MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 22 JUNE 2023
VIA DIGITAL MEETINGS SYSTEM

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Voting Members Present:
Councillor S Akhtar (Chair)
Councillor L Bruce
Mr A Cogan
Mr G Gordon* (*substitute*)
Ms F Ireland
Councillor L Jardine
Councillor C McFarlane
Mr P Murray

Non-voting Members Present:
Ms M Allan
Ms L Byrne
Ms L Cowan
Dr C Mackintosh
Mr T Miller
Mr D Aston
Dr P Conaglen
Ms C Flanagan
Ms M McNeill
Ms F Wilson

Present from NHS Lothian/East Lothian Council:
Ms L Berry
Dr J Hardman
Ms C Johnston
Ms L Kerr
Ms M Burton
Ms J Jarvis
Mr M Kennedy
Mr A Main

Clerk:
Ms F Currie

Apologies:
Ms E Gordon*
Mr D Binnie

Declarations of Interest:
None

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN IJB ON 25 MAY 2023 (FOR APPROVAL)

The minutes of the IJB meeting on 25th May were approved.

2. MATTERS ARISING FROM THE MINUTES OF THE MEETING ON 25 MAY

There were no matters arising.

3. CHAIR'S REPORT

The Chair said she would be meeting individually with all IJB members to get their feedback on what had been working well and on areas for improvement. The feedback to date had suggested that members might benefit from development sessions focusing on Directions and financial matters.

She also updated members on the following:

The launch of the East Lothian Rehabilitation Service annual report at Queen Margaret University. The report provided details of the important and varied work being undertaken by the partnership. The Chair provided a brief overview of the work and commended the report to members.

Carers Week – the Chair had met with representatives of caring groups and organisations across the county to get feedback on the level of support they received from the HSCP.

East Lothian Foodbank AGM – the Chair highlighted the increase in referrals and levels of support provided to individuals with long-term conditions. She suggested that this might be an area for future involvement by the IJB.

Day Centres – the Chair reported on her recent meetings where she had heard how day centres were increasing their outreach across their communities.

The Chair met with members of the Care and Repair Board to hear about their work and how relatively small adjustments could help people get back into their homes.

The Chair also touched on the continuing work around the dementia strategy being prepared by the Scottish Government. She updated members on the delays to work on the National Care Service, confirming that there would be no further action during 2023/24 on the removal of residential charging.

Peter Murray highlighted the recently published Chief Medical Officer's annual report which covered 4 key areas, including health inequalities and value-based healthcare. He commended it to members as a useful and informative read.

Mr Murray also reminded members of the paper produced by Chief Officers on the financial pressures being faced by IJBs across Scotland, as a result of significant funding gaps. The Chairs and Vice Chairs Group had decided to work with the Chief Officers to examine the impact of these reductions and to feedback to the Scottish Government as part of their budget planning for 2024/25.

The Chair said that the reports mentioned by Mr Murray would be circulated to members for information.

4. EAST LOTHIAN IJB ANNUAL PERFORMANCE REPORT 2022/23

A report was submitted by the Chief Officer presenting the East Lothian Integration Joint Board Annual Performance Report for 2022-23.

Fiona Wilson presented the annual report which she said demonstrated the continued success of the ELHSCP in delivering health and social care services across the county. This was a very detailed report; and a summary report would also be prepared. Ms Wilson invited members to review the report and recognise the achievements of staff and services during 2022-23; to note that there may be minor changes once some of the data was finalised; and to formally approve the annual report.

Mr Murray thanked all staff involved for an excellent report which was easy to read and very informative. He asked whether, going forward, it would be possible to provide a clearer correlation between specific Directions and the work outlined in this report. He felt that this would provide greater clarity on the role of the IJB.

Ms Wilson acknowledged this and agreed to take this on board for the future.

Councillor Jardine said she had a number of comments and asked if there was still time to feed these into the final report. Ms Wilson said that there may still be time to make minor adjustments and she asked Councillor Jardine to submit her comments to Claire Goodwin as soon as possible.

Andrew Cogan said that, as a new member, the report had given him an excellent overview, particularly of the good and innovative work, but core services seemed to be less obvious within the report. He also noted that there were many small references to digital innovation but there was no clear strand which showed how digital innovation was being taken forward across all services.

Ms Wilson thanked him for his feedback and acknowledged the need to strike a balance on the information provided in the report. She also encouraged him, and other members, to contact officers if they wanted more information on any area of work.

In response to a question from the Chair on the relevance of some indicators in the report, Laura Kerr advised that the National Indicators were set by the Scottish Government and applied to all areas across Scotland.

The Chair also asked about reflecting the contributions of other partners, such as the voluntary sector, and whether information could be sought from VCEL or others.

Maureen Allan said she would be happy to contribute information to future reports.

The Chair commended the report and the range and significance of the work highlighted within it. She moved to the vote on the recommendations, which was taken by roll call and approved unanimously.

Decision

The IJB:

i. Reviewed the report, and in doing so, recognised the achievements of East Lothian Health and Social Care Partnership and individual services during 2022-23, and commended the contribution made by staff, volunteers, and partner organisations throughout the year.

ii. Noted that there may be changes to the National Integration Indicators data once the final data set was published by Public Health Scotland at the start of July, and that a final version of the APR, incorporating any changes, would be sent to IJB members for information prior to publication at the end of July.

iii. While noting that there was no requirement within the statutory guidance for IJBs to formally sign-off APRs, the IJB approved the publication of the 2022-23 APR, subject to any minor changes as noted in recommendation ii above.

5. CARERS' STRATEGY

A report was submitted by the Chief Officer presenting the East Lothian HSCP Carers Strategy (2023-26), summarising work done over the previous financial year and giving details of how funding would be utilised over 2023/24 to develop carer support.

Maria Burton presented the report. She outlined the background to the development of the strategy and it purpose. She explained that this draft strategy was the second local strategy for East Lothian and had been put together following consultation with carers', carers' groups and other representatives. The draft strategy set out plans to improve support over the next three years and had been shared widely for consultation, including comments from the Strategic Planning Group (SPG). Ms Burton drew members' attention to the 7 outcomes included in the strategy and provided details of current and proposed actions under each of these headings and confirmed that new initiatives and funding would be considered by the Change Board going forward.

George Gordon welcomed the wide consultation on the strategy and commended officers for an excellent piece of work.

Councillor Jardine also commended the work and the recognition of the very valuable role of carers. She asked about the comparison between East Lothian and the national average on the gender split for carers and whether this had impacted the strategy.

Ms Burton said she had not picked up a significant difference from the figures but acknowledged that it had long been recognised that women were more likely to have a role in unpaid caring.

Mr Murray also wished to recognise the good work demonstrated by this strategy. He asked about reporting on outcomes and whether there was confidence in the level of funding available.

Ms Burton confirmed the intention to report annually on progress to carers' groups and the SPG. Mr Murray said that he would like to see progress reported to the IJB to ensure that funding remained appropriate to support the delivery of the strategy.

Ms Kerr acknowledged the challenges associated with securing and maintaining appropriate resources, and of adjusting plans based on what was deliverable. She advised that spending on the strategy was monitored very closely by the Change Board and that this would continue to be the case.

Marilyn McNeill asked if there was any support available for carers where the person being cared for was reluctant to accept outside help.

Ms Burton advised that Carers of East Lothian were the best people to advocate for those involved, as this was quite a common problem.

The Chair asked about the level of support from partners for respite opportunities and how this service was being delivered.

Ms Burton said that people were very aware of the need for respite and she felt that appropriate support was there from partners. She also outlined alternatives being considered for the way in which these services could be accessed, e.g. using self-directed support.

The Chair passed on comments from IJB member and carer representative, David Binnie, who was not present at the meeting. He had commended the work undertaken on the strategy and the engagement with carers' groups and representatives. The Chair added her own remarks on the importance of the strategy and of acknowledging the role and contributions of carers.

The Chair moved to the vote on the recommendations, which was taken by roll call and approved unanimously.

Decision

The IJB:

i. Approved the draft Carers Strategy for implementation; and

ii. Noted the funding agreed for 2023/24.

6. EAST LOTHIAN HEALTH & SOCIAL CARE PARTNERSHIP COMMISSION COMMUNITY SUPPORT 2023/24

A report was submitted by the Chief Officer informing the IJB of the budget and proposed commissioning arrangements for 2023/24 in relation to commissioned community support.

Christine Johnston presented the report and reminded members that this paper related specially to the voluntary sector budget. The approach was underpinned by the commissioning strategy previously approved by the IJB, which focussed on personal outcomes, and took account of relevant regulations. She drew members' attention to key points within the report and appendices, including services such as Community First, the post-diagnostic support service for people with dementia, and day centres. She also highlighted organisations which had been identified for an uplift in funding.

Ms Johnston responded to questions from Mr Murray providing further detail on the arrangements for longer-term commissioning for day centres and the quality assurance processes being put in place. She acknowledged the severe financial pressures facing providers and advised that proposed uplifts had been aligned with Scottish Government adult social care uplift levels while also taking account of affordability.

Ms Kerr provided further detail on options for individuals receiving services and the associated mechanisms for commissioning, funding and delivery to ensure that services met the needs of clients. Matthew Kennedy added that there was a distinction between groups of service users, and that those who arranged services through self-directed support may have more complex needs than those who accessed collectively commissioned services.

Claire Flanagan replied to a question from Mr Cogan on the governance around financial reporting. She acknowledged that there were risks, however the HSCP had their own internal resource to augment the standard financial reporting arrangements.

