of the campus re-development and the proposal to develop the intellectual disability inpatient wards on the REH campus has been included in the Strategic Plans of the four Lothian IJBs, which have undergone extensive public consultation. | Outcomes from consultation have not affected this proposal thus far. Further public consultation will be undertaken as the business case develops. |
| Staff/Resources | Staff affected by this proposal include all of the multidisciplinary team required to deliver care within the proposed wards. Their involvement in its development includes being involved with developing the clinical brief. | Staff representatives were consulted on the final version of this Initial Agreement by [*method*], on [*date*]. Their feedback was [*outline*] which has been incorporated into this proposal by [*outline any direct changes*]. |
| Other key stakeholders and partners | Other key stakeholders identified for this proposal include health and social care partnerships, IJBs and hub. Their involvement in the development of this proposal includes being members of the Project Board. | Confirmed support for this proposal has been gained through the IA being presented to the four Lothian IJBs following support from the Project Board. |

## 3.3 Long-listed Options

The table below summarises the long list of options identified:

1. **Do Minimum**
2. **Transfer services to wards on an existing NHS Lothian Acute site**

   Accommodate the Adult LD wards and NIDAIPU on another of NHS Lothian's sites – the Western General Hospital, the Royal Infirmary of Edinburgh, St Johns Hospital, East Lothian Community Hospital
3. **Transfer services to alternative wards on REH site**

   There is no alternative venue available on the site which could be used for this patient group.
4. **Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU**

   Refurbish exsiting facilities on the REH site for both Adult LD and the NIDAIPU, currently used by Adult LD.
5. **Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU**

   Refurbishment of current LD facilities for Adult LD and new build facility for the 4 bedded national NIDAIPU.
6. **New Build for both services on the Astley Ainslie Hospital Site**

   The Astley Ainslie Hospital site is also located in Morningside and currently provides rehabilitation services, including the SMART centre. There may be land on this site which could be used for a new build facility.
7. **New Build for both services on the REH Site**

   There is a piece of unused land in close proximity to the current adult intellectual disability facilities which can be used to build a bespoke CAMHS Leaning disabilities inpatient unit with sufficient capacity to include the required additional facilities such as family room, educational suite and the potential to consider shared therapy suites as appropriate. There is also space on site which could be used to build a new, high quality, robust facility for adult LD.

**Table 6: Long-listed options**

| Strategic Scope of Option | Option 2 - Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU | Option 3 - Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU | Option 4 – New Build for both services on REH site |
|---|---|---|---|
| Service provision | Reduction in LD bed numbers to 17. Creation of 4 beds for NIDAIPU. | Reduction in LD bed numbers to 17. Creation of 4 beds for NIDAIPU. | Reduction in LD bed numbers to 17. Creation of 4 beds for NIDAIPU. |
| Service arrangements | NHS Lothian staff would deliver inpatient LD care on the REH site. Move to a new model of care of 'assess to admit' rather than 'admit to assess' | NHS Lothian staff would deliver inpatient LD care on the REH site. Move to a new model of care of 'assess to admit' rather than 'admit to assess'. | NHS Lothian staff would deliver inpatient LD care on the REH site. Move to a new model of care of 'assess to admit' rather than 'admit to assess'. |
| Service provider and workforce arrangements | NHS Lothian will continue to be the service provider. | NHS Lothian will continue to be the service provider. | NHS Lothian will continue to be the service provider. |
| Supporting assets | May have some provision for enhanced therapeutic space, but this will depend on availability of space | May have some access to enhanced therapeutic space to improve treatment and patient care | Treatment would be delivered in a high quality environment with the least restrictions possible, with access to therapeutic space for treatment and socialisation |
| Public & service user expectations | Public and service user expectations would be partially met as existing accommodation would be improved and would be supported by a model of care which prioritises keeping people at home or in a homely setting wherever possible | Public and service user expectations would be partially met as existing accommodation would be improved and would be supported by a model of care which prioritises keeping people at home or in a homely setting wherever possible | Public and service user expectations would be met as there would be a top spec intellectual disabilities campus supported by a model of care which prioritises keeping people at home or in a homely setting wherever possible |

The following options were not taken forward for assessment as detailed below:

- The transfer of services to wards on alternative NHS Lothian site was discounted due to the existing capacity pressures on the acute sites in NHS Lothian
- The transfer of services to alternative wards on the Royal Edinburgh Hospital site was discounted as there is no alternative accommodation available that would meet the needs of this patient group
- The option to build on the Astley Ainslie Hospital site was discounted because NHS Lothian Hospital's Plan states that NHS Lothian is moving towards only having 4 main hospital sites, one of which is the Royal Edinburgh Hospital site, which makes it the preferred site for any new build

### 1.1.1 Initial Assessment of Options

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

***Table 7: Assessment of options against investment objectives***

| | Do Minimum | Option 2 - Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU | Option 3 - Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU | Option 4 – New Build for both services on REH site |
|---|---|---|---|---|
| **Advantages (Strengths & Opportunities)** | Lower associated costs | Potentially lower associated costs.<br><br>The ID and NIDAIPU services are refurbished to meet current standards and statuary requirements.<br><br>Delivers on the requirement for NHS Lothian to provide 4 beds for the NIDAIPU | The ID service is refurbished to meet current standards and statutory requirements.<br><br>Delivers on the requirement for NHS Lothian to provide 4 beds for the NIDAIPU | Meets Scottish Government health building requirement for the provision of single bedroom with en-suite facilities.<br><br>Consistent with the benefits register.<br><br>Newly build Integrated centre comprising of ID and NIDAIPU.<br><br>Delivers on the requirement for NHS Lothian to provide 4 beds for the NIDAIPU<br><br>Bespoke new service where staff want to work<br><br>Optimises energy efficiency and compliance with 0 carbon |
| **Disadvantages (Weaknesses & Threats)** | Non-compliance with several current standards and statutory requirements<br><br>Does not deliver on the requirement for NHS Lothian to provide 4 beds for the NIDAIPU | Some non-compliance with several current standards and statutory requirements.<br><br>Lack of additional therapeutic space which would improve patient outcomes.<br><br>Facilities without adequate therapeutic space do not help to attract staff | Some non-compliance with several current standards and statutory requirements<br><br>Lack of additional therapeutic space which would improve patient outcomes.<br><br>Does not optimise energy efficiency and compliance with 0 carbon | Availability of capital funding |

| | Do Minimum | Option 2 - Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU | Option 3 - Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU | Option 4 – New Build for both services on REH site |
|---|---|---|---|---|
| | Out dated facilities do not attract new staff to work within the units<br><br>Does not optimise energy efficiency and compliance with 0 carbon | Does not optimise energy efficiency and compliance with 0 carbon | | |
| | **Does it meet the Investment Objectives (Fully, Partially, No, n/a):** | | | |
| Investment Objective 1 | Yes | Yes | Yes | Yes |
| Investment Objective 2 | No | No | No | Yes |
| Investment Objective 3 | No | Partially | Partially | Yes |
| Investment Objective 4 | No | Partially | Partially | No |
| Investment Objective 5 | No | No | No | Yes |
| Investment Objective 6 | No | Yes | Yes | Yes |
| | **Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)** | | | |
| Affordability | Yes | Unknown | Unknown | Unknown |
| **Preferred/Possible/Rejected** | Rejected | Possible | Possible | Preferred |

# 3.4 Short-listed Options and Preferred Way Forward

## Shortlisted options

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

**Table 8: Short Listed Options**

| Option | Description |
|---|---|
| Option 1 | Do Minimum |
| Option 2 | Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU |
| Option 3 | Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU |
| Option 4 | New Build for both services on the REH Site |

## Non-financial benefits assessment

Each of the shortlisted options was assessed against the benefits included in the benefits register in Appendix 2: Benefits Register and non-financial benefits assessment. Each of the identified benefits was weighted and following this each of the shortlisted options was scored against its ability to deliver the required benefits. Scoring took place at a workshop with key stakeholder representatives in July 2021.

The results of the benefits assessment are summarised below:

***Table 9: Results of Non-Financial Benefits Assessment***

| # | Benefit | Weight (%) | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|---|---|
| 1 | Make the environment in which patients receive care more dignified and respectful of human rights by providing en-suite bathrooms | 30 | 0 | 3 | 5 | 10 |
| 2 | Improve the environment in which patient receive care to reduce the need for restraint and requirement for 1:1 observations | 20 | 0 | 3 | 5 | 10 |
| 3 | The improved care environment will make it safer for staff to | 20 | 0 | 3 | 5 | 10 |

| # | Benefit | Weight (%) | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|---|---|
| | deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention | | | | | |
| 4 | Patient outcomes will be improved and length of stay will be reduced due to increased access to spaces where therapeutic activity and activities can be delivered and where they can spend time with family and friends to maintain skills and relationships and meet social care staff. | 15 | 0 | 5 | 7 | 10 |
| 5 | The creation of an LD campus on the Royal Edinburgh Site will become a centre of excellence which will provide more educational opportunities on site as well as enhancing skills through working within different care environments. This will make LD in NHS Lothian a more attractive place to work and will help to support the staff we already have to enjoy their roles and continue to work in Lothian | 10 | 0 | 3 | 5 | 10 |
| 6 | A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site | 5 | 0 | 0 | 3 | 10 |
| Total Weighted Benefits Points | | | 0 | 315 | 520 | 1000 |

From the table above it is noted that the options that will deliver the most benefits is Option 4, which is therefore the preferred option.

## Indicative costs

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

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

- A discount rate of 3.5% has been used in line with Government guidelines.
- A useful life of 29 years for refurbishment projects (Options 2 and 3), as this is in line with the remaining useful life of the Royal Edinburgh Buildings, a useful life for a new build has been determined as 50 years (Option 4).
- The base date for the proposal is September 2022.
- Phasing of the costs reflects the useful life and the programme of works as identified in the Commercial Case.
- VAT and Inflation are excluded in the NPV calculation – whole life capital costs.

**Table 10: Indicative Costs of Shortlisted Options**

| Cost (£k) | Do Minimum | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|
| Capital cost | 346 | 15,314 | 17,707 | 27,874 |
| Whole life capital costs | 288 | 12,411 | 14,350 | 22,589 |
| Whole life operating costs | 223,267 | 242,845 | 247,642 | 318,666 |
| **Estimated Net Present Value (NPV) of Costs** | **223,555** | **255,256** | **261,992** | **341,255** |

## Overall assessment and preferred way forward

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

***Table 11: Economic Assessment Summary***

| Option Appraisal | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|
| Weighted benefits points | 190 | 380 | 660 | 1000 |
| NPV of Costs (£k) | 223,555 | 255,256 | 261,992 | 341,255 |
| Cost per benefits point (£k) | 1,177 | 672 | 397 | 341 |
| **Rank** | **4** | **3** | **2** | **1** |

The preferred solution was identified as Option 4: New Build for Both Services on REH Site. This was identified as the preferred option because it ranked the highest it both the Non-Financial and the Economic Assessment. Option 4 delivers a greater number of the benefits that have been set out as the criteria for achievement from this project.

It is recommended that NHS Lothian proceeds with this option to Outline Business stage where the implementation of the solution shall be further developed and tested for value for money.

## 3.5 Design Quality Objectives

Design quality objectives have been developed for the preferred strategic / service option by taking the following steps:

1. An AEDET review of existing property arrangements has been undertaken to set a benchmark score from which change is needed.

2. A second multi-stakeholder AEDET review has been undertaken which has identified the main features the new proposal will need to focus on and has set a target score from which design expectations can be measured

3. Design objectives that explain what the design needs to achieve to improve on the existing arrangements have been outlined in the NDAP Design Statement (see Appendix 4).

The AEDET worksheets provided in Appendix 4 demonstrate how the target for improvement has been set against the existing arrangements.

# 4. The Commercial Case

## 4.1 Procurement Strategy

The indicative cost for the preferred option at this stage is £28mincluding VAT.  It is anticipated that the procurement of the project will be led by NHS Lothian supported by Turner Townsend (technical advisers), Thomson Gray (cost advisers), and Burness Paull (legal advisers).

The project will be delivered in accordance with NHS Scotland construction procurement policy and it is anticipated that it will be undertaken in conjunction with Hub South East Scotland Ltd acting as NHS Lothian's development partner.

## 4.2 Timetable

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

**Table 12: Project Timetable**

| Key Milestone | Date |
|---|---|
| Initial Agreement approved | October 2021 |
| Hub appointed | November 2021 |
| Outline Business Case approved | January 2023 |
| Planning permission in principle obtained | In place – expires March 2022 |
| Full Business Case approved | July 2023 |
| Construction starts | September 2023 |
| Construction complete and handover begins | January 2025 |
| Service commences | March 2025 |

# 5. The Financial Case

## 5.1 Capital Affordability

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

**Table 13: Capital Costs**

| Capital Cost (£k) | Option 1: Do Minimum | Option 2 : Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU | Option 3: Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU | Option 4: New Build for both services on the REH Site |
|---|---|---|---|---|
| Construction | 199 | 7,429 | 8,589 | 13,521 |
| Inflation | 8 | 261 | 302 | 475 |
| Professional Fees | - | 900 | 1,041 | 1,639 |
| Equipment | 6 | 278 | 321 | 506 |
| IT & Telephony | 2 | 93 | 107 | 169 |
| Contractor Risk | - | 675 | 781 | 1,229 |
| Optimism Bias | 73 | 3,276 | 3,788 | 5,963 |
| **Total Cost (excl VAT)** | **288** | **12,912** | **14,929** | **23,502** |
| VAT | 58 | 2,582 | 2,986 | 4,700 |
| VAT Recovery | - | (180) | (208) | (328) |
| **Total Capital Cost** | **346** | **15,314** | **17,707** | **27,874** |

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

- Construction costs for Option 2, 3 and 4 have been estimated using a sqm rate provided from the independent quantity surveyors, which were given as a range, the upper of which has been assumed. Costs for option 1 were provided from the NHS Lothian Estates Manager for the Royal Edinburgh site.
- An inflation allowance of 4%, provided by NHS Lothian's external cost advisors, has been included using a base date of September 2022 and the construction timeline detailed in the Commercial Case. This allowance will need to be further refined as the project progresses due to the volatility in the market currently. **Table 14** includes a sensitivity analysis on Inflationary amount only due to this level of uncertainty.
- Professional fees are assumed to be 10% of the total Capital costs provided or estimated.

- Furniture, Fitting & Equipment has been estimated at 3% of total costs, based on another recent project. This has been included in Option 1 also as it would be expected that these items would also need replaced/upgraded in a 'Do Minimum' scenario.
- IT & Telephony has been estimated at 1% of total costs, based on another recent project. This has been included in Option 1 also as it would be expected that these items would also need replaced/upgraded in a 'Do Minimum' scenario.
- Contractor Risk is included at 7.5% as advised by the independent quantity surveyors.
- Optimism bias has been included at 34% of all costs in line with SCIM guidance.
- VAT has been included at 20% on all costs. Recovery has been assumed on Professional Fees only – no further VAT recovery has been assumed. VAT recovery will be further assessed in the OBC.

Over the last twelve to eighteen months there has been a decline in the Tender Price Index (TPI) but a sharp rise in the Building Cost Index (BCI). This reflects the difficult economic conditions. This impact was initially felt by main contractors with fixed price contracts and, the cumulative pressure due to increased material prices. The knock-on effect has been transferred to the client side as contractors look to correct or offset the reduction in margin on existing contracts. When pricing new projects, contractors are inflating their prices (or are qualifying tenders) in order to return their margin to a manageable position and to offset the increase in building costs and risk. This will ultimately result in a rise in the TPI which will need to increase to a position above the BCI which could represent a large jump in inflation. It is unknown how long this fluctuation will last and what impact this will have on inflation.

The impact of the COVID-19 pandemic on future projects is still relatively unknown, the capital costs presented do not have an allowance for a programme extension. It would therefore be prudent to consider a possible impact on costs, should the programme have to be extended.

The sensitivity analysis below aims to set out the possible impact on the total project costs should inflation rise or reduce as well as an extension to programme.

**Table 14: Inflation& Programme Extension Sensitivity Analysis**

| | Total Capital Costs | | | |
|---|---|---|---|---|
| **Sensitivity Scenario** | **Option 1** | **Option 2** | **Option 3** | **Option 4** |
| Scenario 1: no changes (4%) | 346 | 15,314 | 17,707 | 27,874 |
| Scenario 2: inflation percentage doubles (8%) and programme extends (10 weeks) * | 359 | 16,259 | 18,739 | 29,278 |
| Scenario 3: inflation percentage halves (2%) no programme extension | 340 | 15,128 | 17,490 | 27,532 |

**extension time and costs have been based on information provided by an external advisor for another project.*

## 5.2 Revenue Affordability

The estimated recurring revenue costs associated with each of the short-listed options are detailed in the table below. These represent the total revenue costs required to support the project.

| Revenue Cost/Funding (£k) | Option 1: Do Minimum | Option 2 : Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU | Option 3: Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU | Option 4: New Build for both services on the REH Site |
|---|---|---|---|---|
| Inpatient Costs | 12,426 | 6,894 | 6,894 | 6,894 |
| Community & Specialist Teams Costs | | 3,544 | 3,544 | 3,544 |
| Community Places | | 5,271 | 5,271 | 5,271 |
| Depreciation | - | 542 | 627 | 572 |
| NIDAIPU Unit | 2,582 | 2,582 | 2,582 | 2,582 |
| **Total Annual Revenue Cost** | **15,008** | **16,119** | **16,202** | **16,148** |
| Total LD Service Budgets | 10,992 | 10,992 | 10,992 | 10,992 |
| NSS NSD Funding | - | 2,700 | 2,700 | 2,700 |
| Facilities Budgets | 737 | 737 | 737 | 737 |
| West Lothian & Borders Income | 697 | 697 | 697 | 697 |
| NHS Lothian Depreciation Budget | - | 542 | 627 | 572 |
| NHS Lothian NIDAIPU Share (14.8%) | 382 | 382 | 382 | 382 |
| NSD NIDAIPU Funding | 2,200 | 2,200 | 2,200 | 2,200 |
| **Total Annual Revenue Budget** | **15,008** | **15,536** | **15,619** | **15,565** |
| **Funding Gap** | **0** | **(583)** | **(583)** | **(583)** |

**Table 15: Annual Revenue Costs**

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

- Community places have been worked up at individual client level by HSCP managers responsible for commissioning.
- For Inpatient costs, a detailed bottom up exercise has been conducted with the Chief Nurse/General Manager and Clinical Nurse Manager based on nursing requirements forthe commissioned level of beds. HSCP commissioners have confirmed they are not supportive of any changes (increases or decreases) to current levels of staff for support services i.e. AHPs, Psychology.
- NSS NSD Funding is equivalent to the estimated costs of the 4 bed NIDAIPU service. The costs of the nationally commissioned service will be funded through the established process of top slicing territorial boards their NRAC share of the total revenue costs of the service.
- The NHS Lothian share of the NIDAIPU service is estimated at £400k. There are currently no adolescent beds in NHS Lothian therefore there is no funding that can be released to offset the NHS Lothian share of the national costs.
- At the April 2021 Corporate Management Team meeting, members supported including the NHS Lothian contribution of the national costs in the financial plan. Therefore funding of £400k has been assumed in this financial model to offset the NHS Lothian share of the NIDAIPU service.
- NHS Borders income is based on the costs of the two beds they have commissioned.
- West Lothian income is the funding associated with 2 clients currently placed out of area who are to return to community placements (costs of community placements are also included).
- All specialist support teams are assumed to continue in their current form
- Non pays costs are based upon the current William Fraser and Islay ward non costs (LD inpatient wards on REC)
- Depreciation is based on a useful life of 29 years for Option 2 and 3, and 50 years for Option 5 and assumed to be funded from the existing NHS Lothian Depreciation funding allocation. Depreciation excluded in Option 1 as already forms part of Depreciation cost for the Royal Edinburgh Buildings.

There are significant double running costs associated with learning disabilities clients moving from inpatient beds to community supported accommodation. Typically the staff team providing packages of care in the community will begin working with the client 3-6 months before the client is discharged from hospital. Funding from commissioned bed closures cannot be released until beds are closed and NHS staff are redeployed.

There are 33 planned discharges from hospital associated with the learning disability redesign. As described above the cost implications are two fold – the costs of community teams being in place before people are discharged and whilst community costs will happen immediately the release from NHS

budgets will occur in phases as beds or facilities are closed. The estimated double running costs associated with the adult learning disability redesign are shown below in table 15 by financial year:

**Table 15: Double Running Costs**

| | 2021/22 £m | 2022/23 £m | Total £m |
|---|---|---|---|
| Community team costs (social care) | 0.8 | 0.7 | 1.5 |
| Delay in hospital budget release (health) | 0.2 | 0.2 | 0.3 |
| **Total double running costs** | **0.9** | **0.9** | **1.8** |

The costs shown above assume that all discharges take place as planned and that there are no delays in the programme. The cost implications for health (REAS) have been captured as part of the financial planning process for 2021/22.

Discussion is ongoing in partnership with Integration Joint Boards around potential solutions to support the community team double running costs. One such action is the potential application of the community living change fund against these double running costs. The community living change fund totals £3.1m of non recurring funding across the Lothian Integration Joint Boards and was allocated by Scottish Government to support the discharge from hospital of people with complex needs. Whilst the costs shown in table 15 are significant they are one off costs that facilitate the closure of the adult learning disabilities beds as commissioned by the Integration Joint Boards.

Although the Learning Disabilities financial model shows a gap of £0.6m against available funding there is a £5.9m planned release from the out of area budget in total which has not been included. The release from the out of area budget is achieved from the creation of a Low Secure Mental Health facility on the Royal Edinburgh Campus. However this planned release underpins both planned developments on Campus - Learning Disabilities and Mental Health Low Secure and Rehabilitation. Overall both initial agreements present a joint financial gap of £5.9m which is equivalent to the planned release from the out of area budget. In totality once the out of area budget has been released both initial agreements are affordable on a recurring basis.

If the Learning Disabilities project progresses first there will be a challenge around release of the out of area budget as patients will still require to be placed out of area for Low Secure Mental Health inpatient care. Current projections for the out of area budget forecasts a £0.6m underspend for the next few years so if Learning Disabilities progresses ahead of the Mental Health and Low Secure and Rehabilitation case the underspend on the out of area placements can be used to balance the Learning Disabilities financial model. This has been agreed with Chief Officers from each of the Lothian Integration Joint Boards.

These have been reviewed and agreed by the Finance Business Partner (Hamish Hamilton, Finance Business Partner (interim) REAS & West Lothian HSCP). These costs have been reviewed in detail with the Chief Finance Officers of each Lothian Integration Joint Board and Chief Officers also receive regular updates on the financial modelling associated with this initial agreement.

Revenue costs will continue to be refined through the OBC process.

## 5.3 Overall Affordability

The capital costs detailed above are predicted to be funded through traditional capital funding. This project has been prioritised by NHS Lothian and each of the four Lothian Integration Joint Boards and the estimated costs noted above are included in the NHS Lothian Property and Asset FiveYear Investment Plan.

Funding has been identified for the additional revenue costs from the out of area budget and these have been reviewed and agreed by the Finance Business Partner (interim) Hamish Hamilton and agreed in partnership with Chief Finance Officers of each Lothian Integration Joint Board. The projected gap of £0.6m can be managed through the projected underspend on the out of area budget until the out of area budget can be released in full on a recurring basis (following completion of the Low Secure Mental Health unit for NHS Lothian).

All costs will continue to be refined through the OBC process.

# 6 The Management Case

## 6.1 Readiness to proceed

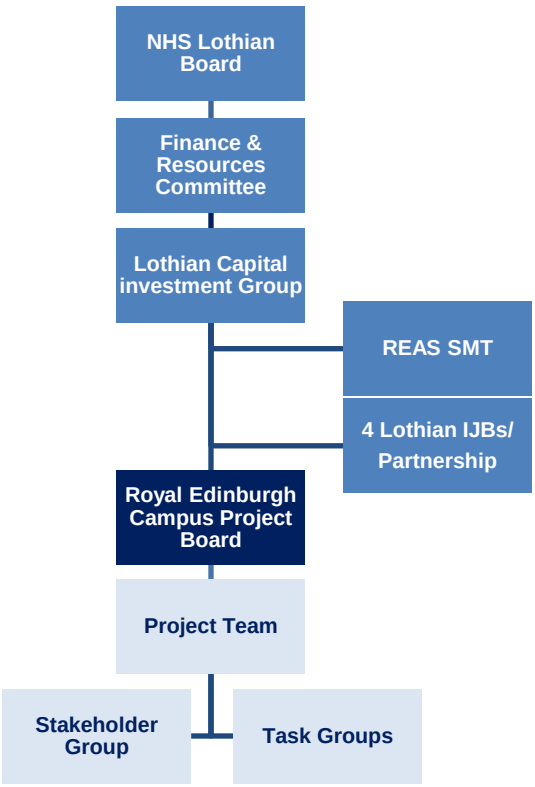
A benefits register and initial high level risk register for the project are included in Appendix 2: Benefits Register and Appendix 3: Risk Register. Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

NHS Lothian is ready to proceed with this proposal and is committed to ensure the necessary resources are in place to manage it. Section 6.2 outlines the governance support and reporting structure for the proposal and section 6.3 details the project management arrangements.

## 6.2 Governance support for the proposal

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

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




## 6.3 Project Management

The table below identifies key members of the project team and the REH Programme Management Board that will be responsible for taking the project forward; the table includesdetails of individuals' capabilities and previous experience.

**Table 14: Project Management Structure**

| Role | Individual | Capability and Experience |
|---|---|---|
| Project Sponsor and Programme Management Board Chair | Professor Alex McMahon Executive Director, Nursing, Midwifery and Allied Healthcare Professionals Executive Lead, REAS and Prison Healthcare | Starting his career as a qualified nurse in 1986, Alex has worked in both the public and private sectors, including time with the Royal College of Nursing and as Nursing Advisor for Mental Health and Learning Disabilities in the Scottish Government. In 2009 he received an Honorary Chair from the University of Stirling for his work in mental health and nursing. Alex chairs the REH Programme Management Board and is ultimately responsible for the project and its overall business assurance i.e. ensuring that it remains on target to deliver the outcomes that will achieve the anticipated business benefits and that it is delivered within its agreed budget and timescale tolerances |
| Senior User and Programme Management Board Deputy Chair | Tracey McKigen, Services Director, Royal Edinburgh and Associated Services | As Senior User Tracey is accountable for ensuring that requirements have been clearly defined in the Clinical Brief and that the proposed development is fit for purpose and fully meets user needs. Following the principles of PRINCE2, the Senior User has primary responsibility for quality assurance and represents the interests of all those who will use and operate the new facilities.<br><br>As REAS Service Director, Tracey has a deep understanding of the clinical and support needs of the services delivered from the REH. She has also held a number of other senior management roles in the NHS |
| Strategic Programme Manager | Nickola Jones, Strategic Programme Manager | Previous experience of NHS capital projects |

| Role | Individual | Capability and Experience |
|---|---|---|
| Project Manager | Steve Shon, Senior Project Manager, Capital Planning | Steve has worked within NHS Capital Planning since 1998 managing and co-ordinating all aspects of the procurement of major new health facilities, from preparation of business cases through to commissioning. In terms of procurement, he has been involved in traditional, D&B, and PFI schemes and is now working on Hub developments, including the redevelopment of the Royal Edinburgh Hospital. Previous projects have ranged from small Learning Disabilities houses, through Care of the Elderly facilities, to the redevelopment of the State Hospital at Carstairs |
| Capital Finance Support | Laura-Jane Smith | Experience supporting capital investment projects |
| Finance Business Partner | Hamish Hamilton | Previous experience at Senior Manager level in similar projects |
| Service Lead | Andrew Watson | Associate Medical Director for the Royal Edinburgh Hospital and Associated Services |
| Service Lead | Karen Ozden | Chief Nurse for the Royal Edinburgh Hospital and Associated Services |
| Partnership Representative | To be confirmed | Dependant on appointee |

The project's external advisers are:

- Turner and Townsend- Technical Adviser
- Burness Paull - Legal Adviser
- Thomson Gray - Cost Adviser

# 7 Conclusion

The strategic assessment for this proposal (included in

Appendix 1: Strategic **Assessment**) scored 22 (weighted score) out of a possible maximum score of 25.

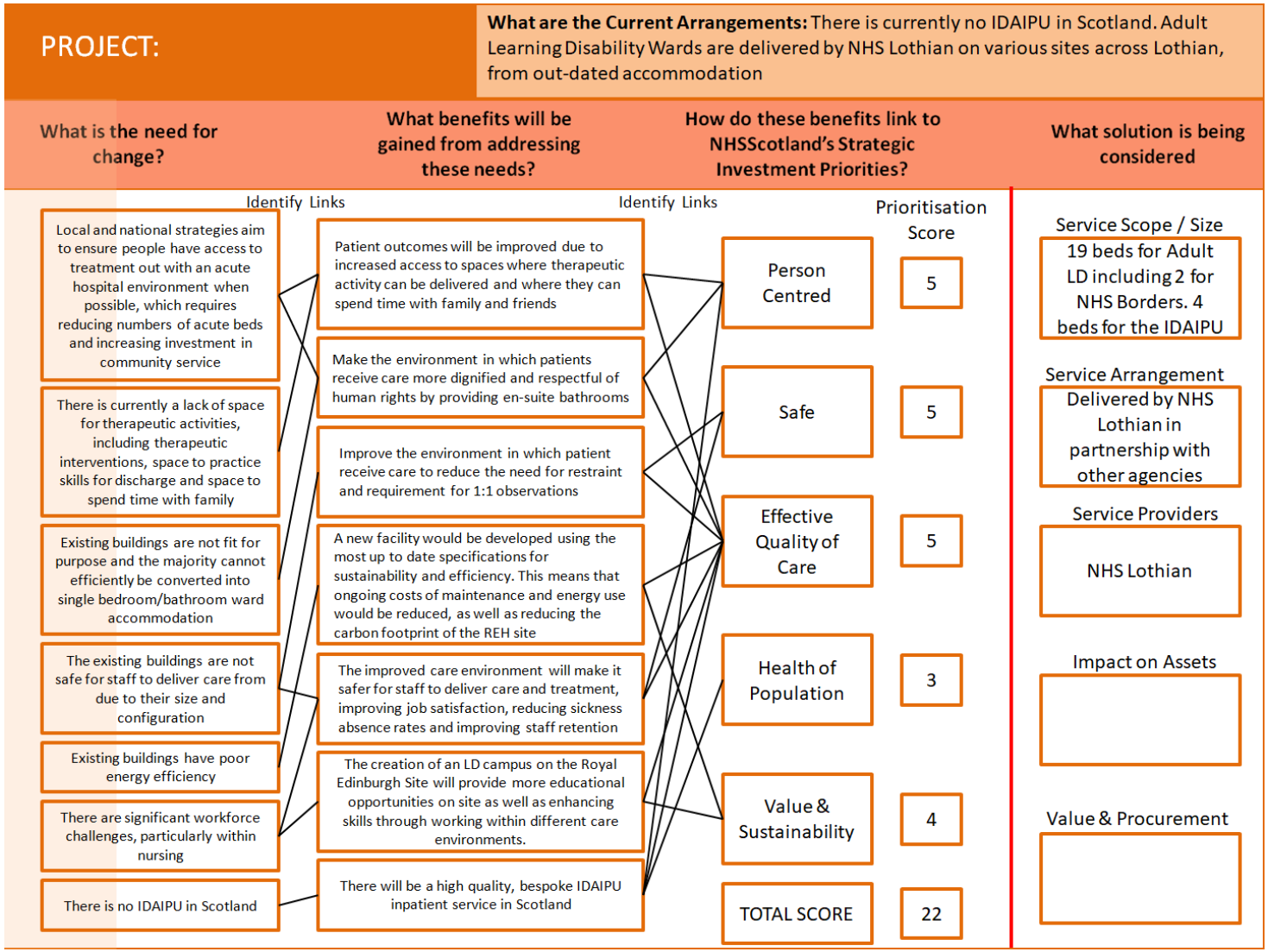
This case clearly describes the need for improved accommodation for those with intellectual disability and mental health needs in NHS Lothian, it also describes the case for providing a bespoke 4 bedded facility for adolescents with these needs across Scotland, as requested by the Scottish Government and supported nationally.

The case presents first hand feedback from those receiving care in the current facilities in NHS Lothian which provides a clear indication of the failings of the current environment. The Scottish Government and IJBs have a strategic direction to care for people in an inpatient setting only when that is the only possible solution. Therefore, when someone does require a hospital admission, it will be because they have a high level of need. The best quality environment is required to ensure those admitted receive the highest quality care, in an appropriate environment and supported by staff who feel valued and well equipped.

Co-locating the national unit with the local unit will create a centre of excellence for supporting people with intellectual disability both in hospital and in the community. It will become more attractive for staff to work in the units because there will be a variety of learning and training opportunities. The environment would be bespoke and fit for purpose and provide dignity to those requiring a hospital admission.

This case is supported by the 4 Lothian IJBs, NHS Borders and Borders IJB and is driven by a genuine desire to provide care for vulnerable patients in the best possible environment to give people the greatest chance of getting better and being able to go home. It is aligned with the ambition to shift the balance of care from hospital to community settings and exhibits NHS Lothian's commitment to this agenda.

# Appendix 1: Strategic Assessment



## Appendix 2: Benefits Register and Non-Financial Benefits Assessment

| Project Name | | | | | | |
|---|---|---|---|---|---|---|
| *1. Benefits Register* | | | | | | *2. Prioritisation* |
| **Ref No.** | **Benefit** | **Assessment** | **As measured by** | **Baseline Value** | **Target Value** | **Relative Importance** |
| 1 | Make the environment in which patients receive care more dignified and respectful of human rights by providing en-suite bathrooms | Quantitative | % of bedrooms with en-suite bathrooms | 30% | 100% | 1 |
| 2 | Improve the environment in which patient receive care to reduce the need for restraint and requirement for 1:1 observations which should reduce reportable incidents | Quantitative | Average no. Of Datix Incidents recorded per month | 85 | 40 | 3 |
| 3 | The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention | Quantitative | Staff sickness absence rate | 9% | 4% | 4 |
| 4 | Patient outcomes will be improved and length of stay will be reduced due to increased access to spaces where therapeutic activity and activities can be delivered and social skills maintained | Quantitative and Qualitative | Patient feedback, patient outcomes, length of stay | TBC | TBC | 2 |
| 5 | The creation of an LD campus on the Royal Edinburgh Site will become a centre of excellence which will provide more educational opportunities on site as well as enhancing skills through working within different care environments. | Quantitative and Qualitative | No. Of staff vacancies | 15 | 2 | 5 |
| 6 | A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site | Quantitative | Cost of maintenance and energy per month | TBC | TBC | 6 |

| # | Benefit | Weighting (%) | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|---|---|
| 1 | Make the environment in which patients receive care more dignified and respectful of human rights by providing en-suite bathrooms | 25% | 1 | 6 | 8 | 10 |
| 2 | Improve the environment in which patient receive care to reduce the need for restraint and requirement for 1:1 observations which should reduce reportable incidents | 20% | 0 | 4 | 6 | 10 |
| 3 | The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention | 20% | 1 | 5 | 7 | 10 |
| 4 | Patient outcomes will be improved and length of stay will be reduced due to increased access to spaces where therapeutic activity and activities can be delivered and social skills maintained | 25% | 0 | 0 | 5 | 10 |
| 5 | The creation of an LD campus on the Royal Edinburgh Site will become a centre of excellence which will provide more educational opportunities on site as well as enhancing skills through working within different care environments. | 5% | 1 | 4 | 7 | 10 |
| 6 | A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site | 5% | 1 | 6 | 8 | 10 |
| | **Total Weighted Benefits Points** | | **55** | **380** | **660** | **1,000** |

# Appendix 3: Risk Register

| 1. Identification | | | 2. Assessment | | | | 3. Control | | 4. Monitoring | |
|---|---|---|---|---|---|---|---|---|---|---|
| Risk No | Risk Grouping | Risk Description | Financial / Non-Financial / Unquantifiable | Consequence (1 - 5) | Likelihood (1 - 5) | Risk | Proposed Treatment / Mitigation | Action Taken | Risk Owner - Type | Risk Owner - Individual |
| 1.1 | **Business risk** | If new build then - Impact of build on capacity – occupancy, clinical space, patient mix | | 2 | 5 | **High** | Traffic management throughout site, sound barriers | | | |
| 1.2 | **Business risk** | If refurb then - Impact of build on capacity – occupancy, clinical space, patient mix | | 5 | 5 | **Very High** | Consider decant facilities and relocation of patients to reduce impact on patients. Traffic management throughout site, sound barriers | | | |
| 1.3 | **Business risk** | Poor stakeholder involvement results in a lack of support for the project | | 4 | 1 | **Medium** | Prepare and implement an appropriate project communication plan which engages with all appropriate stakeholders at appropriate stages of the project | | | |
| 2.1 | **Reputational risk** | Poor communication ignores stakeholder interests | | 4 | 1 | **Medium** | Ensure that the project communication plan covers issues of public perception / consultation feedback / media interest / parliamentary interest / organisational reputation, etc | | | |
| 2.2 | **Reputational risk** | Reputational risk if we do not get the environment right – both for NHS Lothian and NHS Borders, and nationally for the national unit | | 5 | 1 | **Medium** | Ensuring the clinical brief and engagement with contractors is good, learn from previoius builds | | | |
| 3.1 | **Demand risk** | Demand for the service does not match the levels planned, projected or presumed | | 5 | 3 | **High** | Carry out sensitivity testing of assumptions behind service demand projections to understand and manage any underlying risks | | | |
| 4.1 | **Occupancy risk** | Patient discharges – availability of robust community placements that are sustainable | | 5 | 3 | **High** | Partnerships have shared and robust planned for community alternatives. For 4 beds, community services should be developed and there will be discharge planning on admission | | | |
| 4.2 | **Occupancy risk** | Risk around the availability of rooms for contingency and rooms being damaged and being unable to use. Capacity use should be 85% - but not currently at this rate. Legislative change may impact upon this. Need to have safe spaces in the community so hospital is not the default 'safe space' | | 5 | 3 | **High** | Contingency room which would be created through 85% capacity. National unit may not be able to do this. | | | |
| 4.3 | **Operational risk** | IJB strategic direction may change – they may decide to provide elsewhere or change numbers – may make the project not viable – need project board to collectively own and absolutely agree the final bed numbers | | 5 | 2 | **High** | IA will be agreed across all areas, which should mean future changes are limited | | | |

| 1. Identification | | | 2. Assessment | | | | 3. Control | | 4. Monitoring | |
|---|---|---|---|---|---|---|---|---|---|---|
| Risk No | Risk Grouping | Risk Description | Financial / Non-Financial / Unquantifiable | Consequence (1 - 5) | Likelihood (1 - 5) | Risk | Proposed Treatment / Mitigation | Action Taken | Risk Owner - Type | Risk Owner - Individual |
| 4.4 | **Operational risk** | Potential changes to delegation schemes of IJBs – may change decision making | | 3 | 3 | **Medium** | | | | |
| 4.5 | **Operational risk** | If they were to become separate Risk to the adolescent unit linked to the adult unit – staffing risk. Appropriate and properly trained | | 4 | 3 | **High** | Further consultation required | | | |
| 4.6 | **Operational risk** | Recruitment to the units | | 4 | 2 | **Medium** | Campus and national unit should make the campus an attractive place to work. Have looked at skill mix to mitigate pressures on any one staff group | | | |
| 4.7 | **Operational risk** | Formal team for the national unit not yet in place – no agreement yet about the formal governance for this yet | | 3 | 1 | **Low** | Recruitment underway. Identified leads in place despite not being formal team - Clinical lead in place | | | |
| 5.1 | **Planning risk** | Local community objects to the project | | 4 | 1 | **Medium** | Engage with local communities to gain their support for proposals re new site developments. Planning permission in place until March 2022 | | | |
| 6.1 | **Design risk** | The design does not meet the Design Assessment expectations. Affordability and design risk | | 4 | 2 | **Medium** | Get the building specifications right and the contractors decisions to make the building fit for purpose, both in terms of robustness and the physical environment – risk to patients. This will be captured in the clinical brief. The design team need to engage with the Design Assessment team from early design planning stages onwards to avoid confusion over expectations. Robust learning from previous projects | | | |
| 7.1 | **Procurement risk** | Availability of contractors to complete the project | | 4 | 2 | **Medium** | Procured through Hub - experienced contractor in place | | | |
| 8.1 | **Construction risk** | Critical programme dates are unrealistic | | 4 | 2 | **Medium** | A realistic project programme should be developed from IA stage onwards which is regularly monitored and reviewed | | | |
| 8.2 | **Construction risk** | • Unforseen issues with grounds | | 4 | 1 | **Medium** | | | | |
| 9.1 | **Funding risk** | The project estimate is poorly prepared and inaccurate | | 5 | 2 | **High** | The level of detail required for project cost estimates should align with guidance on each planning stage. High optimism bias built in | | | |
| 9.2 | **Funding risk** | The project becomes unaffordable | | 5 | 2 | **High** | The affordability of the project should be tested at IA stage and further explored as part of the OBC and FBC stages of the project | | | |
| 9.3 | **Funding risk** | Availability – at SG level – having robust alternative options | | 5 | 4 | **Very High** | Work with SG | | | |

| 1. Identification | | | 2. Assessment | | | | 3. Control | | 4. Monitoring | |
|---|---|---|---|---|---|---|---|---|---|---|
| Risk No | Risk Grouping | Risk Description | Financial / Non-Financial / Unquantifiable | Consequence (1 - 5) | Likelihood (1 - 5) | Risk | Proposed Treatment / Mitigation | Action Taken | Risk Owner - Type | Risk Owner - Individual |
| 9.4 | **Funding risk** | Revenue affordability – if more beds required, increased costs for staffing, availability of staffing. Costs of out of area if we do not have enough beds – and out of area budget being used to cover costs of the revenue relating to the IA | | 5 | 2 | **High** | Model developed across Lothian to support bed base. Linkwith IJBs to establish process if demand is higher | | | |
| 10.1 | **Economic risk** | Inflation costs rise above those projected | | 5 | 2 | **High** | The likelihood of this occurring needs to be considered as part of the Financial Case. Optimisim bias within estimated costs includes an allowance for increased inflation | | | |
| 11.1 | **Policy risk** | Changes to non-legislation policy affects project cost or progress | | 3 | 2 | **Medium** | The likelihood of this occurring should be considered as part of this risk register | | | |
| 12.1 | **Legislative risk** | Changes in legislation or tax rules increase project costs | | 5 | 1 | **Medium** | Most recent legislative changes relating to carbon included in initial design | | | |

## Appendix 4: AEDET (Achieving Excellence Design Evaluation Toolkit) Evaluation Summary

Included as attachment due to file size.