Councillor Jardine asked about older peoples' day centres and the support for trustees. Ms Johnston confirmed that all trustees had received training through VCEL on their roles, responsibilities and charitable law. As part of the commissioning process they were also required to prepare a trustee development plan identifying strengths and weaknesses.

Maureen Allan advised that VCEL had been working with day centres to support business planning and develop health checks on governance arrangements which would include conversations on training programmes, policies and procedures and HR support available through VCEL and other organisations.

In response to questions from the Chair, Ms Johnston confirmed that those organisations who had received a one year grant were aware that funding had ceased, and that they had had the opportunity to apply for further funding but had not done so. However, she understood that these groups had received funding from other sources and that they were continuing to deliver the same level of service.

Ms Kerr confirmed that grant applications were for a set period or piece of work and these outcomes were monitored closely. However she accepted that, due to budget constraints, the grants programme no longer had the same flexibility.

Ms Allan confirmed that VCEL was providing support to these organisations and that there were other funding sources open to them. She outlined some of the assistance provided to identify alternative funding sources and added that organisations had to take some responsibility when funding was year on year.

In response to further comments from the Chair on Macmerry Men's Shed and Pennypit, Ms Allan reiterated that these organisations were receiving continuing support and had access to alternative funding. The Chair indicated that she would like to discuss this issue further with Ms Allan and Ms Johnston outwith the meeting.

Ms McNeill asked about the arrangements for organisations to approach Area Partnerships for funding.

Ms Allan advised that VCEL representatives attended all Area Partnership meetings and she would encourage organisations to sign up to the VCEL newsletter which contained detailed information on funding opportunities.

Ms Kerr referred to the new One Council fund and outlined the process through which organisations could approach the HSCP for funding on a commissioned or one off basis.

The Chair thanked officers for their work and the importance of funding and support for local groups and communities. She moved to the vote on the recommendations, which was taken by roll call and approved unanimously.

Decision

The IJB:

i. Noted the commissioned community support budget and agreed uplifts for providers for 2023/24 as set out within appendix 1;

ii. Noted the budget for 2023/24 for Older Peoples Day Centres within appendix 2. This now included funding to commission a new day centre in Musselburgh.

iii. Noted the budget for 2023/24 for Housing Support within appendix 3 including the removal of funding from Abbeyfield and the transfer of the NCH Scotland and Blue Triangle budget to East Lothian Council Housing Department within 2023/24.

iv. Noted the short-term funding arrangements for the East Lothian Sexual Abuse Service delivered by Edinburgh Rape Crisis Centre.

7. 2022/23 DRAFT UNAUDITED ANNUAL ACCOUNTS

A report was submitted by the Chief Finance Officer presenting to the IJB its draft (unaudited) Annual Accounts for 2022/23.

Ms Flanagan presented the report. She outlined the content of the draft annual accounts including the management commentary, remuneration report, annual governance statement and financial statements. She set out the year-end position - a deficit of £10.1M – which had occurred as a result of a surplus from 2021/22 and the IJB incurring expenditure against its earmarked reserves. She noted that the performance against the in-year budget had resulted in a £282,000 surplus in social care and a very small, £31,000, overspend in the health budget; however, non-recurring financial support had been provided by NHS Lothian to balance the health budget. Ms Flanagan said there had also been significant movement in the Reserves position during year, however, this had been anticipated. She highlighted the continuing pressures on Set Aside and Prescribing budgets and challenges resulting from external issues, such as the proposed National Care Service.

Fiona Ireland confirmed that the draft accounts had been reviewed at the Audit & Risk Committee meeting on 6th June. She then referred to recent media coverage around the standard of financial controls in East Lothian Council, and asked whether the concerns expressed by Audit Scotland should be reflected in the commentary or annual governance statement within the IJB's accounts.

Ms Flanagan said she was aware of this issue although she did not know the detail behind the report. She advised that the IJB relied on letters of assurance from both NHS Lothian and East Lothian Council regarding the IJBs financial position held by Partners and their financial controls. These letters were required as part of the audit process.

In response to further questions from Ms Ireland, Ms Flanagan said that she had yet to receive the Council's letter of assurance for 2022/23 but would follow this up as part of the audit process. She confirmed that she would only expect the letter to reflect the comments made by Audit Scotland, if anything related to or would impact the IJB.

The Chair advised that a paper on the Audit Scotland report would be presented to the next full Council meeting and that this could be shared with IJB members. She added that the Council's Finance Team had put appropriate checks and balances in place to address the issues highlighted by Audit Scotland.

Cllr Jardine informed members that this had also been raised at recent meetings of the Council's Audit & Governance Committee and its Policy & Performance Review Committee, and Councillors were very mindful of this issue.

The Chair asked whether it would be possible to receive more information so members could better understand East Lothian's use of services covered by the Set Aside budget. She referred to previous work around this issue and asked if there had been any recent progress. She felt it would be useful for members to get a better understanding of the IJB's use of these services.

Ms Flanagan advised that this work had been paused during pandemic and she was not sure of its current status on the work plan. However, it should be possible to gather some data locally and provide this to members.

Ms Wilson acknowledged the point. She advised that some information was contained within the annual performance report, however, it would be useful to see further data on the use of acute services and how this might impact future Direction-setting. She agreed to explore the possibility of a presentation to IJB members on acute service finances.

The Chair thanked Ms Flanagan and other finance colleagues for their work on the annual accounts. She noted the small overspend and said that this demonstrated how hard staff were working to deliver services within budgets. She recognised the continuing pressures faced through population growth within the county, and other factors, and how these impacted on delivering the best possible outcomes for local communities.

The Chair moved to the vote on the recommendations, which was taken by roll call and approved unanimously.

Decision

The IJB:

i. Noted the draft unaudited annual accounts were considered at the Audit & Risk Committee on 6th June 2023; and

ii. Agreed that the draft annual accounts could be published and presented for audit.

Signed .....

Councillor Shamin Akhtar
Chair of the East Lothian Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 21 September 2023

BY: Chief Finance Officer

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SUBJECT: Quarter 1 Financial Forecast for 2023/24

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1 PURPOSE

1.1 This report lays out the results of the partner's (East Lothian Council and NHS Lothian) quarter one financial reviews and considers how these impact on the projected financial position of the IJB for 2023/24. Plus reports on the quarter 1 monitoring of the IJB financial recovery plans and the current reserves position.

2 RECOMMENDATIONS

2.1 As a result of this report, Members are asked to:

i. Note the quarter one financial review undertaken by partners.
ii. Note the update on financial recovery plans.
iii. Note the IJBs general reserve position.

3 BACKGROUND

3.1 At the IJB meetings during March and May 2023, the IJB considered its budget offers from Partners which resulted in the IJB not accepting the East Lothian Council offer due to a reduction of £0.250m in funding included within it. There has been no movement from this position and subsequently the IJB has noted the further recovery actions required to balance the IJBs budget.

3.2 The Budget Offers made by Partners at the start of the financial year are shown below:

IJB Opening Budget 2023/24	£m	£m
East Lothian Council		**69.447**
Baseline Budget	67.788	
New Scottish Government Monies	1.909	
Reduction to Budget	-0.250	
NHS Lothian		**113.112**
Baseline Budget	110.483	
Uplift & Other	2.629	
Total		**182.559**

Fig 1: East Lothian IJB combined budget to the IJB

3.3 Both partner organisations have now completed their quarter one (Q1) financial reviews which provides a forecast financial outturn for 2023/24. The East Lothian Council and NHS Lothian Q1 financial reviews are based on information to the end of June 2023 and should be noted in the context of challenging financial climate and the timing of financial recovery plans being agreed.

3.4 The Q1 financial review position for the IJB is a projected overspend of £8.5m and a breakdown is shown below:

	Q1 Forecast		
	Annual Budget as at end of June 2023	**Forecast Expenditure**	**Under/ (Over) Spend**
	£m	**£m**	**£m**
Core	88.083	88.678	-0.595
Hosted	13.735	13.849	-0.114
Set Aside	24.000	26.347	-2.348
Health	**125.817**	**128.874**	**-3.057**
Social Care	69.447	74.894	-5.447
Total	**195.264**	**203.768**	**-8.504**

Fig 2 : IJB Quarter 1 review forecast

3.5 The budget movements from the partners' budgets offers at the start of the financial year to the budget position at Q1 are additional funding allocations from Scottish Government. Further detail of the Q1 position is shared at appendix 1

3.6 The forecast position reflects the projections for both partners. NHS Lothian have presented their overall Q1 financial projections to their Finance & Resources Committee on the 9th August 2023. East Lothian Council presented their Q1 financial projections to their Council meeting on the 29th August 2023.

3.7 The forecast highlights a significant overspend for the IJB, within the health IJB budgets there is £1.8m projected overspend relating to prescribing and £2.3m relating to set aside budgets. The set aside position within the IJBs financial plan included a £1.9m predicted overspend so a deterioration in the position from budget setting to Q1. This is made up of Gastroenterology drugs, the drugs pressure across acute is significant and has been growing due mainly to new medicines. Within Medicine of the Elderly there are overspends in medical pays predominantly at the RIE. Similarly General Medicine facing increased costs in medical staffing.

3.8 NHS Lothian received additional funding from Scottish Government to support sustainability and new medicines, they have yet to allocate the new medicines funding or the sustainability funding to services and for forecast purposes it has been retained centrally. It is likely that some new medicines funding will be allocated to delegated services given the pressures reported on drugs budgets within set aside services. Further to this and as in previous years, NHS Lothians Director of Finance and the Chief Finance Officers continue to have a shared ambition that providing that NHS Lothian can achieve a breakeven position for 2023/24 then an additional payment will be made to the IJB to meet the final IJB year-end overspend within health services.