## Appendix 5: Pictures of NHS Lothian Current Intellectual Disability Wards

Included as attachment due to file size.

# Integrated Mental Health Rehabilitation and Low Secure Centre



## NHS Lothian

## Initial Agreement

**Project Owner:** Nickola Jones

**Project Sponsor:** Alex McMahon

**Date:** 13/05/2021

**Version:** 1.16

## Version History

| Version | Date | Author(s) | Comments |
|---|---|---|---|
| 1.0 | 13/05/2021 | Nickola Jones | Initial draft, pulling together progress to date |
| 1.1 | 18/09/2021 | Mike Holligan/Andy Wills | Review and update case |
| 1.2 | 19/05/2021 | Andy Wills/Mike Holligan | Review and update case |
| 1.3 | 24/05/2021 | Mike Holligan/Andy Wills | Review and update case |
| 1.4 | 28/05/2021 | Nickola Jones | Review and update case |
| 1.5 | 01/06/2021 | Andy Wills/Mike Holligan | Review and update case |
| 1.6 | 03/06/2021 | Mike Holligan | Editing and Formatting of document changes |
| 1.7 | 10/06/2021 | Andy Wills/Mike Holligan | Review and update case |
| 1.8 | 14/06/2021 | Nickola Jones | Review and update case |
| 1.9 | 15/06/2021 | Mike Holligan | Review and update case |
| 1.10 | 16/06/2021 | Nickola Jones/Steve Shon | Review and update case |
| 1.11 | 21/06/2021 | Nickola Jones/Steve Shon | Review and update case |
| 1.12 | 21/06/2021 | Laura Smith/Hamish Hamilton | Updates to Economic Case & Financial Case |
| 1.13 | 06/07/2021 | Nickola Jones | Review and Update case based on feedback from REAS SMT and REH Project Board |
| 1.14 | 19/07/2021 | Nickola Jones | Review and update case |
| 1.15 | 20/07/2021 | Nickola Jones and Laura Smith | Review and update case, update of financial sections of case |
| 1.16 | 22/07/2021 | Nickola Jones | Review and update case |

# Contents

# 1. Executive Summary

## 1.1 Purpose

This Initial Agreement makes the case for providing Low Secure Mental Health Rehabilitation within NHS Lothian for those currently receiving care out of area and to improve facilities for adults receiving general mental health rehabilitation. It sets out the case for a 60 bedded integrated rehabilitation centre that encompasses psychiatric rehabilitation in both low secure and open environments. This would be made up of 24 beds for Low Secure care and 37 beds for Mental Health Rehabilitation.

This is an innovative approach that aims to support people to spend the least possible amount of time in secure care by making the transition to open settings, and onto the community, as easy as possible. Building a unit with layers of shared, rehabilitative spaces that people can transition to as they build their recovery journey will allow that. The relationships built with all members of a person's network including both statutory staff and wider supports will be maintained as people are accommodated in the least restrictive environment. The integration proposed will embed a recovery and rehabilitative focus throughout all areas of the unit, and allow this to be maintained throughout a person's stay.

A new facility would address all of the current issues described throughout this case and would provide the best possible space to enable optimum rehabilitation and recovery for patients. Additionally, this proposal suggests that the inpatient bed numbers should reduce and the funding transferred to support community alternatives for those currently in rehabilitation wards who have significant needs, but who are not benefitting from active rehabilitation. Thus supporting the ambition to shift resources from acute hospitals to community based resources.

## 1.2 Background and Strategic Context

This IA follows on from the implementation of Phase 1 of the Royal Edinburgh Hospital campus re-development. It seeks to build on knowledge gained from the first phase and to provide high quality facilities for those receiving Mental Health Rehabilitation and Low Secure care.

The case aligns with all current Scottish Government and local strategies and has been included in the four Lothian IJB Strategic Plans for 2019-2022.

Mental Health Rehabilitation and Low Secure care are delegated functions in Lothian, which means that the four Lothian IJBs are responsible for setting the direction for the future. Therefore, the Royal Edinburgh Project Board has worked closely with colleagues from across the four Lothian IJBs to create a joined up plan for Adult Rehabilitation and Low Secure care.

The IJBs have agreed on a reduced bed number for Mental Health Rehabilitation from a current funded capacity of 64 beds to 37 beds. The breakdown across the IJBs is as follows:

| IJB Area | No. Of MH Rehabilitation Beds Commissioned |
|---|---|
| West Lothian | 0 |
| East Lothian | 3.5 |
| Midlothian | 3.5 |
| Edinburgh City | 30 |
| **Total** | **37** |

The IJBs have also commissioned 23 beds for Low Secure care to facilitate the flexible model of care described above and to deliver people's care as close to home as possible. The breakdown per IJB area is as follows:

| IJB Area | No. Of Low Secure MH Beds Commissioned |
|---|---|
| West Lothian | 6 |
| East Lothian | 1 |
| Midlothian | 1 |
| Edinburgh City | 15 |
| **Total** | **23** |

## 1.3 Need for Change

The 'Independent Review into the Delivery of Forensic Mental Health Services – What we think should happen'[1], published in February 2021, expressed surprise that NHS Scotland as a whole spends millions of pounds a year in cross-charges for accommodating people out of area. These out of area placements place people further away from their support networks. The Review advised that Low Secure care should be provided locally and this case seeks to deliver on this recommendation. There are currently 17 Lothian patients receiving care out of area at a cost of around £200,000 per person. Receiving care out of area has a significant detrimental impact on people's ability to get better and to maintain links to and support from family and friends.

The Adult Mental Health Rehabilitation wards on the Royal Edinburgh Hospital (REH) campus are currently delivered from significantly outdated accommodation. There are a number of issues described in this case which makes the inpatient wards not fit for purpose for this patient group, namely; the lack of single bedrooms with en-suite facilities, the lack of access to outdoor space if patient's require and escort, lack of access to appropriate therapeutic space, lack of access to quiet spaces, poor environment which is not robust and is easy to damage, lack of space to store belongings and various other challenges.

## 1.4 Investment Objectives

The Investment Objectives for this case are:

- End out of area secure psychiatric care for people in Lothian
- Shift the balance of care by reducing inpatient beds and developing pathways to support people with complex needs in residential settings
- Establish a high quality, safe and robust inpatient services which meet care standards such as providing single rooms with en-suite bathrooms
- Establish high quality facilities which are robust and maintainable
- Have a facility which meets the current standards for energy efficiency and sustainability
- Provide an inpatient environment designed to meet patient and staff safety.
- Provide integral and secure gardens to each rehabilitation and low secure ward areas.
- Provide therapeutic areas that can be accessed with ease by all.
- A clinical environment which supports rehabilitation national evidence based clinical practice.
- Realistic and sustainable workforce model using the whole multidisciplinary team (MDT)

[1] Independent Review into the Delivery of Forensic Mental Health Services – What we think should happen https://www.gov.scot/groups/forensic-mental-health-services-independent-review/

## 1.5 The Preferred Option(s)

The preferred option is for a New Build facility on the Royal Edinburgh Hospital Site.

This preferred option has been reached following an options appraisal conducted by key representatives of the service and project teams. The Economic Assessment Table below shows that the option to build a new facility is the best ranked option and provides best cost per benefit point.

| Option Appraisal | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|
| Weighted benefits points | 245 | 625 | 815 | 950 |
| NPV of Costs (£k) | 118,340 | 198,898 | 209,600 | 269,714 |
| Cost per benefits point (£k) | 483 | 318 | 257 | 284 |
| **Rank** | **4** | **3** | **2** | **1** |

## 1.6 Readiness to proceed

A benefits register and initial high level risk register for the project are included in Appendix 3: Benefits Register and Appendix 4: Risk Register. Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

NHS Lothian is ready to proceed with this proposal and is committed to ensure the necessary resources are in place to manage it. Section 6.2 outlines the governance support and reporting structure for the proposal and section 6.3 details the project management arrangements.

## 1.7 Conclusion

This proposal is a significant priority for NHS Lothian and the four Lothian IJBs as it realises national advice to provide Low Secure locally and will improve the quality and dignity of care for patients receiving mental health rehabilitation.

At the centre of this case is a desire to provide the best quality of care to those who require mental health care in NHS Lothian. Having to receive care out of area is detrimental to our patient's wellbeing and recovery, as is receiving care in a poor quality environment. Additionally, staff should be delivering care from environments that they are proud to work in, not from environments that they have to work around. This case provides an opportunity to create an innovative facility which is able to provide the flexibility required to care for patients in the least restrictive way possible.

This IA makes a compelling case for investment which would further the Scottish Government's ambition to provide parity between physical and mental health care and to provide care as close to home as possible.

# 2. The Strategic Case

## 2.1 Existing Arrangements

### *Adult Mental Health Low Secure*

A forensic service comprises of 3 different levels of security: high, medium and low. Whilst high secure is provided at the State Hospital in Carstairs, the Orchard Clinic at the REH provides medium secure forensic care. There is currently no step down / low secure acute forensic provision in NHS Lothian and no capacity to deliver this service within existing arrangements. As a result, Lothian patients either receive this service when required out of area or worst case are unable to access this service at the most clinically appropriate time and their length of stay in medium secure is longer than necessary. The current model of care for low secure services relies on outsourcing to a variety of units with varying care models. The average cost of an out of area low secure placement is approximately £200,000 per person per year.

Patients requiring Low Secure rehabilitation are all detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or Criminal Procedures Act (Scotland) 1995. This patient group has diverse needs and many will share similar experiences and symptoms of the Mental Health Rehabilitation group described below. Most will have a history of offending behaviour and present significant risks to self and others. This group are likely to have had previous treatment and care in a medium secure psychiatric environment or placed in private secure care as their local NHS board has not had the resources to care and treat these patients with the safety and security that they had required. There is a greater need for environmental, relational and procedural security compared to the mental health rehabilitation and the goal of the inpatient unit to allow patients to continue their recovery journey safely.

The Unplanned Activity (UNPACS) budget has been used to fund 20 low secure places for NHS Lothian patients in recent years. These have been mainly at private facilities in Ayr and Glasgow, however several patients who have specialist needs due to brain injury or sensory impairment have been placed in private and NHS facilities in England.

Demand predictions for low secure beds are based on the following:

- As of March 2020, there are 17 patients with outsourced care
- An estimated 6 patients from Medium secure may be appropriate to accommodate in low secure facilities
- System changes mean there is now the ability for patients to appeal against the need for medium secure facilities, which may increase demand for low secure care.

### *Adult Mental Health Rehabilitation*

The Mental Health Rehabilitation Service is delivered by NHS Lothian from the Royal Edinburgh Hospital site and specialises in working with people whose long-term and complex needs cannot be met by general mental health services. Services are delivered to anyone in Lothian requiring mental health rehabilitation; however, the majority of patients are from Edinburgh City as there is only small demand from East Lothian and Midlothian and there are local mental health rehabilitation provisions in West Lothian.

**Who might need a mental health rehabilitation service?**

People who require inpatient mental health rehabilitation may have a diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder. Typical difficulties include:

- problems with organising and planning daily life – finding it hard to plan and actually carry out plans
- symptoms of mental illness, such as hearing voices that are distressing or make it difficult to communicate with other people
- being exploited or abused by others
- behaving in ways that other people find difficult or threatening - this can lead to contact with the police or courts
- harmful use of alcohol and non-prescribed ("street") drugs.

People may have these difficulties because:

- standard medications do not work well for them
- the illness affects peoples concentration, motivation and ability to organise themselves
- they also suffer from depression and anxiety
- they may struggle to manage everyday activities – like self-care, budgeting, shopping, cooking, managing your money.[2]

People who are admitted into these units are over the age of 18 and there is no age cap on who may benefit from the model of care offered. Older people, with higher levels of frailty may not be accepted though, due to the limitations of the built environment. Due to the impact of the illnesses on their understanding of their difficulties almost all the patients are detained under the Mental Health (Care and Treatment)(Scotland) Act 2003 and many will be subject to provisions under the Adults with Incapacity (Scotland) Act 2000.

The patient group admitted to this service will be highly symptomatic, have several or severe co-morbid conditions and most will have significant risk histories. Usually people in this group have had difficulty in engaging and maintaining contact with medical and support services in non-hospital-based care and have exhibited limited therapeutic treatment responses to pharmacological and/ or other treatments. A history of coping with trauma will impact on the care and treatment of a substantial proportion of the patients.

**When are people referred to rehabilitation services?**

- Usually after a few years of mental health problems - and a number of hospital admissions. However, it can sometimes be helpful if you are trying to get over a first episode of illness.
- If you can't be discharged from an acute ward, but are unlikely to get any better there.
- If you are moving to a placement with less support and supervision. This can happen if you are leaving a forensic or secure service, or if you are moving from residential care to a more independent home in the community.
- If you might benefit from the structured environment and intensive therapeutic programmes that are available on a rehabilitation unit.[3]

Most people admitted to the rehabilitation wards will have a history of spending substantial periods of time socially and economically disadvantaged e.g. homeless and without work. For most it is predicted that they will require a protracted length of inpatient stay to build a secure base from which they can continue their recovery journey out of hospital. In-patient rehabilitation services are eight times more likely to support these people with complex needs, including psychotic illnesses, to live independently in the community long-term when compared to standard mental health services.

[2] Royal College of Psychiatrists – 'Mental Health Rehabilitation Services' https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-rehabilitation-services
[3] Royal College of Psychiatrists – 'Mental Health Rehabilitation Services' https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-rehabilitation-services

**What are the aims of mental health rehabilitation?**

The rehabilitation wards adopt a holistic bio-psycho-social formulation centred on what is appropriate for the individual, built on evidence-based approaches. The strength is the multidisciplinary team approach, with the individual in the centre. Shared environments and therapy spaces are key to delivering suitable interventions to enable rehabilitation. Patients may be aiming to:

- learn or re-learn life skills.
- get their confidence back.
- cope better without so much help.
- achieve the things they want to, like living in their own flat, getting a job or building family relationships.
- feel independent and comfortable with their life.

The ethos and the basis of the care model is relationships. Clinical staff build relationships with patients over time, through interaction, discussion and interventions/ activities. Trusting relationships that maintain hope are key for promoting recovery in the units. Patients also build relationships with one another, and often enjoy activities which bring them together, building a sense of community e.g. North Wing have regularly organised coffee mornings.

Many patients have had a long history of contact with Mental Health services with over 90% having had multiple episodes of inpatient care in the general Mental Health wards alongside extensive MDT efforts to support them in the community. Patients often need the structure of how the unit functions to help stabilise them; the rehabilitation wards offer a routine and rhythm that allows them to build the confidence that may have been lost over a number of years in care. Many also have high levels of need for personal care due to either physical or mental health. This support can be complicated by issues with patient engagement and capacity, requiring a sophisticated range of MDT skills to overcome these challenges.

**What treatments and support are provided?**

The service provides specialist assessment, treatment, interventions and support to help people to recover from complex mental health problems and to gain the skills and confidence to live successfully in the community. The inpatient unit works in partnership with other agencies that support patients' recovery and social inclusion including third sector and social care agencies in the provision of accommodation, education, employment, advocacy and peer support services. Central to the service's function is a recovery orientation that places collaboration with patients and carers at the centre of all activities.

Treatments may include:

- Medication.
- Talking therapies (e.g. cognitive behaviour therapy and specific work with families and carers).
- Guidance on healthy living (e.g. diet, exercise and stopping smoking).
- Help to reduce or stop alcohol and street drug use.
- Support to manage everyday activities such as personal hygiene, laundry and more complex living skills such as budgeting, shopping and cooking.
- As people get better, they will spend more time in the community. They may do some sport, go to the cinema, do a course, learn some skills for work, or start to get a job.
- Help with accommodation and social security benefits.
- Sometimes legal advice.

Rehabilitation services aim to support patients to regain skills for community living, with the same opportunities as anyone else. The Royal College of Psychiatrists state that ‘Rehabilitation units should

provide a safe and homely space where you can feel comfortable, safe and are able to have safe relationships with other people'[4] – this is the ambition of the current units and for any future plans.

### Current Ward Establishment

The breakdown of existing funded capacity of 63 beds is as follows:

| | | | |
|---|---|---|---|
| Crammond | Mixed | 14 beds | Single rooms, shared dormitories, shared toilets |
| Myreside | Female | 15 beds | Single rooms, shared dormitories, shared toilets |
| North Wing | Male | 15 beds | Single rooms, shared dormitories, shared toilets |
| Craiglea | Male | 15 beds | Single rooms, shared dormitories, shared toilets |
| Margaret Duguid Unit | Mixed | 4 beds | Single room, en suite |

Currently, due to the demands of the service, there are an additional 3 beds being used across the four wards. There are currently 67 inpatients, although the service's funded capacity is 64.

### Patient Activity 2018 - 2021

| | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| No. Of admissions | 28 | 48 | 1 |
| No. Of Discharges | 31 | 49 | 1 |
| Average Length of Stay | 512 | 195 | 266 |

## 2.2 Drivers for Change

The following section expands on the need for change as identified in the Strategic Assessment (included in Appendix 2) and describes the anticipated impact if nothing is done to address these needs and why action should be taken now through this proposal.

### *Low Secure*

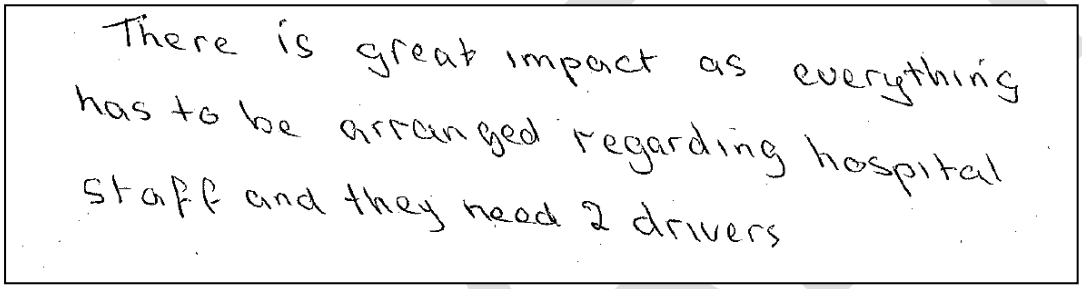
There is currently no low secure provision in the Lothian area. Patients are receiving care far from home which means that connecting with family members becomes even more challenging than it would be normally for this patient group. In addition to this, out of area low secure placements currently cost NHS Lothian approximately £3.2million per year.

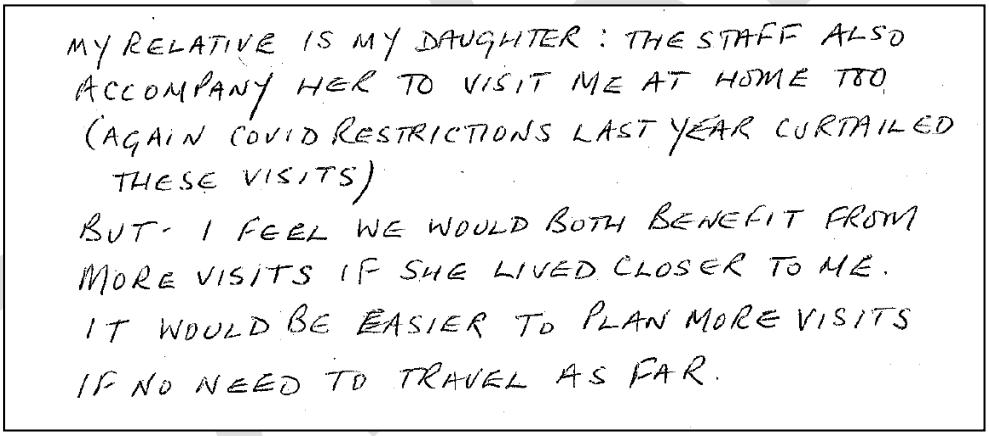
[4] Royal College of Psychiatrists – 'Mental Health Rehabilitation Services' https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-rehabilitation-services

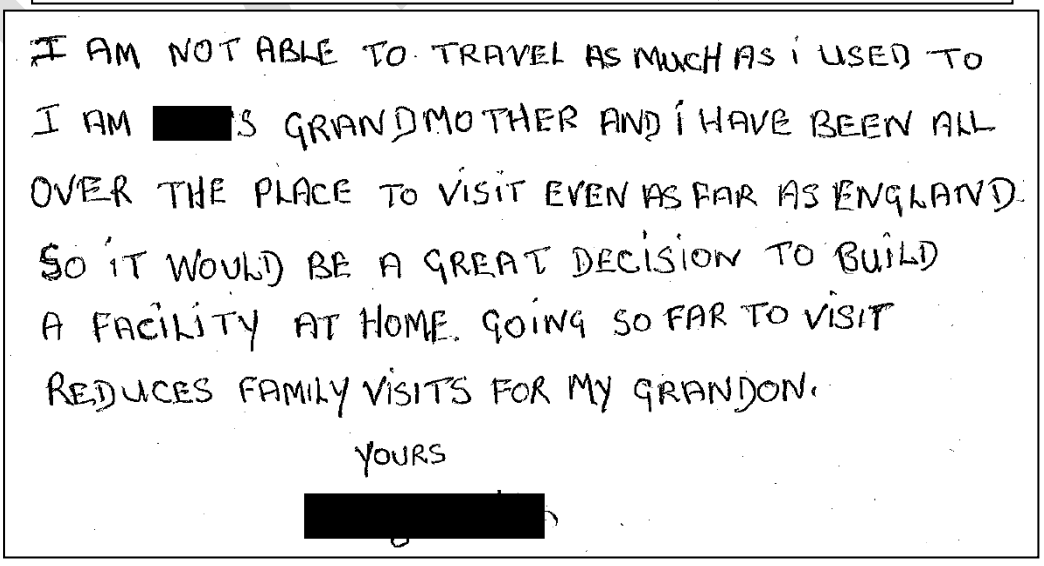
An exercise to gain feedback from patient's currently receiving low secure care out of area and their families was conducted in early 2021. Some of the quotes from this exercise are listed below, which clearly demonstrate some of the challenges currently experienced:

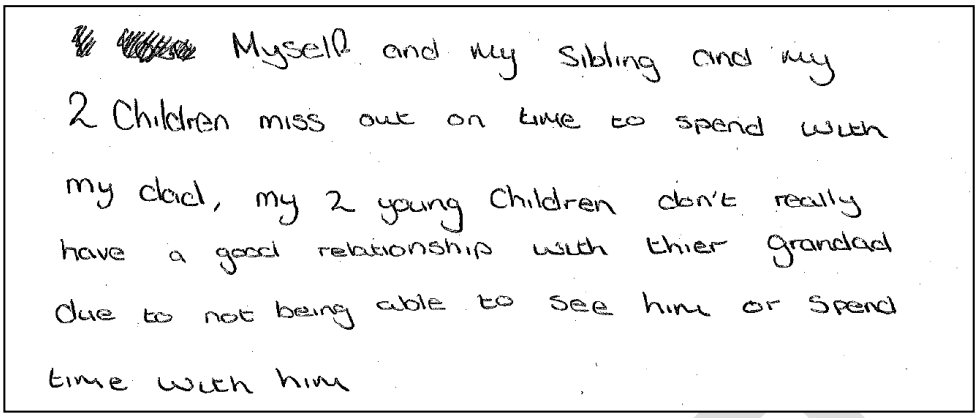
> *'I am from here, why do I need to be sent away? That is not going to make be better'* Low Secure Patient
>
> *'I have not seen my third grandson since he was born, if I was in Edinburgh I would have the chance to meet with him.'* Low Secure patient
>
> *'The day it was decided that my son had to move to a different hospital was the worst day of my life. I just couldn't see how I could help him get back to living a life again from the other side of the country'* Relative of low secure patient

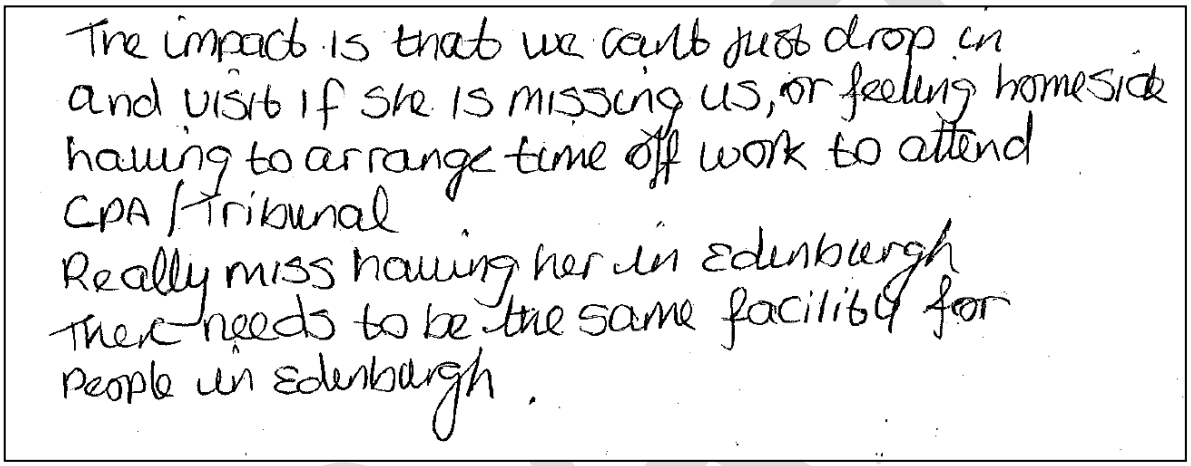
Some of the written responses are shown below:

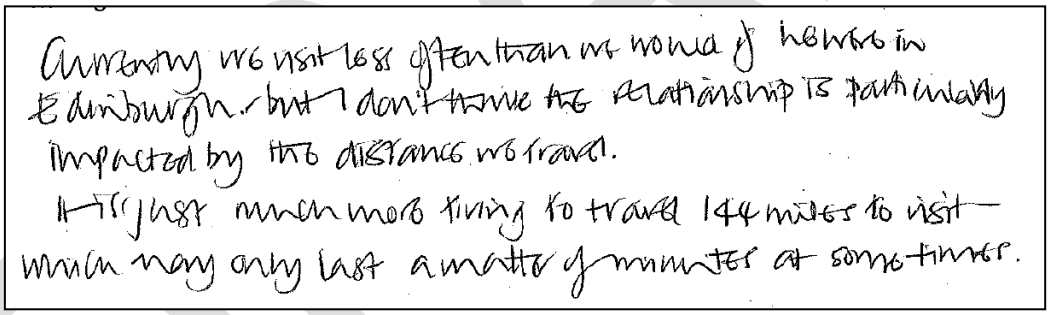

There is great impact as everything has to be arranged regarding hospital staff and they need 2 drivers


MY RELATIVE IS MY DAUGHTER : THE STAFF ALSO ACCOMPANY HER TO VISIT ME AT HOME TOO (AGAIN COVID RESTRICTIONS LAST YEAR CURTAILED THESE VISITS)
BUT I FEEL WE WOULD BOTH BENEFIT FROM MORE VISITS IF SHE LIVED CLOSER TO ME.
IT WOULD BE EASIER TO PLAN MORE VISITS IF NO NEED TO TRAVEL AS FAR.


I AM NOT ABLE TO TRAVEL AS MUCH AS I USED TO
I AM [redacted]S GRANDMOTHER AND I HAVE BEEN ALL OVER THE PLACE TO VISIT EVEN AS FAR AS ENGLAND.
SO IT WOULD BE A GREAT DECISION TO BUILD A FACILITY AT HOME. GOING SO FAR TO VISIT REDUCES FAMILY VISITS FOR MY GRANDON.
YOURS
[redacted]


Myself and my sibling and my 2 Children miss out on time to spend with my dad, my 2 young Children don't really have a good relationship with thier Grandad due to not being able to see him or Spend time with him


The impact is that we can't just drop in and visit if she is missing us, or feeling homesick having to arrange time off work to attend CPA / Tribunal
Really miss having her in Edinburgh There needs to be the same facility for people in Edinburgh.


Currently we visit less often than we would if he was in Edinburgh - but I don't think the relationship is particularly impacted by the distance we travel.
It is just much more tiring to travel 144 miles to visit - which may only last a matter of minutes at sometimes.

The psychological impact on families on taking patients out of their community and support structures can have huge impact of their mental health wellbeing. It can have a significant detrimental impact on people's capacity to recover as they do not have their normal support structures or any access to their local community. It can also cause clinicians to feel they have let down both the patient and their family by not being able to provide care and support them within their local community.

Concerns regarding the adequacy of provision of low secure mental health rehabilitation in Scotland have been raised by a number of sources. This was identified in the Mental Welfare Commission's Intensive Psychiatric Care in Scotland report and from contacts with individual patients and hospitals by the Mental Welfare Commission, and it was noted that NHS Lothian currently do not have local provision for low security services. The 'Independent Review into the Delivery of Forensic Mental Health Services – What we think should happen'[5], published in February 2021, expressed surprise that NHS Scotland as a whole spends millions of pounds a year in cross-charges for accommodating people out of area. These out of area placements place people further away from their support networks.

[5] Independent Review into the Delivery of Forensic Mental Health Services – What we think should happen https://www.gov.scot/groups/forensic-mental-health-services-independent-review/

The review also heard that clinical teams could be inflexible about the timing of these meetings, making it difficult for family members to attend, especially if the person was being cared for out of area. Recommendation 30 of the review states that individual Health Boards should put in place a system to reimburse travel expenses to those family members (or other carers) who have travelled to visit a person receiving forensic mental health services out of area. This additional cost will require to be met by NHS Lothian until further notice.

There are also significant capacity pressures on Medium Secure services, which could be improved with the development of a Low Secure Unit on the Royal Edinburgh Hospital site due to improved flow between services.

## *Mental Health Rehabilitation*

The buildings in which rehabilitation services are currently situated are not fit for purpose. Despite two rehabilitation wards recently moving to new accommodation in the Andrew Duncan Clinic to clear buildings which require demolition in order to progress works on the site, the wards continue to fail to meet requirements such as having single, en-suite rooms. The remaining three wards are delivered from significantly out dated accommodation, the impact of which will be described in the following paragraphs and are shown in the pictures included in Appendix 1.

A 'Residential Environmental Impact Scale' (REIS) was recently conducted by a Specialist Occupational Therapist in two of the rehabilitation wards (Crammond and North Wing). These reviews indicated a number of issues for patients and staff posed by the current ward environment; they also made it clear that environmental changes were on hold due to the expectation that a new facility for these wards was going to be made available. The outcomes of the review have informed the following paragraphs, as well as information gathered from staff and patients on ward rounds conducted in July 2021.

### Shared bathroom and shower facilities

The rehabilitation wards do not have en-suite facilities, with the exception of the 4 bedded Margaret Duiguid Unit. The other wards have between four and six toilets for 15 patients, and two to four showers.

This does not meet modern care standards and can have a particularly detrimental impact on this patient group. Some patients may have a lack of inhibition due to their condition and may therefore leave toilet doors open. This means that they are not granted the dignity and respect of a private place to go to the toilet. It may also be difficult emotionally for some patients to use shared bathroom facilities due to a history of abuse.

Nurses also reported that the bathroom facilities were old and that the toilets clogged very easily.

The provision of single rooms with en-suites would give the rehabilitation service greater flexibility in terms of gender separation, which will support flow through the hospital as demand for these services is high.

### Shared Living Spaces

In all of the rehabilitation wards, with the exception of the newly refurbished Margaret Duguid Unit, there is at least two shared dormitory bedrooms. This means that two patients are sharing one sleeping space. This presents a number of significant issues for patients and staff. Firstly, patient's report that sharing bedroom space makes them feel unsafe and they worry about their belongings, a patient stated "I don't feel safe sleeping with others in my room". Patients can feel very vulnerable at night and are easily disturbed by other patients moving around the bedroom. Patients may feel frightened if the person they are sharing a room with becomes unwell and exhibits distressed behaviour. For the person exhibiting the distressed behaviour, there is no private and safe space which can feel like their own for staff to support them in or to

enable them to have the privacy to spend some time alone. Additionally, patients can be intimidated or bullied by other patients and may be coerced to hand over cigarettes, money or other valuables. They may also be influenced by the person they are sharing a room with, which could have further detrimental impact on their recovery.

For staff, the shared living spaces can present challenges for managing patients and providing meaningful rehabilitation. As would be expected, not all patients get on and sometimes patients need to be moved room because they have fallen out with the person they are sharing with. Sharing a room may make some patients frustrated and more likely to exhibit the behaviours they are trying to move away from as part of the rehabilitation process – this then delays their rehabilitation and can increase their length of stay. Additionally, when a new patient is being admitted to the ward, Charge Nurses need to consider where is best to place them in the ward. Due to the shared living spaces, admitting this new patient could require 3 or 4 other patient moves. Considering the wards are people's homes for a significant period of time, this frequent need to move can make patients feel that they are being uprooted again and further delay their rehabilitation progress as they are distracted by the trauma caused by the move. One Senior Charge Nurse said that they felt that it was 'difficult to get on with the task of rehab as people are preoccupied with trying to survive in the environment'.

## Access to Outdoor Space

Patients and staff express frustration at the lack of safe, contained outdoor space for the ward. There is no direct access to outside space due to current location of 4 out of the 5 wards. Many patients will require an escort to leave the ward at various points during their admission based on clinical risk. This means that they cannot leave the wards without staff accompanying them. Since there is no safe, contained space linked to the ward, this means that patients need to wait for staff to be available in order to go outside. One patient stated "For long periods of times I'm unable to go outside", another stated "Why should I have to ask staff and be escorted when all I want is a bit of day light and fresh air?"

## Wheelchair Accessibility

The ward is not wheelchair accessible and is difficult to access independently for those with other mobility issues such as the use of walking stick. The ward is situated on the first floor and the lift often breaks down which affects wheelchair users being able to leave the ward and access outdoor space. Wheelchair users also struggle with the heavy doors, lack of turning space and small shared toilets. Staff commented that the shared toilets affect the wheelchair users privacy and dignity and the shared bathroom/toilet space is too small for adaptive equipment. The dining room area is also not set up to meet the needs of those in a wheelchair, the height of the kitchen cupboards and the lack of door handles on cupboards make the cupboards difficult to access for all residents.

## Storage of Belongings

There is very limited storage available for each patient in the ward. One patient stated "My belongings are not safe from others in my room and I have don't have enough storage to keep my personal things". Patients in current Rehabilitation service have been in hospital for a considerable period of time and in some cases several years and have accumulated large amounts of personal belongings, which cannot be securely stored within the ward environment.

### Lighting and Temperature

There are challenges with the lighting and the ward temperature. Staff stated that patients complain about the heat on the wards 'all of the time'. Staff commented that the ward temperature is difficult to control i.e. some bedrooms are very cold at times and when the weather is warmer the whole ward is uncomfortably hot. The windows in the current wards are a unique design which means they do not let very much air into the wards.

Some of the corridors are dark and staff reported that it was not nice for them to work in 'dark, dingy places'. The current environment is having a detrimental impact on staff wellbeing which adds to the challenge of recruitment to nursing posts.

### Physical Structure

In order to accommodate this patient group, the ward environment must be robust and able to withstand some stress caused by patients. In North Wing, for example, the door to one bedroom has been slammed so many times that the supporting wall is becoming cracked and therefore unsafe. Repairing this damage will come at significant cost to NHS Lothian and in a newer building, walls would be made more robust and re-enforced to ensure similar damage could not happen.

### Lack of Therapeutic Space

There is very limited access to private space across all of the rehabilitation wards. This has been particularly challenging during the Covid-19 pandemic as there has not been space for patients to sit on their own and it has been challenging to distance patients as their only leisure spaces are shared. One patient stated "When feeling unwell I sometimes like to be alone but there is no escape from a noisy and busy ward".

Additionally, there is very little private space for one to one conversations and support, so often when a therapist meets with a patient, this is in shared, communal spaces which may not feel private and may lead to a less open conversation which could delay progress. Group work also takes place in communal areas, meaning patients cannot use the TV or the space while the group is taking place.