3.9 The Social Care overall forecast is reporting a £5.5m projected overspend a significant swing from the 2022/23 year end position to Q1. The areas of concern reporting an overspend are the commissioned services particularly care homes placements and within the social care learning disability budgets. There is also a recognition though that this social care forecast is a pessimistic forecast and with more data the forecasting assumption will be refined.

3.10 To support the financial position the IJB has a challenging financial recovery plans programme which was part of the budget setting of the IJB, you'll see below the recovery plans totalling £6.3m.

	23/24 Base Target	**23/24 Revised Target**
	£m	**£m**
Financial Recovery Plans		
core	3.110	3.110
hosted	0.298	0.316
set aside*	1.959	1.959
social care	0.536	0.916
Total	**5.903**	**6.301**

Fig 3 : IJB Financial Recovery Plans 2023/24

3.11 Performance against these plans is detailed in appendix 2.

3.12 Given the forecast and the notes above particularly around the assumption regarding set aside breaking even and the new medicines and sustainability funding received by NHS Lothian there is potential improvements in the forecast position, and these are noted in figure 4 below. The table also notes that there may be additional benefit from where financial recovery plans performance improves.

	Q1 Forecast		
	Annual Budget as at end of June 2023	**Forecast Expenditure**	**Under/ (Over) Spend**
	£m	**£m**	**£m**
Core	88.083	88.678	-0.595
Hosted	13.735	13.849	-0.114
Set Aside	24.000	26.347	-2.348
Health	**125.817**	**128.874**	**-3.057**
Social Care	69.447	74.894	-5.447
Total	**195.264**	**203.768**	**-8.504**
assumption on set aside budgets breaking even			2.348
new medicine and sustainability funding			tbc
further delivery on financial recovery plans			tbc
Revised Total Range			**tbc - -6.156**

Fig 4 : IJB Quarter 1 revised position

3.13 Due to the financial position projections, it is worth reviewing the IJBs general reserve position again and the below table shows this position.

	23/24	**24/25**	**25/26**	**26/27**	**27/28**
General Reserves	**£m**	**£m**	**£m**	**£m**	**£m**
Closing balance 2022/23	5.030	4.660	4.290	4.290	4.290
Analogue to Digital	0.370	0.370			
DRAFT closing balance	4.660	4.290	4.290	4.290	4.290
Reserve Policy @ 2%	**4.000**	**4.000**	**4.000**	**4.000**	**4.000**
Position against Policy		0.290	0.290	0.290	0.290

Fig 5 : IJBs DRAFT general reserve projections

3.14 The IJB has made commitment against its general reserve during 2022/23 at its March 2023 meeting the IJB agreed to support the purchase of analogue to digital alarms.

3.15 The outturn projections will continue to be refined throughout the year, and regular updates will be brought back to the IJB. The main outstanding risk included in the above projections is the settlement of the local authority pay award. We await clarity to assess the impact of this

with Partner East Lothian Council. Currently the above projections assume 5% in line with Council, we require early dialogue with East Lothian Council regarding the pass through of any additional funding for a pay award higher than the assumed 3% to the IJBs delegated budgets.

4 ENGAGEMENT

4.1 The IJB makes its papers and reports available on the internet.

4.2 The issues in this report have been discussed with the IJB's partners but do not require wider engagement

5 POLICY IMPLICATIONS

5.1 There are no new policies arising from this paper.

5.2 The recommendations in this report implement national legislation and regulations on the establishment of IJBs.

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

6.2 The issues in this report do not require an integrated impact assessment.

7 DIRECTIONS

7.1 There is no implication for Direction at this stage.

8 RESOURCE IMPLICATIONS

8.1 Financial – There are no immediate resource implications from this report. Any resource implications from the outcome of the process will be highlighted in a future report if required.

8.2 Personnel – None

8.3 Other – None

9 BACKGROUND PAPERS

9.1 Budget Offers from partners – 2023/24 – March 2023 & May 2023

Appendix 1 – Q1 2023/24 Financial Forecasts
Appendix 2 – Financial Recovery Plans

AUTHOR'S NAME	Claire Flanagan
DESIGNATION	Chief Finance Officer
CONTACT INFO	claire.flanagan@nhslothian.scot.nhs.uk
DATE	September 2023

Appendix 1 – Q1 2023/24 Financial Forecast

Q1 Forecast					
Status	**Allocation**	**Service**	**Annual Budget as at end of June 2023** £m	**Forecast Expenditure** £m	**Under/ (Over) Spend** £m
Delegated	Core	Community Equipment	0.656	0.647	0.009
		Community Hospitals	12.878	11.763	1.116
		Complex Care	0.178	0.178	0.000
		District Nursing	3.335	3.176	0.159
		General Surgery	1.091	1.103	-0.012
		Geriatric Medicine	1.139	1.030	0.109
		GMS	18.760	19.231	-0.471
		Health Visiting	2.215	2.333	-0.118
		Hospital Services	0.000	0.009	-0.009
		Learning Disabilities	0.590	0.588	0.001
		Mental Health	6.520	6.441	0.079
		Other	0.171	0.219	-0.048
		PC Management	1.206	1.041	0.164
		PC Services	5.802	5.922	-0.120
		Pharmacy	0.160	0.160	-0.000
		Prescribing	20.711	22.524	-1.812
		Reserves	0.120	0.000	0.120
		Resource Transfer	4.969	4.969	0.000
		Substance Misuse	0.245	0.175	0.070
		Therapy Services	6.604	6.436	0.169
	Core Total		**87.348**	**87.944**	**-0.595**
	Corporate	Non Consolidated Payment for AfC	0.734	0.734	-0.000
	Corporate Total		**0.734**	**0.734**	**-0.000**
	Hosted	Community Equipment	0.285	0.285	-0.000
		Complex Care	0.209	0.199	0.010
		Diabetes & Endocrinology	0.004	0.002	0.002
		Geriatric Medicine	0.000	0.000	-0.000
		GMS	-1.938	-1.836	-0.102
		Hospices & Palliative Care	0.575	0.578	-0.002
		Learning Disabilities	1.713	1.740	-0.027
		LUCS	1.494	1.499	-0.005
		Mental Health	2.981	2.975	0.006
		Oral Health Services	1.109	1.056	0.052
		Outpatients	0.009	0.044	-0.035
		PC Services	0.831	0.982	-0.151
		Pharmacy	0.070	0.070	-0.000
		Prescribing	-0.441	-0.315	-0.126
		Psychology Services	1.091	1.204	-0.113
		Public Health	0.253	0.249	0.004
		Rehabilitation Medicine	1.198	1.055	0.143
		Sexual Health	0.916	0.936	-0.020
		Strategic Services	0.000	0.000	0.000
		Substance Misuse	0.588	0.585	0.002
		Therapy Services	1.999	1.902	0.097
		UNPAC	0.789	0.639	0.150
	Hosted Total		**13.735**	**13.849**	**-0.114**
Delegated Total			**101.817**	**102.527**	**-0.710**
Set Aside	Acute	Acute Management	0.755	0.848	-0.093
		Cardiology	0.928	0.929	-0.001
		Children Therapies	0.024	0.025	-0.001
		Diabetes & Endocrinology	0.509	0.834	-0.325
		ED & Minor Injuries	2.974	3.285	-0.311
		Gastroenterology	1.841	2.488	-0.647
		General Medicine	7.359	7.905	-0.546
		Geriatric Medicine	3.935	4.107	-0.172
		Infectious Disease	0.734	0.559	0.174
		Junior Medical	0.558	0.520	0.038
		Outpatients	0.155	0.150	0.005
		Rehabilitation Medicine	0.420	0.458	-0.038
		Respiratory Medicine	1.534	1.794	-0.260
		Therapy Services	2.276	2.446	-0.170
	Acute Total		**24.000**	**26.347**	**-2.348**

Set Aside Total			**24.000**	**26.347**	**-2.348**
Health Total			**125.817**	**128.874**	**-3.057**
Social Care	Health & Social Care	Adult Social Work	28.033	29.585	-1.552
		Acute & Ongoing Care	11.619	11.470	0.149
		Rehabilitation	2.211	2.563	-0.352
		Learning Disability & MH Community services	17.803	19.827	-2.024
		Head of Operations	3.302	5.083	-1.781
		Business & Performance	4.985	4.872	0.113
	Health & Social Care Total		**67.953**	**73.400**	**-5.447**
	Development	PSHG	0.256	0.256	0.000
	Development Total		**0.256**	**0.256**	**0.000**
	HRA Capital	Disabled Adaptations	1.000	1.000	0.000
	HRA Capital Total		**1.000**	**1.000**	**0.000**
	HRA	Garden Aid - HRA Community Housing (East)	0.068	0.068	0.000
	HRA	Garden Aid - HRA Community Housing (Musselburgh)	0.067	0.067	0.000
	HRA	Garden Aid - HRA Community Housing (Prestonpans)	0.049	0.049	0.000
	HRA	Garden Aid - HRA Community Housing (Tranent)	0.054	0.054	0.000
	HRA Total		**0.238**	**0.238**	**0.000**
Social Care Total			**69.447**	**74.894**	**-5.447**
IJB Total			**195.264**	**203.768**	**-8.504**

Appendix 2 – Financial Recovery Plans

Grouping	Financial Recovery Plans	Base Target: March 2023 £m	Revised Target: 23/24 £m	Q1 Target £m	Q1 Saving £m	Q1 Variance: Over/(Under) £m
Core	Workforce	**0.140**	**0.140**	0.035	0.035	0.000
Core	GP Prescribing	**1.000**	**1.000**	0.250	0.059	-0.191
Core	Procurement and Contracts	**0.415**	**0.415**	0.104	0.100	-0.004
Core	Capacity/Service Redesign	**0.400**	**0.400**	0.000	0.000	0.000
Core	NHS Lothian Thematic Programmes	**0.022**	**0.022**	0.006	0.000	-0.006
Core	Other	**1.133**	**1.133**	0.000	0.000	0.000
Core sub total		**3.110**	**3.110**	**0.394**	**0.194**	**-0.200**
Hosted	Workforce	**0.104**	**0.104**	0.026	0.022	-0.004
Hosted	GP Prescribing	**0.000**	**0.000**	0.000	0.000	0.000
Hosted	Procurement and Contracts	**0.039**	**0.057**	0.014	0.006	-0.008
Hosted	Capacity/Service Redesign	**0.150**	**0.150**	0.038	0.038	0.000
Hosted	NHS Lothian Thematic Programmes	**0.005**	**0.005**	0.001	0.000	-0.001
Hosted sub total		**0.298**	**0.316**	**0.079**	**0.066**	**-0.013**
Set Aside	Workforce	**0.236**	**0.236**	0.059	0.031	-0.028
Set Aside	Acute Medicines	**0.067**	**0.067**	0.017	0.000	-0.017
Set Aside	Capacity/Service Redesign	**0.030**	**0.030**	0.008	0.008	0.000
Set Aside	NHS Lothian Thematic Programmes	**0.007**	**0.007**	0.002	0.002	0.000
Set Aside	Other	**1.619**	**1.619**	0.000	0.000	0.000
Set Aside sub total		**1.959**	**1.959**	**0.085**	**0.041**	**-0.045**
Social Care	Workforce	**0.100**	**0.100**	0.025	0.000	-0.025
Social Care	Procurement and Contracts	**0.315**	**0.315**	0.079	0.010	-0.069
Social Care	Capacity/Service Redesign	**0.121**	**0.501**	0.464	0.451	-0.013
Social Care sub total		**0.536**	**0.916**	**0.567**	**0.461**	**-0.106**
Grand Total		**5.903**	**6.301**	**1.125**	**0.761**	**-0.364**

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 21 September 2023

BY: Chief Officer

6

SUBJECT: Changes to the IJB Membership

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1 PURPOSE

1.1 To inform and seek approval from the Integration Joint Board (IJB) regarding changes to its non-voting membership.

2 RECOMMENDATIONS

2.1 The IJB is asked to:

(i) agree the appointment of Dr John Hardman as a non-voting member of the IJB for the maximum term of office;

(ii) agree the appointment of Sarah Gossner as a non-voting member of the IJB, replacing Lorraine Cowan in the role of Chief Nurse, for the maximum term of office; and

(iii) note the appointment of David Hood as a non-voting member of the IJB, replacing Iain Gorman in the role of Head of Operations within East Lothian HSCP.

3 BACKGROUND

3.1 At its meeting on 21st June 2023, NHS Lothian's Board agreed to the appointment of Dr John Hardman as a non-voting member of the East Lothian IJB, with immediate effect and until June 2026. Dr Hardman takes over the vacant IJB membership role of 'Registered Medical Practitioner (GP)', previously held by Dr Jon Turvill.

3.2 Sarah Gossner was recently appointed as the new Chief Nurse, following the departure of Lorraine Cowan. Ms Gossner will take up her new role on Monday 27th November 2023. Her appointment as a non-voting member of the IJB in the role of Registered Nurse/Chief Nurse will also take effect from that date, and will be for a term of 3 years.

3.3 David Hood was recently appointed as the new Head of Operations in East Lothian Health & Social Care Partnership, following the departure of Iain Gorman. Mr Hood will take up his new role on Monday 2nd October 2023 and his appointment as a non-voting member of the IJB will also take effect from that date.

3.4 All IJB members, except those where their membership is by virtue of their role, e.g. Chief Officer, Chief Finance Officer, Head of Operations of the HSCP and CSWO, are appointed to the IJB for a maximum term of office of 3 years. Thereafter, appointments may be renewed for subsequent terms.

4 ENGAGEMENT

4.1 The appointments in this report have been discussed with the relevant nominating body or, where appropriate, have been advertised publicly.

5 POLICY IMPLICATIONS

5.1 The recommendations in this report implement national legislation and regulations on the establishment of IJBs.

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 The subject of this report does not affect the IJB's current Directions or require an additional Direction to be put in place.

8 RESOURCE IMPLICATIONS

8.1 Financial – None.

8.2 Personnel – None.

8.3 Other – None.

9 BACKGROUND PAPERS

9.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 (SSI 2014 No.285).

9.2 The Scheme of Integration of the IJB.

AUTHOR'S NAME	Fiona Currie
DESIGNATION	Committees Officer
CONTACT INFO	fcurrie@eastlothian.gov.uk
DATE	September 2023

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 21 September 2023

BY: Chief Officer

7

SUBJECT: East Lothian IJB Revised Joint Integration Scheme 2023

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1 PURPOSE

1.1 To inform the East Lothian Integration Joint Board (IJB) of the approval by Scottish Ministers of a revised Joint Integration Scheme jointly developed by NHS Lothian and East Lothian Council.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Note the process for the development of the revised Integration Scheme and the external factors causing delays to its completion.

2.2 Note that although notification of the revised Scheme's approval was only formally received in July 2023, the revisions within have applied to the IJB from 15th May 2023.

2.3 Note that the next review of the Integration Scheme will be in 2028 unless otherwise directed by Scottish Ministers.

2.4 Note that the revised Scheme was presented to the East Lothian Strategic Planning Group on 24 August 2023.

3 BACKGROUND

3.1 The Public Bodies (Joint Working) Scotland Act 2014 imposed statutory duties on councils and health boards to integrate specified health and social care services. The vehicle for achieving this was formal delegation through an 'Integration Scheme' of certain statutory duties by each council and health board to a new integration authority (or Integration Joint Board).

3.2 The so-established integration authority's responsibilities included: preparation of a strategic plan every five years; management of a budget allocated from the council and health board; and issuing of directions to the council and health boards to instruct them on their delivery of relevant delegated functions and use of associated resources.

3.3 The integration authority is required to maintain oversight of the delivery of all its functions and relevant partner functions and to present these in a statutory annual performance report.

3.4 On its establishment in July 2015, East Lothian IJB took on duties in the East Lothian Council area for the development of integrated planning and delivery of health and social care services and criminal justice social work, as well as certain acute hospital services managed on its behalf by NHS Lothian.

3.5 **Integration Scheme Review**

3.5.1 Given the legal requirement to review schemes within 5 years of the date they were approved, the joint NHS Lothian and individual council reviews for all Lothian IJBs should have been completed by spring/summer of 2020.

3.5.2 For several reasons, including Covid-related disruptions, it was not possible to carry out the reviews within the planned timescale. In May 2020, NHS Lothian Board formally approved a delay to commencement of the reviews for all four IJBs. This was communicated to Scottish Government.

3.5.3 Following consideration of the national position by the Scottish Government in May 2021, NHS Lothian and partner local authorities committed to commencing a review in that year. This was further delayed until early 2022.

3.5.4 The review process and the partners' duty to lead the review and to carry out consultation is set out in the 2014 Act. There is no role for the IJB in this process.

3.5.5 The review of the Integration Scheme has three stages:

Stage 1:

- Consultation must take place with the persons and groups specified by the Scottish Ministers and with others identified by the council and health board.

- The council and health board must take account of views expressed before proceeding to decide if changes are required.

Stage 2:

If the council and health board decide changes are required, they must:

- Prepare a revised Scheme.
- Consult again with the same people and groups.
- Take account of views expressed before proceeding to finalise the Scheme.

Stage 3:

- The revised Scheme must be submitted by the council and health board to the Scottish Ministers for approval.
- Once approved, the revised Scheme must be published, with the changes taking effect.

3.6 The original, 2015 East Lothian scheme text required:

- updating to replace a significant number of out-of-date references to work anticipated (in 2015) to support the initial establishment of business processes etc. for the IJB.
- Changes, following the revision to the scheme in 2019 to reflect the Carers' Act consequentials.

3.7 In recognition of changes to the statutory review timetable resulting from the Covid pandemic, only stages 2 and 3 of the consultation process were followed.

4 ENGAGEMENT

4.1 NHS Lothian Strategic Planning Department, in partnership with East Lothian Council legal department and with input from East Lothian HSCP officers drafted the revised Integration Scheme for consultation. The consultation commenced on 1 March 2022 and concluded on 31 March 2022.

4.2 Consultation was carried out across the other three Lothian IJB areas for their revised Integration Schemes, although consultation timetables varied.

4.3 Although there was no formal role for IJBs in the review of the Integration Scheme, in revising the document or in the consultation process, East Lothian IJB members were informed of progress with the review and invited to engage with the consultation process. This meant their views could be considered, alongside those of other consultees.

5 POLICY IMPLICATIONS

5.1 There are no further policy implications, beyond adoption of the new Integration Scheme

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 implications for Directions arising from this report.