There is also no therapy kitchen in some of the wards, which limits patients ability to practice cooking, which is a key skill to prepare for going home. There are shared kitchens in communal spaces, but this means that cooking sessions are interrupted by other patients making cups of tea etc.

### Combined Treatment room and Dispensary

The room where treatment and dispensary takes place is very small. If a patient is in the room receiving treatment, it is difficult and invasive for nurses to go in to dispense medications. It is also distracting for patients to receive treatment in a room which is also used for dispensing medications and also contains medical supplies.

## *A Vision for the Future*

This IA sets out the case for an integrated rehabilitation centre that encompasses psychiatric rehabilitation in both low secure and open environments. This is an innovative approach that aims to support people to spend the least possible amount of time in secure care by making the transition to open settings, and onto the community, as easy as possible. Building a unit with layers of shared, rehabilitative spaces that people can transition to as they build their recovery journey will allow that. The relationships built with all members of a person's network including both statutory staff and wider supports will be maintained as people are

accommodated in the least restrictive environment. The integration proposed will embed a recovery and rehabilitative focus throughout all areas of the unit, and allow this to be maintained throughout a person's stay.

A new facility would address all of the issues described above and would provide the best possible space to enable optimum rehabilitation and recovery for patients. Additionally, this proposal suggests that the inpatient bed numbers should reduce and the funding transferred to support community alternatives for those currently in rehabilitation wards who have significant needs, but who are not benefitting from active rehabilitation.

Mental Health Rehabilitation and Low Secure care are delegated functions in Lothian, which means that the four Lothian IJBs are responsible for setting the direction for the future. Therefore, the Royal Edinburgh Project Board has worked closely with colleagues from across the four Lothian IJBs to create a joined up plan for Adult Rehabilitation and Low Secure care.

## Proposed Bed Numbers

Working through the Royal Edinburgh Hospital Campus Project Board, all 4 Lothian IJBs have agreed on a reduced bed number from a current funded capacity of 64 beds to 37 beds. The breakdown across the IJBs is as follows:

| IJB Area | No. Of MH Rehabilitation Beds Commissioned |
|---|---|
| West Lothian | 0 |
| East Lothian | 3.5 |
| Midlothian | 3.5 |
| Edinburgh City | 30 |
| **Total** | **37** |

The reduction in Mental Health Rehabilitation beds will be facilitated by a transfer of investment from current hospital based services to alternative services in the community. The new model of care will help to facilitate a reduction in the length of stay in the rehabilitation wards, which will improve flow through the wards and enable NHS Lothian to stay within the reduced bed base. This will be further supported by community based developments such as the recent re-tendering of the Edinburgh support contract which will enable providers greater flexibility which should further improve flow through community support services.

The IJBs have also commissioned 23 beds for Low Secure care to facilitate the flexible model of care described above and to deliver people's care as close to home as possible. The breakdown per IJB area is as follows:

| IJB Area | No. Of Low Secure MH Beds Commissioned |
|---|---|
| West Lothian | 6 |
| East Lothian | 1 |
| Midlothian | 1 |
| Edinburgh City | 15 |
| **Total** | **23** |

The Low Secure provision will be across three wards, one for people with higher levels of frailty, one for females and one for males.

This proposal is therefore for a 60 bedded facility which provides Mental Health Rehabilitation and Low Secure care within the same building, benefitting from flexibility for patients and staff.

## Alignment with National and Local Strategy

### National Strategy

1. *Mental Health Strategy for Scotland 2017-2027*

   The Scottish Government's 2017-2027 Mental Health Strategy has the vision of "a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma". The strategy aims to provide parity between mental and physical health services and to ensure equal access to the most effective and safest care and mental health treatment. This campus redevelopment supports this goal by replacing existing poor quality facilities with high quality facilities.

2. *National Health and Wellbeing Outcomes Framework 2015*

   The development of new rehabilitation facilities will be supported by a model of care which is aligned with the PANEL principles[6], supporting flow through the system to ensure people are only in hospital when they require that level of care. This is aligned with a focus on human rights which is promoted throughout the existing review of mental health legislation.

3. *Forensic Mental Health Services: Independent Review 2021*

   The current configuration of forensic mental health services for inpatients developed from principles set down by the Scottish Executive in its letter HDL (2006)48 to NHS CEOs in July 2006. There are three different levels of secure hospital provision as described by the Forensic Network in its Security Matrix and each has been developed at a different national, regional or local level. In general:

   - High secure is provided at a national level.
   - Medium secure services are provided at a regional level; and,
   - Low secure services are provided at a local level.

   The review states "People recognised that flexibility to respond to local need was necessary to deliver person-centred care. However, the differences in services highlighted to the Review were experienced more as inconsistencies, inequalities and frustrations by the people for whom these services were provided and the staff delivering them. Such differences mean that people's experiences and outcomes are affected by factors that are not related to their care needs or risk management requirements. There were calls for a more integrated approach to service development and resourcing rather than what was described as a 'postcode lottery' affecting care and treatment."

   This proposal meets the review's recommendations to provide Low Secure care at a local level, and to ensure there is consistent and high quality care for people requiring care in the forensic system.

   The Review also states that there is a pressure on Medium Secure facilities across Scotland. Having Low Secure provision on site would help NHS Lothian to manage flow through its medium secure service.

4. *National Clinical Strategy for Scotland*

   The National Clinical Strategy describes the rationale for an increased diversion of resources to primary and community care. This proposal supports this direction of travel by proposing a reduction in the inpatient bed base and a transfer of resource to community based services. This caso also advocates for improved therapeutic spaces for patients to gain skills they require to be discharged

[6] National Health and Wellbeing Outcomes Framework – Description of PANEL principles - https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/pages/9/

to the community. The new facility would build upon established relationships with third sector providers, both on and off the REH site.

5. *2020 Vision*

   The 2020 Vision is for more care to be delivered at home or in a homely setting. This case builds upon decades of work within mental health services to shift focus from hospital based services to community services. However, it also advocates for the highest possible standard of care when someone does require admission to hospital, which should minimise the amount of time people need to receive care in a more restrictive, inpatient setting. Bringing Low Secure care to NHS Lothian also helps to meet the aim of delivering care more locally.

6. *The Healthcare Quality Strategy for NHS Scotland 2010*

   This proposal supports key priorities stated in the Healthcare Quality Strategy such as clean and safe environment, continuity of care and delivering clinical excellence. Specifically, providing low secure care on the REH site is more person centred as it improves people's ability to maintain links with their family and local community, it is also more efficient in terms of time and money both for the health service and for families visiting patient's in low secure care.

7. *Public Health Priorities for Scotland*

   Priority one is for 'A Scotland where we live in vibrant, healthy and safe places and communities' It advocates asset-based approaches and the importance of changing the places and environments where people live so that all places support people to be healthy and create wellbeing; strategic approaches to greenspace, community gardens and developing walking and cycling networks are given as examples. Greenspace is important to the recovery of patients within rehabilitation services and would be incorporated into any design going forwards.

8. *The Sustainable Development Strategy for NHS Scotland*

   The strategy includes actions in relation to facilities management (promoting greenspace and the outdoor estate as a healthcare facility), community engagement (engaging local people in the design and use of the outdoor healthcare estate and promoting access to it) and travel (ensuring health services can be accessed by good quality footpaths and cycle routes, and encouraging people to make active and sustainable travel choices). The site development, including this proposal, has these actions at the forefront of planning and will incorporate the existing strong links with third sector services on site which host some of the important green spaces such as the Community Garden and Glass Houses.

**Local Strategies**

1. *NHS Lothian Hospitals Plan*

   The Lothian Hospitals Plan describes the Royal Edinburgh Hospital as one of the four key strategic planning priorities for NHS Lothian alongside the 4 Lothian IJBs and Borders IJB. NHS Lothian's property and asset management strategy (2015 – 2021) states that NHS Lothian's vision is for major hospital services to be focused around four main sites, one of which is the Royal Edinburgh Hospital Campus.

2. *NHS Lothian Quality Strategy*

   REAS has been at forefront of implementing the quality management approach in NHS Lothian and staff across services have implemented over 100 tests of change. The improved environment proposed in this case would give staff more time to focus on improvement work without being

distracted by environmental concerns.

3. *Our Health Our Care Our Future: NHS Lothian Strategic Plan 2014-2024*

   The NHS Lothian strategy states a commitment to re-developing the Royal Edinburgh Hospital site and to developing community services to support inpatient services. This proposal aims to realise this ambition.

4. *Greenspace and Health Strategic Framework for Edinburgh & Lothians*

   The NHS Lothian board has made a commitment to make development of green spaces across NHS Lothian a priority. This will be included within any design proposals for this case.

5. *IJB Strategic Plans*[7][8][9][10]

   The four Lothian IJBs strategic plans state the intention to support the redesign of the REH campus alongside the development of broader care pathways for people with mental health conditions. This broader piece of work is focused on ensuring people have access to treatment outwith an acute hospital environment when possible, which requires reducing numbers of acute beds and increasing investment in community service. The reduction in bed numbers described in this IA aids the realisation of these local aims.

6. *Property and Asset Management Strategy*

   A key part of NHS Lothian's service delivery is ensuring best use of estate in supporting operational and corporate delivery. To achieve this, the Board has in place a Property and Asset Management Strategy (PAMS). NHS Lothian's current strategy reflects its commitment to improving the healthcare environment whilst reducing the number of hospital and other sites it currently manages, to reduce property expenditure. The Royal Edinburgh Hospital site is a major part of this strategy and its retention has been predicated on the aim to maximise its development potential. This decision has been reviewed through various updates to the site masterplan (most recently in 2019) and it continues to be viable.

   The Scottish Government's commitment to deliver a greener, zero carbon Scotland will be pursued through a focus on sustainability in this new development. In this way NHS Lothian will continue to maximise the sustainability of its estate.

7. *AEDET*

   A multi-stakeholder AEDET review has been used to set a benchmark score for the existing facilities highlighting their limitations.



[7] Edinburgh IJB Strategic Plan 2019 - 2022 - https://www.edinburghhsc.scot/wp-content/uploads/2020/01/Strategic-Plan-2019-2022-1.pdf
[8] East Lothian IJB Strategic Plan 2019 – 2022 - https://www.eastlothian.gov.uk/downloads/file/28278/east_lothian_ijb_strategic_plan_2019-22
[9] West Lothian IJB Strategic Plan 2019 – 2022 - https://westlothianhscp.org.uk/media/33786/West-Lothian-IJB-Strategic-Plan-2019-23/pdf/West_Lothian_IJB_Strategic-Plan_2019-23.pdf?m=636917136505370000
[10] Midlothian IJB Strategic Plan 2019 – 2022 - https://www.midlothian.gov.uk/info/1347/health_and_social_care/200/health_and_social_care_integration

The table below summarises the need for change, the impact it is having on present service delivery and why this needs to be actioned now:

**Table 1: Summary of the Need for Change**

| What is the cause of the need for change? | What effect is it having, or likely to have, on the organisation? | Why action now? |
|---|---|---|
| There is currently no low secure provision in the Lothian area | Patients are receiving care far from home which means that connecting with family members becomes even more challenging than it would be normally for this patient group. Out of area low secure placements currently cost NHS Lothian approximately £3.2million per year | Reduction in out of area spend will support NHS Lothian to shift resource from hospital to community, aligning with its strategies as well as those of the 4 Lothian IJBs |
| Existing buildings are not fit for purpose and the majority cannot efficiently be converted into single bedroom ward accommodation | The organisation is failing to meet requirements such as having single, en-suite rooms.<br><br>Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older. | The redevelopment is required now to provide a safe, financially sustainable and high quality environment to those requiring inpatient care for a long term mental health illness |
| Existing buildings have poor energy efficiency | Current facilities incur high facilities costs and have poor energy efficiency which is not aligned with the national aim to decrease carbon footprint | Spending on energy is higher than it could be because it is not efficient or sustainable |
| Existing building has poor environmental patient safety measures. | Current anti-ligature strategy coherence is poor and difficult to address in current building. | Existing building has poor environmental patient safety measures. |
| Patients unable to access fresh air. | Due to lack of direct and safe outdoor space many patients who due their mental health condition and mental health act status are unable to access fresh air unless escorted by staff. | Lack of compliance with mental health act.<br>Lack of compliance with human rights. |
| Patients with physical disabilities unable to access centralised therapeutic rooms. | Main therapeutic area for current patients has no lift, and current infrastructure of the building unsuitable to provide one, No practical other space available, | Lack of compliance with the Equality Act 2010 DDA |
| Current building does not support services care model. | Prolonged waiting times to access rehabilitation services from other clinical areas such as acute / admission mental health wards and low secure provision currently out of Lothian. | Difficulties in accessing local mental health acute inpatient services when required / referred, |
| There are significant workforce challenges, particularly within nursing | High vacancy rate across mental health services | The proposed bed reduction in MH Rehabilitation will enable the recruitment of staff for the new Low Secure wards. |

## 2.3 Investment Objectives

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

**Table 2: Investment Objectives**

| Effect of the need for change on the organisation | What has to be achieved to deliver the necessary change? (Investment Objectives) |
|---|---|
| **Care far from home** - Patients are receiving care far from home which means that connecting with family members becomes even more challenging than it would be normally for this patient group. Out of area low secure placements currently cost NHS Lothian approximately £3.2million per year | End out of area secure psychiatric care for people in Lothian |
| **Shifting resource from hospital to community** - The proposal set out within this IA is to reduce the number of beds within the adult mental health rehabilitation service and transfer investment into community services. | Shift the balance of care by reducing inpatient beds and developing pathways to support people with complex needs in residential settings |
| **Quality standards** - The organisation is failing to meet requirements such as having single, en-suite rooms. | Establish a high quality, safe and robust inpatient services which meet care standards such as providing single rooms with en-suite bathrooms |
| **Backlog maintenance** - Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older. | Establish high quality facilities which are robust and maintainable |
| **Facilities costs** - Current facilities incur high facilities costs and have poor energy efficiency which is not aligned with the national aim to decrease carbon footprint | Have a facility which meets the current standards for energy efficiency and sustainability |
| **Ligature risks** - Current anti-ligature strategy coherence is poor and difficult to address in current building. | Provide an inpatient environment designed to meet patient and staff safety. |
| **Poorly designed space to manage patient safety** - Building requires numerous exit and entrances for the building to operational work, however, creates patient and staff safety concerns ranging from entry of unauthorised persons to staff being aware of patient whereabouts. | |

| | |
|---|---|
| **Lack of outdoor space** - Due to lack of direct and safe outdoor space many patients who due their mental health condition and mental health act status are unable to access fresh air unless escorted by staff. | Provide integral and secure gardens to each rehabilitation and low secure ward areas. |
| **Lack of access to main therapeutic area** - Main therapeutic area for current patients has no lift, and current infrastructure of the building unsuitable to provide one, No practical other space available, | Provide therapeutic areas that can be accessed with ease by all. |
| **Prolonged waiting times** - Prolonged waiting times to access rehabilitation services from other clinical areas such as acute / admission mental health wards and low secure provision currently out of Lothian. | A clinical environment which supports rehabilitation national evidence based clinical practice. |
| **High vacancy rate** - High vacancy rate across mental health services | Realistic and sustainable workforce model using the whole multidisciplinary team (MDT) |

## 2.4 Benefits

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

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

The above investment objectives and the Strategic Assessment (see Appendix 2) have informed the development of a Benefits Register (see Appendix 3). As per the Scottish Capital Investment Manual guidance on `Benefits Realisation`, this initial register is intended to record all the main benefits of the proposal. A full Benefits Realisation Plan will be developed at OBC stage.

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

1. A new integrated mental health rehabilitation /low secure centre will make the environment in which patients receive care and treatment more dignified and respectful of human rights by providing single bedroom with en-suite facilities and direct access to secure outdoor green space. This will promote patient independence and improve patient outcomes, enabling patients to leave hospital with more clearly defined needs and more able to manage their mental health and living skills independently.

2. Low secure care will be provided in NHS Lothian, preventing patients from having to receive care out of area. Provision of low secure facilities will improve continuity of care, maximising the ability of patients to engage in activities through fluctuations in their mental health. Integration of low secure and open rehabilitation will reduce secure care to the minimum time necessary further improving patients' ability to maintain links to friends, family and the local community for those now able to receive low secure care in Lothian.

3. A well-designed building which has had input from clinical staff, patients, and carers will assist in the reduction of violence and aggression, self harm behaviours, missing persons and use of illicit substances. In addition, provision of adequate secure storage for personal belongings will result in

lower incidence of items going missing.

4. The creation of a mental health rehabilitation and low secure service on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments. This will make this centre in NHS Lothian a more attractive place to work and will help to support the staff we already have to enjoy their roles and continue to work in Lothian

5. The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff recruitment and retention

6. Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends and the improved ability of staff supported by improved access to health technology which provides continuity of care in one setting.

7. A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site

## 2.5 Strategic Risks

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

***Table 3: Strategic Risks***

| Theme | Risk | Safeguard |
|---|---|---|
| Workforce | Staff will need to be recruited to deliver low secure on the REH site. Currently, there are challenges recruiting to nursing within mental health. | The general risk surrounding nursing recruitment has been escalated to the Nurse Director. The low secure posts should be attractive to current and new nursing staff. Additionally, the reduction in rehabilitation bed numbers should make some nursing capacity available. Also, the clinical team will explore how a multidisciplinary team approach could mitigate this challenge. |
| Funding– Capital | NHS Lothian is aware that there is a high level of demand for capital funds across Scotland, therefore there may be challenges securing capital funding | The IA presents a convincing case for investment. The project team have worked to ensure the proposal presents best value. |

| | | |
|---|---|---|
| Funding - Revenue | IJBs will be required to issue directions to both reduce the bed base and to fund the staff required for rehabilitation | The project team has worked closely with IJB colleagues to ensure the proposal is supported by all four Lothian IJBs |
| Capacity | This proposal is for a reduced bed base for rehabilitation. The model of care and community provision to support this can be delivered out with this case, however, if not delivered, there is a risk that there will not be enough beds when the new facility is built | The four Lothian IJBs are already working to identify community alternatives for those with complex needs currently in hospital. There are plans to recruit a project manager to focus on this commissioning. Additionally, Edinburgh IJB are re-tendering their mental health support contracts and the new contracts will include more flexibility for providers which should support flow through support in the community. |
| Training | Low secure will be a new service so training will need to be undertaken to up skill staff | Medium secure care is already delivered on the site so there is local expertise that can be shared |
| Greenspace assets on site | Green space is an important element of rehabilitation for people receiving care on the site. There is a risk that this is compromised as development happens on the site. | The project team are working to ensure there is as minimal disruption as possible as works go forward. Green space is an important consideration within the design of the build and will be incorporated into any plans. |

A register of strategic risks is included in Appendix 4. This was developed by a group of key stakeholders at a workshop held on Thursday 15th July 2021. A full risk register will be developed for the project at the OBC stage.

## 2.6 Constraints and Dependencies

The key constraints to be considered are:

- Workforce availability is a key constraint for this case. The availability of sufficient multidisciplinary staff, particularly nursing, for the Low Secure facility is dependent on the reduction in bed numbers in Mental Health Rehabilitation
- Capital availability may also be a constraint due to a high demand on Scottish Government Capital Finance

The key dependencies to be considered are:

- The proposal to reduce the bed numbers in Mental Health Rehabilitation is dependent on community-based developments as alternative places of care for those currently in hospital, these developments will require extensive partnership working with support providers as the level of support required is higher than they currently deliver.

# 3. Economic Case

## 3.1 Do nothing/baseline

The table below defines the 'Do Nothing 'option. This is based on the existing arrangements as outlined in the Strategic Case.

**Table 4: Do Nothing**

| Strategic Scope of Option | Do Nothing |
|---|---|
| Service provision | Low secure would continue to be delivered out with Lothian at high cost. Rehabilitation would continue to be delivered from unsuitable accommodation. |
| Service arrangements | Low secure would continue to be delivered by private providers. Move to a more intensive, shorter length of stay model for MH Rehabilitation. |
| Service provider and workforce arrangements | Private Services in Ayr and Glasgow for Low Secure. Service and workforce for MH rehabilitation would continue to be provided by NHS Lothian. |
| Supporting assets | Low secure would continue to be delivered out of area by private providers and rehabilitation would continue to be delivered from the outdated, non-compliant wards on the Royal Edinburgh Hospital site. |
| Public & service user expectations | People within low secure and their families would continue to have the challenge of being out of area. People within rehabilitation wards would continue to be cared for in poor quality environments with shared bathrooms. |

## 3.2 Engagement with Stakeholders

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

**Table 5: Engagement with Stakeholders**

| Stakeholder Group | Engagement that has taken place | Confirmed support for the proposal |
|---|---|---|

| | | |
|---|---|---|
| Patients/service users | Patients and service users affected by this proposal include patients receiving care out of area in low secure, patients receiving care within rehabilitation and the families of these groups. Their involvement in its development includes being involved with the development of the clinical model through the Patients Council and Carers council. The impact that this has had on the proposal's development includes additional evidence to support a move towards en-suite bathrooms to promote privacy. They have also been asked to provide feedback about services to provide evidence for support of this case. | Patient / service user groups were consulted on the final version of this Initial Agreement by [*method*], on [*date*]. Their feedback was [*outline*] which has been incorporated into this proposal by [*outline any direct changes*]. |
| General public | The general public will not be directly affected by this proposal. There has been public consultation in relation to the masterplan to redevelop the campus and the proposal to develop low secure and rehabilitation has been included in the Strategic Plans of the four Lothian IJBs, which have undergone extensive public consultation. | Outcomes from consultation have not affected this proposal thus far. Further public consultation will be undertaken as the business case develops. |
| Staff/Resources | Staff affected by this proposal include all of the multidisciplinary team required to deliver care within the proposed wards. Their involvement in its development includes being involved with developing the clinical brief and informing the strategic case. | Staff representatives were consulted on the final version of this Initial Agreement by [*method*], on [*date*]. Their feedback was [*outline*] which has been incorporated into this proposal by [*outline any direct changes*]. |
| Other key stakeholders and partners | Other key stakeholders identified for this proposal include health and social care partnerships, IJBs and hub. Their involvement in the development of this proposal includes being members of the Project Board. | Confirmed support for this proposal has been gained through the IA being presented to the four Lothian IJBs following support from the Project Board. |

## 3.3 Long-listed Options

The table below summarises the long list of options identified:

1. **Do minimum**

   There are fire risks associated with the current wards and therefore works would be required to bring them up to specification. There are also backlog maintenance works required to be undertaken with an estimated cost of £5-7million.

2. **Refurbishment of existing facilities for Rehabilitation and continue to provide Low Secure out of Lothian**

   Work has already been undertaken to improve facilities for rehabilitation patients; however, these still do not meet care standards such as providing en-suite bathrooms. There is no alternative venue available on the site which could be refurbished for this patient group.

3. **Transfer services to wards on an existing NHS Lothian Acute site**

Accommodate the Rehabilitation and Low Secure wards on another of NHS Lothian's sites – the Western General Hospital, the Royal Infirmary of Edinburgh, St Johns Hospital, East Lothian Community Hospital

4. **Transfer services to alternative wards on REH site**

   There is no alternative venue available on the site which could be used for this patient group.

5. **Refurbishment of existing facilities for both Rehabilitation and Low Secure**

   Identification of accommodation on site which could be refurbished to provide 60 beds for both low secure and rehabilitation. There is no alternative venue available on the site which could be refurbished for this patient group.

6. **Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure**

   Identification of accommodation on site which could be refurbished to provide 37 rehabilitation beds and a new build for the 23bed Low Secure service. There is accommodation on REH site which could be refurbished and there is a piece of unused land available for the Low Secure service.

7. **New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site**

   The Astley Ainslie Hospital site is also located in Morningside and currently provides rehabilitation services, including the SMART centre. There may be land on this site which could be used for a new build facility.

8. **New Build for both Rehabilitation and Low Secure on REH Site**

   There is a piece of unused land in close proximity to the current Royal Edinburgh Building and Orchard Clinic (Medium Secure) facilities which can be used to build a bespoke Rehabilitation and Low Secure Centre inpatient unit with sufficient capacity to include the required additional facilities such as therapy space, family room, educational suite, administration and the potential to provide secure outdoor space

9. **Provide no inpatient beds for either low secure or general rehabilitation in NHS Lothian**

   Transfer of all resources to community based teams and have no inpatient provision. Unlikely to meet statutory duties, but being considered as part of long listed options.

The following options were not taken forward for assessment as detailed below:

- Option 2 as does not meet the requirement set by Scottish Government, NHS Lothian, Mental Welfare Commission, Forensic Network, and the 2021 Independent review that Low Secure services should be provided in the patients local area
- Option 3 was discounted due to the existing capacity pressures on the acute sites in NHS Lothian
- Option 4 was discounted as there is no alternative accommodation on the REH site available that would meet the needs of this patient group
- Option 9 was discounted as the four Lothian IJBs have commissioned the beds required after extensive strategic planning to determine bed numbers required. There are also minimal bed numbers required to ensure there are safe places for people to be admitted to in an emergency.

**Table 6: Long Listed options (not discounted above)**

| Strategic Scope of Option | Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure | Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure | Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site | Option 8- New Build for both Rehabilitation and Low Secure on REH Site |
|---|---|---|---|---|
| Service provision | Low secure would be delivered on the REH site alongside rehabilitation, from mostly unsuitable accommodation | Low secure would be delivered from high quality facilities which have appropriate therapeutic and private space. Rehabilitation would be delivered from mostly unsuitable accommodation | Low secure would be delivered outwith the REH site alongside rehabilitation, from high quality facilities which have appropriate therapeutic and private space | Low secure would be delivered on the REH site alongside rehabilitation, from high quality facilities which have appropriate therapeutic and private space |
| Service arrangements | Low secure and rehabilitation would be delivered by NHS Lothian on their dedicated mental health site. Move to a more intensive, shorter length of stay model | Low secure and rehabilitation would be delivered by NHS Lothian on their dedicated mental health site. Move to a more intensive, shorter length of stay model | Low secure and rehabilitation would be delivered by NHS Lothian outwith their dedicated mental health site. Move to a more intensive, shorter length of stay model | Low secure and rehabilitation would be delivered by NHS Lothian on their dedicated mental health site. Move to a more intensive, shorter length of stay model |
| Service provider and workforce arrangements | NHS Lothian for both Low Secure and MH rehabilitation | NHS Lothian for both Low Secure and MH rehabilitation | NHS Lothian for both Low Secure and MH rehabilitation | NHS Lothian for both Low Secure and MH rehabilitation |
| Supporting assets | Rehabilitation and Low Secure would be delivered from adequate accommodation | Low Secure would be delivered from high quality, top specification accommodation. Rehabilitation would be delivered from adequate | Low Secure and rehabilitation would be delivered from high quality, top specification accommodation | Low Secure and rehabilitation would be delivered from high quality, top specification accommodation |

| Strategic Scope of Option | Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure | Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure | Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site | Option 8- New Build for both Rehabilitation and Low Secure on REH Site |
|---|---|---|---|---|
| | | accommodation | | |
| Public & service user expectations | Service user and public expectations would be met to an extent, because low secure care will be delivered on the REH site from refurbished accommodation | Service user and public expectations would be met to an extent, because low secure care will be delivered on the REH site from new accommodation | Service user and public expectations will be met to an extent, but services will not be delivered from a dedicated mental health site, therefore no benefitting from this co-location | Service user expectation would be met because there would be high quality, bespoke services which are delivered as close to home as possible |

## Initial Assessment of Options

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

***Table 7: Assessment of options against investment objectives***

| | Do Minimum | Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure | Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure | Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site | Option 8- New Build for both Rehabilitation and Low Secure on REH Site |
|---|---|---|---|---|---|
| **Advantages (Strengths & Opportunities)** | Smaller costs associated with this option. | The rehabilitation patients' service is refurbished to meet current standards and statuary requirements. | The rehabilitation patient's service is refurbished to meet current standards and statuary requirements<br><br>Provision of low secure within REH estate. | Newly build Integrated centre comprising of mental health rehabilitation and low secure.<br><br>Ending out of area care for low secure.<br><br>Meets Scottish Government health building requirement for the provision of single bedroom with en-suite facilities.<br><br>Consistent with the benefits register. | Newly build Integrated centre comprising of mental health rehabilitation and low secure.<br><br>Improving flexibility of the service(s) and patient flow.<br><br>Ending out of area care for low secure.<br><br>Meets Scottish Government health building requirement for the provision of single bedroom with en-suite facilities.<br><br>Consistent with the benefits register. |

| | Do Minimum | Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure | Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure | Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site | Option 8- New Build for both Rehabilitation and Low Secure on REH Site |
|---|---|---|---|---|---|
| **Disadvantages (Weaknesses & Threats)** | The current building is over 50 years old. Non-compliance with several current standards and statutory requirements. .e.g. minimal ventilation therefore unable to control air changes, electrics and heating in excess of 50 years old - parts now obsolete.<br><br>The costs of maintenance over the next 5-7 years are estimated £5m to £7m<br><br>Out of area care for those patients requiring low secure continues | To undertake refurbishment is estimated to take 12months plus. The rehabilitation service and patients would require to be decanted during this and there is no current decant facility.<br><br>Low secure provision would remain out of area.<br><br>The current building would not be able to be refurbished to provide individual bedrooms with en-suites.<br><br>The therapeutic basement of the current building would remain non-compliant with EA regulations as the structure cannot accommodate a lift.<br><br>The cost of the refurbishment is estimated | As per option 5 for rehabilitation service<br><br>The threat would be that there is no Suitable accommodation within the REH campus site to allow low secure provision to take place. | Lack of co-location with other mental health services which would reduce safety and increase staffing levels required.<br><br>Would not align with NHS Lothian's hospitals plan to move services away from the Astley Ainslie Hospital site and focus on the Royal Edinburgh Hospital. Patients often go from acute wards to rehabilitation wards, so there would be less continuity of care if they were transferred to another site which may be detrimental to their rehabilitation.<br><br>Lack of capital funding. | Lack of capital funding. |

| | Do Minimum | Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure | Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure | Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site | Option 8- New Build for both Rehabilitation and Low Secure on REH Site |
|---|---|---|---|---|---|
| | The current masterplan for the campus assumes that the existing building is demolished. | to cost in excess of 10 million.<br>Retaining the current building does not fit with the current master plan for the campus. | | | |
| | | | | | |
| Investment Objective 1 | No | Fully | Fully | Fully | Fully |
| Investment Objective 2 | Fully | Fully | Fully | Fully | Fully |
| Investment Objective 3 | Partial | Partial | Partial | Fully | Fully |
| Investment Objective 4 | No | Partial | Partial | Fully | Fully |
| Investment Objective 5 | No | No | Partial | Fully | Fully |
| Investment Objective 6 | No | Partial | Partial | Fully | Fully |
| Investment Objective 7 | No | No | Partial | Fully | Fully |
| Investment Objective 8 | No | No | No | Fully | Fully |

| | Do Minimum | Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure | Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure | Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site | Option 8- New Build for both Rehabilitation and Low Secure on REH Site |
|---|---|---|---|---|---|
| Investment Objective 9 | No | No | No | No | Fully |
| Investment Objective 10 | No | No | No | Partial | Partial |
| **Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)** | | | | | |
| Affordability | Yes | Unknown | Unknown | Unknown | Unknown |
| **Preferred/Possible/Rejected** | Possible | Possible | Possible | Rejected | Preferred |

# 3.4 Short-listed Options and Preferred Way Forward

## 3.4.1 Shortlisted options

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

**Table 8: Short Listed Options**

| Option | Description |
|---|---|
| Option 1 | Do minimum |
| Option 2 | Refurbishment to existing facilities for both rehabilitation and low secure |
| Option 3 | Refurbishment of existing services for Rehabilitation and new build for low secure |
| Option 4 | New Build |

## 3.4.2 Non-financial benefits assessment

Each of the shortlisted options was assessed against the benefits included in the benefits register in Appendix 3: Benefits Register and Non-Financial Benefits Assessment. Each of the identified benefits was weighted by a group of stakeholder representatives and following this each of the shortlisted options was scored against its ability to deliver the required benefits. The full assessment is contained in Appendix 3: Benefits Register and Non-Financial Benefits Assessment.

The results of the benefits assessment are summarised below:

***Table 9: Results of Non-Financial Benefits Assessment***

| # | Benefit | Weight (%) | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|---|---|
| 1 | A new integrated mental health rehabilitation /low secure centre will make the environment in which patients receive care and treatment more dignified and respectful of human rights by providing single bedroom with en-suite facilities and direct access to secure outdoor green space | 25 | 5 | 7 | 10 | 3 |
| 2 | Low secure care will be provided in NHS Lothian, preventing patients from being required to travel out of area. Provision of low secure facilities will improve continuity of care, maximising the ability of patients to engage in activities through fluctuations in their mental health | 25 | 8 | 10 | 10 | 0 |
| 3 | A well-designed building which has had input from | 10 | 6 | 8 | 10 | 5 |

| # | Benefit | Weight (%) | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|---|---|
| | clinical staff, patients, and carers will assist in the reduction of violence and aggression, self harm behaviours, missing persons and use of illicit substances | | | | | |
| 4 | The creation of a mental health rehabilitation and low secure service on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments | 5 | 6 | 8 | 10 | 0 |
| 5 | The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention | 15 | 7 | 9 | 10 | 4 |
| 6 | Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends and the improved ability of staff supported by improved access to health technology which provides continuity of care in one setting | 15 | 7 | 9 | 10 | 4 |
| 7 | A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site | 5 | 3 | 7 | 10 | 0 |
| **Total Weighted Benefits Points** | | **100** | 245 | 625 | 815 | 950 |

From the table above it is noted that the option that will deliver the most benefits is Option 4

### 3.4.3 Indicative costs

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

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

- A discount rate of 3.5% has been used in line with Government guidelines.
- A useful life of 29 years for refurbishment projects (Options 2 and 3), as this is in line with the remaining useful life of the Royal Edinburgh Buildings, a useful life for a new build has been determined as 50 years (Option 4).
- The base date for the proposal is September 2022.
- Phasing of the costs reflects the useful life and the programme of works as identified in the Commercial Case.

**Table 10: Indicative Costs of Shortlisted Options**

| Cost (£k) | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|
| Capital cost | 12,265 | 29,548 | 41,354 | 49,750 |
| Whole life capital costs | 9,941 | 23,948 | 33,514 | 40,291 |
| Whole life operating costs | 108,399 | 174,950 | 209,600 | 269,714 |
| **Estimated Net Present Value (NPV) of Costs** | **118,340** | **198,898** | **243,114** | **310,005** |

### 3.4.4 Overall assessment and preferred way forward

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

***Table 11: Economic Assessment Summary***

| Option Appraisal | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|
| Weighted benefits points | 245 | 625 | 815 | 950 |
| NPV of Costs (£k) | 118,340 | 198,898 | 209,600 | 269,714 |
| Cost per benefits point (£k) | 483 | 318 | 257 | 284 |
| **Rank** | **4** | **3** | **2** | **1** |

The preferred solution was identified as Option 4: New Build for Both Services on REH Site. This was identified as the preferred option because it ranked the highest it both the Non-Financial and the Economic Assessment. Option 4 delivers a greater number of the benefits that have been set out as the criteria for achievement from this project.

It is recommended that NHS Lothian proceeds with this option to Outline Business stage where the implementation of the solution shall be further developed and tested for value for money.

## 3.5 Design Quality Objectives

Design quality objectives have been developed for the preferred strategic / service option by taking the following steps:

1. An AEDET review of existing property arrangements has been undertaken to set a benchmark score from which change is needed.

2. A second multi-stakeholder AEDET review has been undertaken which has identified the main features the new proposal will need to focus on and has set a target score from which design expectations can be measured

3. Design objectives that explain what the design needs to achieve to improve on the existing arrangements have been outlined in the NDAP[11]Design Statement (see Appendix 5).

The AEDET worksheets provided in Appendix 5 demonstrate how the target for improvement has been set against the existing arrangements.



[11] NDAP is the mandated NHSScotland Design Assessment Process.

# 3 The Commercial Case

## 4.1 Procurement Strategy

The indicative cost(construction only) for the preferred option at this stage is £49.8m including VAT. It is anticipated that the procurement of the project will be led by NHS Lothian supported by Turner Townsend (technical advisers), Thomson Gray (cost advisers), and Burness Paull (legal advisers).

The project will be delivered in accordance with NHS Scotland construction procurement policy and it is anticipated that it will be undertaken in conjunction with Hub South East Scotland Ltd acting as NHSLothian's development partner.

## 4.2 Timetable

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

**Table 12: Project Timetable**

| Key Milestone | Date |
|---|---|
| Initial Agreement approved | October 2021 |
| Hub appointed | November 2021 |
| Outline Business Case approved | July 2022 |
| Planning permission in principle obtained | In place – expires March 2022 – would require extension |
| Full Business Case approved | December 2022 |
| Construction starts | February 2023 |
| Construction complete and handover begins | June 2024 |
| Service commences | July 2024 |

# 4 The Financial Case

## 5.1 Capital Affordability

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

**Table 13: Capital Costs**

| Capital Cost (£k) | Option 1: Do Minimum | Option 2 : Refurbishment of existing facilities for Rehab & Low Secure | Option 3: Refurbishment of existing facilities for Rehab and New Build for Low Secure | Option 4: New Build for both services on the REH Site |
|---|---|---|---|---|
| Construction | 7,000 | 14,226 | 19,909 | 25,892 |
| Inflation | 280 | 500 | 700 | 910 |
| Professional Fees | - | 1,724 | 2,413 | 3,138 |
| Furniture, Fitting & Equipment | 218 | 532 | 745 | 969 |
| IT & Telephony | 73 | 177 | 248 | 323 |
| Contractor Contingency & Risk | - | 1,293 | 1,810 | 2,354 |
| Optimism Bias | 2,650.00 | 6,459 | 9,039 | 8,396 |
| **Total Cost (excl VAT)** | **10,221** | **24,911** | **34,864** | **41,982** |
| VAT | 2,044 | 4,982 | 6,973 | 8,396 |
| VAT Recovery | | (345) | (483) | (628) |
| **Total Capital Costs** | **12,265** | **29,548** | **41,354** | **49,750** |

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

- Construction costs for Option 4 have been provided by independent quantity surveyors, their costs have then been used to estimate the costs for Options 2 and 3, which were given as a range, the upper of which has been assumed. Costs for option 1 were provided from the NHS Lothian Estates Manager for the Royal Edinburgh site.
- An inflation allowance of 4%, provided by NHS Lothian's external cost advisors, has been included using a base date of September 2022 and the construction timeline detailed in the Commercial Case. This allowance will need to be further refined as the project progresses due to the volatility in the market currently. **Table 14** includes a sensitivity analysis on Inflationary amount only due to this level of uncertainty.
- Professional fees are assumed to be 10% of the total Capital costs provided or estimated.
- Furniture, Fitting & Equipment has been estimated at 3% of total costs, based on another recent project. This has been included in Option 1 also as it would be expected that these items would also need replaced/upgraded in a 'Do Minimum' scenario.
- IT & Telephony has been estimated at 1% of total costs, based on another recent project. This has

been included in Option 1 also as it would be expected that these items would also need replaced/upgraded in a 'Do Minimum' scenario.

- Contractor Risk is included at 7.5% as advised by the independent quantity surveyors.
- Optimism bias calculated in line with SCIM guidance, it has been calculated and 25% for Option 4, and 35% for all other options due to the level of design already carried out for Option 4.
- VAT has been included at 20% on all costs. Recovery has been assumed on Professional Fees only – no further VAT recovery has been assumed. VAT recovery will be further assessed in the OBC.

### Inflation

Over the last twelve to eighteen months there has been a decline in the Tender Price Index (TPI) but a sharp rise in the Building Cost Index (BCI). This reflects the difficult economic conditions. This impact was initially felt by main contractors with fixed price contracts and, the cumulative pressure due to increased material prices. The knock-on effect has been transferred to the client side as contractors look to correct or offset the reduction in margin on existing contracts. When pricing new projects, contractors are inflating their prices (or are qualifying tenders) in order to return their margin to a manageable position and to offset the increase in building costs and risk. This will ultimately result in a rise in the TPI which will need to increase to a position above the BCI which could represent a large jump in inflation. It is unknown how long this fluctuation will last and what impact this will have on inflation.

The impact of the COVID-19 pandemic on future projects is still relatively unknown, the capital costs presented do not have an allowance for a programme extension. It would therefore be prudent to consider a possible impact on costs, should the programme have to be extended.

The sensitivity analysis below aims to set out the possible impact on the total project costs should inflation rise or reduce as well as an extension to programme.

**Table 14: Inflation & Programme Extension Sensitivity Analysis**

| | Total Capital Costs | | | |
|---|---|---|---|---|
| **Sensitivity Scenario** | **Option 1** | **Option 2** | **Option 3** | **Option 4** |
| Scenario 1: no changes (4%) | 12,265 | 29,548 | 41,354 | 49,750 |
| Scenario 2: inflation percentage doubles (8%)and programme extended (10 weeks) * | 11,795 | 30,696 | 42,804 | 55,549 |
| Scenario 3: inflation percentage halves (2%) | 11,137 | 28,856 | 40,382 | 52,518 |

** Programme extension and costs are estimated based on details provided by external advisors for another project.*

## 5.2 Revenue Affordability

The estimated recurring revenue costs associated with each of the short-listed options are detailed in the table below. These represent the total revenue costs required to support the project.

**Table 14: Incremental Revenue Costs**

| Revenue Cost/Funding (£k) | Option 1: Do Minimum | Option 2 : Refurbishment of existing facilities for Rehab & Low Secure | Option 3: Refurbishment of existing facilities for Rehab and New Build for Low Secure | Option 4: New Build for both services on the REH Site |
|---|---|---|---|---|
| MH Rehab Community Costs | 5,694 | 2,064 | 2,064 | 2,064 |
| Inpatient Costs | | 7,092 | 7,092 | 7,092 |
| Supplies Costs | | 216 | 216 | 216 |
| OOA Costs | | 460 | 460 | 460 |
| Facilities Costs | | 1,179 | 1,179 | 1,179 |
| Depreciation Costs | - | 1,094 | 1,530 | 1,154 |
| **Total Annual Revenue Cost** | **5,694** | **12,105** | **12,541** | **12,165** |
| Rehab Service Budget Release | 4,310 | 4,310 | 4,310 | 4,310 |
| Facilities Budgets | 1,384 | 1,384 | 1,384 | 1,384 |
| NHS Lothian Depreciation Budget | - | 1,094 | 1,530 | 1,154 |
| **Total Annual Revenue Budget** | **5,694** | **6,788** | **6,788** | **6,788** |
| **Funding Gap** | **0** | **(5,317)** | **(5,317)** | **(5,317)** |

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

- Inpatient costs a detailed bottom up exercise has been conducted with the Chief Nurse/General Manager and professional leads based on workforce requirementsfor the commissioned level of beds.
- Community costs are currently included as a proxy estimate equivalent to the bed reductions for rehabilitation (24 places at wayfinder model grade 5) however as the project progresses to OBC these will be refined as community services move to a detailed commissioning stage.
- Non pay costs are based upon the current Braids ward non pay costs (rehabilitation ward within REB).
- Facilities costs are based on the Royal Edinburgh Phase 1 building.
- Rehabilitation funding (existing ward budgets) Depreciation is based on a useful life of 29 years for Option 2 and 3, and 50 years for Option 5 and assumed to be funded from the existing NHS Lothian Depreciation funding allocation. Depreciation excluded in Option 1 as already forms part of Depreciation cost for the Royal Edinburgh Buildings.

Additional one-off revenue costs associated with commissioning of the project have yet to be identified and costed. One off costs are likely to relate to start-up costs for community accommodation commissioned by Integration Joint Boards. Discussion is ongoing in partnership with Integration Joint Boards around potential solutions to support the community start up costs. One such action is the potential application of the community living change fund against these double running costs. The community living change fund totals £3.1m of non recurring funding across the Lothian Integration Joint Boards and was allocated by Scottish Government to support the discharge from hospital of people with complex needs.

Funding has been identified for the additional revenue costs from the NHS Lothian out of area budget. Although the financial model shows a gap of £5.3m against available funding there is a £5.9m

planned release from the out of area budget in total which has not been included. The release from the out of area budget is achieved from the creation of a Low Secure Mental Health facility on the Royal Edinburgh Campus. However this planned release underpins both planned developments on Campus - Learning Disabilities and Mental Health Low Secure and Rehabilitation. Overall both initial agreements present a joint financial gap of £5.9m which is equivalent to the planned release from the out of area budget. In totality once the out of area budget has been released both initial agreements are affordable on a recurring basis.

If the Learning Disabilities project progresses first there will be a challenge around release of the out of area budget as patients will still require to be placed out of area for Low Secure Mental Health inpatient care. Current projections for the out of area budget forecasts a £0.6m underspend for the next few years so if Learning Disabilities progresses ahead of the Mental Health and Low Secure and Rehabilitation case the underspend on the out of area placements can be used to balance the Learning Disabilities financial model. This has been agreed with Chief Officers from each of the Lothian Integration Joint Boards.

Revenue affordability has been reviewed and agreed by the Finance Business Partner (Hamish Hamilton, Finance Business Partner (interim) REAS & West Lothian HSCP). These costs have been reviewed in detail with the Chief Finance Officers of each Lothian Integration Joint Board and Chief Officers also receive regular updates on the financial modelling associated with this initial agreement.

Revenue costs will continue to be refined through the OBC process.

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

## 5.3 Overall Affordability

The capital costs detailed above are predicted to be funded through traditional capital funding. This project has been prioritised by NHS Lothian and each of the four Lothian Integration Joint Boards and the estimated costs noted above are included in the NHS Lothian Property and Asset Five Year Investment Plan.

Funding has been identified for the additional revenue costs from the out of area budget and these have been reviewed and agreed by the Finance Business Partner (interim) Hamish Hamilton and agreed in partnership with Chief Finance Officers of each Lothian Integration Joint Board. The joint projected gap of £5.9m across this initial agreement and the Learning Disabilities project can be funded in full through the release of the out of area budget. In the scenario that Learning Disabilities progresses first the operational financial risk can be mitigated from the existing out of area budget.

All costs will continue to be refined through the OBC process.

# 5 The Management Case

The purpose of the Management Case is to demonstrate that NHS Lothian is prepared for the successful delivering of this project.

## 6.1 Readiness to proceed

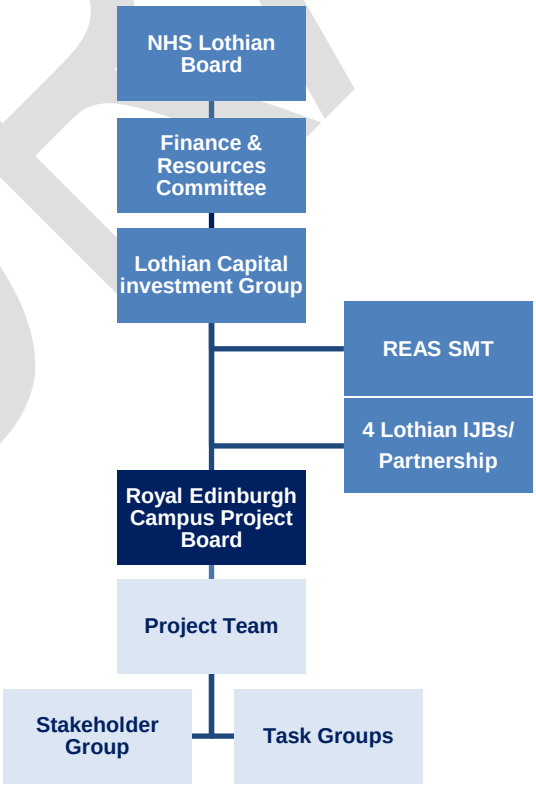
A benefits register and initial high level risk register for the project are included in Appendix 3: Benefits Register and Appendix 4: Risk Register. Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

NHS Lothian is ready to proceed with this proposal and is committed to ensure the necessary resources are in place to manage it. Section 0 outlines the governance support and reporting structure for the proposal and section430details the project management arrangements.

## 6.2 Governance support for the proposal

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

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



## 6.3 Project Management

The table below identifies key members of the project team and the REH Programme Management Board that will be responsible for taking the project forward; the table includes details of individuals' capabilities and previous experience.

**Table 15: Project Management Structure**

| Role | Individual | Capability and Experience |
|---|---|---|
| Project Sponsor and Project Management Board Chair | Professor Alex McMahon<br>Executive Director, Nursing, Midwifery and Allied Healthcare Professionals<br>Executive Lead, REAS and Prison Healthcare | Starting his career as a qualified nurse in 1986, Alex has worked in both the public and private sectors, including time with the Royal College of Nursing and as Nursing Advisor for Mental Health and Learning Disabilities in the Scottish Government. In 2009 he received an Honorary Chair from the University of Stirling for his work in mental health and nursing. Alex chairs the REH Programme Management Board and is ultimately responsible for the project and its overall business assurance i.e. ensuring that it remains on target to deliver the outcomes that will achieve the anticipated business benefits and that it is delivered within its agreed budget and timescale tolerances |
| Senior User and Project Management Board Deputy Chair | Tracey McKigen, Services Director, Royal Edinburgh and Associated Services | As Senior User Tracey is accountable for ensuring that requirements have been clearly defined in the Clinical Brief and that the proposed development is fit for purpose and fully meets user needs. Following the principles of PRINCE2, the Senior User has primary responsibility for quality assurance and represents the interests of all those who will use and operate the new facilities.<br><br>As REAS Service Director, Tracey has a deep understanding of the clinical and support needs of the services delivered from the REH. She has also held a number of other senior management roles in the NHS |
| Strategic Planning | Nickola Jones, Strategic Programme Manager | Previous experience of NHS capital projects |

| Role | Individual | Capability and Experience |
|---|---|---|
| Project Manager | Steve Shon, Senior Project Manager, Capital Planning | Steve has worked within NHS Capital Planning since 1998 managing and co-ordinating all aspects of the procurement of major new health facilities, from preparation of business cases through to commissioning. In terms of procurement, he has been involved in traditional, D&B, and PFI schemes and is now working on Hub developments, including the redevelopment of the Royal Edinburgh Hospital. Previous projects have ranged from small Learning Disabilities houses, through Care of the Elderly facilities, to the redevelopment of the State Hospital at Carstairs |
| Capital Finance Support | Laura-Jane Smith | Experience supporting capital investment projects |
| Finance Business Partner | Hamish Hamilton | Previous experience at Senior Manager level in similar projects |
| Service Lead | Andrew Watson | Associate Medical Director for the Royal Edinburgh Hospital and Associated Services |
| Service Lead | Karen Ozden | Chief Nurse for the Royal Edinburgh Hospital and Associated Services |
| Partnership Representative | To be confirmed | Dependant on appointee |

The project's external advisers are:

- Turner and Townsend- Technical Adviser
- Burness Paull - Legal Adviser
- Thomson Gray - Cost Adviser

# 6 Conclusion

This proposal is a significant priority for NHS Lothian and the four Lothian IJBs as it realises national advice to provide Low Secure locally and will improve the quality and dignity of care for patients receiving mental health rehabilitation.

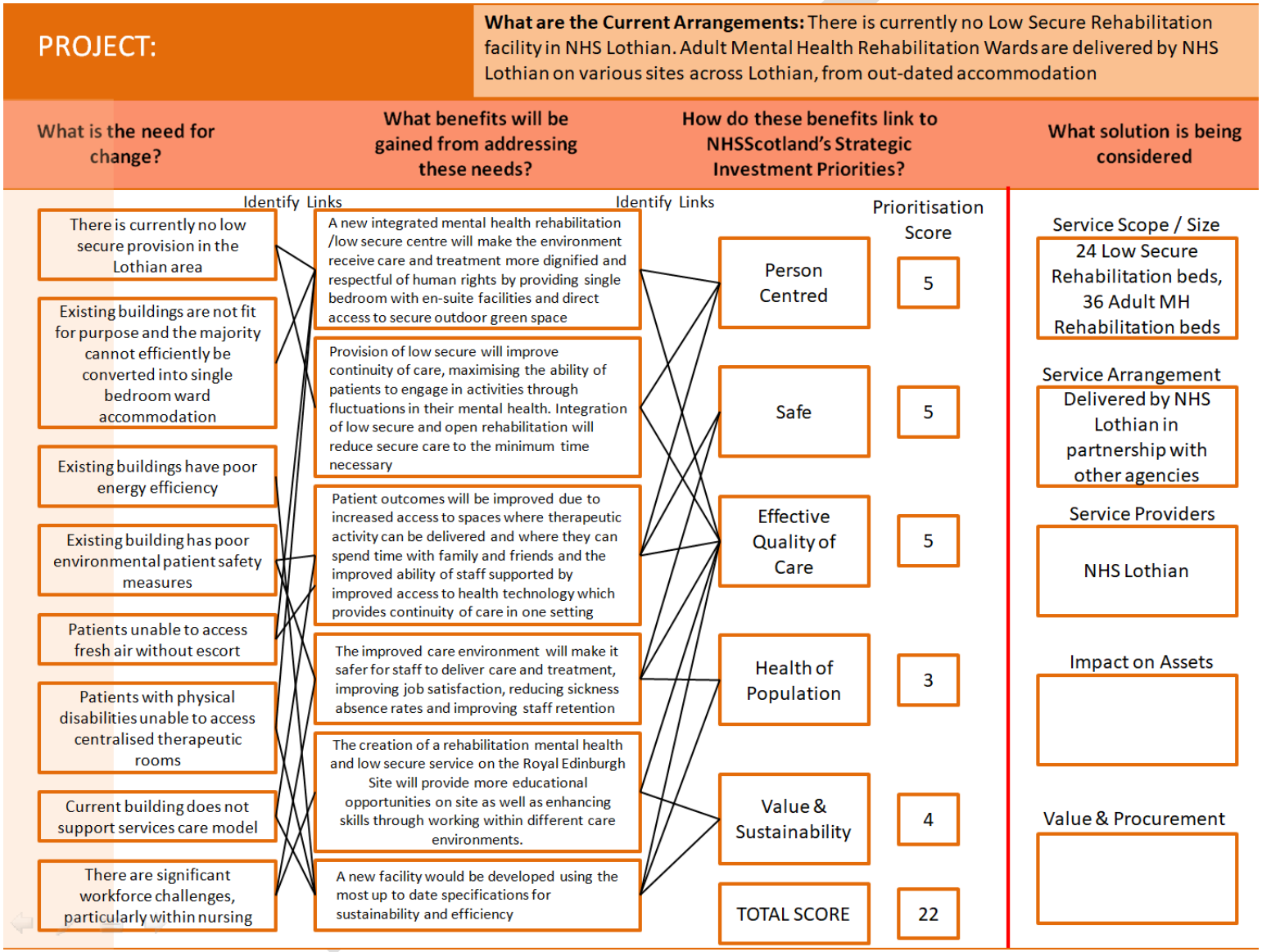
At the centre of this case is a desire to provide the best quality of care to those who require mental health care in NHS Lothian. Having to receive care out of area is detrimental to our patient's wellbeing and recovery, as is receiving care in a poor quality environment. Additionally, staff should be delivering care from environments that they are proud to work in, not from environments that they have to work around. This case provides an opportunity to create an innovative facility which is able to provide the flexibility required to care for patients in the least restrictive way possible.

This IA makes a compelling case for investment which would further the Scottish Government's ambitions to provide parity between physical and mental health care and to provide care as close to home as possible.

# Appendix 1: Pictures of Current Mental Health Rehabilitation Wards

To be added.

# Appendix 2: Strategic Assessment



# Appendix 3: Benefits Register and Non-Financial Benefits Assessment

## *Benefits Register*

| Project Name | | | | | | |
|---|---|---|---|---|---|---|
| *1. Benefits Register* | | | | | | *2. Prioritisation* |
| **Ref No.** | **Benefit** | **Assessment** | **As measured by** | **Baseline Value** | **Target Value** | **Relative Importance** |
| 1 | A new integrated mental health rehabilitation/low secure centre will make the environment in which patients receive care and treatment more dignified and respectful of human rights by providing single bedroom with en-suite facilities and direct access to secure outdoor green space | Quantitative | % of bedrooms with en-suite bathrooms | 6% | 100% | 5 |
| 2 | Low secure care will be provided in NHS Lothian, preventing patients from being required to travel out of area for treatment. Provision of low secure facilities will improve continuity of care, maximising the ability of patients to engage in activities through fluctuations in their mental health | Quantitative | No. Of patients out of area for Low Secure care | 23 | 3 | 5 |
| 3 | A well-designed building which has had input from clinical staff, patients, and carers will assist in the reduction of violence and aggression, self harm behaviours, missing persons and use of illicit substances | Quantitative | Average number of Datix incidences per month | 60 | 30 | 4 |
| 4 | The creation of a mental health rehabilitation and low secure service on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments | Quantitative and Qualitative | Staff feedback | Limited appropriate space for education | Staff say they have good opportunities for learning and development | 3 |
| 5 | The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention | Quantitative and Qualitative | % Of staff vacancies, sickness absence rate | Vacancies = 40%, Sickness rate = 10% | Vacancies = 5%, Sickness rate = 5% | 4 |
| 6 | Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends and the improved ability of staff supported by improved access to health technology which provides continuity of care in one setting | Quantitative | Average Length of stay (days) | 317 | TBC | 4 |
| 7 | A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site | Quantitative | Monthly cost of maintenance and energy | TBC | TBC | 3 |

## *Non Financial Benefits Assessment*

| # | Benefit | Weighting (%) | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|---|---|
| 1 | A new integrated mental health rehabilitation /low secure centre will make the environment in which patients receive care and treatment more dignified and respectful of human rights by providing single bedroom with en-suite facilities and direct access to secure outdoor green space | 25% | 3 | 5 | 7 | 10 |
| 2 | Low secure care will be provided in NHS Lothian, preventing patients from having to recieve care out of area. Provision of low secure facilities will improve continuity of care, maximising the ability of patients to engage in activities through fluctuations in their mental health | 25% | 0 | 8 | 10 | 10 |
| 3 | A well-designed building which has had input from clinical staff, patients, and carers will assist in the reduction of violence and aggression, self harm behaviours, missing persons and use of illicit substances | 10% | 5 | 6 | 8 | 10 |
| 4 | The creation of a mental health rehabilitation and low secure service on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments | 5% | 0 | 6 | 8 | 10 |
| 5 | The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention | 15% | 4 | 7 | 9 | 10 |
| 6 | Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends and the improved ability of staff supported by improved access to health technology which provides continuity of care in one setting | 15% | 4 | 7 | 9 | 10 |
| 7 | A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site | 5% | 0 | 3 | 7 | 10 |
| | **Total Weighted Benefits Points** | | **245** | **625** | **815** | **950** |

# Appendix 4: Risk Register

| 1. Identification | | | 2. Assessment | | | | 3. Control | | 4. Monitoring | |
|---|---|---|---|---|---|---|---|---|---|---|
| Risk No | Risk Grouping | Risk Description | Financial / Non-Financial / Unquantifiable | Consequence (1 - 5) | Likelihood (1 - 5) | Risk | Proposed Treatment / Mitigation | Action Taken | Risk Owner - Type | Risk Owner - Individual |
| 1.1 | **Business risk** | If new build then - Impact of build on capacity – occupancy, clinical space, patient mix | | 2 | 5 | **High** | Traffic management throughout site, sound barriers | | | |
| 1.2 | **Business risk** | If refurb then - Impact of build on capacity – occupancy, clinical space, patient mix | | 5 | 5 | **Very High** | Consider decant facilities and relocation of patients to reduce impact on patients. Traffic management throughout site, sound barriers | | | |
| 1.3 | **Business risk** | Poor stakeholder involvement results in a lack of support for the project | | 4 | 1 | **Medium** | Prepare and implement an appropriate project communication plan which engages with all appropriate stakeholders at appropriate stages of the project | | | |
| 2.1 | **Reputational risk** | Poor communication ignores stakeholder interests | | 4 | 1 | **Medium** | Ensure that the project communication plan covers issues of public perception / consultation feedback / media interest / parliamentary interest / organisational reputation, etc | Communication plan in place which was agreed by project board. Project update newsletters were shared and will start again | | |
| 3.1 | **Demand risk** | Demand for the service does not match the levels planned, projected or presumed | | 2 | 2 | **Medium** | Carry out sensitivity testing of assumptions behind service demand projections to understand and manage any underlying risks. Existing facilities could be used if demand was higher than planned, with revenue costs associated. NHS Lothian funding Braids | | | |
| 4.1 | **Occupancy risk** | Patient discharges to reduce to new bed base – availability of robust community placements that are sustainable | | 4 | 3 | **High** | Work ongoing to identify alternative community provision to reduce bed numbers. | Edinburgh work on supported accomodation | | |
| 4.2 | **Operational risk** | IJB strategic direction may change – they may decide to provide elsewhere or change numbers – may make the project not viable – need project board to collectively own and absolutely agree the final bed numbers | | 5 | 2 | **High** | IA will be agreed across all areas, which should mean future changes are limited | | | |
| 4.3 | **Operational risk** | Potential changes to delegation schemes of IJBs – may change decision making | | 3 | 3 | **Medium** | | | | |
| 4.4 | **Operational risk** | Recruitment to the units | | 4 | 4 | **High** | Have added the Low Secure unit into the projected nurses required for nurses in training to government colleagues. Currently exploring how to skill make to make best use of qualified staff. Reduction in rehab bed numbers should create some nursing capacity | | | |
| 4.5 | **Operational risk** | Low secure will be a new service so training will need to be undertaken to up skill staff | | 3 | 1 | **Low** | Medium secure care is already delivered on the site so there is local expertise that can be shared | | | |
| 5.1 | **Planning risk** | Local community objects to the project | | 4 | 1 | **Medium** | Engage with local communities to gain their support for proposals re new site developments. Planning permission in place until March 2022 | | | |

| 1. Identification | | | 2. Assessment | | | | 3. Control | | 4. Monitoring | |
|---|---|---|---|---|---|---|---|---|---|---|
| Risk No | Risk Grouping | Risk Description | Financial / Non-Financial / Unquantifiable | Consequence (1 - 5) | Likelihood (1 - 5) | Risk | Proposed Treatment / Mitigation | Action Taken | Risk Owner - Type | Risk Owner - Individual |
| 6.1 | **Design risk** | The design does not meet the Design Assessment expectations. | | 4 | 1 | **Medium** | Get the building specifications right and the contractors decisions to make the building fit for purpose, both in terms of robustness and the physical environment – risk to patients. This will be captured in the clinical brief. The design team need to engage with the Design Assessment team from early design planning stages onwards to avoid confusion over expectations. Robust learning from previous projects | Pathfinder work is already underway for this project, with a focus on meeting energy and carbon aims | | |
| 7.1 | **Procurement risk** | Availability of contractors to complete the project | | 4 | 2 | **Medium** | Procured through Hub - experienced contractor in place | | | |
| 8.1 | **Construction risk** | Critical programme dates are unrealistic | | 4 | 2 | **Medium** | A realistic project programme will be developed with Hub - however, there may be an impact of the Covid-19 pandemic | | | |
| 8.2 | **Construction risk** | Unforseen issues with grounds | | 4 | 1 | **Medium** | | | | |
| 9.1 | **Funding risk** | The project estimate is poorly prepared and inaccurate | | 5 | 2 | **High** | High optimism bias built in to cost estimates, worked closely with Hub to develop | | | |
| 9.2 | **Funding risk** | The project becomes unaffordable | | 5 | 2 | **High** | The affordability of the project should be tested at IA stage and further explored as part of the OBC and FBC stages of the project | | | |
| 9.3 | **Funding risk** | Capital Availability – at SG level – having robust alternative options | | 5 | 4 | **Very High** | Work with SG | | | |
| 9.4 | **Funding risk** | Revenue affordability – if more beds required, increased costs for staffing, availability of staffing. Costs of out of area if we do not have enough beds – and out of area budget being used to cover costs of the revenue relating to the IA | | 3 | 1 | **Low** | Model developed across Lothian to support bed base. Linkwith IJBs to establish process if demand is higher. UNPACS budget used to offset additional costs of bringing people back from out of area | | | |
| 10.1 | **Economic risk** | Inflation costs rise above those projected | | 5 | 2 | **High** | The likelihood of this occurring is considered as part of the Financial Case. Optimisim bias within estimated costs includes an allowance for increased inflation | | | |
| 11.1 | **Policy risk** | Changes to non-legislation policy affects project cost or progress | | 3 | 2 | **Medium** | The likelihood of this occurring should be considered as part of this risk register | | | |
| 12.1 | **Legislative risk** | Changes in legislation or tax rules increase project costs | | 5 | 1 | **Medium** | Most recent legislative changes relating to carbon included in initial design | | | |

# Appendix 5: AEDET (Achieving Excellence Design Evaluation Toolkit) Evaluation Summary

Provided as a separate document due to file size.

# Appendix 6: Pictures of Current MH Rehabilitation Wards

Provided as a separate document due to file size.

East Lothian
Integration Joint Board

**SBAR – IJB Annual Performance Report 2020 – 2021** **5**

**Date:** 28th October 2021
**Completed by:** Hannah Gray
**Area:** Planning and Performance

| | |
|---|---|
| **Situation** | In April 2021, in view of continuing service pressures, the Scottish Government made the decision to extend the Coronavirus Scotland Act 2020. In respect of this, Integration Joint Boards were allowed, if necessary, to extend the date of publication of Annual Performance Reports (APRs) from July 2021 to November 2021. |
| **Background** | The Public Bodies (Joint Working) legislation requires Integration Joint Boards to publish an APR covering the period 1st April to 31st March by the end of July each year. These reports are primarily intended to inform the local community of service delivery and developments and attainments in the preceding year.<br><br>There have been many impacts of COVID-19 on East Lothian HSCP and numerous reporting requirements to Scottish Government and other partners have affected scheduled work. In light of this, and as a result of COVID-19 pressures on East Lothian HSCP services and infrastructures, the Planning and Performance Team gained IJB approval to extend the deadline for the 2020-21 report to November 2021. |
| **Assessment** | The East Lothian IJB Annual Report for 2020-21 describes performance over the year from 1st April 2020 to the 31st March 2021. It includes elements of the Scottish Government's Core Suite of 23 National Integration Indicators, first published in 2015. It also reflects on the Ministerial Strategic Group for Health and Social Care additional indicators. Between them, these indicators provide a means for Health and Social Care Partnerships to measure progress in delivering the National Health and Wellbeing Outcomes.<br><br>The APR also sets out financial performance. As in previous years, East Lothian IJB received a financial allocation from its partners, East Lothian Council and NHS Lothian for the functions delegated to it. For 2020-21, East Lothian IJB had a budget of just under £193m and ended the year with an underspend of £7.2m.<br><br>The APR reflects on the management of responses to the complex and rapidly evolving challenges presented by COVID during the year. This required a high degree of coordination and agility by the HSCP and flexibility and dedication across all staff groups.<br><br>It is intended to produce a version of the APR targeted at the public. This will be in summarised form, designed to be more accessible and inclusive of images and 'infographics' and will assist the reader in interpretation of performance data. |
| **Recommendations** | East Lothian IJB is asked to:<br>• Accept the Annual Performance Report for 2020-21.<br>• Recognise the achievements of East Lothian HSCP and individual services during a uniquely challenging year.<br>• Commend the contribution made by staff, volunteers, communities and partner organisations.<br>• Agree a summary Annual Performance Report should be produced. |
| **Further information** | Coronavirus Act extension legislation can be accessed here. |

# DRAFT

## East Lothian Integration Joint Board

## Annual Performance Report 2020-21

# Contents

## Foreword

This report covers a year where most of us faced significant changes to how we lived our daily lives. As an organisation at the forefront of delivering essential local health and social care services, these changes presented us with particular challenges. Throughout the year, our services adapted and evolved to work in partnership to continue to provide key services to those in need.

Whilst we were making good progress previously, our collective response to COVID has provided a further catalyst for integration and partnership working.

You will read about the immense effort and commitment of our staff throughout this report. Staff working collaboratively across existing teams, services and organisations has been a crucial factor in our efforts to respond to the pandemic. We owe our staff a huge debt of gratitude.

We must also acknowledge the work of the range of third sector and independent sector organisations who provide vital services to some of our most vulnerable local residents. We recognise that this has been a hugely challenging year for them, and value their flexibility, hard work and commitment in the face of this. We are also grateful for the support of East Lothian Council and its staff in planning and in delivering practical assistance and support to those requiring to shield and in assisting with the administration of our vaccination centre.

Many of the new ways of working and delivering services developed during 2020-21 have resulted in a real step-change in service development. For example, the need to find alternative ways to deliver adult day services resulted in the development of new, innovative approaches based on building strong community connections and supporting people to participate in their local communities.

Similarly, COVID restrictions meant that many new and existing services relied heavily on telephone and online appointments instead of seeing patients face-to-face. This proved to be a quick, accessible and effective approach to delivery, resulting in excellent outcomes for many patients and helping to overcome some of the impacts of East Lothian's geography and dispersed communities.

Last year's Annual Report, highlighted the opening of East Lothian Community Hospital (ELCH) as an exciting new local development. Since its opening, the number and range of services available at the hospital has expanded, helping to deliver one of our key ambitions of providing health services as close to home as possible for East Lothian residents. ELCH also played a central role in our COVID response, acting as a hub for PPE and COVID tests supply, before becoming the home of the East Lothian COVID Vaccination Centre.

Even with the challenges presented by a global pandemic, we continued to make good progress during 2020-21 in delivering our strategic objectives. The following report describes our progress and presents key data demonstrating our performance over the year.

| | |
|---|---|
| **Peter Murray** | **Alison Macdonald** |
| **IJB Chair** | **Chief Officer** |

# Managing the COVID-19 response in 2020-21

Whilst presenting the HSCP with additional and complex challenges, the impact of COVID in the period this annual report covers has also accelerated some of the developments already planned to deliver the IJB's strategic objectives (which are set out on page 44).

The introduction of new ways of working, including the use of online platforms and other technology to support people and manage services, will help to make services more sustainable in the longer term, as well as giving people more flexibility, choice and control while reducing the need to travel.

Providing services for people with complex needs in their local community rather than as part of building-based service has also been a key feature of our COVID response and has helped to inform the continued development of our Transformation Programme. This proposes new models for the delivery of community provision, involving local communities and with reduced reliance on traditional health and social care services – you can read more about this on page 19.

Managing the response to the complex and rapidly evolving challenges presented by COVID during the year required a high degree of coordination and agility by the HSCP. Systems were put in place in the very early stages of the pandemic to support our response, including:

- A 'daily update' reporting procedure was introduced in March 2020 and continued into 2020-21. This ensured the HSCP management team could maintain a clear overview of the situation; this was particularly important in terms of identifying emergent risks. Daily update reports were required from all services, covering a range of operational matters, including staffing, personal protective equipment (PPE - such as masks, gloves and aprons) supplies, risks and actions.
- Systems were put in place to manage the flow of information and guidance to and from the Partnership. This included setting up a central, online repository for COVID related communication and documentation.
- COVID Management Briefings took place daily, bringing the management team together to monitor the situation and to manage a collective response. These meetings reduced in regularity as the situation became more stable, but with the option to step them up to daily again if needed.
- An Audit Governance Log was developed to record ELHSCP decisions made in response to COVID. The Log included details of the rationale behind each decision; who was consulted; who made the decision; and any expenditure involved.
- Communication with staff was key from the outset, with 'Alison's Blog' updates from the Chief Officer playing an important role in communicating the latest information and advice and allowing a two-way dialogue with staff.

## COVID Vaccination Programme

East Lothian Community Hospital (ELCH) became home to the East Lothian COVID Vaccination Centre in February 2021, set up to supplement the work of the Mass Vaccination Centres in Edinburgh. The East Lothian Centre was developed in the existing foyer of ELCH and includes individual vaccination pods and a post-vaccine observation area.

A dedicated clinical and administrative team was established to develop, manage and deliver the East Lothian COVID Vaccination Programme. Since the start of the programme, the team has made excellent progress, keeping pace with national priority targets. The success of the programme has been made possible by the hard work and commitment of HSCP staff, East Lothian Council staff, partner organisations and hospital and Volunteer Centre East Lothian (VCEL) volunteers.

> 'This is the biggest vaccination programme in history and involves a massive and coordinated team effort from our staff and the community to deliver this as quickly and safely as possible'
>
> Krista Clubb, Primary Care Vaccination Service Manager

East Lothian COVID Vaccination Programme facts and figures:

- East Lothian staff vaccinations commenced on 8th December 2020, by 31st December **1,441** staff had received their first vaccine.
- Between 1st January 2021 and 31st March 2021, **1,619** first dose vaccinations and **2,027** second dose vaccinations were delivered to staff.
- **2,249** Care Home staff and residents were vaccinated between 17th December and 31st March.
- GP surgeries vaccinated **14,882** patients aged 75 years and over and patients identified as extremely clinically vulnerable.
- The mass vaccination programme commenced at East Lothian Community Hospital on 1st February 2021, by the end of March, the team had vaccinated **14,888** patients.
- **Equating to over 37,000 COVID vaccinations delivered in East Lothian in less than 4 months.**

## Additional Hospital Beds in East Lothian Community Hospital

As part of the COVID response, ELCH was able to offer an additional 44 beds in two unoccupied wards. This additional capacity was used flexibly as part of the remobilisation plan during the first and second waves of COVID. This helped to provide welcome resilience to respond to any surge in demand for acute in-patient beds across the Lothians or local community need.

## COVID Assessment Hub at Musselburgh Primary Care Centre

In April 2020, a COVID-19 Assessment Hub opened in Musselburgh as part of NHS Lothian's regional strategy for managing the assessment of people with possible coronavirus infection. Mobile testing units were also set up to help identify positive cases.

# Working in partnership

## Supplying PPE and Lateral Flow Tests

A PPE (Personal Protective Equipment) Hub was set up at East Lothian Community Hospital (ELCH) in April 2020 to provide PPE for health and social providers, Personal Assistants and unpaid carers / families. The Hub played a vital role in ensuring that individuals and organisations had access to suitable and sufficient PPE, particularly in the early months of the pandemic when resources were scarce and supply lines were being set up.

A dedicated order line and email drop box were set up, as was a PPE delivery service. The Hub was also able to offer supplies out of hours in an emergency.

PPE facts and figures - by the end of 2020-21:

- Approximately 280 local organisations had made use of the Hub to access essential PPE supplies.
- Around 1,000,000 masks; over 4,000,000 pairs of gloves; 95,000 aprons; and just under 300,000 visors had been supplied by the Hub.
- This amounted to nearly 6,000,000 items of PPE in total.

In the later months of 2020-21, ELCH also became the distribution Hub for Lateral Flow Test (LFT) kits. ELCH's experience of managing the PPE Hub meant that it was ideally placed to take on this additional task. Training, guidance and distribution of LFT kits was quickly arranged for 146 staffing groups, involving almost 1,700 staff.

## Supporting the Shielding Population

A multi-agency group was set up in the early stages of the COVID pandemic to support people needing to shield. This group included staff from key Council and HSCP services and met daily initially, reducing to weekly and then monthly as progress was made.

An Action Plan was quickly developed and continued to evolve in response to the rapidly changing landscape, reflecting new developments in legislation and guidance. Council and HSCP staff were redeployed to work together to support the delivery of priority actions contained in the Plan.

Local Community Resilience Groups also played a key role in supporting shielding individuals, with local volunteers providing practical support including the delivery of food and other essentials.

Over time, the group's focus shifted to a broader 'Care for People' remit, linking with national 'Care for People' activity to respond to the needs of people at highest risk, rather than just those required to shield.

## Commissioned Community Support

ELHSCP commissions a range of Community Support services, including advocacy; support for carers; community link workers; mental health services; older people's day services; dementia services; drug and alcohol services; sensory impairment; and volunteer developments. Housing support services were also commissioned in 2020-21.

## Independent Advocacy

ELHSCP has a legislative duty to make independent advocacy available[1]. The Partnership is strongly committed to ensuring that there is sufficient provision of independent advocacy that it is easy to access; and that information on advocacy services is readily available.

In 2020-21, following a needs assessment, we allocated additional funding for independent advocacy for adults with autism, adults with physical disabilities and for people with alcohol and substance use issues. Our existing independent advocacy providers – Partners in Advocacy, EARS and CAPS were commissioned to take this work forward. We contracted on a 2-year basis to help establish continuity in the services and will look to provide an extended contracting period in future years.

## Mental Health Services

ELHSCP commissions a number of organisations to provide community services, care at home and rehabilitation services to people needing support with mental health issues. During the pandemic we worked closely with these organisations to help ensure the safety and wellbeing of clients.

In the early stages of the pandemic, risk assessments were carried out for all clients, with each individual assessed for their level of vulnerability and need. This allowed those who were most vulnerable to be identified and additional support quickly provided.

A weekly forum brought colleagues together from provider organisations and statutory services to enable them to provide mutual support and to share information. ELHSCP facilitated access to training on infection prevention and control and use of PPE.

ELHSCP staff maintained frequent contact with providers, offering support, information and advice, and allowing emergent issues to be identified and quickly addressed.

## Mental Health Review

Since the pandemic, we have seen increased demand across adult mental health and substance use services. There have also been significant increases in referrals for adults with neurodevelopmental disorders

It has also been reported in some clinical areas that people are not coming forward and seeking help for their mental health until the acuity level is very high or they are in crisis.

[1] Under the Mental Health (Care and Treatment)(Scotland) Act 2003

Those that need more specialist care are generally more unwell, which has put our Intensive Home Treatment Service and inpatient services under considerable pressure.

ELHSCP commissioned a review of Adult Mental Health services in 2020, in partnership with staff and stakeholders to ensure that East Lothian Mental Health Services:

- Reflect national strategic direction and guidance, with a focus *on 'access to care and treatment and integrated accessible services'* to ensure people living in East Lothian get the right help at the right time.
- Are well placed to meet the challenges presented by the COVID-19 pandemic, including responding to the longer term impact of COVID-19 on the population
- Are able to respond to the changing operational context resulting from the Redesign of Urgent Care.

Feedback and themes arising from the review were collated and fed back to staff, and work initiated to explore options and to clarify roles and functions in order to implement improved service delivery.

## Support for Adults under 65 with Complex Needs

At the start of the pandemic, services providing support to adults under 65 with complex needs carried out risk assessments for all their service users, to assess their level of vulnerability. This enabled social work colleagues to identify individuals most in need of additional care and support in the community.