8 RESOURCE IMPLICATIONS

8.1 There are no Financial, Personnel, or other resource implications arising from this report.

9 BACKGROUND PAPERS

9.1 East Lothian Integration Joint Board, Revised Joint Integration Scheme (Body Corporate) Effective date 15/05/2023

AUTHOR'S NAME	Paul Currie
DESIGNATION	Interim General Manager, Strategic Integration
CONTACT INFO	paul.currie@nhslothian.scot.nhs.uk
DATE	11 August 2023

East Lothian Integration Joint Board

Revised Joint Integration Scheme
(Body Corporate)

East Lothian Integration Scheme 2023
Final. Effective date 15/05/2023

Contents

PREAMBLE

Health and Wellbeing Outcomes, and the Aims, Vision and Values of the Integration Joint Board ("IJB")

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. This revised integration scheme is intended to achieve the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Public Bodies (Joint Working) (Scotland) Act 2014, namely:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

5. Health and social care services contribute to reducing health inequalities.

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

7. People using health and social care services are safe from harm.

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9. Resources are used effectively and efficiently in the provision of health and social care services.

Our vision and aims

The IJB's vision for the integration of health and social care in East Lothian is to support all people in East Lothian to live the lives they want as well as possible, achieving their potential to live independently and exercising choice over the services they use[1].

The IJB's strategic objectives are:

A. to make health and social care services more sustainable and proportionate to need and to develop our communities.

B. to explore new models of community provision which involve local communities and encourage less reliance on health and social care services.

C. to improve prevention and early intervention.

D. to reduce unscheduled care and delayed discharges.

E. to provide care closer to home.

F. to deliver services within an integrated care model.

G. to enable people to have more choice and control.

H. to reduce health inequalities.

I. to build and support partnership working.

J. to support change and improvement across our services.

The **values** that will underpin delivery of the IJB's vision and outcomes are:

- to give people control over what happens to them is in itself promoting good health and wellbeing. The IJB will seek to maximise people's control over their lives as an integral part of the services we provide

- it is better to prevent health and social problems than to deal with them once they have occurred. The IJB will focus our attention and resources on prevention and early intervention

- that some people's social and economic circumstances lead to them having poorer health, wellbeing and life chances than others. IJB will work to tackle these inequalities by focusing our efforts on those at greatest risk

- it is right to offer people services as close to home as possible

- in working in partnership

[1] East Lothian IJB Strategic Plan 2019 - 2022, page 12

- in a single health and social care economy for East Lothian. We will invest the resources of the health and social care economy wherever it will have the greatest impact on meeting our shared objectives.

- recognise the interdependencies of services and will take a holistic approach to service provision, considering each individual in the context of their circumstances.

- value the views of people who use our services.

- value the diversity of East Lothian. We will work closely with our diverse communities to ensure they can contribute to the health and wellbeing of the population.

Throughout all its work the Parties expect the IJB to be guided by the following ambitions:

- provide the highest quality health and care services.

- always respect people's dignity and rights.

- support people to live independently at home.

- promote the principles of independent living and equality.

- do everything we can to reduce health inequalities.

- provide support and services so that people only have to go to hospital if it is appropriate and necessary.

- listen to people who use our services, and the people who care for them, working together to develop the services that are right for them.

- make sure that East Lothian people feel safe at home and in their communities.

- support people to take more responsibility for their own health and wellbeing.

The provisions within this preamble are not part of the Scheme and are not intended to create legally binding obligations. They do however, give the context within which this revised integration scheme should be read.

Integration Scheme

The Parties:

East Lothian Council, the local authority for the County of East Lothian constituted by the Local Government etc (Scotland) Act 1994 and having its principal offices at John Muir House, Brewery Park, Haddington, EH41 3HA ("the Council");

and

Lothian Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Lothian") and having its principal offices at Waverley Gate, 2-4 Waterloo Place, Edinburgh ("NHS Lothian")

(together referred to as "the Parties", and each being referred to as a "Party")

Background

A. The Parties are required to comply with either subsection (3) or (4) of section 2(2) of the Act (hereinafter defined), and elected to comply with subsection (3) such that the Parties jointly prepared a joint integration scheme (as defined in section 1(3) of the Act) for East Lothian Area.

B. The Parties entered into the East Lothian Joint Board Joint Integration Scheme in 2015.

C. In preparing the said East Lothian Joint Board Joint Integration Scheme, the Parties had regard to the integration planning principles set out in section 4(1) of the Act and the national health and wellbeing outcomes prescribed by the Public Bodies (Joint Working)(National Health and Wellbeing Outcomes)(Scotland) Regulations 2014, and have complied with the provisions of section 6(2) of the Act (consultation); and in finalising the said Joint Board Integration Scheme, the Parties took account of any views expressed by virtue of the consultation processes undertaken under section 6(2) of the Act.

D. Under s.45(3) of the Act, the Parties are obligated upon the instructions of the Scottish Ministers in the exercise of their power conferred by s.1(3)(f) of the Act, to jointly carry out a review of the said Joint Board Integration Scheme for the purpose of identifying and formalising any necessary or desirable changes required by the Scottish Ministers.

E. The Scottish Ministers instructed the Parties to revise the said Joint Board Integration Scheme to reflect changes necessitated by provisions contained in the Carers (Scotland) Act 2016, in so far as such requires a relevant local authority and health board to delegate some of their duties in relation to adult carers to the IJB (hereinafter more specifically defined as "IJB"). The

Parties therefore determined to delegate certain functions set out in the said Carers (Scotland) Act 2016 to the IJB and revised the said Joint Board Integration Scheme.

F. The Parties agreed to a new partially revised integration scheme in accordance with the provisions set out in s.47 of the Act to reflect the instructions of the Scottish Ministers. The first revised integration scheme was entered into in 2019.

G. Full review and subsequent revision of the Joint Board Integration Scheme as envisaged by s.44 of the Act has been carried out by the Parties in accordance with the provisions of s.44 (5) of the Act and it has been agreed that this agreement would constitute a revised and new Integration Scheme. The revised 2023 scheme was given ministerial approval on 15th of May 2023 and is effective from this date.

In implementation of their obligations under the Act, the Parties hereby agree as follows:

1 Definitions and Interpretation

1.1 In this Scheme the following expressions have the following meanings, unless the context otherwise requires:-

"Act" means the Public Bodies (Joint Working) (Scotland) Act 2014 (unless otherwise specified by reference to another Act);

"Chief Officer" means the officer described in Section 7 of this Scheme;

"Chief Finance Officer" means the finance officer appointed by the Board under the finance and audit requirements in section 13 of the Act and section 95 of the Local Government (Scotland) Act 1973, and described in section 9 of the Scheme;

"Chief Social Work Officer" means the officer described in Scetion 3 of the Social Work (Scotland) Act 1968

"East Lothian Area" means the local authority area served by the Council

"IJB Strategic Plan" means the plan which the IJB is required to prepare and implement in relation to the delegated provision of health and social care services in accordance with section 29 of the Act.

"Integration Dataset" means the collective Integration Indicators;

"Integration Indicators" means the indicators and metrics gathered by the IJB and required for monitoring and reporting purposes in compliance with the IJB's statutory and policy obligations;

"IJB" means the East Lothian Integration Joint Board established by Order under section 9 of the Act pursuant to this Scheme;

"IJB Order" means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014;

"Scheme" means this revised integration scheme;

"Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014;

"Lothian IJBs" means the IJBs to which functions are delegated in pursuance of the integration schemes in respect of the local authority areas served by, City of Edinburgh Council, the Council, Midlothian Council and West Lothian Council respectively;

"Neighbouring IJBs" means the Lothian IJBs excluding the IJB;

"Operational Budget" means the amount of payment made from the IJB to a Party in order to carry out delegated functions;

"Outcomes" means the health and wellbeing outcomes prescribed by the Scottish Ministers in The Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014;

"Performance Framework" means the IJB's agreed measurement and standard for managing, gathering and reporting the Integration Dataset and/or the Integration Indicators as the case may be;

1.2 Words and expressions defined in the Act shall bear the same respective meanings in this Scheme unless otherwise specified herein.

1.3 References to Sections are to the sections of this Scheme unless otherwise specified as being sections of an Act of Parliament, or has statutory meaning.

1.4 Reference to Annexes are to annexes to this Scheme and reference to Parts are the parts of the relevant Annex.

2 The Model to be implemented

2.1 The integration model set out in section 1(4)(a) of the Act applies in relation to the East Lothian Area, namely the delegation of functions by each of the Parties to a body corporate established by Order under section 9 of the Act.

2.2. The original scheme came into effect on the date the IJB Order to establish the IJB came into force.

2.3 This Scheme comes into effect on the date of approval by Scottish Ministers (approval granted 15/05/2023)

3 Local Governance Arrangements

3.1 Membership

3.1.1 The IJB shall have the following voting members:

a) **4** councillors nominated by the Council; and
b) **4** non-executive directors nominated by NHS Lothian in compliance with articles 3(4) and 3(5) of the IJBs Order.

3.1.2 The Parties may determine their own respective processes for deciding who to nominate as voting members of the IJB.

3.1.3 Non-voting members of the IJB will be appointed in accordance with article 3 of the IJB's Order.

3.1.4 The term of office of members shall be prescribed by regulation 7 of the IJB's Order.

3.2 Appointment of chair and vice chair

3.2.1 The IJB shall have a chairperson and a vice-chairperson who will both be voting members of the IJB.

3.2.2 The term of office for the chairperson and vice chairperson will be two years.

3.2.3 The Council and NHS Lothian may determine (out of those voting members nominated in terms of paragraph 3.1.2 of this Scheme) who they appoint as chairperson or vice-chairperson.