Working under COVID restrictions, whilst trying to support service users and their families at a particularly challenging time, placed a huge demand on providers. ELHSCP maintained close contact with providers throughout the year to ensure that they were supported in this role. In the early stages of the pandemic, providers submitted daily situation reports, moving to weekly reports as time progressed. These reports covered issues relating to staffing, PPE and other resources, as well as any concerns in relation to individual service users which were escalated via adult social work if required.

Centres were operating for people with critical needs only, but with outreach support being provided to other service users. Providers quickly developed alternative approaches to more traditional, centre-based support.

Responding to COVID has required flexibility and creativity from all those involved in service delivery. This has brought some valuable learning which is helping to shape plans for service redesign.

## Older People's Day Centres

Older People's Day Centres were also forced to close as a result of COVID, and again providers responded flexibly to provide support to people on an outreach basis. As with other services, individuals' risk levels were assessed to help identify those most in need of support.

The Council's Connected Communities service, local resilience groups, and other third sector groups also helped deliver a range of valuable outreach activities for this group of service users.

Once more, the experience of responding to COVID is helping to shape development of the HSCP's Transformation Programme.

## Care at Home

Working with our commissioned Care at Home providers was also a priority during 2020-21. Again, we maintained close communication with providers, requiring updated business continuity plans and regular situation reports from them, allowing us to identify and respond to any emergent issues. We also supported providers with PPE through the provision of emergency supplies and by providing advice and training on its use.

We developed a process to make Social Care Provider Sustainability Payments (totalling £1.565m) to all our commissioned social care services, helping to provide a level of financial sustainability for the third sector.

## Funding Voluntary and Community Organisations

ELHSCP provides over £1million in funding to voluntary and community organisations through a number of different funding streams. The funding is used support core services and statutory services as well as project-based initiatives related to adult services.

ELHSCP introduced a formal grants process following recommendations from East Lothian Council's Internal Audit and Procurement Board in 2019. A new process was agreed and used to administer grants from April 2020, with the process published on East Lothian Council's website to encourage wider applications. The funding available for allocation was just over £25,000.

We received a total of 8 applications in 2020/21 – two applications from existing providers and six from new applicants.

We recognise that the current budget is relatively small and are looking to increase the amount available in the future to help encourage innovation and increase the number and range of services we can support.

## Communication and Engagement

We know that health and social care services are of huge importance to local people and communities. We recognise the importance of communicating effectively with all our stakeholders and of giving people the opportunity to influence the development and delivery of the health and social care services that matter to them.

We continue to build our social media presence. We now have 800 Twitter and around 3,000 Facebook followers – this is one of the largest Facebook followings for any HSCP in Scotland, and larger than Glasgow, Edinburgh and Aberdeen. The use of social media

proved to be particularly valuable throughout 2020-21 as a means of quickly sharing information and advice on keeping safe and well during the pandemic. We also used social media channels to inform people of sources of practical and emotional support.

We continue to make good progress in helping to develop engagement opportunities in local communities:

- There are now Health and Wellbeing Sub-Groups established in each of East Lothian's six Local Area Partnership areas.
- The number of GP practices with Patient Participation Groups rose to over 60%, with our Communications and Engagement Manager continuing to support practices to set up and develop groups.
- Our Change Board structure offers opportunities for local people to be involved in Reference Groups covering a number of priority areas.
- We ran a number of consultation / engagement exercises on a range of issues during 2020-21 – these related to matters including patient experience during COVID; the Public Sector Equalities Duty; Near Me; and the East Lothian Community Hospital Cycle Path.
- We also actively promoted local involvement in national consultation exercises, for example, the Independent Review of Adult Social Care and Alliance's 'Conversation with the People of Scotland'.

## Managing Delayed Discharges

We continued through the year to maintain our position as one of the top performing areas in Scotland in relation to delayed discharges.

This level of performance comes from key services working collaboratively to help ensure that East Lothian patients do not remain in hospital longer than is medically necessary. These include the following services / teams, all of which are based in East Lothian Community Hospital:

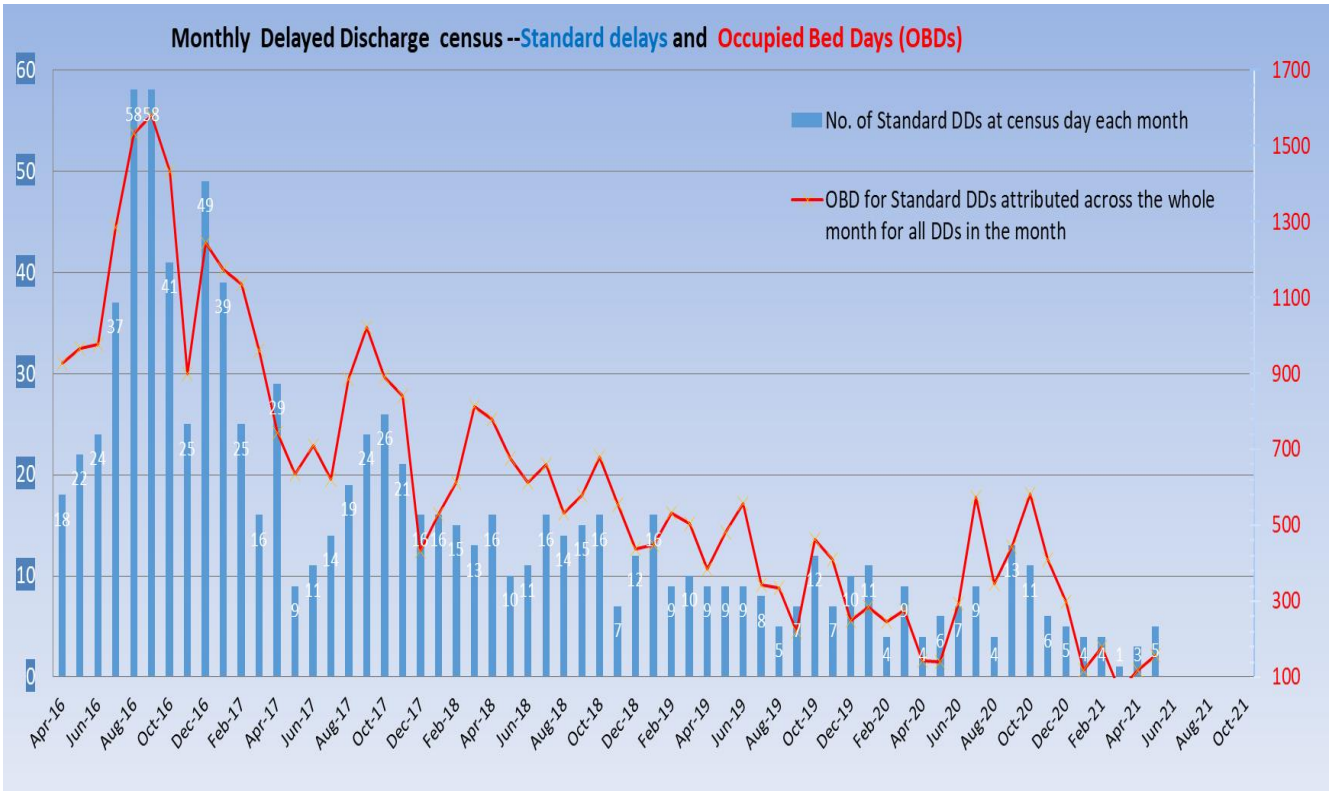
- Hospital to Home Team.
- Hospital at Home Team.
- Capacity and Flow (Discharge) Team.
- Discharge to Assess.
- Home Care Team.
- Emergency Care Team.
- Social Work.
- Care Broker Team.

During 2020-21, the Capacity and Flow (Discharge) Team extended from 5 to 7 days a week, operating for 12 rather than 8 hours a day. The capacity of the Hospital to Home and Home Care teams was also increased over the year.

Staff continue to focus on maintaining and improving the low level of delayed discharges achieved in East Lothian, as well as on avoiding hospital admission where possible. There has been a shift in practice so that coordinated discharge planning is integral to ward rounds. Early and continuous conversations with patients, relatives and carers also helps to promote the 'Home First' philosophy, where supporting individuals to return home where possible is a key objective.

Towards the end of 2020-21, plans were underway to bring teams all under a single overseeing body, the Integrated Care and Assessment Team (ICAT).

The graph below demonstrates ongoing and sustained reductions in the level of East Lothian delayed discharges since 2016.


Monthly Delayed Discharge census --Standard delays and Occupied Bed Days (OBDs)
No. of Standard DDs at census day each month
OBD for Standard DDs attributed across the whole month for all DDs in the month
60
50
40
30
20
10
0
1700
1500
1300
1100
900
700
500
300
100
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Jun-17
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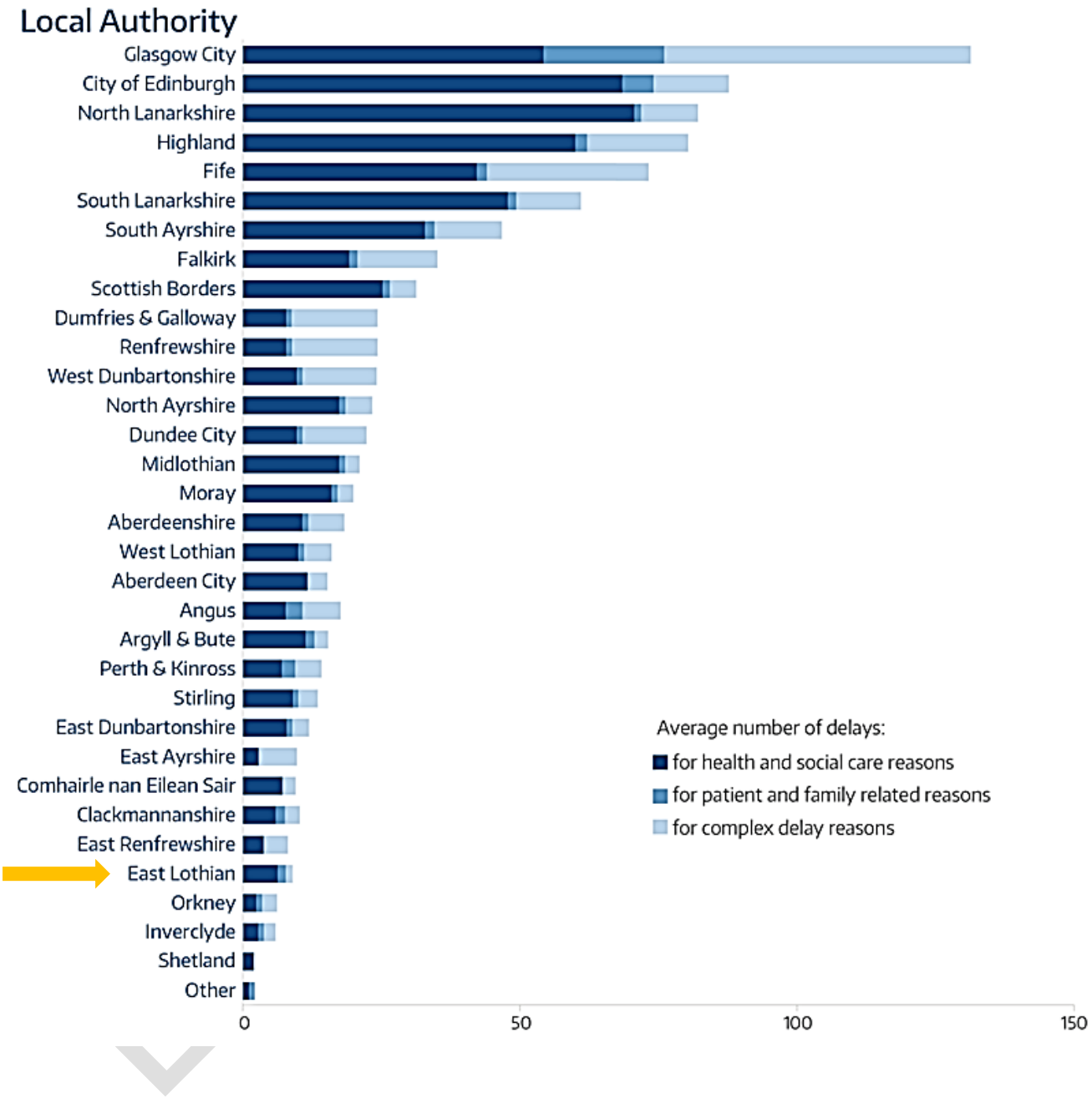
Oct-21

The graph below shows East Lothian performance compared to the national picture (April 2020 – March 2021 – reason and average number)



## Discharge to Assess

Our Discharge to Assess (D2A) service is just one of the ways we reduce the length of hospital stay for patients. Embedding D2A as a core East Lothian service has been the focus of a three-year project which featured in the Chartered Society of Physiotherapy's Frontline magazine. It was also included in the 'Innovations in Physiotherapy' database and featured at several conferences including the NHS Scotland conference and annual conferences of the Royal College of Occupational Therapists and the Chartered Society of Physiotherapy.

The D2A model prevents a wait for Occupational Therapy (OT) and/or Physiotherapy (PT) assessment before leaving hospital, for patients who are clinically fit and appropriate to have their therapy assessment completed at home. A joint OT/PT assessment is completed on the day of discharge, reducing length of stay and enabling assessment and rehabilitation to be conducted in the person's own home, bringing better functional outcomes for the service user.

From March 2016 to March 2021, the estimated cost saving by D2A in East Lothian, was estimated to be £1,549,800 from bed days saved (calculated as an average of 3 days per person, costing £300 per day).

# Care Homes

## Supporting Care Homes through COVID

Colleagues from the Care Home Team, the Care Home Assessment and Review Team (CHART) and the District Nursing Team played a vital role in supporting local care homes as the pandemic developed.

Daily 'huddles' led by the Chief Nurse, were quickly established to help monitor developments in care homes and effective partnership working enabled a quick response to any developing problems and to ensure national guidance was communicated and implemented across East Lothian Care Homes. The submission of daily situation reports allowed care home managers to flag up any issues with PPE supply, staffing levels, COVID cases or deaths and any other risks or concerns. This group reported daily to the Lothian Operational group and weekly to the Lothian Strategic Oversight Group led by the Executive Nurse Director.

Support provided to homes by the Care Home Team included:

- Clinical support for care home residents.
- Supported connection with lead General Practices for each care home.
- Practical and emotional support to care home staff and managers.
- Escalated support to homes with positive COVID cases.
- Support with the application of Health Protection Scotland (HPS) guidance.
- Training and advice on the use of personal protective equipment (PPE) and other infection prevention and control (IPC) measures. This was provided via video link, but with training visits to homes where requested – e.g., to demonstrate how to put on and take off PPE safely.
- Support with care home resident and staff COVID testing
- Help to ensure homes had adequate PPE, and in arranging urgent supplies if needed
- Administering winter flu and COVID vaccinations to care home residents and staff

The Partnership also offered supplementary staffing support to homes through the NHS Staff Bank Service. This helped to ensure that homes had appropriate staffing levels as increased staff testing began to result in more staff absences.

As part of our contingency planning, Leuchie House was changed from a respite service to a temporary care home, with the potential to offer up to 12 care home beds if needed. Haddington Care Home also earmarked an additional 5 beds to be used in the event that an individual's usual support within the community broke down as a result of COVID.

Overall, the range of support provided by the HSCP helped care home managers respond to the challenges the pandemic presented, including supporting them to comply with Health Protection Scotland guidance – this made a significant contribution to reducing the number of COVID positive residents in East Lothian care homes.

## About the Care Home Team

The East Lothian Care Home Team was established in 2015 and now delivers medical management, education and support to 19 Care Homes across the county.

The Team provides Nurse Practitioner support in relation to anticipatory care, long-term conditions and acute illness presentations in HSCP managed and independent care homes. Staff from the Team work closely with GP colleagues for advice regarding medical conditions. This greatly reduces the need for GPs to attend care homes and has helped to reduce hospital admissions for care home residents.

The Care Home Team also plays an important role by providing training, information and clinical support and advice to care home staff, which helps to support the delivery of local and national care standards in homes.

During 2020-21, the Team worked with the Living Well in Communities (LWiC) team from the Improvement Hub to develop an approach to measuring the Team's impact. Some of the findings included:

- Care Home Team Nurse Practitioners are now the first point of clinical contact for Care Homes in East Lothian.
- A close working relationship has developed between the Care Home Team and Care Home staff – this has allowed any training or educational needs to be addressed and has promoted multidisciplinary working.
- In one study area (Tranent) an average of 8.25 hours of GP time was being saved each week.
- There had been a downward trend in the number of 999 calls from Care Homes.
- Anticipatory Care Planning had improved.

As described above, the Care Home Team provided vital support to care homes during the pandemic, helping to reduce pressure on primary care. As one GP said:

> *"The Care Home Team has been a huge asset to us in primary care during the pandemic. They have provided a joined-up approach across the county. At the outset of the pandemic in 2020, the Team worked very hard to help update anticipatory care plans, arrange medication where required and to provide a pragmatic approach to care. The Team has also been involved in delivering vaccinations to Care Home residents which was organised in a timely manner."*
>
> East Lothian GP

# In your community

## Care at Home

Care at Home services responded to increased demand throughout 2020-21. This was generated by COVID-driven restrictions on day support and carers needing additional support to cope with the additional pressure placed on them. Staffing pressures also contributed to the challenges facing Care at Home providers.

The HSCP was able to step up the number of hours delivered by the internal homecare service in response to this demand. Use of Hospital to Home funding and block contract awards to external providers also helped.

The Partnership also provided ongoing practical support to Care at Home providers as described above.

## Transforming Community Support

The Community Transformation Programme focuses on two areas of service provision:

- Community based day services for adults **under 65** with complex needs.
- Community based day services for adults **over 65** with complex needs.

Specific activities since the start of the Community Transformation Programme in 2018 have included:

- Comprehensive needs assessment / data analysis.
- An extensive programme of community and stakeholder engagement.
- Capacity building with provider organisations.
- Collaboration with the Reference & Engagement Group and Change Board for Adults with Complex Needs to agree recommendations and proposed service models.
- Exploration with iHub (improvement Hub of Healthcare Improvement Scotland) of options for service design and new commissioning models.

The proposed service model developed as a result of these activities for adults under 65 is based on enabling people to be as independent of services as possible, whilst ensuring community based supports are available as option for those who need them, as well as specialist centre(s) for people with multiple complex needs.


**Proposed Service Model for Adults Under 65**

A similar service model is proposed for adults over 65, which reflects the fact that capacity in centres is reduced due to COVID infection control measures. Those needing most support being able to attend Day Centres (or the proposed new Meeting Centre in Musselburgh), with outreach support also being provided from Centres and the planned expansion of Shared Lives.


**Proposed Service Model for Adults Over 65**

The onset of the pandemic accelerated the move to more community based and outreach services, reflecting the direction of travel envisaged by the Transformation Programme. A further needs analysis was carried out by HSCP staff to identify service users most in need of building-based services. Where service users did not require a building-based service, providers offered alterative community-based provision (see below).

## Day Services for Adults with a Learning Disability

There are three Resource Centres for Adults with a Learning Disability in East Lothian which are managed by Health and Social Care staff – Fisherrow, Port Seton and Tynebank. The centres operated at reduced capacity during 2020-21 in line with infection prevention and control guidance. Due to reduced capacity people with assessed critical needs were prioritised.

In line with the Transformation Programme, and in response to the pandemic, we developed a range of different approaches to provide support to people who previously attended day services, including outreach support to enable people to take part in activities in their local communities.

## Resource Coordinators

A pilot Resource Coordinator Service for people under 65 with a Learning Disability was launched in 2020-21 based on a recommendation of the Transformation Programme. The Resource Coordinators' role is to support people with Learning Disabilities who can no longer access building based services to reconnect with friendships; build connections with their communities; and maintain skills and interests or develop new ones.

To date, resource coordinators have developed various community activities across the county. Community based activities such as football, lunch groups and gardening have been developed for people who do not require a centre-based service. The aim of these activities is to meet individual outcomes, whilst supporting people in their local communities.

The Health and Social Care Partnership continues to work closely with other support agencies to map what community resources are already available and to develop additional support opportunities. We are looking at using local venues to provide small group activities as we know that people have felt isolated and want to reconnect with their friends.

## Older People's Day Centres

East Lothian's nine Older People's Day Centres were also forced to significantly reduce building-based provision as a result of the pandemic, moving instead to provide outreach support where possible. The number of building-based hours of support was reduced by 65% over 2020-21. Prior to the pandemic, around 15-20 people could attend each of the Centres for approximately 6 hours a day; this reduced to a maximum of 2-3 people attending for approximately 1-2 hours a day.

Despite some individuals' needs being met, securing care to replace that previously provided at a Day Centre grew to account for 60% of social work referrals for older people. A significant proportion of these referrals were for people affected by dementia.

## Shared Lives

Shared Lives is a model of community/family-based care that provides long-term, short breaks and day support within Shared Lives Carer's homes. It is based on relationships, sharing family, social networks and community life and delivers safe and highly personalised care and support. In 2020-21, we agreed a new payment structure for our self-employed Shared Lives carers which builds a platform for expanding the scheme.

## Hardgate Court

In October 2020 Hardgate Court in Haddington opened as a short-break service for adults with complex learning disabilities and specific health needs. This bespoke service offers support from nursing and social care staff and its integrated approach delivers a person centred service. In addition, external support agencies can access the accommodation to provide respite to carers of people they support. There is opportunity to support up to three

people within the service, however, since opening it has operated at reduced capacity in line with COVID guidance.

Hardgate Court has proved to be a very valuable and much needed resource, providing critical short-breaks for those with complex health needs and in once particular case, this resource has reduced the number of A&E presentations due to the specialist care provided.

The Hardgate staff team have been shortlisted for a national Nursing Times Award 2021, which describes the journey they have been on to deliver this specialist Learning Disability service within a local and community setting.

## Learning Disability Service

Planning in 2020, delivered the transfer in April 2021of a number of social work, community care workers and the learning disability commissioned budgets and workstreams from Adult Social Work to align with the Community Learning Disability Team to create and develop a specialist learning disability service across health and social care.

## Meeting Centres

In February 2020, we started conversations about developing a dementia Meeting Centre in Musselburgh, with a view to this starting in 2020-21. Unfortunately, this work had to be paused temporarily due to COVID-19. We are still committed to this work and plan to develop discussions further during 2021-22.

A Meeting Centre is a local resource, operating out of ordinary community building, and offering friendly, expert support to people with mild to moderate dementia and their families. At the heart of the Meeting Centre is a social club where people meet to have fun, talk to others and get help in relation to what they feel they need. Meeting Centres are based on research evidence on what helps people cope well when adjusting to living with dementia

# Healthcare when and where you need it

## East Lothian Community Hospital

In last year's Annual Report, we highlighted the opening of the new East Lothian Community Hospital (ELCH) as a one of our key achievements of that year. A year on, the hospital is providing East Lothian residents with local access to an ever growing range of services. It also played a key role in our pandemic response.

Health services delivered at ELCH now include:

- In-patient care.
- Urology.
- Orthopaedics.
- Rheumatology.
- Gynaecology.
- Adult Ear, Nose and Throat and Audiology.
- Plastic surgery for hands.
- Adult Psychiatry.
- Antenatal Services.
- Dietetics.
- Palliative Care.
- Phototherapy.
- Osteoporosis.
- Lymphoedema.

Although clinical departments at the hospital had to pause or significantly restrict delivery at the height of the pandemic, every effort was made to recommence appropriate levels of provision as soon as safe and practical.

Clinical services were still operating at Amber level at the end of 2020-21 but continued to increase the number of initial face-to-face outpatient appointments offered. Throughout the year, clinics also made effective use of 'Near Me' video appointments.

Collaborative work with Western General Hospital resulted in delivery of intravenous therapies and venesection for some patient groups within the Endoscopy Suite as part of their treatment, rather than requiring trips into the Edinburgh Cancer Centre. This has been a welcome service development for patients.

Nurse-led monitoring clinics were established within outpatients, covering; Diabetes, Gastrointestinal, Haematology and Renal specialties, and have run successfully for the last year. This has allowed patients to be routinely checked without the need for a Consultant appointment, unless test results warrant further investigation. More specialties will be added in the coming months, such as Rheumatology

ELCH also played a key role in the COVID response by offering additional beds and as the base for the East Lothian COVID Vaccination Centre and the PPE hub.

## Developments in Primary Care Services

Our Primary Care Improvement Plan (PCIP) sets out to deliver the 2018 General Medical Services (GMS) contract aim of:

*'Developing collaborative multi-disciplinary teams working alongside GPs in their role as Expert Medical Generalists to manage patients in their own community'*

In East Lothian, we have also been guided by our priority of ensuring that primary care services are equally accessible to patients, regardless of where they live in the county and which GP practice they are registered with.

Progress during 2020-21 included:

- The establishment of a **Community Link Worker Service** for all GP practices.
- HSCP delivery of a **Flu Vaccination Programme** (with plans for the team to deliver all flu vaccinations for 2021-22, including those previously administered by GP practices).
- The provision of **Pharmacotherapy Services** to all GP practices, with plans to increase provision further.
- The establishment of **Community Treatment and Care Service** (CTACS) bases around the county.
- The expansion of the **Care When It Counts (CWIC)** service from one GP practice to four, resulting in the service now being available to 47% of the East Lothian population.
- The provision of direct access to a **Musculoskeletal (MSK) Service**, making access quicker and easier for patients.
- The establishment of a **CWIC Mental Health Service**, providing people from across East Lothian with access to support for mild to moderate mental health issues.

You can read more about some of these primary care services below.

## Community Link Worker Service

Work to establish a new, East Lothian wide, Community Link Worker (CLW) service took place during 2020, with the new service being launched in February 2021. Community Link Worker services are embedded in local community areas and delivered across the county by three third sector providers: We Are With You, Penumbra, and the Royal Voluntary Service (RVS). Each organisation brings their own expertise and skills in service delivery and works collaboratively with the East Lothian HSCP to ensure a high quality service across East Lothian.

The East Lothian Community Link Worker service provides targeted support to individuals (aged 18 and over) who are experiencing difficulties due to social-economic factors, social isolation, relationship breakdown, or other factors related to health inequalities.

The aim of the CLW service is to support clients in achieving their identified health and well-being goals through offering social prescribing and support for clients to benefit from wider community support and resources.

Community Link Workers work closely with all 15 GP Practices in East Lothian, and work in partnership with wider third sector and community organisations to ensure appropriate support in relation to non-clinical needs is available, or to identify any gaps.

What our partners say:

> *'Our link worker Sam has quickly become an integral part of our team. He is able to engage really well with our patients who have non-medical problems that are impacting their physical or mental health and support them to make changes. This can be anything from starting a new hobby, enrolling on a course, joining a social group, increasing their exercise or help addressing financial or housing.'*
>
> Dr Anna Beedel, Prestonpans Group Practice

## Flu Vaccination Programme

ELHSCP worked with partners to ensure that all those eligible could access flu vaccinations over the winter period. Flu vaccinations for adults were delivered by a combination of GP practices, community pharmacies, CTACS and ELHSCP run clinics. This was the first year that the HSCP had directly delivered flu vaccination clinics, held at a range of community venues, including local high schools. HSCP clinics targeted eligible adults between 18 and 64 years of age, allowing GP surgeries to focus on delivery for the over 65s.

Between them, partners vaccinated:

- 8,594 'at risk' adults between 18 and 64 – 58% of those eligible (up from 40% the previous year).
- 10,161 adults aged 65 to 75 – 81% of those eligible (up from 70%).
- 8,979 adults aged 75 and over – 85% of those eligible (up from 80%).
- An overall total of 27,734 adults – 73% of the target eligible population and an increase of 12% from 2019/20.
- 1,976 pre-school and 5,771 primary school pupils were also vaccinated, 66% of the target population (up from 50% in 2019/20).

As well as reducing the pressure on GP surgeries over the winter period, our role in delivering flu vaccinations allowed the team to gain experience and develop capacity for the role they were to play in delivering COVID-19 vaccinations (see page 40 above). The HSCP is well placed to assume full responsibility for the 2021-22 adult flu vaccination programme.

## Pharmacotherapy Services

Since the introduction of the new GMS (General Medical Services) contract in 2018, ELHSCP has expanded the number of pharmacy support posts (both pharmacists and pharmacy technicians) to all GP practices in East Lothian. This support helps to reduce GP workload and improves efficiency in relation to medicine-related issues.

## Community Treatment and Care Services (CTACS)

Although launch of the Community Treatment and Care Service (CTACS) was delayed as a result of COVID, the new service commenced delivery in June 2020. Initially covering patients at the Haddington GP practices, the service was extended to practices across the whole of East Lothian from August 2020.

CTACS offers a range of 'treatment room' activities including phlebotomy; management of minor injuries and dressings, ear syringing; suture removal; and chronic disease monitoring. Delivery of these activities by an HSCP employed team helps to reduce workload pressures for GP surgeries and enables the delivery of centrally managed, standardised treatment by skilled practitioners, whilst meeting the needs of local communities.

Patient feedback has demonstrated extremely high levels of satisfaction, with 94% of patients saying the service they had received was 'very good' or 'excellent'.

What our colleagues say:

> *"We have a fantastic team of experienced NHS nurses in our team. CTACS can offer patients longer appointments when needed, allowing the team to take time to fully assess and plan individualised care to patients.*
>
> *This is a new way of receiving care – one which helps us to ensure people are able to see the right person, at the right place, at the right time, which I know people are coming to value."*
>
> Deirdre Quigley, CTACS Lead

Collation and analysis of CTACS service data has enabled the deployment of staffing resources where they can have the most impact. This analysis has also informed proposals to employ new Health Care Support Workers in 2021-22 to help boost the service's capacity to carry out more routine health care tasks.

## CWIC (Care When it Counts)

Launched in 2018, the CWIC service offers a 'seen on the day' service, delivering person-centred, safe and timely care.

Although the service was suspended for around 4 months as a result of COVID, it resumed delivery for Musselburgh patients in July 2020 and had extended its service to Harbours, Inveresk and Tranent practices by the end of the year. At the end of 2020, around 75% of CWIC consultations were taking place over the phone, with the remainder face-to-face.

The expansion of CWIC to cover 4 GP practices means that the service is now available to 47% of the East Lothian population. Working collaboratively with GP practices has been key to shaping the CWIC service. CWIC staff have worked with GP colleagues on Quality Improvement activities throughout 2021-22.

CWIC is based on a multidisciplinary model of care, involving skilled and experienced practitioners working collaboratively alongside GPs in their role as expert medical

generalists. The CWIC team currently consists of nurse practitioners, advanced nurse practitioners, physician associates and GPs.

A sample of GP practice data (February 2021) showed that 89% of patients had their needs resolved by a CWIC practitioner on the day they contacted the service.

Feedback from a survey of CWIC patients identified that:

- 98% were either 'very satisfied' or 'satisfied' with how quickly they were contacted by a CWIC practitioner
- 98% said the practitioner they saw was 'very good' in terms of really listening, and 90% reported the practitioner was 'very good' at understanding what mattered to them
- 93% said the practitioner made them feel at ease, and 93% also said they were 'very good' at explaining things clearly

Patients described the service as:

> 'Professional, attentive, reassuring and friendly'
>
> 'Prompt and efficient…the Practitioner was fab and very thorough'
>
> 'Fast, efficient and patient centred'
>
> 'The best experience I've had in a doctor's surgery'

## CWIC (Care When it Counts) Mental Health Service

The CWIC Mental Health multi-disciplinary team was established in April 2020 as a direct response to COVID-19, in order to maximise existing resources, ensure workforce resilience across the county, and establish easy-to-access mental health support.

The CWIC MH service is available to residents aged over 18 across the whole of East Lothian. The service is based in East Lothian Community Hospital and Musselburgh Primary Care Centre and works in partnership with all East Lothian GP practices.

CWIC MH provides access to a mental health practitioner via a dedicated phone line. Patients can be referred to the service by their GP or other health practitioner, or they can contact the service directly without the need for a referral. By March 2021, 33% of all appointments were being made directly by individuals.

Mental Health Occupational Therapists (OTs) in the CWIC MH Team help patients to better self-manage and to be less reliant on health and social care services. Patients benefit from meaningful intervention, leading to avoidance of crisis and reducing the need for referral on to secondary mental health services.

Throughout most of 2020-21, the CWIC MH service had been delivered via telephone or by using Near Me, however the option of face-to-face consultations was introduced in spring 2021.

The main benefits of CWIC MH can be summarised as:

- CWIC MH provides a brief treatment model for common mental health issues.
- Individuals with low to moderate mental health concerns can quickly access specialist mental health support over the phone.
- CWIC MH provides a clear, easy to understand pathway for patients.
- Help is provided where possible the same day or within 72 hours of a patient's initial phone call.
- The service helps to reduce pressures on GPs (data suggests that up to 40% of visits to GPs are now in relation to mental health needs).
- GPs and other health practitioners benefit from an accessible mental health support service to refer patients to, with the assurance that they will receive a quick response.
- It is contributing to a shift in patient expectations, whereby patients no longer automatically see their GP as their first port of call for all health concerns.
- Patient feedback has suggested that the service offers a caring and compassionate approach, a timely response and easy access to support.

CWIC MH facts and figures:

- Around 66% of people using the service were female, 33% were male.
- The age groups making most use of the service were aged18-25 and 50-65.

Feedback from a survey of CWIC MH patients:

- 98% were 'very satisfied' or 'satisfied' with how easy it was to use the service.
- 87% said the CWIC MH practitioner was 'excellent' or 'very good' at really listening to them.
- 93% said the practitioner was 'excellent' or 'very good' in terms of showing care and compassion.
- 91% said the practitioner had been 'excellent' or 'very good' at helping them to take control.

What people using the service have said:

*'Wonderful that I was seen on the day I needed help.'*

*'Really approachable and caring staff.'*

'*Really helped me stay working despite feeling anxious and stressed*.'

*'I can't begin to thank you enough; I feel like I know what to do now.'*

A recent survey of GP practices found that:

- 78% agreed that CWIC MH is a useful resource to signpost patients to during a consultation.
- 86% felt confident in the service that CWIC MH provides to patients.

Comments from GPs suggested that CWIC MH offers:

> *'Equitable access across the country. Fast response times. Reduced pressure on practices.'*
>
> *'Better access for patients to obtain help for their mental health. Helps patients take initiative for their mental health.'*

# Maintaining and improving your quality of life

## East Lothian Rehabilitation Service

Rehabilitation services are key to maintaining and improving people's quality of life, as well as to helping them to retain their independence after illness. Rehabilitation services also play an important role in keeping people out of hospital, or allowing them to be discharged sooner, and, as such, help to reduce pressures and costs on all parts of the health and social care system.

East Lothian Rehabilitation Service (ELRS) has expanded its capacity over recent years to meet growing and increasingly complex patient needs. The service developments during this year are described below.

## Post-COVID Rehabilitation

As more people started to experience challenges in recovering from COVID, the HSCP began to look at ways of delivering effective and efficient post-COVID rehab. This resulted in development of a multidisciplinary post-COVID pathway, resource pack and education strategy.

The development of a single point of contact for GPs, secondary care and other professionals is also planned as part of this approach. This will ensure ease of access (and re-access) to the service, enabling patients to get the right help, delivered by the right person at the right time.

Our response to post-COVID rehabilitation is to manage referrals through the long-term condition pathways. This means that Advanced Practitioners within Occupational Therapy and Physiotherapy will assess and treat service users, using a blend of telephone, Near Me and face-to-face contact. 'Test of Change' funding has been secured for a year for an Advanced Practice Occupational Therapy post for long-term conditions in one of our geographical clusters.

## Technology Enabled Care (TEC)

Our TEC team continued to provide patient consultations remotely throughout the year. Provision included the introduction of a 'self-install service' of supportive technology, which was well received.

The team worked with clusters and inpatient teams to trial, and later embed into practice, the Alcuris lifestyle monitoring tool. In some cases, Alcuris reduced or removed the need for a care package, in others, it facilitated discharge home or helped to prevent hospital admission.

Plans for 2021-22 include replicating the successful Wellwynd SMART TEC Hub in the east of the county. The TEC team is also working on further development of self-management information available on the East Lothian digital platform – ensuring that information on TEC

and how it can help support effective self-management, is readily available to East Lothian citizens.

## Request for Assistance (R4A)

Request for Assistance is a new model of practice where 'Good Conversations' and an assets-based approach is used in determining what matters to the person requesting support. Senior Practitioner Occupational Therapists take all the calls. After talking with the caller using the 'good conversation' approach they either signpost the person to appropriate support, allocate them directly for an assessment, or place them on the waiting list if the request is for routine intervention.

## Community Clusters

In May 2020, we reorganised our community teams into three integrated geographical clusters, covering the whole of East Lothian. These clusters bought together Occupational Therapists from both East Lothian Council and the NHS, alongside Physiotherapists. The clusters deliver several workstreams including facilitating discharge from hospital and prevention of admission, as well as community rehabilitation and the assessment and provision of adaptations and equipment. Processes are constantly evolving and developing but this integrated model has improved communication, reduced duplication and increased efficiency for service users.

## Physical Activity and Community Education (PACE) Service

The Physical Activity and Community Education (PACE) service had to adjust its approach significantly during 2020-21 due to COVID restrictions. PACE staff created 'Exercise Fundamentals' allowing patients to continue with tailored activity, at their own pace, remotely, with telephone contact also provided at set times. Content was made available online via YouTube as well also in paper format for those who needed it.

## Pain Management

The East Lothian Pain Management Service was launched in September 2020, accepting referrals from GPs, Allied Health Professionals and Consultants. The service aims to reduce the impact pain is having on an individual's quality of life through teaching ways of self-management and coping with persistent pain.

After an initial assessment, a number of treatment options are offered. These include online resources, pain management groups (virtual or face-to-face where restrictions allow) individual treatment, or onward referral to other services within ELRS, for example PACE or the Lothian Chronic Pain Service at Astley Ainslie Hospital.

The East Lothian Chronic Pain Service was the first to deliver digital online pain management groups in Lothian. This approach improved the patient experience by

enabling direct access to pain management services from their own home during COVID restrictions.

To date 129 patients have accessed the service receiving support in response to individual need. Eight online and face-to-face pain management groups have been delivered, providing pain management support and education for individuals experiencing a range of long-term conditions. Services are delivered locally at ELCH and more recently at the Edington hospital, facilitating easier access and minimising travel for this patient group.

A recent patient experience evaluation has demonstrated high levels of satisfaction with the service provided:

> *"This is a long awaited helpful period for long0-term health condition from genuinely understanding professionals."*
>
> *"Well paced and good level of teaching, empathy from evidence based professionals."*

Anticipated future service developments include the support from Pharmacy and Mental Health Services on a sessional basis.

## Musculoskeletal (MSK) Service

East Lothian Physiotherapy Musculoskeletal (MSK) Service underwent significant service redevelopment during 2020-21. This included the launch of a new MSK Advice Line in May 2020, significantly improving patient access routes to physiotherapy.

By the end of March 2021, the MSK Advice Line had generated over 6,000 referrals directly into the MSK Service, with 40% of these managed with a one-off telephone consultation. The remainder were passed on to the core Physiotherapy team to continue the rehabilitation in a timeframe guided by individual clinical need, rather than by patients being added to a waiting list.

This direct access approach has improved patient experience, by removing the need to go via their GP. It also led to a significant reduction in waiting times for core MSK services (to 1 week). The approach also benefits GP practices by decreasing MSK related demands on their time.

The Advanced Practice Physiotherapy team are currently undergoing training to allow them to generate their own X-Ray requests, helping to further decrease GP workload.

Patient experience evaluation carried out in 2020-21 demonstrated high levels of satisfaction with the service provided – all respondents rated the service as 'excellent' or 'good/ great', with no respondents suggesting it was 'fair' or 'poor'. Comments about the service included:

> *"Got through to service quickly. Very professional, helpful and empathetic support. I feel reassured about my recovery."*

*"Clear, concise, easy exchange of information, no need to leave home for the assessment."*

*"Wouldn't change anything, I was happy after speaking to the physio and knowing I could contact them again."*

Anticipated future service developments include an electronic self-referral option and 'webchat' function for those unable or choosing not to engage with Physiotherapy services via the MSK Advice line.

What our colleagues say:

*"With joint or muscle pain, the earlier you get advice and support the better. Putting up with pain may be brave, but it's not good for you. We wanted to make sure that people could access physio and occupational therapy and support as soon as they needed it,"*

Lesley Berry, General Manager for Access and Rehabilitation

## Mental-Wellbeing Playlist

The East Lothian Psychological Therapies Service developed a resource during 2020-21 which can be accessed by anyone looking for support with their mental wellbeing. There are nine video playlists in total, each one focusing on different aspects of mental wellbeing. The team designed the videos so that they can be watched in sequence or dipped into according to individual preference. This initiative received generous support from the Edinburgh and Lothians Health Foundation.

*"I know that we have all been through the mill with COVID-19 and many people have been feeling anxious or low. These are normal feelings and, even without a pandemic to contend with, ones that most of us will experience at some time in our lives. These videos are really useful in helping us to understand why we might be feeling low and suggests simple things that we can do to start feeling better."*

Peter Murray, Chair of East Lothian IJB

# Reducing health inequalities

## Tackling Poverty

The East Lothian Poverty Plan (2021-23) was developed by a working group involving East Lothian Council, NHS Lothian, Volunteer Centre East Lothian, the two local Citizens Advice Bureaux and ELHSCP. The new plan combines the previous Poverty and Child Poverty Action Plans. Monitoring of the previous plans demonstrated that progress had been made against most of the actions in the plans. The new plan identifies ongoing action required by all partners to tackle inequality and poverty and to deal with the consequences of the pandemic.

## Financial Inclusion

Two services new to East Lothian in 20200-21are set to play a role in promoting financial inclusion.

The East Lothian Community Link Worker service (see page 42) was launched in early 2021 to support people across East Lothian. The service, available in all GP practices, offers support with a range of non-medical issues, which can include issues that contribute to financial hardship such as employment, debt and household costs. Community Link Workers can signpost service users to financial inclusion and other advice services.

Work to establish the Macmillan Improving the Cancer Journey service in East Lothian began in East Lothian in 2020-21, with a range of partners, including the HSCP, involved in the steering group for this initiative. The service will provide person-centred support to help people affected by cancer in relation to non-clinical issues including employment, housing and financial inclusion.

## Health Improvement Fund

NHS Health Improvement Fund is administered by the East Lothian Health Improvement Alliance. Projects funded in 2020-21 included:

- Ageing Well – an initiative promoting physical activity and providing groups, classes and other activities for older adults.
- Pennypit Community Nutritionist – a project providing information, advice and training to local people on nutrition – for example, through family cooking groups.
- People Know How – an initiative providing mental health support to vulnerable young people.
- Start Well – a project promoting physical activity for the under 5s.
- Carefree Kids – a service lending equipment to vulnerable families and offering a uniform / winter clothes bank.

## Community Justice

The East Lothian Community Justice Partnership published its new Community Justice Local Outcome Improvement Plan 2021-2024 in June 2021.

The Partnership includes a range of organisations including East Lothian Council, Police Scotland, the Scottish Prison Service, Skills Development Scotland, Queen Margaret University, NHS Lothian, ELHSCP and third sector representatives.

Throughout 2020-21 the Partnership continued delivery of its three main workstreams:

- Early Intervention and Prevention.
- Community Engagement.
- Reducing Reoffending.

## Integrated Impact Assessments

ELHSCP, like all public sector organisations, is required to assess the impact of decisions and policies on equalities groups. We do this through a process called Integrated Impact Assessment (IIA).

Representatives for people affected by our decisions (including staff, service-users, the third and independent sectors) work through an IIA framework together. They look at the potential and actual positive, neutral and negative impacts of decisions on the groups they represent. This allows for appropriate adjustments to be taken into account in planning and delivery of services and policies.

# Supporting carers

Caring for someone can be a rewarding experience, but coping day to day with meeting the needs of a loved one can be challenging for carers. We continue to work closely with young carers, adult carers and with carer organisations to try to ensure carers have the information and support they need.

We made further progress with implementing the East Lothian Carers Strategy in 2020-21, but also responded proactively to help support carers and organisations with the additional challenges posed by COVID.

As the pandemic developed, ELHSCP worked with carer organisations to provide support to carers during this particularly challenging time. Our shared priority was to make sure that carers continued to access existing services as much as possible. Care organisations acted swiftly, moving to online or telephone support and reduced or stopped face-to-face contact in line with government guidance.

Carer organisations responded flexibly and creatively to maintain support over the year – examples of different approaches include:

- The Bridges Project reported high levels of young carer engagement via online platforms (around 90% engaging with online support).
- East Lothian Young Carers (ELYC) moved their activity clubs online, delivered activity packs to young people's homes and offered tutoring and 1:1 support when required.
- Alzheimer Scotland kept in touch with carers using Near Me and GoTo platforms.
- Dementia Friendly East Lothian (DFEL) ran online weekly friendship groups.
- Carers of East Lothian (COEL) and DFEL worked with local community resilience groups, with COEL developing a directory of local resilience resources that carers could access.
- COEL reported contacting a significantly higher number of carers than usual over the year, including carers who were on their database but who had not been in contact for a long time.
- As restrictions eased, organisations moved to implement their recovery plans, again showing creativity with service delivery options – for example, COEL began to offer garden visits, making use of 'pop up pods' to allow support workers to sit outside to chat to carers regardless of the weather.

Prior to COVID, micro grant funding was available to carers to help provide respite breaks. As respite could not be accessed due to lockdown, we agreed with COEL that this money could be used to provide grants to families on low incomes with children under 21 living at home. Grants could be used to purchase items such as toys, games and subscriptions to help alleviate the pressure of keeping children and young people occupied at home during lockdown.

Connected Community Hubs across East Lothian supported families with food deliveries and other practice support. Carers' feedback suggested that the Hubs were well organised and responsive, providing much appreciated additional support during the pandemic.

Carers' organisations reported that lockdown was having a significant impact on carers' mental health. COEL continued to provide counselling sessions via Zoom and ELYC reported an increased need to provide emotional support to parents of young carers as well as young carers themselves. We also worked with organisations to promote uptake of the new CWIC Mental Health service by carers (see page 45).

ELHSCP made PPE supplies available to carers via the PPE Hub at East Lothian Community Hospital. We received positive feedback from carers saying that they were able to access PPE quickly and easily from the Hub.

## Looking Ahead

A workshop was held with carer organisations and other third sector partners in October 2020 to begin work on reviewing the outcomes in the current East Lothian Carers Strategy. The workshop included discussion of how COVID may have impacted on some of these outcomes. Feedback from the workshop will help to shape a redraft of the Carers Strategy.

# Safe from harm

## Public Protection

The East Lothian and Midlothian Public Protection Committee (EMPPC) is committed to working in partnership to improve services to support and protect all people at risk of harm within our communities. EMPPC covers all aspects of Public Protection across East and Midlothian, including Adult Support and Protection; Child Protection; Violence Against Women and Girls; and Multiagency Public Protection Arrangements (MAPPA). One of its key strengths is the involvement of a wide range of multiagency senior representatives from across services and key agencies.

EMPPC and partner agencies continued to deliver robust public protection arrangements throughout the pandemic, adapting service provision where required – its Annual Report for 2020-21 describes its main activities and performance in more detail - some of the key figures for 2020-21 included in the report are outlined below.

## Adult Support and Protection

In response to lockdown, the HSCP produced *'Managing Risk During the COVID-19 Epidemic'* guidance, which was quickly followed by EMPCC *'COVID-19 Practice Guidance for Adult Support and Protection 2020-21'*. The guidance included the interim measure of carrying out Inter-agency Referral Discussions in place of Adult Protection Case Conferences. Provision was also made for maintaining contact with individuals through the safe and appropriate use of PPE and electronic methods such at MS Teams and Skype were used to carry out meetings remotely.

Figures for Adult Support and Protection activity during 2020-21 include:

- 511 Adult Support and Protection (ASP) referrals were received over the year, a 9.1% reduction from the previous year.
- Police, followed by Health were the largest single referrers.
- 69.9% of referrals progressed to a Duty to Inquire (DTI), and 14.3% of DTIs progressed to Adult Support and Protection (ASP) Investigations.
- The rate for referrals being converted to DTIs increased by 28% in 2020-21, although the conversion from DTIs to Adult Support and Protection Investigations decreased by 5.7%.
- The most common type of harm investigated under ASP was financial harm. Over the last 5 years this has been the most common type of harm in all but one year.
- The most common category of client group with an ASP Investigation was 'infirmity due to age, accounting for 39% of the total.
- 82% of DTIs were completed within the standard of 7 days.
- 88% of ASP Case Conferences were held within the standard of 28 days.
- Where ASP Case Conferences were delayed this was in order to ensure good multi-agency representation – performance measured indicate a very good level of multi-agency attendance, including Police and Health colleagues.

## Violence Against Women and Girls (VAWG)

The impact of the COVID pandemic on domestic abuse saw increased opportunities for perpetrators to exert coercive control, and concerns for the increased invisibility of victims and perpetrators during lockdown. Being able to access help during lockdown was an issue for victims, and those who were able to access support often needed more frequent contact, longer sessions and longer term support.

We put in place a number of measures to ensure that victims and services were able to access information about available support. This included working with Children's Services to enhance their support for survivors of domestic abuse and for children through the local Hubs where there was capacity.

We developed East Lothian Council *'COVID-19 and Domestic Abuse Community Housing and Homelessness'* staff briefings to raise awareness and give guidance on how to support survivors and set up four single points of contact.

Justice Services, the Police and the VAWG Co-ordinator collaborated to provide a SNAPfax-style leaflet with advice and supports for help with stress which police gave to perpetrators when attending an incident.

The figures below describe the context we delivered services in during 2020-21:

- 1,163 incidents of domestic abuse were recorded by the Police during 2020-21 – this was a reduction of 8% from the previous year
- 16 Multi Agency Risk Assessment Conferences (MARAC) were held for 111 victims – this was an increase of 20% on the number of MARACs held the previous year, a reflection of the increased need for this type of intervention.
- 344 referrals were made to the Domestic Abuse Referral Pathway, up 20.5% on the previous year
- Children were involved in 64.9% of cases referred to MARACs
- 235 sexual crimes were reported to Police in 2020-21, an increase of 19.3% from the previous year
- There was an increase in non-recent sexual crimes being reported, as well as an increase in non-contact online sexual offences
- There was a 20% increase in survivors requesting support from domestic abuse services after reporting an incident to the Police, with individuals needing more intense and longer term support.

## Drug and Alcohol Use

There was a heightened risk of harm during 2020-21 due to the increase in availability of Etizolam (also known as 'street Valium'), Xanax and other forms of illicit benzodiazepine in East Lothian. Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) and partner organisations responded by working together to share intelligence on drug availability and to issue advice and information to those at risk. People who use a number of drugs at the same time (poly drug use) are at particular risk, and work was focused on

this group, including providing them with harm reduction information and discussing with them strategies to help minimise risk.

The Substance Misuse Service also continued to deliver assertive outreach in primary care. This consists of providing direct access to a specialist consultant, nurses and Peer Support Workers in GP practices across East Lothian. Specialist nursing staff also provide support, information and advice to primary care colleagues to help improve prescribing practices.

During the year, our Substance Misuse Service consistently met and exceeded the Waiting Times Local Delivery Plan Standard.

## Justice Social Work

Justice Social Work, in line with other aspects of Public Protection activity, was identified as an 'essential' service and adapted its approach throughout the year to ensure continuity of service delivery.

A system to assess all service users was quickly established as lockdown began. This was based on assessment of risk of harm to self or others, alongside consideration of issues such as severe and enduring poverty / deprivation, mental ill-health or substance use which, if left unchecked or unsupported, could have resulted in serious harm or self-neglect. Where such risks were identified, individuals were provided with in-person support in appropriate office spaces and / or on their doorsteps, if necessary. To continue delivering our essential services we redeployed staff and utilised PPE in all client-related activities.

Justice Social Workers continued to provide services based on risk and need. All those subject to oversight relating to domestic abuse offences were reviewed and the team made specific efforts to increase contact and support where there was a victim / survivor in the home and / or the perpetrator was in contact with an intimate partner. Staff undertook additional training to deliver a behaviour intervention programme to men convicted of domestic abuse offences, with the aim of reducing the risk of re-offending on an individual basis.

In relation to the Early Prisoner Release programme, we developed multi-agency pre-release planning groups to address the risk and needs of individuals prior to release (including housing, mental health, substance use, finances, etc.).

# Workforce

## Rising to the Challenge

We recognise that our single most valuable resource is our workforce. The role played by staff in responding to the challenges brought by COVID demonstrates just how exceptional our workforce is. Without the staff commitment, creativity, flexibility and enthusiasm shown, we would have been unable to continue the delivery of key health and social care services to the people of East Lothian.

To successfully deliver transformational change, our workforce will be required to do things differently to support new models of care. We will rely on having an experienced, skilled, innovative and adaptable workforce doing new and different things. The flexibility required from our workforce to respond to COVID-19 demonstrate that they have the enthusiasm, skills, and commitment to rise to the challenge.

## Engaging and Supporting Our Staff

Throughout the year, our staff had to work in very different ways to previously. A significant proportion moved to home working, adapting to carrying out their roles using telephone and online platforms. Others were faced with working in workplaces that had changed dramatically due to social distancing and infection prevention and control measures. All the while, they continued to respond to new and changing service demands and changing COVID guidance.

ELHSCP, along with East Lothian Council and NHS Lothian took a range of actions to engage and support staff throughout the pandemic. These included:

- Communication with staff was key from the outset, with the Chief Officer's Blog updates playing an important role in communicating the latest information and allowing two way dialogue with staff.
- NHS Lothian's COVID 'Speedreads' also provided staff with up to the minute information, advice and guidance.
- Many teams set up 'daily huddles', either face-to-face or online, allowing sharing of information and providing support to staff.
- Focus on Wellbeing Programmes delivered throughout the year to empower and encourage staff to focus on personal resilience and self-care – including topics such as sleep, stress and anxiety, mindfulness and balancing work and home life.
- Wellbeing Wednesdays – run by East Lothian Council.

## Workforce Development

Our ELHSCP Workforce Plan (2021-22) reflects our commitment to ensuring that we have the right level of skilled and experienced staff, working together in the right settings and with the right support, to deliver high quality, integrated and sustainable health and social care services.

Our Workforce Plan outlines how we intend to deliver on this commitment. The Plan identities how we will work with East Lothian Council and NHS Lothian to deliver integrated workforce planning which will include:

- Profiling the workforce.
- Re-designing jobs and services.
- Undertaking a 'skills gap analysis' to identify skills development requirements.
- Integrating workforce policies and practices as far as possible.
- Supporting proactive recruitment campaigns.

# East Lothian IJB Strategic Plan

East Lothian Integration Joint Board approved its current Strategic Plan in April 2019, covering the period from 2019 to 2022. The Plan outlines ten strategic objectives:

1. To make health and social care services more sustainable and proportionate to need and to develop our communities.
2. To explore new models of community provision which involve local communities and encourage less reliance on health and social care services.
3. To improve prevention and early intervention.
4. To reduce unscheduled care and delayed discharges.
5. To provide care closer to home.
6. To deliver services within an integrated care model.
7. To enable people to have more choice and control.
8. To reduce health inequalities.
9. To build and support partnership working.
10. To support change and improvement across our services.

Two years into our current Strategic Plan, we continue to make good progress in relation to each of these objectives. Every one of the East Lothian Health and Social Care (HSCP) delivered service developments or activities described in this Annual Report can be seen to contribute to one or more of these objectives, with many contributing to multiple objectives.

## Change Board Review

Change Boards were established to deliver the strategic priorities identified in our Strategic Plan – there is a Change Board for each of the following areas:

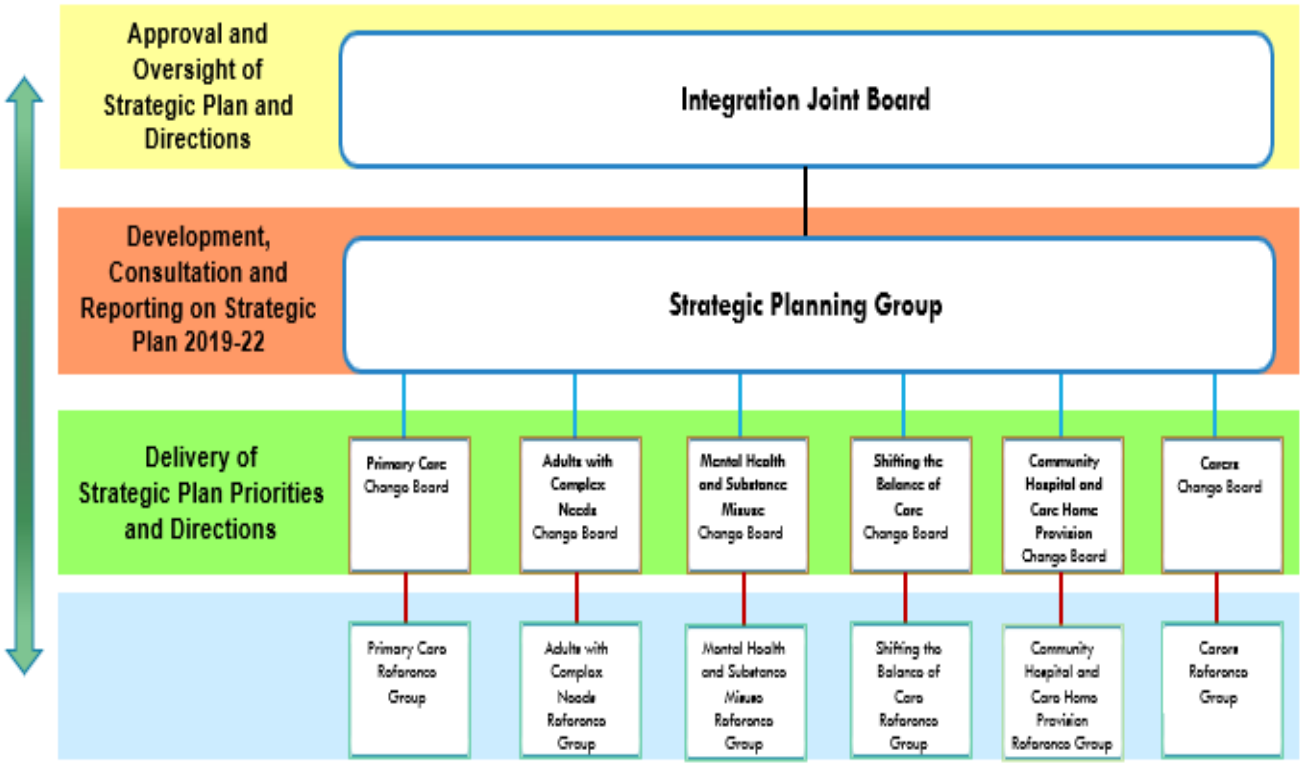
- Primary Care.
- Adults with Complex Needs.
- Mental Health and Substance Misuse.
- Shifting the Balance of Care.
- Community Hospital and Care Home Provision.
- Carers.

Each of these Change Board has an associated Reference Group. The membership of Reference Groups is made up of service-users, carers and professional, operational, management and planning colleagues. Reference Groups provide a 'sounding board' to help inform the work of each Change Board.

The relationship between Reference Groups, Change Boards, the Strategic Planning Group and the Integration Joint Board are shown in diagram 1 below.

An Internal Audit of Changes Boards in 2020 suggested that Change Boards operated well, but that there were some improvement opportunities in terms of enhancing governance arrangements. The HSCP went on to carry out a review of Change Boards during 2020-21 which included consulting the range of stakeholders currently involved in these groups. Review recommendations will be actioned during 2021-22.

**Diagram 1 - East Lothian IJB Strategic Groups**



# How we performed

## National Integration Indicators

The Scottish Government published a Core Suite of 23 National Integration Indicators in 2015. The Ministerial Strategic Group for Health and Social Care later developed a number of additional indicators. Between them, these indicators provide a means for Health and Social Care Partnerships to measure progress in delivering the National Health and Wellbeing Outcomes.

The tables below provide the more recent available data for each of these indicators, along with the figure for Scotland and trend information where available / appropriate.

Data for the Core Suite of Indicators is published on the Public Health Scotland website, the most recent publication can be found here.

## Core Suite of National Indicators

### (i) Scottish Health and Care Experience Survey (2019/20)

Nine of the national integration indicators are based on data from the biennial Scottish Health and Care Experience (HACE) survey (table 1). The most recent survey was in 2019/20, so reflects data from the year before this annual report covers.

Public Health Scotland (PHS) notes that the HACE survey is carried out with a sample of patients aged 17+ registered with GP practices in Scotland and is therefore affected by sampling error. The effect of sampling error is identified by PHS as being *'relatively small for national estimates'* but is more significant when looking a smaller sub-sections of the population due to the results being based on a relatively small sample size.

Sampling error may be the case in relation to East Lothian where the sample size for the 2019/20 survey was 7,579, with only 2,633 surveys completed (a 35% response rate). The number of responses was lower still for the questions that were only relevant to a subset of respondents (for example, carers). As a result, care should be taken in making any comparison between the Scottish and East Lothian figures.

In Table 1, the column 'Statistically Significant?' relates to the degree of uncertainty around the survey results due to sample size, and whether differences between the East Lothian and Scotland result should be seen as significant or not. This was determined using the 95% confidence intervals included in the survey results. More detail on this can be found in Appendix 2.

| Table 1: National Integration Indicators based on Health and Social Care Experience Survey (2019/20) | | East Lothian | Scotland | Statistically Significant? |
|---|---|---|---|---|
| 1. | Percentage of adults able to look after their health very well or quite well | 94% | 93% | No |
| 2. | Percentage of adults supported at home who agree that they are supported to live as independently as possible | 72% | 81% | No |
| 3. | Percentage of adults supported at home who agree they had a say in how their help, care or support was provided | 75% | 75% | No |
| 4. | Percentage of adults supported at home who agree that their health and social care services seemed to be well coordinated | 61% | 74% | Yes |
| 5. | Percentage of adults receiving any care or support who rate it as 'excellent' or 'good' | 76% | 80% | No |
| 6. | Percentage of people with positive experience of care at their GP practice | 72% | 79% | Yes |
| 7. | Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life | 70% | 80% | No |
| 8. | Percentage of carers who feel supported to continue in their caring role | 33% | 34% | No |
| 9. | Percentage of adults supported at home who agree they felt safe | 70% | 83% | Yes |

Due to changes to data methodology, only indicators 1, 6 and 8 are comparable with previous years.

- Indicator 1 remained unchanged from the previous survey (carried out in 2017/18).
- Indicator 6 had fallen from 80% to 72%.
- Indicator 8 had fallen from 36% to 33%.

### (ii) Operational Performance Indicators

The Core Suite of indicators includes a number of indicators based on hospital and other health and social care service activity, along with data from National Records of Scotland's death records. Performance against each of these indicators is shown below.

It should be noted that, where indicated, the figures given are for calendar year 2020. Calendar year 2020 is used as a proxy for 2020-21 due to the national data for 2020-21 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and other Health and Social Care Partnerships.

Please note that the figures presented will not take into account the full impact of COVID-19 during 2020-21.[2]

[2] Text as advised in 'Public Health Scotland guidance regarding the reporting of National Integration Indicators in 2020/21 Annual Performance Reports' (June 2021)

| Performance Symbols Key | | | | | |
|---|---|---|---|---|---|
| Improvement trend | ✔ | Performance similar to previous years / only slight change | — | Downward trend | ↓ |
| Performance above the Scottish level | ✔ | Performance around the same as Scottish level | — | Performance below the Scottish level | ✕ |

| 11. Premature mortality rate for people aged under 75 per 100,000 persons (by calendar year) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **Trend** | **6-year Trend** | The premature mortality rate for people aged under 75 rose slightly in 2020, showing a similar level of increase as with the Scottish rate.<br>East Lothian's rate **remains significantly below** the national figure, with the **fourth lowest premature morality in Scotland**. |
| **East Lothian** | 320 | 375 | 372 | 333 | 313 | 342 | ↓ | ↓ | |
| **Scotland** | 441 | 440 | 425 | 432 | 426 | 457 | ✔ | - | |

| 12. Emergency admission rate for adults (per 100,000 population) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020** | **Trend** | **6-year Trend** | Performance improved, with a lower rate of emergency admissions than the previous year.<br>East Lothian's emergency admission rate remains lower than the Scottish rate. |
| **East Lothian** | 10,053 | 9,634 | 10,337 | 10,069 | 10,959 | 10,157 | ✓ | ↓ | |
| **Scotland** | 12,295 | 12,230 | 12,211 | 12,279 | 12,524 | 11,111 | ✓ | - | |

| 13. Emergency bed day rate for adults (per 100,000 population) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020** | **Trend** | **6-year Trend** | There were a higher number of emergency bed days for East Lothian residents (per 100,000 population) during 2020.<br>Although the number of bed days had risen from the previous year, the level was still lower than the Scottish rate and showed an overall positive trend. |
| **East Lothian** | 119,053 | 120,373 | 120,661 | 99,549 | 96,617 | 101,588 | ↓ | ✓ | |
| **Scotland** | 127,659 | 126,077 | 122,868 | 120,276 | 118,607 | 102,961 | ✗ | - | |

| 14. Readmission to hospital within 28 days of discharge (rate per 1,000 discharges) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020** | **Trend** | **6-year Trend** | Performance was down from previous years, with slightly more readmissions (although the numbers involved were small –equating to an additional 11 readmissions per 100,000 population). |
| **East Lothian** | 99 | 100 | 106 | 99 | 102 | 113 | ↓ | ↓ | East Lothian's readmission rate was similar to the Scottish rate (which shows a similar trend over the 6 year period). |
| **Scotland** | 98 | 101 | 103 | 103 | 105 | 115 | ✓ | - | |

| 15. Proportion of last 6 months of life spent at home or in a community setting | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020** | **Trend** | **6-year Trend** | Performance improved from the previous year and continued to be in line with the Scottish rate. |
| **East Lothian** | 84.7% | 85.6% | 85.6% | 87.8% | 87.5% | 89.7% | ✓ | ✓ | A 5% improvement can be seen in the East Lothian figure over the last 6 years. |
| **Scotland** | 87.0% | 87.3% | 88.0% | 88.0% | 88.4% | 90.0% | — | - | |

| 16. Falls rates per 1,000 population aged 65+ | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020** | **Trend** | **6-year Trend** | The falls rate per 1,000 population for aged 65+ stayed at the same level as the previous year. |
| **East Lothian** | 19.4 | 18.9 | 18.8 | 19.0 | 22.9 | 23.4 | — | ↓ | |
| **Scotland** | 21.1 | 21.4 | 22.2 | 22.5 | 22.8 | 21.7 | — | - | |

| 17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** | **Trend** | **6-year Trend** | 84% of care services were graded 'good' or better in Care Inspectorate inspections – around the same level as the previous year.<br>A strong upward trend can be noted for East Lothian since 2015/16. |
| **East Lothian** | 76.6% | 76.6% | 85.0% | 84.2% | 84.7% | 83.5% | — | ✓ | |
| **Scotland** | 82.9% | 83.8% | 85.4% | 82.2% | 81.8% | 82.5% | — | - | |

| 18. Percentage of adults with intensive care needs receiving care at home | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **Trend** | **6-year Trend** | Performance remained consistent with the previous year and in line with the Scottish rate. |
| **East Lothian** | 65.6% | 65.1% | 64.9% | 61.0% | 63.3% | 62.7% | — | ↓ | |
| **Scotland** | 61.2% | 61.6% | 60.7% | 62.1% | 63.0% | 62.9% | — | - | |

| 19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** | **Trend** | **6-year Trend** | Performance improved significantly in relation to the number of delayed discharge bed days for the 75+ age group.<br>This improvement trend has continued over a number of years, with the East Lothian rate now sitting significantly below the Scottish rate. |
| **East Lothian** | 1,314 | 1,158 | 775 | 641 | 327 | 262 | ✓ | ✓ | |
| **Scotland** | 915 | 841 | 762 | 793 | 774 | 488 | ✓ | - | |

| 20. Percentage of health and care resources spent on hospital stays where the patient was admitted in an emergency | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020** | **Trend** | **6-year Trend** | Performance improved from the previous year, with 2% less spent on hospital stays where a patient was admitted in an emergency. This performance is in line with the Scottish average |
| **East Lothian** | 21.8% | 22.0% | 24.3% | 22.5% | 22.5% | 21.4% | ✓ | ✓ | |
| **Scotland** | 23.2% | 23.4% | 24.1% | 24.2% | 24.1% | 21.2% | – | - | |

There are a further four National Indicators which cannot be reported on currently as national data is not yet available or there is no nationally agreed definition for the indicator as yet. These indicators are:

- Indicator 10 - % of staff who say they would recommend their workplace as a good place to work.
- Indicator 21 - % of people admitted to hospital from home during the year, who are discharged to a care home.
- Indicator 22 - % of people who are discharged from hospital within 72 hours of being ready.
- Indicator 23 - Expenditure on end of life care costs in last 6 months per death.

## Ministerial Strategic Group (MSG) Indicators

The indicators shown below were developed by the Ministerial Strategic Group for Health and Social Care. Health and Social Care Partnerships have been required to set their own targets for each of these indicators – East Lothian's are shown in the table below. These figures are based on reports released for management information only. Due to different configuration of services, figures for the hospital / hospice categories may not be comparable across partnership areas.

| **Performance Symbols Key** | | | | | |
|---|---|---|---|---|---|
| Improvement trend | ✓ | Performance similar to previous years / only slight change | – | Downward trend | ↓ |

| Indicator | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | Trend | 6-year Trend |
|---|---|---|---|---|---|---|---|---|
| 1. Number of Emergency Admissions (18+) | 7,935 | 7,659 | 8,259 | 8,194 | 9,003 | **8,261** | ✓ | ↓ |
| 2i. Number of Unscheduled Hospital Bed Days – Acute (18+) | 77,549 | 80,150 | 80,627 | 66,269 | 65,769 | **64,946** | ✓ | ✓ |
| 2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay[3] (18+) | 3,365 | 2,154 | 446 | 455 | 2,637 | **6,669** | **Issue with data** | **-** |

[3] Issue with data completeness for 2020

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 2ii. Number of Unscheduled Hospital Bed Days – Geriatric Long Stay[4] (65+) | 3,226 | 2,154 | 446 | 281 | 2,230 | **6,577** | **Issue with data[5]** | **-** |
| 2iii. Number of Unscheduled Hospital Bed Days – Mental Health[6] | 15,633 | 16,659 | 16,858 | 15,440 | 13,345 | **12,134** | ✔ | ✔ |
| 3. New Accident and Emergency attendances (18+) | 19,004 | 19,532 | 20,063 | 21,176 | 21,304 | **17,902** | ✔ | ✔ |
| 4. Total number of Bed Days lost to delays (all delays and all reasons 18+) | 15,829 | 14,762 | 10,668 | 7,839 | 4,781 | **3,935** | ✔ | ✔ |
| 5. Percentage of last six months of life spent in community setting | 84.7% | 85.6% | 85.6% | 87.8% | 87.6% | **88.9%** | ✔ | ✔ |
| 6. Percentage of the population at home – supported and unsupported (aged 65+) | 96.2% | 96.3% | 96.4% | 96.7% | 96.8% | **96.8%** | — | ✔ |



[4] Issue with data completeness for 2020
[5] Issues with this data are like to be related to changes in coding so meaningful comparisons with previous years are not valid
[6] Issue with data completeness for 2020

# Our financial performance

## Budget spend in 2020-21

As in previous years, East Lothian Integration Joint Board (IJB) received a financial allocation from its partners – East Lothian Council and NHS Lothian – for the functions delegated to it.

East Lothian IJB had a budget of just under £193m and ended the year with an underspend of £7.2m – this means that the charges from partners for services delivered on behalf of the IJB were less than the income available to the IJB. However, this underspend is largely made up of committed funds that have been carried forward into 2021-22 with the 'operational' underspend being c. £1.3m.

A significant element of the committed funds carried forward relates to COVID-19 funding. The IJB received funding of £10.7m to meet the net additional costs of the pandemic and spent £7.1m. COVID-19 related costs will span across financial years, therefore funding allocations which have not been fully used in 2020-21 have been carried forward to 2021-22.

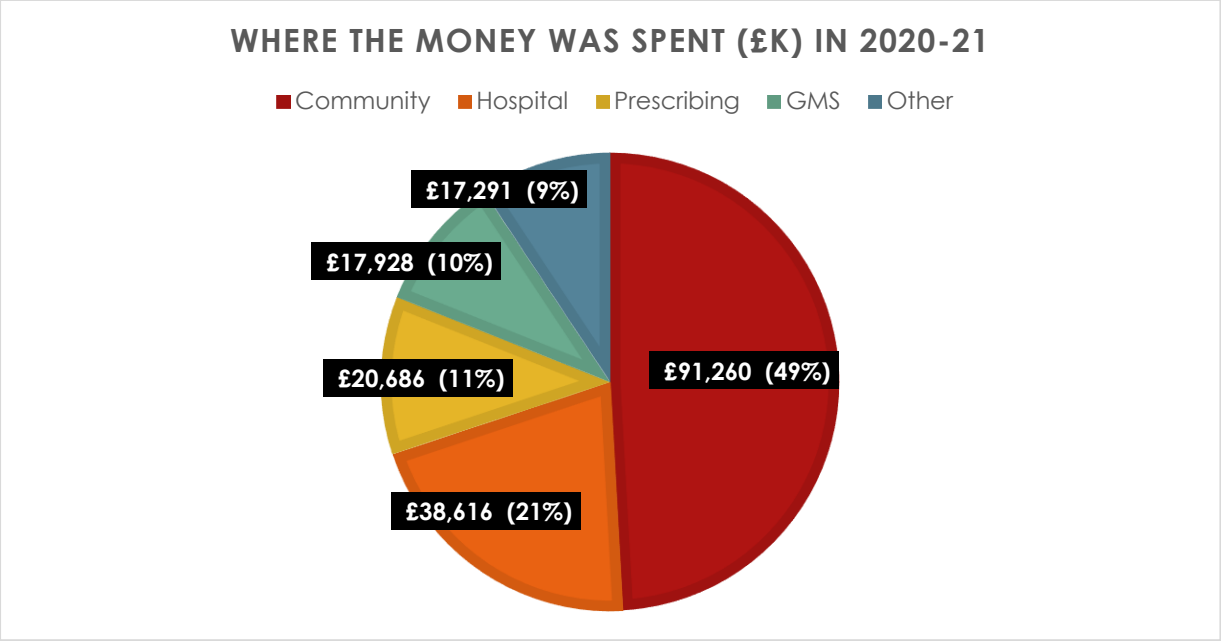
The operational underspend will be taken to the general reserve which was £3.1m at March 2021.

Further details of our total reserves balance are shown below.

| | **2020-21 Budget**<br>**£k** | **2020-21 Expenditure**<br>**£k** | **Variance**<br>**£k** |
|---|---|---|---|
| **Health** | £143,606 | £136,829 | £6,777 |
| **Social Care** | £49,385 | £48,952 | £433 |
| **Total** | £192,991 | £185,781 | £7,210 |

The financial position of the IJB at the end of 2020-21 is explained in more detail in the annual accounts.

The graph below shows our budget spend according to category of activity.




| | Community £000 | Hospital £000 | Prescribing £000 | GMS* £000 | Other £000 | Total £000 |
|---|---|---|---|---|---|---|
| Expenditure | 91,260 | 38,616 | 20,686 | 17,928 | 17,291 | 185,781 |
| % of total | 49% | 21% | 11% | 10% | 9% | 100% |

* GMS (General Medical Services) expenditure is the cost of running the GP service in East Lothian. Prescribing expenditure is the costs of prescriptions for the 15 East Lothian GP practices.

Breakdown of the budget and expenditure by service for 2020-21 is shown below:

| | Budget £000 | Expenditure £000 | Variance £000 |
|---|---|---|---|
| **Direct East Lothian Services** | | | |
| Community Allied Health Professionals | 4,037 | 3,993 | 44 |
| Community Hospitals | 11,613 | 11,608 | 5 |
| District Nursing | 2,600 | 2,488 | 112 |
| General Medical Services | 17,746 | 17,928 | (182) |
| Health Visiting | 1,900 | 1,740 | 160 |
| Mental Health | 8,165 | 7,887 | 277 |
| Other | 21,568 | 13,546 | 8,022 |
| Prescribing | 20,599 | 20,686 | (87) |
| Resource Transfer | 4,733 | 4,738 | (4) |
| Older People | 26,466 | 28,126 | (1,660) |
| Physical Disabilities | 3,378 | 3,073 | 305 |
| Learning Disabilities | 16,103 | 16,325 | (222) |
| Planning & Performance | 2,871 | 2,543 | 328 |
| **East Lothian share of pan-Lothian Services** | | | |
| Set Aside | 21,921 | 21,957 | (36) |
| Mental Health | 2,411 | 2,492 | (81) |
| Learning Disabilities | 1,816 | 1,786 | 30 |
| GP Out of Hours | 1,392 | 1,517 | (125) |
| Rehabilitation | 875 | 773 | 103 |
| Sexual Health | 801 | 748 | 53 |
| Psychology | 908 | 990 | (82) |
| Substance Misuse | 411 | 407 | 4 |
| Allied Health Professionals | 1,500 | 1,391 | 109 |
| Oral Health | 2,098 | 2,060 | 38 |
| Other | 3,846 | 3,746 | 100 |
| Dental | 6,824 | 6,824 | 0 |
| Ophthalmology | 2,046 | 2,046 | 0 |
| Pharmacy | 4,363 | 4,363 | 0 |
| **Total** | **192,991** | **185,781** | **7,210** |

## Reserves

As discussed above, the IJB's underspend is largely made up of committed funds that have been carried forward into 2021-22 with the 'operational' underspend being around £1.2m. This is laid out in detail in the analysis of reserves below. This operational underspend will take the general reserve to £3.1m at March 2021. The IJB's reserve strategy proposed a reserve of around 2% of the IJB's turnover which would equate to around £3.8m.

The IJB has set aside future amounts of reserves for future policy purposes; funds that are set aside for specific purposes; and funds which are not earmarked for specific purposes but are set aside to deal with unexpected events or emergencies (general).