3.2.4 The Council appointed the first chairperson and NHS Lothian appointed the first vice-chairperson of the Integration Joint Board for the initial two year period from 1 April 2015.

3.2.5 The right to appoint the chairperson and vice chairperson respectively will continue to alternate between each of the Parties on a two-year cycle and on the basis that during any period when the power to appoint the chairperson is vested in one Party, the other Party shall have power to appoint the vice-chairperson.

3.2.6 The chairperson shall not have a casting vote.

3.2.7 Each Party may change its appointment as chairperson (or, as the case may be, vice-chairperson) at any time; and it is entirely at the discretion of the Party which is making the appointment to decide who it shall appoint.

4 Delegation of Functions

4.1 The functions that are to be delegated by NHS Lothian to the IJB (subject to the exceptions and restrictions specified or referred to in Part 1 of Annex 1) are set out in Part 1 of Annex 1. The services currently provided by NHS Lothian in carrying out these functions are described in Part 2 of Annex 1.

4.2 The functions that are to be delegated by the Council to the IJB (subject to the restrictions and limitations specified or referred to in Parts 1A and 1B of Annex 2) are set out in Parts 1A and 1B of Annex 2. For indicative purposes only, the services which are currently provided by the Council in carrying out these functions are described in Part 2 of Annex 2.

5 Local Operational Delivery Arrangements

5.1 Directions issued by the IJB via the Chief Officer

5.1.1 The IJB membership will be involved in the operational governance of integrated service delivery via two particular arrangements: (1) directions issued by the IJB via the Chief Officer of the IJB; and (2) oversight of performance management by the voting members of the IJB.

5.1.2 The IJB will issue directions to the Parties via its Chief Officer. The IJB must direct the Parties to carry out each of the functions delegated to the IJB. A direction in relation to a given function may be given to one or other of the Parties, or to both Parties. The primary responsibility for delivering capacity (that is to say, activity and case mix) in respect of the services associated with the carrying out of a given function shall lie with the IJB, and shall be reflected in the directions issued from time to time by the IJB. Subject to the provisions of the Act and this Scheme, the Parties are then required to follow those directions.

5.2 Oversight of performance management by the voting members of the IJB

5.2.1 The IJB shall oversee delivery of the services associated with the functions delegated to it by the Parties. The IJB is the only forum where health and social care functions for the East Lothian Area are governed by members of both NHS Lothian and the Council. Accordingly the Parties agree that the primary responsibility for performance management in respect of delivery of the delegated functions will rest with the IJB.

5.2.2 The Parties will provide performance information so that the IJB can develop a comprehensive performance management system.

5.2.3 The IJB performance management reports will be available to both Parties for their use in their respective performance management systems. However it is expected that the voting members of the IJB will take responsibility for performance management at the IJB, and will provide an account of highlights and/or exceptional matters to meetings of NHS Lothian and the Council.

5.2.4 In the interests of efficient governance, the relevant committees of NHS Lothian and the Council will continue to discharge their existing remits for assurance and scrutiny of the carrying out of NHS Lothian and the Council functions, regarding matters such as internal control, quality and professional standards, and compliance with the law. The IJB will not duplicate the internal operational oversight role carried out by the Parties' respective committees other than in exceptional circumstances where the IJB considers that direct engagement by the IJB (or by a committee established by the IJB) is appropriate and agreed by the Parties in order to secure the proper discharge by the IJB of its statutory responsibilities or duties under this Scheme.

5.2.5 Each of the Parties shall use reasonable endeavours to procure that in the event that one of its committees identifies an issue which is of direct and material relevance to the IJB, the chair of that committee will advise the Chair of the IJB and the Chief Officer of that matter and will co-operate with the IJB in supplying such further information and evidence in respect of that matter as the IJB may reasonably request.

5.2.6 The Parties shall ensure that their respective standing orders, schemes of delegation and other governance documents are amended (if required) to reflect the IJB's powers and remit, and its place as a common decision-making body within the framework for delivery of health and social care within the East Lothian Area.

5.2.7 The voting members of the IJB are councillors of the Council and non-executive board members of NHS Lothian. In their capacity as councillors and non-executive board members, they will be engaged in the governance of their respective constituent bodies, and it is likely that they will be members of one or more committees of those constituent bodies.

5.2.8 Given the overall vision as outlined in the preamble of this Scheme, it is the intention that the operational governance functions of both Parties and the IJB should be integrated. In all matters associated with the work of the IJB, the voting members of the IJB will be expected by the Parties to play a crucial role in:

a) communicating, and having due regard to, the interests of NHS Lothian or (as the case may be) the Council in overseeing the carrying out of the integrated functions, but on the understanding that, in carrying out their role as a member of the IJB, their primary duties and responsibilities are those which attach to them in that capacity; and

b) communicating, and having due regard to, the interests of the IJB in overseeing the carrying out of the integrated functions whilst discharging their role as a councillor or (as the case may be) as a non-executive board member of NHS Lothian, but on the understanding that, in carrying out their role as a councillor or non-executive board member, their primary duties and responsibilities are those which attach to them in that capacity.

5.2.9 This Scheme sets out detailed measures on the governance of integration functions throughout the text. Over and above these measures, the Parties will ensure that the IJB members are involved in overseeing the carrying out of integration functions through the following action:

a) The terms of reference, membership and reporting arrangements of the relevant committees of the Parties will be reviewed and the IJB will be consulted within this process (and all future reviews).

5.2.10 Without prejudice to the role of the voting members of the IJB (as specified above) in relation to oversight of operational delivery of services in accordance with directions issued to either or both of the Parties by the IJB, the IJB will, through the Chief Officer, have an oversight role in the operational delivery of services by the Parties in the carrying out of integration functions. The Parties acknowledge that the Chief Officer's role in operational delivery will represent an important means by which closer integration of services, in accordance with the integration delivery principles specified in the Act, can be achieved. For the avoidance of doubt, the Chief Officer's role in operational delivery shall not displace:

(a) the responsibilities of each Party regarding compliance with directions issued by the IJB; or

(b) the principle that each Party's governance arrangements must allow that Party to manage risks relating to service delivery.

5.2.11 In addition to the specific commitments set out above and the obligations regarding provision of information attaching to the Parties under the Act, each of the Parties will provide the IJB with any information which the IJB may require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability.

5.3 Support for Strategic Planning

5.3.1 The Parties will support the IJB in ensuring that the consultation process associated with the preparation of each Strategic Plan for the East Lothian Area includes other Integration Authorities likely to be affected by the Strategic Plan. The Integration Authorities that are most likely to be affected by the Strategic Plan for the East Lothian Area are:

(a) Midlothian Integration Joint Board
(b) Edinburgh Integration Joint Board
(c) West Lothian Integration Joint Board.

5.3.2 NHS Lothian will procure that reciprocal provisions to those set out in Sections 5.1, 5.2 and 5.3 are contained in the integration schemes of the Neighbouring IJBs in Lothian.

5.3.3 In addition the Scottish Borders Integration Joint Board shares a border with East Lothian Integration Joint Board and may be affected by the East Lothian Strategic Plan.

5.3.4 The Parties will to ensure that the IJB can:

(a) effectively engage in all of the planning process and support the Neighbouring IJBs in discharging their role including contributing to the work of the strategic planning groups for the Neighbouring IJBs as required;

(b) provide such information and analysis as Neighbouring IJBs reasonably require for the production of their Strategic Plans;

(c) inform Neighbouring IJBs as to how the services, facilities and resources associated with the functions delegated to the IJB by the Parties are being or are intended to be used with respect to carrying out of those functions in line with these planning processes;

(d) in a situation where Strategic Plans in one area are likely to have an impact on the plans in another area, ensure that these matters are raised with other relevant Integration Joint Boards and resolved in an appropriate manner;

(e) in a situation where Strategic Plans in another area are likely to have an impact on the East Lothian Area, ensure that these matters are raised and any associated risks are mitigated for the benefit of service users.

5.4 Lothian Hospitals Strategic Plan, and Lothian Strategic Development Framework

5.4.1 NHS Lothian developed a plan (the "Lothian Hospitals Strategic Plan") to support the IJB initial Schemes to fulfil their duties. The Lothian Hospitals Strategic Plan does not and will not bind the IJB though the IJB Strategic Plans are intended to inform and support the Lothian Hospital Strategic Plan. The Lothian Hospitals Strategic Plan encompasses both functions delegated to the Lothian IJBs and functions that are not so delegated.

5.4.2 The Lothian Hospitals Strategic Plan (which is or shall be replaced either in whole or part by the Lothian Strategic Development Framework referred to in 5.4.4 herein) was initially developed in partnership with the Lothian IJBs where integration functions are delivered by NHS Lothian in a hospital. Such reflected the relevant provisions of the Strategic Plans prepared by the respective Lothian IJBs, as well as NHS Lothian plans for non-delegated functions and it is intended that the Lothian Strategic Development Framework shall reflect the same.

5.4.3 The purpose of the Lothian Hospital Strategic Plan (and the purpose of the forthcoming Lothian Strategic Development Framework) is to ensure that planning for hospital functions and use of hospital facilities are:

(a) responsive to and supports each Strategic Plan prepared by the Lothian IJBs for delegated functions; and

(b) supportive of the requirement of NHS Lothian to deliver hospital services required by the IJB and other hospital services that are not the responsibility of the Lothian IJBs (e.g. tertiary, trauma, surgical, planned and children's services).