In 2020-21 investment was given by the Scottish Government for COVID-19, programmes in Primary Care, Mental Health and Alcohol and Drug Partnerships. The reserve is broken down as follows into specific purposes and general reserves:

| **Earmarked Reserves** | **£000** |
|---|---|
| COVID-19 | 3,623 |
| Primary Care Improvement Fund | 226 |
| Action 15 – Scottish Government Mental Health Strategy | 53 |
| Alcohol and Drugs Scottish Government Allocation | 766 |
| Community Living Change Fund | 346 |
| Locally Committed Programmes | 1,512 |
| Committed Project Funds | **6,526** |
| General Reserves | **3,082** |
| Total Reserves | **9,608** |

## Financial pressures

Existing recurring financial pressures in some service areas continued in 20200-21. In other areas, financial pressures have been minimal due to reduced levels of activity.

During the course of the year the Scottish Government provided £10.7 m of funding to meet all additional costs and unachieved savings associated with the pandemic. This reflected the funding requested through the IJB's Local Mobilisation Plan submissions and further funding confirmed by the Scottish Government in February 2021 in respect of ongoing COVID related cost pressures. Expenditure of £7.1 m was incurred during the year, leaving a balance of £3.6m to be transferred to reserves to meet ongoing costs during 2021-22.

The main additional COVID related costs during 2020-21 included those related to:

- Sustainability payments to local social care providers to enable them to continue to deliver a sustainable service.
- Opening up an additional 44 hospital beds at East Lothian Community Hospital.
- Delivering a COVID Assessment Hun in Musselburgh.
- Delivering the East Lothian COVID Vaccination Programme.
- Supporting the health and social care staff bonus payments.
- Developing a long-COVID and post-COVID rehabilitation provision.
- Supporting Care Homes with challenges relating to outbreaks through Infection Prevention and Control training and advice.

## Future financial pressures

As noted above COVID-19 allocations not fully used in 2020-21 were carried forward by IJBs to support remobilisation in 2021-22. The Remobilisation Plan submitted by NHS Lothian to the Scottish Government identified that Health and Social Care Partnerships are unlikely to be able to continue to redeploy resources to meet COVID pressures, suggesting that increased additional resources will be necessary. At the time of writing, the level of COVID related funding for 2021-22 has still to be confirmed but it is the expected that additional costs incurred will be fully funded.

Aside from the immediate cost impact of COVID-19, there are other, longer term, financial challenges likely to result from the pandemic. These include uncertainty regarding long-term prescribing issues, the impact of COVID on our independent sector providers and the implications for future service reconfiguration. These issues are common across Scotland and continue to be a regular feature of discussions between IJBs and the Scottish Government.

East Lothian HSCP will continue to face increasing demands on services brought by an ageing and growing population. The challenge of meeting the needs of a range of different communities, both urban and rural also places additional financial pressures on the Partnership.

# Efficient and effective use of resources

As noted in last year's report, the duty of 'Best Value' applies to all public bodies in Scotland and underpins East Lothian IJB's strategic planning, procurement and service evaluation processes.

Audit Scotland is committed to ensuring that Best Value auditing across the public sector:

- Adds value to existing arrangements.
- Is risk-based and builds on our knowledge of individual public bodies.
- Reports on the delivery of outcomes for people who use services.
- Protects taxpayers' interests by examining the use of resources.
- Puts an increasing emphasis on self-assessment by public bodies with audit support and validation.
- Works collaboratively with NHS Quality Improvement Scotland to ensure our work is aligned and to prevent duplication.

East Lothian IJB works within NHS Lothian and East Lothian Council internal audit programme. All areas of work are audited, including planning, performance and engagement. The East Lothian IJB's Audit and Risk Committee and ELHSCP Clinical Governance Group also play key roles in ensuring Best Value.

In terms of procurement, commissioning and delivery of services:

- We have a clear procurement timetable to ensure services operate under clear contractual terms.
- Our contracts include performance measures and service specifications that service outcomes can be measured against.
- We have a Commissioning Board in place to oversee the commissioning and decommissioning of services.
- Our scorecard system ensures that services are reviewed annually, and evidence is provided of year-on-year service improvement.

Examples of the impact of Best Value on ELHSCP's commissioning and procurement include:

- Delivery of an in-house Financial Management Service to mitigate external provider risks.
- Implementation of a Carers Support Providers Framework (covering contracts with providers).
- Implementation of a Community Support Framework.

The HSCP Commissioning Team monitors and evaluates the delivery of outcomes with service users and ELHSCP staff. We also have specialist teams such as the Community Review Team and Care Home Assessment and Review Team who work closely with providers to monitor and evaluate outcomes.

# Challenges and opportunities ahead in 2021-22

## Remobilisation

Ongoing work to remobilise all HSCP services safely and appropriately will continue throughout 20210-22. Whilst providing the best possible services in the 'new normal' presents challenges, the Partnership has proven to be adept at developing new and innovative responses to service delivery. We will continue to fully engage with NHS Lothian Remobilisation planning and activity throughout the year.

## Long-term impact of COVID

The longer term impact of COVID in terms of additional demand health and social care services has been widely discussed.

Particular attention has been given to the potential impact on the number of mental health related presentations, although estimates vary. The introduction of the CWIC Mental Health service during 2020-21 reflects our commitment to improve access to mental health support. Work to look at patient pathways in mental health services began in 2020-21 and will result in improvements to these pathways being introduced in the coming year.

The need for post-COVID rehabilitation has also emerged as a longer term impact of COVID, although, again, it is hard to predict the level of service demand this will generate. We have made good progress in developing a service response and will continue to develop our multidisciplinary approach to deliver effective post-COVID rehabilitation.

## Adult Social Care

The February 2021 report on the Independent Review of Adult Social Care (IRASC) commonly called the Feeley Report, generated bold and far-reaching recommendations that are set to have a significant impact on the duties and powers of IJBs and the environment HSCPs work within over the coming years.

The principles set out in the Feeley Report, such as empowering people and embedding a human rights approach to social care, already guide our service development and delivery, and will continue to do so. However, the implications of the proposed development of a National Care Service and resulting changes to governance and accountability for delivery of health and social care at a local level and the timetable for change cannot be predicted with any certainty.

Although some aspects of the change ahead of us may not be introduced for several years, the development of the new IJB Strategic Plan and its priorities will be informed by the initial outcomes of the consultation on the National Care Service,

## Service Providers

This Annual Report has described how we worked with external providers throughout the year to support their continued delivery of services across the county. The challenging operational environment during 2020-21 looks set to continue into the new financial year. This causes particular concern in terms of providers' resilience and their ability to operate in a pressurised context over a sustained period of time. The workforce challenges faced by the HSCP, in terms of staff recruitment and retention, are also a significant issue for providers.

## Transformation Programme

We made significant progress during 2020-21 in developing our Community Transformation Programmes for adults under and over 65 with complex needs. Work will continue to further develop our proposed new service models over the coming year.

Engagement with communities, provider organisations and other stakeholders to date has helped to establish a strong foundation for continued collaboration on the development of innovative and flexible approaches to service delivery.

## Vaccination Programme

We are proud of the role played by staff and volunteers in the delivery of the COVID vaccination programme during 2020-21, the largest and most ambitious vaccination programme in history. This built on the success of the HSCP's new role in delivering the 2020-21 winter Flu Vaccination Programme. However, the ongoing need for COVID vaccinations and boosters, along with increased responsibility for delivering the 2021-22 Flu Vaccination Programme, places a significant additional responsibility on the HSCP, with implications for already stretched resources.

## Workforce

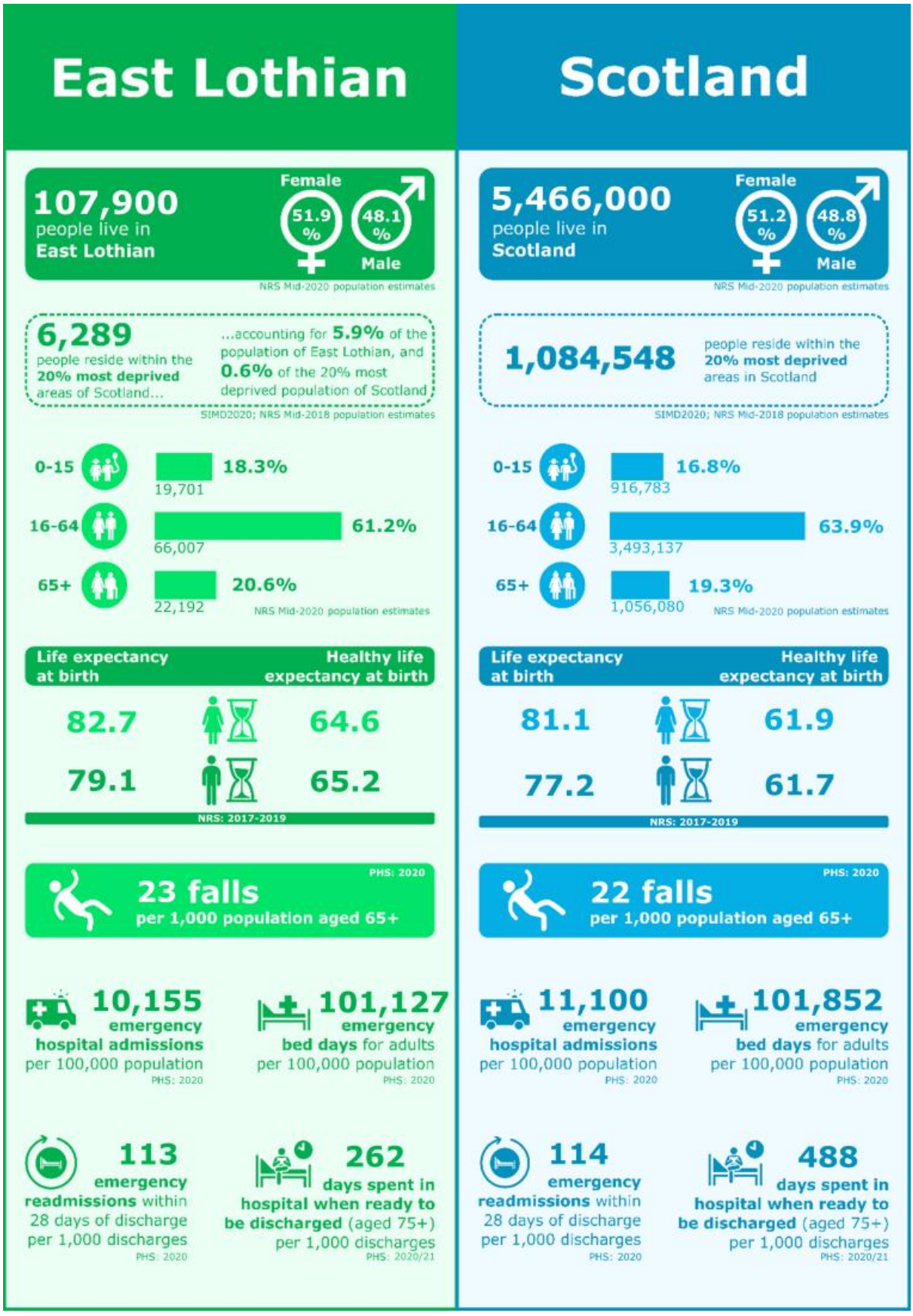
Our workforce demonstrated an extraordinary level of professionalism and commitment during the year to ensure services were delivered to those most in need. We will continue to support and invest in our workforce over the coming year. However, we share concerns expressed regarding the impact on health and social care staff of continuing to work under this level of pressure over a sustained period of time.

Recruitment and retention of staff will continue to present a challenge. The ongoing shortage of health and social care staff at a national level is well documented. This is reflected in our local experience of difficulties in recruiting and retaining staff to deliver key services.

## Primary Care

Work will continue on delivering the commitments within the Memorandum of Understanding for Primary Care Improvement, as agreed between Scottish Government, British Medical Association, Integration Authorities (IJBs) and NHS Boards. This will further develop services in East Lothian to support the transfer of activity from GP practices to the HSCP as part of the continuing delivery of the next stage of the GP contract. In support of this, we will, within the limitations of available capital funding, progress GP premises developments as set out in the East Lothian Primary Care Premises Strategy.

## Appendix 1 – East Lothian by numbers



## Appendix 2 – Confidence Intervals

Alongside the results for the Health and Care Experience Survey from the Core Suite of Integration Indicators, 95% confidence intervals have been produced to allow further interpretation of the East Lothian results when compared to Scotland.

95% confidence intervals indicates the 95% probability that the survey result lies within the range between the upper and lower confidence limits. If these ranges do not overlap (e.g. the upper confidence limit for East Lothian is lower than the lower confidence limit for Scotland) we have labelled the results as 'statistically significant'.

Confidence intervals tend to be smaller for results where the sample size was larger e.g. Scotland, and larger for smaller sample sizes, such as in East Lothian.

National Integration Indicators based on Health and Social Care Experience Survey (2019/20)

| Indicator | Area | Result | Lower Confidence Limit | Upper Confidence Limit |
|---|---|---|---|---|
| Percentage of adults able to look after their health very well or quite well | East Lothian | 94 | 93 | 95 |
| | Scotland | 93 | 93 | 93 |
| Percentage of adults supported at home who agree that they are supported to live as independently as possible | East Lothian | 72 | 61 | 82 |
| | Scotland | 81 | 80 | 82 |
| Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided | East Lothian | 75 | 65 | 86 |
| | Scotland | 75 | 74 | 77 |
| Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated | East Lothian | 61 | 50 | 72 |
| | Scotland | 74 | 72 | 75 |
| Percentage of adults receiving any care or support who rate it as excellent or good | East Lothian | 76 | 66 | 86 |
| | Scotland | 80 | 79 | 81 |
| Percentage of people with positive experience of care at the ir GP practice | East Lothian | 72 | 70 | 74 |
| | Scotland | 79 | 78 | 79 |
| Percentage of adults supported at home who agree that their services and support had an impact in improving or maintain | East Lothian | 70 | 59 | 81 |
| | Scotland | 80 | 79 | 81 |
| Percentage of carers who feel supported to continue in their caring role | East Lothian | 33 | 28 | 38 |
| | Scotland | 34 | 34 | 35 |
| Percentage of adults supported at home who agree they felt safe | East Lothian | 70 | 59 | 81 |
| | Scotland | 83 | 82 | 84 |

East Lothian
Integration Joint Board

**SBAR – National Care Service Consultation** **6**

| |
|---|
| **Date:** 21st October 2021<br>**Completed by:** Paul Currie<br>**Area:** Planning and Performance |

| | |
|---|---|
| **Situation** | The consultation concerning the proposed establishment of a National Care Service (NCS) is nearing completion, with an end date of 2nd November 2021. The NCS was a recommendation of the Independent Review of Adult Social Care (IRASC).<br><br>The establishment of a National Care Service and associated organisational changes would see IJBs replaced by Community Health and Social Care Boards (CHSCBs). |
| **Background** | The IRASC, which reported on 3rd February 2021, was set up to recommend improvements to adult social care in Scotland. It focussed on the outcomes for people who use services, their carers and families and the experience of those working in the sector in all settings.<br><br>The IRASC suggested that to develop social care support and to ensure consistency of delivery across Scotland a 'National Care Service' needed established to:<br><br>*"…drive national improvements where they are required, to ensure strategic integration with the National Health Service, to set national standards, terms and conditions, and to bring national oversight and accountability…"*<br><br>IRASC suggested this National Care Service would provide transformational leadership for all those involved in the planning and delivery of social care support and give a voice to those with lived experience. It would seek to establish across the sector:<br>• Common purpose.<br>• Trusting relationships rather than competition.<br>• Partnerships, not marketplaces.<br><br>Several IRASC recommendations focus on IJBs, with a view to:<br>• Delivering improvements in carer participation.<br>• Reforming IJBs to give them new duties and powers (including for GP contracts).<br>• Providing direct funding from Scottish Government.<br>• Working collaboratively with the National Care Service on various matters.<br>• Taking on responsibility for planning, commissioning and procurement - investing in preventative care and admission avoidance rather than crisis responses.<br><br>East Lothian IJB provided its response to the IRASC consultation in November 2020. |

| | |
|---|---|
| **Assessment** | The NCS consultation document sets out the Scottish Government's ambitious developments of the core IRASC recommendations. These go beyond the creation of a National Care Service for adult social care alone. The proposals seek to establish the NCS as an organisation to set strategic direction and quality standards for community health and social care in Scotland across a wide range of domains, in partnership with Community Health and Social Care Boards (CHSCBs, as successors to IJBs) as their delivery body and with other organisations.<br><br>The consultation document suggests CHSCBs will be funded directly by the Scottish Government and will be accountable to ministers. They will work with the NHS, local authorities and third and independent sectors to plan, commission and deliver local support and services to meet the assessed needs of communities.<br><br>It is proposed that membership of the CHSCBs will include local elected members, health and care professionals, and local representatives, including people with lived experience of service use and carers. All members are likely to have voting powers.<br><br>Each CHSCB will employ its own Chief Executive and staff to plan, commission, and procure care and support, including the management of GP contractual arrangements.<br><br>The NCS consultation document contains 96 questions across several domains of health and social care delivery. Several online consultation events were also held on Teams by Scottish Government, focussed on specific aspects of the consultation. These were very well attended.<br><br>East Lothian IJB members were invited by HSCP Planning and Performance to provide comments on the consultation to inform a response from the IJB. The response was limited. Members were also encouraged to reply direct, in their own right to the consultation. It is unknown how many members took up this option.<br><br>In view of the initial limited response, a development session on the NCS consultation was held on 8th October with IJB members and HSCP General Managers attending. This facilitated event allowed for discussion on the implications of the NCS for health and social care services in East Lothian and for the IJB itself.<br><br>The discussion showed there was a range of views among the IJB membership on some matters, as well as consensus that some of the NCS consultation recommendations were necessary to further develop integration.<br><br>The outputs of the development session are included in the attached consultation response (appendix 1) along with those gathered in the previous request to IJB members. |
| **Recommendations** | East Lothian IJB is asked to:<br><br>• Note that the consultation response contains a range of views, reflecting the different perspectives of the IJB membership.<br>• Agree to the attached National Care Service (NCS) consultation response (appendix 1) being passed to the NCS consultation Team at Scottish Government on behalf of the IJB. |
| **Further information** | NCS Consultation document – click here. |

**A National Care Service for Scotland - Consultation**

**RESPONDENT INFORMATION FORM**

**Please Note** this form **must** be completed and returned with your response.

To find out how we handle your personal data, please see our privacy policy: https://www.gov.scot/privacy/

Are you responding as an individual or an organisation?

☐ Individual

☒ Organisation

Full name or organisation's name

East Lothian Integration Joint Board (IJB)

Phone number 01620827765

Address

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Brewery Park,
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Postcode EH41 3HA

Email paul.currie@nhslothian.scot.nhs.uk

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

☒ Publish response with name

☐ Publish response only (without name)

☐ Do not publish response

**Information for organisations:**

The option 'Publish response only (without name)' is available for individual respondents only. If this option is selected, the organisation name will still be published.

If you choose the option 'Do not publish response', your organisation name may still be listed as having responded to the consultation in, for example, the analysis report.

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

- ☒ **Yes**
- ☐ No

**Individuals - Your experience of social care and support**
If you are responding as an individual, it would be helpful for us to understand what experience you have of social care and support. Everyone's views are important, and it will be important for us to understand whether different groups have different views, but you do not need to answer this question if you don't want to.

Please tick all that apply

- ☐ I receive, or have received, social care or support
- ☐ I am, or have been, an unpaid carer
- ☐ A friend or family member of mine receives, or has received, social care or support
- ☐ I am, or have been, a frontline care worker
- ☐ I am, or have been, a social worker
- ☐ I work, or have worked, in the management of care services
- ☐ I do not have any close experience of social care or support.

**Organisations – your role**
Please indicate what role your organisation plays in social care

- ☐ Providing care or support services, private sector
- ☐ Providing care or support services, third sector
- ☐ Independent healthcare contractor
- ☐ Representing or supporting people who access care and support and their families
- ☐ Representing or supporting carers
- ☐ Representing or supporting members of the workforce
- ☐ Local authority
- ☐ Health Board
- ☒ **Integration authority**
- ☐ Other public sector body
- ☐ Other

**Questions**

## Improving care for people

### Improvement

**Q1.** What would be the benefits of the National Care Service taking responsibility for improvement across community health and care services? (Please tick all that apply)

- ☒ Better co-ordination of work across different improvement organisations
- ☒ Effective sharing of learning across Scotland -
- ☒ Intelligence from regulatory work fed back into a cycle of continuous improvement
- ☒ More consistent outcomes for people accessing care and support across Scotland
- ☒ Other – please explain below

There is a range of views among East Lothian IJB members regarding this question:

Fair and consistent terms and conditions for people working in social care. (Q1)

Career development pathways for the sector. (Q1)

Set national standards – advocacy services, waiting times for delivery of care packages. (Q1)

A better understanding in central government of the funding needed to achieve all of this. (Q1)

**Q2.** Are there any risks from the National Care Service taking responsibility for improvement across community health and care services?

There is a range of views among East Lothian IJB members regarding this question as follows:

It is important that small local service providers are supported, as they can be vehicles for delivering innovation and improving outcomes. If there is too much bureaucracy then it could stifle fruitful local relationships and associated creativity. (Q2)

A centralised bureaucracy risks loss of local knowledge and influence. (Q2)

Expectations of change will be raised but the change may not be delivered.

Possible loss of local democratic control. (Q2)

One member suggested experience of centralising services so far in Scotland has delivered an inferior service, including communication through centralised services not being as responsive as local services, for example waiting times for 101 calls to the police. (Q2)

The input of local people into planning of community health and care services for their area may be reduced. (Q2)

## Access to Care and Support

### Accessing care and support

**Q3.** If you or someone you know needed to access care and support, how likely would you be to use the following routes if they were available?

Speaking to my GP or another health professional.

| Not at all likely | Unlikely | Neither likely nor unlikely | Likely | Very likely |
|---|---|---|---|---|
| | | | | |

Speaking to someone at a voluntary sector organisation, for example my local carer centre, befriending service or another organisation.

| Not at all likely | Unlikely | Neither likely nor unlikely | Likely | Very likely |
|---|---|---|---|---|
| | | | | |

Speaking to someone at another public sector organisation, e.g. Social Security Scotland

| Not at all likely | Unlikely | Neither likely nor unlikely | Likely | Very likely |
|---|---|---|---|---|
| | | | | |

Going along to a drop in service in a building in my local community, for example a community centre or cafe, either with or without an appointment.

| Not at all likely | Unlikely | Neither likely nor unlikely | Likely | Very likely |
|---|---|---|---|---|
| | | | | |

Through a contact centre run by my local authority, either in person or over the phone.

| Not at all likely | Unlikely | Neither likely nor unlikely | Likely | Very likely |
|---|---|---|---|---|
| | | | | |

Contacting my local authority by email or through their website.

| Not at all likely | Unlikely | Neither likely nor unlikely | Likely | Very likely |
|---|---|---|---|---|
| | | | | |

Using a website or online form that can be used by anyone in Scotland.

| Not at all likely | Unlikely | Neither likely nor unlikely | Likely | Very likely |
|---|---|---|---|---|
| | | | | |

Through a national helpline that I can contact 7 days a week.

| Not at all likely | Unlikely | Neither likely nor unlikely | Likely | Very likely |
|---|---|---|---|---|
| | | | | |

Other – Please explain what option you would add.

As this question seeks individual views on personal choices to access support it is not considered relevant for completion by the IJB. (Q3)

**Q4.** How can we better co-ordinate care and support (indicate order of preference)?

**2** ☐ Have a lead professional to coordinate care and support for each individual. The lead professional would co-ordinate all the professionals involved in the adult's care and support.

**3** ☐ Have a professional as a clear single point of contact for adults accessing care and support services. The single point of contact would be responsible for communicating with the adult receiving care and support on behalf of all the professionals involved in their care, but would not have as significant a role in coordinating their care and support.

**1** ☐ Have community or voluntary sector organisations, based locally, which act as a single point of contact. These organisations would advocate on behalf of the adult accessing care and support and communicate with the professionals involved in their care on their behalf when needed.

## Support planning

**Q5.** How should support planning take place in the National Care Service? For each of the elements below, please select to what extent you agree or disagree with each option:

### a. How you tell people about your support needs

Support planning should include the opportunity for me and/or my family and unpaid carers to contribute.

| | Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| **Yes** | | | | | |

If I want to, I should be able to get support from a voluntary sector organisation or an organisation in my community, to help me set out what I want as part of my support planning.

| | Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| **Yes** | | | | | |

### b. What a support plan should focus on:

Decisions about the support I get should be based on the judgement of the professional working with me, taking into account my views.

| | Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| **Yes** | | | | | |

Decisions about the support I get should be focused on the tasks I need to carry out each day to be able to take care of myself and live a full life.

| | Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| **Yes** | | | | | |

Decisions about the support I get should be focused on the outcomes I want to achieve to live a full life.

| | Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| **Yes** | | | | | |

The above questions (5a and 5b) are answered from the perspective of the IJB in seeking to develop services responsive to individuals' needs

**c. Whether the support planning process should be different, depending on the level of support you need:**

I should get a light-touch conversation if I need a little bit of support; or a more detailed conversation with a qualified social worker if my support needs are more complex.

| Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| **Yes** | | | | |

If I need a little bit of support, a light-touch conversation could be done by someone in the community such as a support worker or someone from a voluntary sector organisation.

| Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| **Yes** | | | | |

However much support I need, the conversation should be the same.

| Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| **Yes** | | | | |

Light touch and/or more detailed support planning should take place in another way – please say how below

This will be dependent on the emphasis and delivery arrangements for the support. (Q5)

**Q6.** The Getting It Right For Everyone National Practice model would use the same language across all services and professionals to describe and assess your strengths and needs. Do you agree or disagree with this approach?

☒ **Agree**

☐ Disagree

Please say why.

This has the potential to ensure minimum service levels across Scotland. It needs to be regularly reviewed and all partners, including COSLA, advocacy providers, service users and carers, the third sector and all the professions involved in delivering care should be involved in its development. (Q6)

Housing is an important part of care planning and these colleagues should be involved as appropriate. (Q6)

There should be some flexibility for local amendments to feature, if desirable following local consultation. (Q6)

**Q7.** The Getting It Right for Everyone National Practice model would be a single planning process involving everyone who is involved with your care and support, with a single plan that involves me in agreeing the support I require. This would be supported by an integrated social care and health record, so that my information moves through care and support services with me. Do you agree or disagree with this approach?

☒ **Agree**

☐ Disagree

Please say why.

There are some reservations among East Lothian IJB members. Some ask who would have access to all this information and who would contribute and how would this be done practically across different IT systems? (Q7)

Such a development presents a huge challenge in developing an integrated health and care record given the history of delivering IT systems in public sector and associated cost overruns. (Q7)

**Q8.** Do you agree or disagree that a National Practice Model for adults would improve outcomes?

☒ **Agree**

☐ Disagree

Please say why.

It would standardise care. (Q8)

Although, success hinges on whether at a time of severe fiscal challenges the financial and other resources and necessary workforce can be secured and maintained to deliver the ambitions. (Q8)

## Right to breaks from caring

**Q9.** For each of the below, please choose which factor you consider is more important in establishing a right to breaks from caring. (Please select one option from each part. Where you see both factors as equally important, please select 'no preference'.)

Standardised support packages versus personalised support

| | | |
|---|---|---|
| ☒ **Personalised support to meet need** | ☐ Standardised levels of support | ☐No preference |

A right for all carers versus thresholds for accessing support

| | | |
|---|---|---|
| ☐ Universal right for all carers | ☒ **Right only for those who meet qualifying thresholds** | ☐ No preference |

Transparency and certainty versus responsiveness and flexibility

| | | |
|---|---|---|
| ☐ Certainty about entitlement | ☒ **Flexibility and responsiveness** | ☐ No preference |

Preventative support versus acute need

| | | |
|---|---|---|
| ☒ **Provides preventative support** | ☐ Meeting acute need | ☐ No preference |

One IJB member commented that the 'Feeley Report' recommendation to make respite a right was universally welcomed by carers in East Lothian. However the NCS consultation seeks to dilute this. The original recommendation is strongly supported. Rather than seeking to avoid granting this right the focus should be on working on the practicalities of defining levels of eligibility criteria and cost management principles. (Q9)

**Q10.** Of the three groups, which would be your preferred approach? (Please select one option.)

- ☐ Group A – Standard entitlements
- ☒ Group B – **Personalised entitlements**
- ☒ Group C – **Hybrid approaches**

Please say why.

There is a range of views among East Lothian IJB members, as noted above.

One member commented that carers' need vary and an individualised approach would better meet these. Others though hybrid approaches provided flexibility. (Q10)

It is critical that there is a sustainable plan to fund these services and to respond to future growth in demand, arising from population and demographic changes. (Q10)

## Using data to support care

**Q11.** To what extent do you agree or disagree with the following statements?

There should be a nationally-consistent, integrated and accessible electronic social care and health record.

| Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| **Yes** | | | | |

Information about your health and care needs should be shared across the services that support you.

| Strongly Agree | Agree | Neither Agree/Disagree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| **Yes** | | | | |

**Q12.** Should legislation be used to require all care services and other relevant parties to provide data as specified by a National Care Service, and include the requirement to meet common data standards and definitions for that data collection?

☒ **Yes**

☐ No

Please say why.

There is a range of views among East Lothian IJB members regarding whether legislation should be pursued to deliver common data solutions (linked or otherwise) across all service providers in the public and third sectors and in commissioned services. (Q12)

There are concerns about application of this across all sizes of organisations, as some, such as smaller local third sector organisations, may not have the technical or other capacities to deliver. (Q12)

Any blanket application of this approach may raise concerns about security and confidentiality (such as were expressed concerning the Named Person legislation). (Q12)

It needs to be clarified if there will there be an expectation this will apply to Personal Assistants and Self Directed Support. (Q12)

**Q13.** Are there alternative approaches that would address current gaps in social care data and information, and ensure a consistent approach for the flow of data and information across the National Care Service?

Only if the independent and third sectors are excluded, and that is not desirable. (Q13)

The development of client/carer/family held digital notes might be worthy of exploration. (Q13)

## Complaints and putting things right

**Q14.** What elements would be most important in a new system for complaints about social care services? (Please select 3 options)

- ☒ **Charter of rights and responsibilities, so people know what they can expect**
- ☐ Single point of access for feedback and complaints about all parts of the system
- ☒ **Clear information about advocacy services and the right to a voice**
- ☐ Consistent model for handling complaints for all bodies
- ☒ **Addressing complaints initially with the body the complaint is about**
- ☐ Clear information about next steps if a complainant is not happy with the initial response
- ☐ Other – please explain:

As all the other (unselected) options above have merit, they should also be considered for inclusion within any new system. (Q14)

**Q15.** Should a model of complaints handling be underpinned by a commissioner for community health and care?

☒ **Yes**

☐ No

Please say why.

To ensure accountability. (Q15)

It is however questioned why there is so much emphasis on complaints and whether this came up as an issue in the IRASC. (Q15)

It is unclear where the Care Inspectorate sit in relation to any new system for complaints about social care services, or whether they will be subsumed into the NCS. One East Lothian IJB member asked whether the Care Inspectorate should be given a role in investigating complaints. (Q15)

It is suggested that carers find the current complaints process confusing and complicated with several pathways and often, no resolution. The proposed creation of a national care body with responsibility for complaints, offering a single transparent and accountable process is therefore viewed as a very positive development. (Q15)

One member commented that there is variation in the standard and provision of care across the country. They were of the view that a new national care body with responsibility to set and monitor standards for care is needed and in the context of provision must also have responsibility for workforce planning. (Q15)

**Q16.** Should a National Care Service use a measure of experience of those receiving care and support, their families and carers as a key outcome measure?

☒ **Yes**

☐ No

Please say why.

This principle should underpin all good practice. It is difficult to see why any respondent would reply no. (Q16)

## Residential Care Charges

**Q17.** Most people have to pay for the costs of where they live such as mortgage payments or rent, property maintenance, food and utility bills. To ensure fairness between those who live in residential care and those who do not, should self-funding care home residents have to contribute towards accommodation-based costs such as (please tick all that apply):

- ☒ **Rent**
- ☒ **Maintenance**
- ☒ **Furnishings**
- ☒ **Utilities**
- ☒ **Food costs**
- ☐ Food preparation
- ☐ Equipment
- ☒ **Leisure and entertainment**
- ☒ **Transport**
- ☐ Laundry
- ☐ Cleaning
- ☐ Other – what would that be?

Any costs should continue to be based on assessment of the ability to pay at commencement of residential care, with reassessment regularly thereafter. (Q17)

**Q18.** Free personal and nursing care payment for self-funders are paid directly to the care provider on their behalf. What would be the impact of increasing personal and nursing care payments to National Care Home Contract rates on:

Self-funders

No views were expressed by IJB members concerning this question. (Q18)

Care home operators

No views were expressed by IJB members concerning this question. (Q18)

Local authorities

No views were expressed by IJB members concerning this question. (Q18)

Other

**Q19.** Should we consider revising the current means testing arrangements?

☒ Yes

☐ No

If yes, what potential alternatives or changes should be considered?

The view of one member of the \IJB was that the current means testing discriminates against those who have saved to some extent for their family's as well as their own care. This person also suggested that the level at which a person has to pay for care should be raised. (Q19)

## National Care Service

**Q20.** Do you agree that Scottish Ministers should be accountable for the delivery of social care, through a National Care Service?

☒ **Yes**

☒ **No, current arrangements should stay in place**

☐ No, another approach should be taken (please give details)

There is a range of views among East Lothian IJB members on whether Scottish Ministers should be accountable for the delivery of social care, in place of local authorities, through a National Care Service, or if current arrangements should remain. (Q20)

There is some uncertainty over the implications of IJBs being reformed to become Community Health and Social Care Boards. This includes the role of the new organisation as a local delivery body for the National Care Service and how at a local level the NCS, CHSCBs, NHS Board, local authorities, and third and independent sectors, will achieve the co-ordinated planning, commissioning and delivery of services currently delivered by the IJBs under existing arrangements. (Q20)

Consideration should be given to how IJBs can, within their current powers, begin to deliver on the ambitions of the NCS consultation. (Q20)

**Q21.** Are there any other services or functions the National Care Service should be responsible for, in addition to those set out in the chapter?

No. (Q21)

**Q22.** Are there any services or functions listed in the chapter that the National Care Service should not be responsible for?

No. (Q22)

## Scope of the National Care Service

### Children's services

**Q23.** Should the National Care Service include both adults and children's social work and social care services?

☐ Yes

☒ **No**

Please say why.

Children's social work and social care is best aligned to education, in line with GIRFEC. (Q23)

Seamless transition from children's to adult services is important, so effective joint working between those who plan, commission and deliver services needs to continue. (Q23)

**Q24.** Do you think that locating children's social work and social care services within the National Care Service will reduce complexity for children and their families in accessing services?

For children with disabilities,

☐ Yes

☒ **No**

Please say why.

Education has a key role to play in assessment and service provision. Better to keep this local link and to keep access local. (Q24)

For transitions to adulthood

☐ Yes

☒ **No**

Please say why.

This change is not needed to improve transitions. There is a National Practice Model for this and a duty on children's and adult services to begin planning at a key stage, working with service users and carers to identify post-education service requirements. (Q24)

For children with family members needing support

☐ Yes

☒ **No**

Please say why.

Support to these children is effectively provided through locally agreed arrangements and through coordinated action by all relevant local services. (Q24)

**Q25.** Do you think that with community child health services including primary care, and paediatric health services?

☐ Yes

☒ **No**

Please say why.

Changes to locate children's social work services within the NCS risks disrupting the existing and efficient communication, decision-making and service delivery arrangements between local services. (Q25)

**Q26.** Do you think there are any risks in including children's services in the National Care Service?

☒ **Yes**

☐ No

If yes, please give examples

It seems ill-advised to include children's services in an as-yet unproven approach. (Q26)

The model should be tested by starting with adults and following review, after an appropriate period, consider if the approach should be extended to children's services. There is too much risk in including children at this stage. (Q26)

A further comment is that children's social care was not part of the original terms of reference for the Independent Review of **Adult** Social Care. (Q26)

## Healthcare

**Q27.** Do you agree that the National Care Service and at a local level, Community Health and Social Care Boards should commission, procure and manage community health care services which are currently delegated to Integration Joint Boards and provided through Health Boards?

☒ **Yes**

☒ **No**

Please say why.

The answer to this is dependent on the outcomes of IJBs being reformed to become Community Health and Social Care Boards and the powers and duties that these new bodies hold. (Q27)

Under current arrangements, community healthcare services are provided through Health and Social Care Partnerships, under strategic direction from the IJB. (Q27)

If, as proposed, Community Health and Social Care Boards (CHSCBs) are successors to IJBs with more powers over and responsibilities for community healthcare services which the IJBs currently oversee, then the answer above is **yes**. (Q27)

If CHSC Boards are developed with a regional focus, rather than operating within local authority areas, then the answer is **no**, as operating at this level will stifle innovation and within the Lothian area, Edinburgh, as a result of its size, would dominate over neighbouring areas. (Q27)

Support to set up the required infrastructure (finance, HR procurement etc.) which is currently provided by Council and NHS Board partners will be of paramount importance before this work could be transferred. (Q27)

**Q28.** If the National Care Service and Community Health and Social Care Boards take responsibility for planning, commissioning and procurement of community health services, how could they support better integration with hospital-based care services?

Through further development of existing joint strategic and operational planning processes to deliver improved services at local/CHSCB/NHS Board level as well as for regional services. (Q28)

IT systems within NHS Boards, at best, hinder the effective communication between Hospital based services and Community based services. NHS Boards already concentrate far more on Hospital Based Services to the hindrance of Primary & Community Services, which means that this is not tackled effectively. (Q28)

There is a huge risk that this change could exacerbate a growing wedge between Hospital and Community care services. (Q28)

**Q29.** What would be the benefits of Community Health and Social Care Boards managing GPs' contractual arrangements? (Please tick all that apply)

- ☒ **Better integration of health and social care**
- ☒ **Better outcomes for people using health and care services**
- ☒ **Clearer leadership and accountability arrangements**
- ☒ **Improved multidisciplinary team working**
- ☒ **Improved professional and clinical care governance arrangements**
- ☒ **Other (please explain below)**

Benefits may also include improved service planning, data sharing and outcomes monitoring. (Q29)

Any local management of GP contractual arrangements should focus on the planning and delivery of local service delivery across the multidisciplinary primary care team to meet the assessed needs of communities. (Q29)

Local management should not seek to deviate from delivery of core primary care priorities and the national GP contract as set out in the Memorandum of Understanding between the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards. (Q29)

**Q30.** What would be the risks of Community Health and Social Care Boards managing GPs' contractual arrangements? (Please tick all that apply)

- ☒ **Fragmentation of health services**
- ☐ Poorer outcomes for people using health and care services
- ☐ Unclear leadership and accountability arrangements
- ☐ Poorer professional and clinical care governance arrangements
- ☒ **Other** (please explain below)

It is unclear what problem is being fixed as a result of this suggestion as this should go in hand with changing how GPs as a workforce are managed. (Q30)

There may be a risk of 'drift' away from delivery of core GP contract requirements and resulting variation in contract delivery across the country. (Q30)

The current infrastructure supporting the contractual arrangements at NHS Board level would need to be replicated at CHSCB level. This would involve huge upheaval and would be a distraction of management time that would be better utilised on the various other complex matters in NCS delivery. (Q30)

**Q31.** Are there any other ways of managing community health services that would provide better integration with social care?