5.4.4 The forthcoming Lothian Strategic Development Framework shall be developed jointly by NHS Lothian and the Lothian IJBs, until such time as such is completed the Lothian Hospitals Strategic Plan shall continue to subsist. The elements of the Lothian Strategic Development Framework addressing non-delegated functions shall only be agreed by the NHS Lothian Board after the four Lothian IJBs have been consulted and their views and requirements appropriately considered. Elements of the Lothian Strategic Development Framework which cover functions delegated to the respective Lothian IJBs will be signed off by relevant Lothian IJBs in consultation with NHS Lothian and all Lothian IJBs.

5.5 Professional, technical or administrative support services

5.5.1 The Parties agree to provide the IJB with the corporate support services that it requires to discharge fully its duties under the Act.

5.5.2 The Parties and the IJB will regularly undertake review of the support services put in place pursuant to the IJB Scheme to ensure that the IJB has available to it all necessary professional, technical or administrative services for the purpose of preparing its Strategic Plan and carrying out the integration functions. This process will from part of the annual budget setting process for the IJB.

5.6 Performance targets, improvement measures and reporting arrangements

5.6.1 All national and local Outcomes, improvement measures and performance targets (including the Annual Performance Report (as defined and required under the Act) which are connected exclusively with the functions delegated by the Parties to the IJB under this Scheme will become the responsibility of the IJB to deliver; and the IJB will also be responsible for providing all such information regarding integration functions which is required by either of the Parties to enable each of them to fulfil its obligations regarding reporting arrangements in respect of those functions.

5.6.2 Where particular national or local Outcomes, measures or targets (and associated reporting arrangements) relate to services which are associated with both integration functions and functions which are not delegated by a Party to the IJB, the responsibility for the outcomes, measures or targets (and associated reporting arrangements) will be shared between the IJB and the Party or Parties which exercise those functions, and the IJB will be responsible for providing all such information regarding those integration functions as is required by the relevant Party to enable it to fulfil its obligations regarding reporting arrangements.

5.6.3 A set of shared principles will be developed and agreed between the Parties for targets and measurement based on existing best practice, and will be reviewed regularly as required.

5.6.4 A core group of senior managers and relevant support staff from each Party will continue to review and where necessary revise and further develop the Performance Framework, taking account of relevant national guidance. The Performance Framework will be underpinned by the Outcomes and will be further developed on an ongoing basis to drive change and improve effectiveness. The Performance Framework will be informed by an assessment of current performance arrangements and the development of a set of objectives which the framework will be intended to achieve.

5.6.5 A core set of Integration Indicators and measures will be identified by the Parties from publicly accountable and national indicators and targets which relate to services delivered in carrying out of the functions delegated to the IJB.

5.6.6 An Integration Dataset will be created for the IJB. The Integration Dataset shall include information on the data gathering, reporting requirements and accountability for each of these measures and targets and include, in relation to each target, the extent to which responsibility sits with or is to transfer to the IJB. Such shall be shared with and reviewed by the IJB and amended as appropriate following such review.

5.6.7 The Outcomes which apply to integrated health and social care, and the associated national indicators which underpin the nine health and wellbeing Outcomes will be used by the IJB to inform the development of the Performance Framework.

5.6.8 The IJB shall apply the Outcomes and Integration Indicators to inform and assist in setting local priorities and monitoring performance, and will be reported per national and local reporting arrangements.

5.6.9 The Integration Indicators will be aligned with the priority areas identified in the joint strategic needs assessment and the Strategic Plan and will be refined as these documents are reviewed and refreshed. The Integration Indicators shall be in line with IJB strategy and will demonstrably evidence the IJB's endeavours to achieve the Outcomes.

5.6.10 The Parties have obligations to meet targets for functions which are not delegated to the IJB, but which are affected by the performance and funding of integration functions. Therefore, when preparing performance management information, the Parties agree that the effect on both integration and non-integration functions must be considered and details must be provided of any targets, measures and arrangements for the IJB to take into account when preparing the Strategic Plan**.** Where responsibility for performance measures and targets is shared, this will be set out clearly for agreement by the relevant Parties.

5.6.11 The Performance Framework may require information on functions which are not delegated to the Integration Board. Either one of the Parties, or the IJB, will be able to reasonably require information of that nature to be included within the Integration Dataset.

5.6.12 The continuous development of an effective Performance Framework, taking account of relevant national guidance, will be supported by the parties and the IJB. The framework will be underpinned by the Outcomes, and national integration indicators, and will used by the Parties and the IJB to drive change and improve effectiveness.

6 Clinical and Care Governance

6.1 Introduction

6.1.1 This Section of this Scheme sets out the arrangements that will be put in place to allow the IJB to fulfil its role with professional advice and with appropriate clinical and care governance in place. The Parties will expect the IJB to develop more integrated governance arrangements in East Lothian to complement the existing clinical and care governance arrangements.

6.1.2 The Parties have well established systems to provide clinical and care governance as well as assurance for professional accountabilities. Those systems will continue and the scope of these systems will extend to provide the IJB with the requirements to fulfil their clinical and care governance responsibility.

6.1.3 This Section describes the relationship between the Parties' clinical and care governance systems and the IJB. The relationship between these systems and the Strategic Planning Group and delivery of services within localities will be via the Chair and Chief Officer of the IJB. The IJB non-voting membership includes the Chief Social Work Officer and three health professionals who are determined by NHS Lothian. These members will provide a further link between the Parties clinical and care governance systems and the IJB as described in Section 6.2. It is for the IJB to ensure that the Strategic Planning Group has sufficient information to undertake its function and the Parties shall provide such information to the IJB as is necessary for it to do so. This is in line with the commitment in this scheme at 5.3.1 to provide the IJB with the corporate support services required to fully discharge its responsibilities under the Act, which includes support to the IJB, its Strategic Planning and localities.

6.1.4 Continuous improvement and the quality of service delivery (and its impact on Outcomes) will be addressed through the development of the IJB's Performance Framework (pursuant to Section 5.6 of this Scheme).

6.1.5 The IJB will not duplicate the role carried out by the Parties existing governance arrangements other than in exceptional circumstances where the IJB considers that direct engagement by the IJB is appropriate in order to secure the proper discharge by the IJB of its statutory responsibilities.

6.1.6 The Parties agree that in the event that one of its committees within its governance arrangements identifies an issue which is of direct and material relevance to the IJB, the chair of that committee will advise the chairperson of the IJB and the Chief Officer of that matter and will co-operate with the IJB in supplying such further information and evidence in respect of that matter as the IJB may reasonably request.

6.1.7 The Parties shall ensure that its standing orders, schemes of delegation and other governance documents are amended (if required) to reflect the IJB's powers and remit, the IJB's place as

a common decision-making body within the framework for delivery of health and social care within the East Lothian Area and the Parties role in supporting the IJB to discharge its duties.

6.1.8 The voting members of the IJB are engaged in the governance of their respective Party, and it is likely that they will be members of one or more committees of the relevant Party.

6.1.9 The Parties will use reasonable endeavours to appoint voting members of the IJB (regardless of which party nominated the voting members) onto the NHS Lothian and Council governance arrangements with a remit relevant to the clinical and care governance of integration functions.

6.1.10 Within its existing governance framework, NHS Lothian has:

(a) A healthcare governance committee, the remit of which is to provide assurance to the Board that the quality of all aspects of care in NHS Lothian is person-centred, safe, effective, equitable and maintained to a high standard and to provide assurance to the Board of NHS Lothian that the Lothian NHS Board meets its responsibilities with respect to:-

- NHS Lothian participation standards
- volunteers/carers
- information governance
- protection of vulnerable people including children, adults, offenders
- relevant statutory equality duties

and

(b) A staff governance committee, the remit of which is to support and maintain a culture within Lothian NHS Board where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within NHS Lothian and is built upon partnership and collaboration. The staff governance committee must ensure that robust arrangements to implement the (NHS Scotland) Staff Governance Standard are in place and monitored

6.1.11 The staff governance committee has the primary role on staff governance matters, but can and does refer matters of relevance to the healthcare governance committee.

6.1.12 The healthcare governance committee can request assurance from the staff governance committee on matters of direct relevance to its remit, e.g. quality of recruitment, learning and development, completion of mandatory training.

6.1.13 Within the Council, the Chief Social Work Officer has overall responsibility for the professional standards of the Council's social work and social care staff. The workforce is also regulated by the Scottish Social Services Council ("SSSC"), and all professional staff must by law be

registered with the SSSC. This registration requirement will, in due course, extend to all social care staff employed by the Council and the voluntary and independent sectors.

6.1.14 The Chief Social Work Officer reports annually to the Council on standards achieved, governance arrangements (including supervision and case file audits), volume/quantity of statutory functions discharged, the registration of the workforce and on training, including mandatory training and post-qualifying learning and development.

6.1.15 These reports must comply with national guidance issued by the Scottish Government. The Chief Social Work Officer will also provide a copy of these annual reports to the IJB.

6.1.16 The intention of using the existing NHS Lothian and Council internal governance as a primary source of assurance is to recognise that the Parties will have continuing governance responsibilities for both delegated and non-delegated functions, and that the Parties wish to minimise unnecessary bureaucracy. The IJB will be engaged through its voting membership being part of the Parties' internal governance arrangements. The IJB will be in a position to holistically consider the information/assurance received from the Parties and arrive at a determination for all of its functions. If the IJB is in any way dissatisfied with the information or assurance it receives from the Parties, or the effectiveness of the Parties internal governance arrangements, it may give a direction to the Parties to address the issue, or revise its own system of governance.