Integration has been hampered by the need to deal with multiple contracts types, multiple IT systems, two sets of HR departments and other matters that require individual teams dealing with two separate organisations to get anything completed. The ability to ensure that terms and conditions as well as IT are consistent would assist better integration. (Q31)

## Social Work and Social Care

**Q32.** What do you see as the main benefits in having social work planning, assessment, commissioning and accountability located within the National Care Service? (Please tick all that apply.)

- ☐ Better outcomes for service users and their families.
- ☒ **More consistent delivery of services.**
- ☐ Stronger leadership.
- ☐ More effective use of resources to carry out statutory duties.
- ☐ More effective use of resources to carry out therapeutic interventions and preventative services.
- ☒ **Access to learning and development and career progression.**
- ☐ Other benefits or opportunities, please explain below:

| |
|---|
| |

**Q33.** Do you see any risks in having social work planning, assessment, commissioning and accountability located within the National Care Service?

| |
|---|
| As social work was not a focus of the Independent Review of Adult Social Care (albeit the important role of social workers was acknowledged) and the NCS consultation extends its plans beyond those few IRASC recommendations that mentioned social workers, there are concerns there has not been an opportunity to engage on this to properly examine the implications. (Q33)<br><br>Any altered arrangements have to allow for local flexibility and maintenance of relationships with local providers. (Q33)<br><br>Local planning may not occur to the level it does currently. (Q33) |

## Nursing

**Q34.** Should Executive Directors of Nursing have a leadership role for assuring that the safety and quality of care provided in social care is consistent and to the appropriate standard? Please select one.

☐ Yes

☐ No

☒ **Yes, but only in care homes**

☒ **Yes, in adult care homes and care at home**

Please say why

There is a range of views among East Lothian IJB members regarding this question:

One comment is that the medical and social models are different, with each having separate registration and inspectorate regimes. (Q34)

One view was that having Executive Directors of Nursing in the proposed leadership role would provide consistency and accountability. (Q34)

The use of the term social care nursing is not common, so needs explanation, particularly to clients and families. (Q34)

Senior nurse leadership was important in improving the quality of care and in infection prevention and control in care homes during Covid, as was training and support to care home staff from HSCP nurse colleagues. (Q34)

**Q35.** Should the National Care Service be responsible for overseeing and ensuring consistency of access to education and professional development of social care nursing staff, standards of care and governance of nursing? Please select one.

☒ **Yes**

☒ **No, it should be the responsibility of the NHS**

☐ No, it should be the responsibility of the care provider

Please say why

There is a range of views among East Lothian IJB members regarding this question.

One view is that this arrangement would ensure equity of access and consistency. (Q35)

A counter view is that if the NCS took on educational and professional development of those nurses working in social care, this would disrupt existing and effective structures operating within HSCPs and links to NHS Board Directors of Nursing who are current professional leads. It might be better to forge links between those nurses operating in care homes and social care in the third and independent sectors and the existing professional leads. (Q35)

**Q36.** If Community Health and Social Care Boards are created to include community health care, should Executive Nurse Directors have a role within

the Community Health and Social Care Boards with accountability to the National Care Service for health and social care nursing?

☒ **Yes**

☒ **No**

If no, please suggest alternatives

There is a range of views among East Lothian IJB members regarding whether or not Executive Nurse Directors should have a role within the CHSCB. Currently, the IJB has a HSCP senior nurse sitting on the board and providing representation for all nursing matters. This serves the IJB well. (Q36)

It is not clear if the Executive Nurse Director refers to that role within the health board, or if this is a new position. In the case of NHS Lothian, it is difficult to see how the Board's Executive Nurse Director could find time to have a meaningful role in what would be four local CHSCBs. (Q36)

One comment was that the difference between social care and medical models need to be recognised as each has its purpose. (Q36)

The question was raised of what *'social care nursing'* was. This needs defined, as the term is not widely used. (Q36)

## Justice Social Work

**Q37.** Do you think justice social work services should become part of the National Care Service (along with social work more broadly)?

☐ Yes

☒ **No**

Please say why.

In East Lothian, justice social work and Community Justice Partnerships both work well, with all stakeholders fully involved. (Q37)

In other IJBs, work perhaps needs done to forge local links – any necessary local improvements should not require justice social work to be drawn into national arrangements without further consideration. (Q37)

Similar to the answer to Q26, the NCS model should be tested by starting with adults and following review, after an appropriate period consider if the approach should be extended to justice social work. There is no need to include it at this stage. (Q36)

**Q38.** If yes, should this happen at the same time as all other social work services or should justice social work be incorporated into the National Care Service at a later stage?

☐ At the same time

☒ **At a later stage**

Please say why.

As stated above, the NCS model should be tested by starting with adults and following review, after an appropriate period, there should be consideration of whether the approach should be extended to justice social work. There is no pressing need to include it at this stage. (Q38)

**Q39.** What opportunities and benefits do you think could come from justice social work being part of the National Care Service? (Tick all that apply)

- ☐ More consistent delivery of justice social work services
- ☐ Stronger leadership of justice social work
- ☐ Better outcomes for service users
- ☐ More efficient use of resources
- ☒ **Other opportunities or benefits - please explain**

Any number of the benefits listed above may come from justice social work being part of the National Care Service, however, it is not possible to comment on benefits when the parameters of the proposal are uncertain and when there have not been preparatory discussions. (Q39)

**Q40.** What risks or challenges do you think could come from justice social work being part of the National Care Service? (Tick all that apply)

- ☐ Poorer delivery of justice social work services.
- ☐ Weaker leadership of justice social work.
- ☐ Worse outcomes for service users.
- ☐ Less efficient use of resources.
- ☒ **Other risks or challenges - please explain:**

As with Q39, any number of the risks set out above are possible, if justice social work becomes part of the National Care Service, however, it is not possible to comment on risks when the parameters of the proposal are uncertain and when there have not been preparatory discussions. (Q40)

A further risk is that such a change will not facilitate the joining up of the other agencies who are key to improving outcomes for justice social work clients. (Q40)

**Q41.** Do you think any of the following alternative reforms should be explored to improve the delivery of community justice services in Scotland? (Tick all that apply)

☒ **Maintaining the current structure (with local authorities having responsibility for delivery of community justice services) but improving the availability and consistency of services across Scotland.**

☐ Establishing a national justice social work service/agency with responsibility for delivery of community justice services.

☒ **Adopting a hybrid model comprising a national justice social work service with regional/local offices having some delegated responsibility for delivery.**

☐ Retaining local authority responsibility for the delivery of community justice services, but establishing a body under local authority control to ensure consistency of approach and availability across Scotland.

☒ **Establishing a national body that focuses on prevention of offending (including through exploring the adoption of a public health approach).**

☐ No reforms at all.

☐ Another reform – please explain:

There is a range of views amongst East Lothian IJB members.

One view is that current structures of community justice services delivered by local authorities should continue as this approach works locally. (Q41)

One member suggested the both the 'hybrid' model and the 'prevention of offending' model should be explored to assess the merit/s of each. (Q41)

**Q42.** Should community justice partnerships be aligned under Community Health and Social Care Boards (as reformed by the National Care Service) on a consistent basis?

☐ Yes

☒ **No**

Please say why.

| |
|---|
| As long as community justice is delivering, such as it is in East Lothian, local decision making should be supported, under an approach of robust self-evaluation and external evaluation to maintain standards. (Q42) |

## Prisons

**Q43.** Do you think that giving the National Care Service responsibility for social care services in prisons would improve outcomes for people in custody and those being released?

☒ **Yes**

☒ **No**

Please say why.

There is a range of views among East Lothian IJB members regarding this question.

One view is that maintenance of local arrangements will ensure continuity of service provision. (Q43)

Another view is that a national focus is needed to deliver integrated services to those in custody and in planning to support their release, in view of their often complex social, housing, employment and mental health needs and in some cases drug use. (Q43)

**Q44.** Do you think that access to care and support in prisons should focus on an outcomes-based model as we propose for people in the community, while taking account of the complexities of providing support in prison?

☒ **Yes**

☐ No

Please say why.

Such an approach is essential in view of the complex needs of prisoners. (Q44)

## Alcohol and Drug Services

**Q45.** What are the benefits of planning services through Alcohol and Drug Partnerships? (Tick all that apply)

- ☒ **Better co-ordination of Alcohol and Drug services**
- ☒ **Stronger leadership of Alcohol and Drug services**
- ☒ **Better outcomes for service users**
- ☒ **More efficient use of resources**
- ☒ **Other opportunities or benefits - please explain**

Effective partnership working with other agencies, in the statutory and non-statutory sectors. (Q45)

**Q46.** What are the drawbacks of Alcohol and Drug Partnerships? (Tick all that apply)

- ☐ Confused leadership and accountability
- ☐ Poor outcomes for service users
- ☐ Less efficient use of resources
- ☐ Other drawbacks - please explain

**None of these** are considered as issues for the Alcohol and Drug Partnership (MELDAP) serving East Lothian. (Q46)

**Q47.** Should the responsibilities of Alcohol and Drug Partnerships be integrated into the work of Community Health and Social Care Boards?

- ☐ Yes
- ☒ **No**

Please say why.

There is no need to make this change, as the current relationship with HSCPs is good and the services provided are effective. (Q47)

**Q48.** Are there other ways that Alcohol and Drug services could be managed to provide better outcomes for people?

Better client outcomes could be delivered by investing more in ADPs and their development, rather than changing management arrangements. (Q48)

In addition, there needs to be increased investment in drug and alcohol rehabilitation services accessible to all communities. (Q48)

**Q49.** Could residential rehabilitation services be better delivered through national commissioning?

☒ **Yes**

☐ No

Please say why.

There is a lack of investment in the provision of suitable rehabilitation services. The commissioning approach, model/s of delivery and whether these are local or national, should be decided once investment is secured and following consultation. (Q49)

**Q50.** What other specialist alcohol and drug services should/could be delivered through national commissioning?

There needs to be a conversation with ADPs and local partners and with service users on the commissioning approach and the specifications of any service to be delivered. Dependent on the service to be delivered, national commissioning is not necessarily better than local commissioning. (Q50)

**Q51.** Are there other ways that alcohol and drug services could be planned and delivered to ensure that the rights of people with problematic substance use (alcohol or drugs) to access treatment, care and support are effectively implemented in services?

## Mental Health Services

**Q52.** What elements of mental health care should be delivered from within a National Care Service? (Tick all that apply)

- ☐ Primary mental health services
- ☐ Child and Adolescent Mental Health Services
- ☐ Community mental health teams
- ☒ **Crisis services**
- ☐ Mental health officers
- ☐ Mental health link workers
- ☐ Other – please explain

There is a range of views across East Lothian IJB members. One perspective is that all elements above should be included another is that the focus should be on crisis services only. (Q52)

**Q53.** How should we ensure that whatever mental health care elements are in a National Care Service link effectively to other services e.g. NHS services?

If the NCS takes on responsibility for the full range of mental health services listed in Q52, there is a real risk of fragmentation of service delivery and disconnectedness from locally and regionally delivered mental health services. (Q53)

Any development to move mental healthcare elements into the NCS will need to be accompanied by an integrated health record accessible by all services providing support at all points of the service users' journey. (Q53)

## National Social Work Agency

**Q54.** What benefits do you think there would be in establishing a National Social Work Agency? (Tick all that apply)

- ☒ **Raising the status of social work**
- ☒ **Improving training and continuous professional development**
- ☐ Supporting workforce planning
- ☐ Other – please explain

There are merits in establishing a National Social Work Agency to oversee training and professional development for the Social Work profession. (Q54)

It is less clear how in practical terms the IRASC proposal for the NSWA to address recruitment and retention (which are often the result of local issues) can be delivered through a national agency. (Q54)

The IRASC also proposes a review of the SSSC. As this has yet to be carried out, it is unclear what impact that review will have on proposed arrangements for the establishment and operation of the NSWA. (Q54)

**Q55.** Do you think there would be any risks in establishing a National Social Work Agency?

The proposed model is untested. More work is needed to consider the implications of this change for professional colleagues and for the delivery of integrated services at a local level. (Q55)

**Q56.** Do you think a National Social Work Agency should be part of the National Care Service?

☐ Yes

☒ **No**

Please say why

There needs to be more explanation of the parameters of such an arrangement, to inform consideration of the proposal. (Q56)

**Q57.** Which of the following do you think that a National Social Work Agency should have a role in leading on? (Tick all that apply)

☒ **Social work education, including practice learning**

☒ **National framework for learning and professional development, including advanced practice**

☒ **Setting a national approach to terms and conditions, including pay**

☐ Workforce planning

☐ Social work improvement

☒ **A centre of excellence for applied research for social work**

☐ Other – please explain

## Reformed Integration Joint Boards: Community Health and Social Care Boards

### Governance model

**Q58.** "One model of integration… should be used throughout the country." (Independent Review of Adult Social Care, p43). Do you agree that the Community Health and Social Care Boards should be the sole model for local delivery of community health and social care in Scotland?

☒ **Yes**

☐ No

Please say why.

| |
|---|
| |

**Q59.** Do you agree that the Community Health and Social Care Boards should be aligned with local authority boundaries unless agreed otherwise at local level?

☒ **Yes**

☐ No

| |
|---|
| IJB members were of the view that the CHSCBs should remain aligned with local authorities to maintain progress in partnership working, particularly through the organisational changes ahead for social care in the next few years. (Q59) |

**Q60.** What (if any) alternative alignments could improve things for service users?

| |
|---|
| It is essential that alignment with local authorities is maintained for joint planning of services delivered within the local area. (Q60)<br><br>Other alignments should be established for services that are planned and delivered at joint local authority, or regional levels. (Q60) |

**Q61.** Would the change to Community Health and Social Care Boards have any impact on the work of Adult Protection Committees?

The implications of this will need to be properly appraised at local level. (Q61)

**Membership of Community Health and Social Care Boards**

**Q62.** The Community Health and Social Care Boards will have members that will represent the local population, including people with lived and living experience and carers, and will include professional group representatives as well as local elected members. Who else should be represented on the Community Health and Social Care Boards?

The trade unions and third sector membership, currently on IJBs, should continue within the CHSCBs. (Q62)

**Q63.** "Every member of the Integration Joint Board should have a vote" (Independent Review of Adult Social Care, p52). Should all Community Health and Social Care Boards members have voting rights?

☒ **Yes**

☒ **No**

There were mixed views across the IJB membership on the merits or otherwise of giving all members a vote in the new CHSCBs. Concern was expressed by some that difficult decisions, such as those concerning necessary service redesign might not be possible. (Q63)

**Q64.** Are there other changes that should be made to the membership of Community Health and Social Care Boards to improve the experience of service users?

No. (Q64)

**Community Health and Social Care Boards as employers**

**Q65.** Should Community Health and Social Care Boards employ Chief Officers and their strategic planning staff directly?

☒ **Yes**

☐ No

Some IJB members suggested the reporting route for Chief Officers was unclear and needed further clarification. (Q65)

Reservations were expressed about the practicality of all Chief Officers reporting to the NCS if this option is developed. (Q65)

It was suggested that all staff currently working within HSCPs needed to be under the same employer to further deliver on integration. (Q65)

**Q66.** Are there any other staff the Community Health and Social Care Boards should employ directly? Please explain your reasons.

Directors of Finance, in view of the need to set financial strategy and to manage financial resources and financial commitments. (Q66)

## Commissioning of services

### Structure of Standards and Processes

**Q67.** Do you agree that the National Care Service should be responsible for the development of a Structure of Standards and Processes

☒ **Yes**

☐ No

If no, who should be responsible for this?

☐ Community Health and Social Care Boards

☐ Scotland Excel

☐ Scottish Government Procurement

☐ NHS National Procurement

☐ A framework of standards and processes is not needed

**Q68.** Do you think this Structure of Standards and Processes will help to provide services that support people to meet their individual outcomes?

☒ **Yes**

☐ No

**Q69.** Do you think this Structure of Standards and Processes will contribute to better outcomes for social care staff?

☒ **Yes**

☐ No

**Q70.** Would you remove or include anything else in the Structure of Standards and Processes?

The development of any National Commissioning and Procurement Structure of Standards and Processes must fully involve partners, as listed above in Q66 in as well as consulting with representatives of those people using services. (Q70)

Any development should take into account existing national arrangements/standards and build on the positive aspects of these, whilst addressing any current issues/shortfalls identified by stakeholders. (Q70)

Scotland Excel currently plays an important role in relation to commissioning & procurement and may form the basis for future developments. (Q70)

Consideration should be given to whether newer arrangements are desirable or whether similar outcomes can be achieved by adjustments to existing arrangements. (Q70)

The implementation, monitoring and regulation of standards potentially places significant additional pressure on all partners, not least third and independent sector organisations. (Q70)

It is also suggested that new arrangements may provide an opportunity to address some of the equity and transparency issues perceived currently. (Q70)

**Market research and analysis**

**Q71.** Do you agree that the National Care Service should be responsible for market research and analysis?

☒ **Yes**

☐ No

If no, who should be responsible for this?

☐ Community Health and Social Care Boards

☐ Care Inspectorate

☐ Scottish Social Services Council

☐ NHS National Procurement

☐ Scotland Excel

☐ No one

☐ Other- please comment

As in Q69, market research and analysis carried out by the NCS must fully involve all partners, as listed above. (Q71)

If the NCS is to be responsible for the development of a Structure of Standards and Processes, responsibility should also fall with the NCS for market research & analysis. (Q71)

Again, existing good practice in relation to this should not be lost along the way. (Q71)

A broader issue relates to NCS playing a role in helping to address some of the current 'market issues' witnessed in relation to health and social care commissioning/procurement. (Q71)

One concern is the dominance of 'larger players' in the market, dominating decision making to the detriment of 'smaller players' (for example, the situation witnessed within NHS Lothian area in relation to equipment purchasing where Edinburgh HSCP's needs can overshadow the needs of the other HSCPs in the area). (Q71)

**National commissioning and procurement services**

**Q72.** Do you agree that there will be direct benefits for people in moving the complex and specialist services as set out to national contracts managed by the National Care Service?

☒ **Yes**

☐ No

If no, who should be responsible for this?

☐ Community Health and Social Care Boards

☒ **NHS National Procurement**

☐ Scotland Excel

National contracts managed by the NCS are necessary in terms of cost effectiveness. However, arrangements need to safeguard local access to these services. Effective engagement with CHSCBs (or their equivalent) is also necessary to ensure national contracts meet local needs effectively. (Q72)

## Regulation

### Core principles for regulation and scrutiny

**Q73.** Is there anything you would add to the proposed core principles for regulation and scrutiny?

No views were expressed by IJB members concerning this question. (Q73)

**Q74.** Are there any principles you would remove?

No views were expressed by IJB members concerning this question. (Q74)

**Q75.** Are there any other changes you would make to these principles?

No views were expressed by IJB members concerning this question. (Q75)

## Strengthening regulation and scrutiny of care services

**Q76.** Do you agree with the proposals outlined for additional powers for the regulator in respect of condition notices, improvement notices and cancellation of social care services?

☒ **Yes**

☐ No

☐ Please say why.

For the protection of service users and the maintenance of standards. (Q76)

**Q77.** Are there any additional enforcement powers that the regulator requires to effectively enforce standards in social care?

No views were expressed by IJB members concerning this question. (Q77)

## Market oversight function

**Q78.** Do you agree that the regulator should develop a market oversight function?

- ☒ **Yes**
- ☐ No

**Q79.** Should a market oversight function apply only to large providers of care, or to all?

- ☐ Large providers only
- ☒ **All providers**

**Q80.** Should social care service providers have a legal duty to provide certain information to the regulator to support the market oversight function?

- ☒ **Yes**
- ☐ No

**Q81.** If the regulator were to have a market oversight function, should it have formal enforcement powers associated with this?

- ☒ **Yes**
- ☐ No

**Q82.** Should the regulator be empowered to inspect providers of social care as a whole, as well as specific social care services?

- ☒ **Yes**
- ☐ No

Please say why

All providers of social care services need to be subject to inspection to improve and maintain service delivery standards and to ensure standardisation between providers across the country. (Q82)

## Enhanced powers for regulating care workers and professional standards

**Q83.** Would the regulator's role be improved by strengthening the codes of practice to compel employers to adhere to the codes of practice, and to implement sanctions resulting from fitness to practise hearings?

Yes. (Q83)

**Q84.** Do you agree that stakeholders should legally be required to provide information to the regulator to support their fitness to practise investigations?

Yes. (Q84)

**Q85.** How could regulatory bodies work better together to share information and work jointly to raise standards in services and the workforce?

No views were expressed by IJB members concerning this question. (Q85)

**Q86.** What other groups of care worker should be considered to register with the regulator to widen the public protection of vulnerable groups?

Personal Assistants and others employed through SDS payments. (Q86)

## Valuing people who work in social care

### Fair Work

**Q87.** Do you think a 'Fair Work Accreditation Scheme" would encourage providers to improve social care workforce terms and conditions?

☒ **Yes**

☐ No

Please say why.

Members commented that such a scheme needs to be worked up and consulted on before introduction. (Q87)

**Q88.** What do you think would make social care workers feel more valued in their role? (Please rank as many as you want of the following in order of importance, e.g. 1, 2, 3…)

| | |
|---|---|
| **1** | Improved pay |
| **2** | Improved terms and conditions, including issues such as improvements to sick pay, annual leave, maternity/paternity pay, pensions, and development/learning time |
| **5** | Removal of zero hour contracts where these are not desired |
| **8** | More publicity/visibility about the value social care workers add to society |
| **3** | Effective voice/collective bargaining |
| **4** | Better access to training and development opportunities |
| **9** | Increased awareness of, and opportunity to, complete formal accreditation and qualifications |
| **7** | Clearer information on options for career progression |
| **6** | Consistent job roles and expectations |
| **10** | Progression linked to training and development |

| | |
|---|---|
| **12** | Better access to information about matters that affect the workforce or people who access support |
| **13** | Minimum entry level qualifications |
| **11** | Registration of the personal assistant workforce |
| | Other (please say below what these could be) |

Please explain suggestions for the “Other” option in the below box

| |
|---|
| |

**Q89.** How could additional responsibility at senior/managerial levels be better recognised? (Please rank the following in order of importance, e.g. 1, 2, 3…):

| | |
|---|---|
| **1** | Improved pay |
| **2** | Improved terms and conditions |
| **4** | Improving access to training and development opportunities to support people in this role (for example time, to complete these) |
| **3** | Increasing awareness of, and opportunity to complete formal accreditation and qualifications to support people in this role |
| | Other (please explain) |

Please explain suggestions for the “Other” option in the below box

| |
|---|
| |

**Q90.** Should the National Care Service establish a national forum with workforce representation, employers, Community Health and Social Care Boards to advise it on workforce priorities, terms and conditions and collective bargaining?

☒ Yes

☐ No

Please say why or offer alternative suggestions

This is important to establish partnership working, to secure support from the workforce and to ensure equity across the country. (Q90)

This is recognised as important to improving terms and conditions for the workforce. However, limitations imposed by longer term financial impact need to be acknowledge. (Q90)

Early engagement with all stakeholders regarding the role, remit and membership of any national forum is important. (Q90)

## Workforce planning

**Q91.** What would make it easier to plan for workforce across the social care sector? (Please tick all that apply.)

☒ **A national approach to workforce planning**

☒ **Consistent use of an agreed workforce planning methodology**

☒ **An agreed national data set**

☒ **National workforce planning tool(s)**

☒ **A national workforce planning framework**

☒ **Development and introduction of specific workforce planning capacity**

☒ **Workforce planning skills development for relevant staff in social care**

☐ Something else (please explain below)

## Training and Development

**Q92.** Do you agree that the National Care Service should set training and development requirements for the social care workforce?

☒ **Yes**

☐ No

Please say why

To improve standards for staff and service users. (Q92)

**Q93.** Do you agree that the National Care Service should be able to provide and or secure the provision of training and development for the social care workforce?

☒ **Yes**

☐ No

## Personal Assistants

**Q94.** Do you agree that all personal assistants should be required to register centrally moving forward?

☒ **Yes**

☐ No

Please say why.

In order to protect them and the service users. (Q94)

**Q95.** What types of additional support might be helpful to personal assistants and people considering employing personal assistants? (Please tick all that apply)

☒ **National minimum employment standards for the personal assistant employer**

☒ **Promotion of the profession of social care personal assistants**

☒ **Regional Networks of banks matching personal assistants and available work**

☐ Career progression pathway for personal assistants

☒ **Recognition of the personal assistant profession as part of the social care workforce and for their voice to be part of any eventual national forum to advise the National Care Service on workforce priorities**

☐ A free national self-directed support advice helpline

☒ **The provision of resilient payroll services to support the personal assistant's employer as part of their Self-directed Support Option 1 package**

☐ Other (please explain)

**Q96.** Should personal assistants be able to access a range of training and development opportunities of which a minimum level would be mandatory?

☒ **Yes**

☐ No

Completed responses should be submitted, before the closing date of 2 November 2021, to: NCSconsultation@gov.scot or by post to:

National Care Service Team
Scottish Government Area GE-15
St Andrew's House
Regent Road
EDINBURGH,

East Lothian
**Integration Joint Board**

**REPORT TO:** East Lothian Integration Joint Board

**MEETING DATE:** 28th October 2021

**BY:** Interim Chief Finance Officer

**SUBJECT:** Financial Position August 2021, Financial Out-turn 2021/22 and Financial Planning 2022/23 to 2025/26

7

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## 1 PURPOSE

1.1 This paper has five objectives :-

- Update the IJB on its current (month 5) financial position
- Inform the IJB of the current projected out-turn for 2021/22
- Note the deployment of the earmarked reserves in 2021/22
- Consider the current issues and the future the financial challenges in 22/23 and beyond
- Discuss the current progress towards the production of a five year, balanced financial plan

## 2 RECOMMENDATIONS

2.1 As a result of this report Members are being asked to:-

i. Note the financial position at August 2021
ii. Note the projected out-turn position for 2021/22
iii. Note the deployment of the earmarked reserves in 2021/22
iv. Support the further development of the IJB's five year financial plan

## 3 BACKGROUND

### 3.1 August 2021 Position

Although the IJB is not a board of management and relies on its partners to manage the operational delivery of the services that have been delegated to the IJB, it's useful to have an update on the current financial position as that is the baseline for the forecast for the current financial year and also an indication of financial pressures within the system.

Both partners have provided the following position for month 5 and year-end forecasts as noted below –

| | East Lothian IJB Annual Budget '000 | East Lothian IJB YTD Budget £'000 | East Lothian IJB YTD Actual £'000 | East Lothian IJB YTD Variance £'000 | East Lothian IJB Forecast Variance £'000 |
|---|---|---|---|---|---|
| **NHS Services** | | | | | |
| Core | 86,846 | 26,064 | 26,659 | -595 | 385 |
| Hosted | 15,333 | 6,077 | 6,008 | 69 | 17 |
| Acute | 21,805 | 8,445 | 8,592 | -147 | -662 |
| **NHS Services** | **123,984** | **40,586** | **41,259** | **-673** | **-261** |
| **Social Care **** | **57,230** | **21,566** | **21,894** | **-328** | **-1762** |
| **IJB Services for East Lothian** | **181,214** | **62,480** | **40,931** | **-1,001** | **-2,023** |
| ****Further COVID funding agreed for Social Care position** | | | | | **305** |
| **Revised Out turn for IJB Services for East Lothian** | | | | | **-1,718** |

There is an overspend of £1m at end of August 2021, there being three main pressures within that position:

- Overspends within the Core NHS Services relates to prescribing, pressures in GMS and the staffing of GPs within the CWIC service. This overspend is expected to reduce as plans are in place to mitigate these pressure areas and an element of the IJB's uplift (the current use of which has still to be agreed) will also support this position.

- Pressures within the Set Aside budget – largely within the Junior Doctors budget lines. Discussions are on-going with Acute colleagues to understand this position and to action a resolution.

- Social Care overspends within Commissioned Services. This appears to be driven by increased activity pressures and work is underway to identify the drivers behind this to take remedial action. This is discussed further below.

### 3.2 Projected out-turn position 2021/22

Both partners have provided the IJB with an updated outturn forecast:

- East Lothian Council forecast an overspend of c. £1,762k at Month 5 for Adult Social care, and this has been this revised to take into account further funding for costs relating to Covid, resulting in a revised forecast overspend of £1,475k. Further analysis on the projected overspend for Social Care is being carried out and a further update will be shared at the next IJB once this work is complete.

- NHS Lothian (having taken account of the IJB's uplift as discussed above) are projecting an overspend of c. £261k on delegated services. Further discussions with the HSCP management team and colleagues within NHSiL suggest that a break-even position will be achieved within the health element of the IJB's budget at the end of the financial year

Both these positions make the assumption that additional costs incurred by the IJB as a result of the Covid pandemic will be covered by the Scottish Government.

3.3 Use of the IJB's Reserves

At the end of March 2021, the IJB had c. £9.6m of reserves of which c. £3.6m was the Covid reserve. The Covid reserve will be used to support the partners as appropriate in 21/22 with the reserves available to the IJB operationally being c. £6m of which £3.1m is held in the general reserve with the remainder being funds carried forward from previous periods for agreed projects.

Appendix 2 shows the reserves balances as 31/3/21 and lays out the in year use of the carried forward balances (the earmarked reserves).

The IJB has a reserves strategy which was agreed at its March 2017 meeting. This policy discussed the use of the general reserve and set a target value of 2% of the total budget. That would be, based on the budget above but excluding the Covid funding, c. £3.5m. The balance on the general reserve at 31/3/21 was £3.1m which is slightly below target.

3.5 Potential financial pressures – 22/23 onwards

There are three major areas of challenge:-

**3.5.1 Further impact of the Covid Pandemic**

In 20/21, the IJB used £7.1m of support from the Scottish Government to underpin the additional costs incurred by its partners due to the impacts of the Covid pandemic. There are two underlying issues which now require to be developed:-

On the presumption that no further funds are available in 2022/23 to support Covid costs what is the financial impact on the current operations of the partners? Appendix 2 shows the totality of this risk in financial

terms, discussions are underway with partners and the Scottish Government around the management of this position.

What is the financial impact on health and social care services for the delivery of post pandemic services? Both partners are considering this position but, at this time, no further financial forecasts are available.

### 3.5.2 Pay Awards and other staff settlements

Within the NHS system, pay awards are generally recognised as part of an uplift to the Health Board's base budget. However, the uplift only applies to the base recurring budget and services funded from other allocations (for example PCIF or Action 15) do not have any uplift applied and therefore any pay award generates a financial pressure therein.

Councils do not, generally, get an uplift to recognise the full financial impact of pay awards and the Scottish Government's requirements for 'fair work' and the appropriate pay for staff employed by third party provides of social care services also has a further inflationary impact on these costs. Whilst negotiations for the 2021 pay uplifts have yet to be concluded the offers currently being discussed exceed the uplift that Councils received to their core funding as part of the 2021/22 local government settlement and may bring a further pressure to the system

As employers both NHS and the Council will face an increased NIC employer cost as a result if the 1.25% increase in employer NIC rates to fund social care investment. This is part of the UK governments plan to provide additional resources to both Health and Social Care but will also increase the cost base of the services provided by the IJB's partners. This is discussed further below.

### 3.5.3 Demographic Pressures

East Lothian's population growth is forecast to grow 7.2% (between 2018 and 2028) the second fastest growth in Scotland and this generates additional demand on both the Health and Social Care services. While the Scottish Government distribution methods that recasts the share of the total resources available for both health and social care take account of population movements they do not react sufficiently swiftly to population increases in operational terms. For local government there is also a floor mechanism which gives a degree of protection to Councils' with reducing populations which is self-funded by reducing the allocation to growing councils There is also the question of how any additional resources are to be distributed amongst the services that the partners provide. This is not a new issue and colleagues will be aware that it has been discussed previously.

### 3.6 Opportunities

It should be recognised that a range of additional investments has been made available to the IJB over the past few years – Change Fund, Integrated Care Fund, additional Delayed Discharge funding, Action 15, SCF, PCIF, Carers, etc and these investments have supported the IJB's transformational model. It's worth considering if these investments have indeed delivered the benefits that was intended. This consideration has been raised with the SPG and further work is on-going to review the costs/benefits of all the investments.

There are two further pieces of work underway which should provide additional resources which can then be incorporated into the IJB's financial plans :-

- NHS Recovery plan - On 25th August 2021 the Scottish Government published its NHS recovery plan which sets out key ambitions and actions to be developed and delivered now and over the next 5 years in order to address the backlog in care and meet ongoing healthcare needs for people across Scotland.

- Winter Planning for Health and Social Care - announcement on 5th October 2021 from John Burns, CEO of NHS Scotland that £300m additional recurring funding to be available to support lasting and sustainable recovery and improve social care support.

### 3.7 Further development of the IJB's Financial Plan

The IJB is required to prepare a financial plan that articulates (in financial terms) how it will achieve its Strategic Plan. In principle this plan should be multi-year (ideally over the period of the Strategic Plan) and be balanced – that is break-even year on year. Work continues to further develop this plan although that will require the partners to provide financial forecasts to the IJB for the services which they manage on the IJB's behalf.

#### 3.7.1 Most recent Financial Plan Update

At its April 2021 workshop, an updated financial projection for the next five financial years was presented to the IJB. This showed a pre-Covid forecast (extracted from both partners financial forecasts) and projected financial gaps ranging from £3.0m in 21/22 to £22m in 25/26. It was noted that these were pre-Covid forecasts, that the current Covid crisis was hindering development work and that actions to close these gaps were being developed.

#### 3.7.3 Forecasting bias

Financial forecasts for future years tend to show financial gaps. Efficiency schemes are rarely sufficiently developed to project their future impact, projections are generally based on assumptions of fully

staffed services and the impact of any transformation work being developed by the IJB may not be taken into account.

### 3.7.4 What needs to be done?

The partners, having updated the financial forecasts to take account of the impact of Covid, will provide a revised set of financial forecasts to the IJB. It is accepted that building in the impact of Covid will be difficult so any forecasts will have to be clearly caveated. It's likely that this work will generate the usual set of financial gaps.

The IJB requires to be presented with a set of 'balancing actions' which will be a mixture of operational efficiency plans and the assumed impact of any transformational programmes developed through the SPG. The IJB needs to be able to make clear decisions regarding any such proposals and then issue the appropriate directions.

### 3.7.5 Actions

The IJB has developed and continues to develop a range of transformation programmes based on the principles of increased integration of services, delivery of care close to the person being cared for and a move from institutional to community based care. Future actions will include:-

- Further engagement with the SPG – the SPG should be the engine of transformational change. Thus any transformational programme will have to consider what financial or resource impact it will have on the IJB's overall budgetary position.

Engage the partners to -

- Identify efficiency plans in Set Aside and Hosted
- Ensure that the impacts of transformation programmes are understood by Set Aside and Hosted management teams to Identify actions that can be taken collaboratively with the other IJBs
- Identify HSCP efficiency plans both for current year and future years
- Consider current operational overspends – action to manage current overspends and proposals to manage future overspend.

## 3.8 Capital

The IJB does not have any assets delegated to it nor any resources for capital investments. However, in order to deliver the functions delegated to it does require the use of its Partners assets and it's worth indicating to the partners where the IJB considers that investments (capital expenditure) to support these assets is required. There are three potential capital investments that the IJB would indicate to its partners.

3.8.1 At this time the IJB is considering the future provision of Care Homes across the county and it may be that a new care home will be required to be provided by the Council

3.8.2 As part of the overall review of the GP practices, further investments are required to the infrastructure of Primary Care premises in the county and NHSiL would make these investments

3.8.3 The Social Care services are supported by a computer system (Mosaic) which is now approaching the end of its operational life and required to be replaced/updated. This may require a significant investment from the council.

## 4 ENGAGEMENT

4.1 The IJB makes its papers and reports available on the internet.

## 5 POLICY IMPLICATIONS

5.1 There are no new policies arising from this paper.

## 6 INTEGRATED IMPACT ASSESSMENT

6.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy

## 7 DIRECTIONS

7.1 There are no Directions implications arising from this paper

## 8 RESOURCE IMPLICATIONS

8.1 Financial – discussed above

8.2 Personnel – none

8.3 Other – none

## 9 RISK

9.1 The “business as usual” risks raised by this report are already included within the IJB risk register.

## 10 BACKGROUND PAPERS

None

| | |
|---|---|
| **AUTHOR'S NAME** | David King |
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| **DATE** | October 2021 |

**Appendices:**

**Appendix 1 – Disbursement of Reserves**
**Appendix 2 – Covid Exit Analysis**

**Appendix 1 - East Lothian Reserves Analysis**

| | Opening Balance | To East Lothian Council | To NHSL | Closing Balance | Notes |
|---|---|---|---|---|---|
| **Earmarked Reserves** | **£k** | **£k** | **£k** | **£k** | |
| COVID | 3,623 | | | 3,623 | Funding will be allocated to partners based on actual spend incurred |
| Alcohol and Drugs Scottish Government Allocation | 766 | | - 766 | - | |
| Locally Committed programmes | 1,512 | | - 1,512 | - | |
| Community Living Change Fund | 346 | | | 346 | Held in reserves until needed |
| Primary Care Improvement Fund | 226 | | - 226 | - | |
| Action 15 - Scottish Government Mental Health Strategy | 53 | | - 53 | - | |
| | | | | | |
| **Committed Project Funds** | 6,526 | - | - 2,557 | 3,969 | |
| | | | | | |
| **General Reserves** | 3,082 | | | 3,082 | |
| | | | | | |
| **Total** | **9,608** | **-** | **-2,557** | **7,051** | |

**Appendix 2 – East Lothian Partnership COVID Exit Details for Staffing**

| **Covid Services /Expenditure** | **21/22 Est Cost £** | **21/22 WTE's** | **Exit Plan** *(Update of arrangements to withdraw extra staff/service)* | **Exit Trigger** *(set out any criteria that needs to be met in order to implement the Exit Plan)* |
|---|---|---|---|---|
| Additional Hospital to Home Runs | £658,000 | 18.00 | Funding received from NHSL Gold or staff put on redeployment as per NHSL Gold agreement | Recommendation from NHSL Gold Command |
| Additional IHTT posts | £98,000 | 2.00 | | |
| Additional Rehab posts | £126,000 | 2.00 | No exit, plan to continue | |
| Expansion of Care Home Team | £458,000 | 8.15 | Funding received from NHSL Gold or staff put on redeployment as per NHSL Gold agreement | Recommendation from NHSL Gold Command |
| Opening Ward 5 ELCH | £2,019,000 | 39.00 | Funding received from NHSL Gold or staff put on redeployment as per NHSL Gold agreement | Recommendation from NHSL Gold Command |
| Opening Ward 6 ELCH | £1,872,000 | 36.00 | Funding received from NHSL Gold or staff put on redeployment as per NHSL Gold agreement | Recommendation from NHSL Gold Command |
| Funding for upgraded post due to extra responsibility (OT/PT & Vaccinations) | £26,800 | N/A | | |
| CMHT & PTS Posts | £156,000 | 3.60 | | |
| Additional D2A Posts | £121,000 | 2.24 | No exit, plan to continue | |
| **Total EL Partnership Prefund Value** | **£5,534,800** | **110.99** | | |