6.2 Clinical and Care Governance Risk

6.2.1 There is a risk that the plans and directions of the IJB could have a negative impact on clinical and care governance, and professional accountabilities. Section 6.3 of this Scheme sets out the arrangements that have been or will be put in place to avoid this risk.

6.3 Professional Advice

6.3.1 NHS Lothian has within its executive membership three clinical members (referred to below as "Executive Clinical Directors"); a Medical Director, a Nurse Director, and a Director of Public Health. Their roles include responsibility for the professional leadership and governance of the clinical workforce (medical, nursing, allied health professionals, healthcare scientists, psychology, pharmacy), as well as clinical governance within NHS Lothian generally. The creation of the IJB does not change their roles in respect of professional leadership, and they remain the lead and accountable professionals for their respective professions.

6.3.2 The Council has a Chief Social Work Officer who reports to the Chief Executive and councillors. The Chief Social Work Officer monitors service quality and professional standards in social care

and social work, for staff employed in both adult and children's services, together with standards in relation to the protection of people at risk of harm. The Chief Social Work Officer role also includes quality assurance of decision-making with regard to adult social care, mental health criminal justice and children's services, in particular in relation to public protection and the deprivation of liberty.

6.3.3 The creation of an IJB does not change the Chief Social Work Officer's role in respect of professional leadership and they will remain the lead and accountable professional for their profession.

6.3.4 The IJB may elect to appoint one or both of the Medical Director and the Nurse Director as additional non-voting members of the IJB. The IJB's Order requires NHS Lothian to fill the following non-voting membership positions on the IJB:

(a) A registered medical practitioner whose name is included in the list of primary medical services performers prepared by NHS Lothian in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;
(b) A registered nurse who is employed by NHS Lothian or by a person or body with which NHS Lothian has entered into a general medical services contract; and
(c) A registered medical practitioner employed by NHS Lothian and not providing primary medical services.

6.3.5 NHS Lothian will consider the advice of the Executive Clinical Directors, and any other relevant officer it deems fit before making appointments to fill the membership positions referred to in Section 6.3.4. The appointees will be professionally accountable to the relevant Executive Clinical Director. NHS Lothian will develop a role description for the appointments referred to in Section 6.3.4, to ensure that their role on the IJB with regard to professional leadership and accountability is clearly defined and understood.

6.3.6 The three health professional representatives referred to in Section 6.3.4 will each also be:
(a) A member of an integrated professional group (should it be established); and/or
(b) A member of a NHS Lothian committee; and/or
(c) A member of a consultative committee established by NHS Lothian.

6.3.7 If a new "integrated professional group" is established, the Chief Social Work Officer must also be a member.

6.3.8 The three health professional representative set out in Section 6.3.4 and the Chief Social Work Officer will be expected by the Parties to play a lead role in:

(a) Communicating and having regard to their duties to NHS Lothian or the Council as the case may be whilst discharging their role as a member of the IJB;

(b) Communicating and having regard to the interests of the IJB whilst discharging their duties as professionals employed by NHS Lothian or (as the case may be) the Council.

(c) The members will be expected to communicate regularly with the Executive Clinical Directors, and the Council's Chief Executive as and when appropriate.

6.3.9 The presence of these four members will ensure that the decisions of the IJB are informed by professional advice from within the membership of the IJB.

6.3.10 NHS Lothian includes a governance statement in its annual accounts, the content of which is informed by the annual reports of its governance committees (such as healthcare governance and staff governance) and certificates of assurance from its Executive Clinical Directors. The IJB may place reliance on these existing processes, and the Parties will provide any such reports from those processes as the IJB may require.

6.3.11 The Executive Clinical Directors shall be entitled to raise issues directly with the IJB in writing. The IJB shall be required to respond in writing when issues are raised in this way. The Chief Social Work Officer will be a non-voting member of the IJB, and can therefore raise any issues directly at the IJB.

6.3.12 The engagement of professionals throughout the process to develop and consult on the Strategic Plan is intended to ensure that the IJB has all the required information to prepare a Strategic Plan, which will not compromise professional standards.

6.3.13 In the unlikely event that the IJB issues a direction to NHS Lothian, which is reasonably likely to compromise professional standards, then in the first instance, the relevant Executive Clinical Director will write to the IJB.

6.3.14 If the issue is not resolved to their satisfaction, they must inform the board of NHS Lothian before it takes action to implement the direction, and the following measures will apply:

(a) The relevant Executive Clinical Director must ensure that appropriate advice is tendered to the board of NHS Lothian on all matters relating to professional standards;

(b) The relevant Executive Clinical Director must set out in writing to NHS Lothian any objections they may have on a proposal that may compromise compliance with professional standards;

(c) The board of NHS Lothian will inform the IJB that it has received such objections, along with a statement of the views of the board of NHS Lothian on those objections;

(d) If the board of NHS Lothian decides to proceed with a proposal despite those objections, the relevant executive clinical director will be provided with written authority from the board of NHS Lothian to act on the proposal. NHS Lothian must inform the Scottish Government Health and Social Care Directorate if a request for such a written authority is made. A copy of that authority must be sent to the appropriate regulatory body, e.g. General Medical Council;

(e) Once the relevant Executive Clinical Director has received that written authority, they must comply with it;

6.3.15 Regardless of whether a written authority has been given, the Executive Clinical Directors, in their capacity as NHS Lothian members, should always vote against a proposal that they cannot endorse as accountable officers. It is not sufficient to abstain from a decision.

6.3.16 The three professional clinical members on the IJB (two medical practitioners, one nurse) are non-voting members. They will be expected by the Executive Clinical Directors to raise any concerns in relation to matters which may compromise professional standards with the IJB.

6.3.17 If any of the three professional clinical members becomes aware of a matter arising from the conduct of IJB business, which may compromise professional standards, they must immediately notify the relevant Executive Clinical Director(s) of their concerns.

6.3.18 The Chief Social Work Officer must be a non-voting member of the Integration Joint Board, and as such, will contribute to decision-making, and will provide relevant professional advice to influence service development.

6.3.19 In the event that the Integration Joint Board issues an direction to the Council or NHS Lothian, which in the view of the Chief Social Work Officer compromises professional social work standards or the discharge of statutory functions, the Chief Social Work Officer must immediately notify the Chief Officer of their concerns and if their concerns are not resolved by the Chief Officer to their satisfaction they must then raise the matter with the Chief Executive of the Council.

6.4 Professionals Informing the IJB Strategic Plan

6.4.1 With regard to the development and approval of its Strategic Plan, the IJB is required to:

(a) establish a strategic planning group (which will review the draft Strategic Plan). This strategic planning group must include a nominee from both NHS Lothian and the Council in its membership, as well as representation from health professionals and social care professionals. NHS Lothian and the Council will make recommendations to the IJB with regard to the representation from health professionals and social care professionals;

(b) consult both NHS Lothian and the Council on its Strategic Plan, and take into account their views before it finalises the Strategic Plan.

6.4.2 There will be three opportunities within these arrangements for professional engagement in the planning process;

(a) at the IJB;
(b) in the context of the work of the strategic planning group; and
(c) as part of the consultation process with the Parties associated with the Strategic Plan.

6.4.3 The membership of the IJB will not be the only source of professional advice available to the IJB. In advance of the establishment of the IJB the Parties agreed that the chairs of all appropriate committees and groups will be informed that they are able to, and expected to, directly provide advice to the IJB. Those committees and groups may also advise an integrated professional group that provides advice to the IJB. Those committees and groups include, but are not limited to:

(a) local consultative committees that have been established under section 9 of the National Health Service (Scotland) Act 1978;
(b) managed clinical/ care networks;
(c) East and Mid Lothian Public Protection Committee (adult and child protection, drug and alcohol, violence against women, offender management etc). The IJB will consult this committee on any plans that may impact on the protection of children or vulnerable adults or people who are assessed as posing a risk; and
(d) any integrated professional group established.

6.4.4 NHS Lothian and the Council will ensure that the draft Strategic Plan is sent to the following senior professionals in order to secure their input and advice:

- NHS Lothian Executive Medical Director;
- NHS Lothian Executive Director of Nursing and Allied Health Professions;
- NHS Lothian Director of Public Health & Health Policy; and
- Chief Social Work Officer.

6.4.5 The engagement of the Council's professionals will not be limited to social work staff, but will extend to related professionals within social care, such as, but not exclusively, occupational therapists, home care and social care staff.

6.4.6 The approach to locality planning and delivery including the arrangements for clinical and social care governance will be developed through the strategic planning process in a collaborative manner for the IJB.

6.5 External scrutiny of clinical and care functions

6.5.1 NHS Lothian seeks assurance for internal control/quality through its Healthcare Governance Committee, which includes reports by external bodies such as Healthcare Improvement Scotland.

6.5.2 The Care Inspectorate (Social Care and Social Work Improvement Scotland) regulates, inspects and supports improvement of adult and children's social work and social care, and their reports feed into the Council's system of governance.

6.5.3 The IJB will consequently be informed of any relevant issues from external scrutiny, as a consequence of drawing from the systems already established by the Parties.

6.6 Service User and Carer Feedback

6.6.1 The Parties have a range of systems already in place to capture and respond to service users' experience, and these will continue to be used as the Parties implement the directions of the IJB.

7 Chief Officer

7.1 The Chief Officer will be appointed by the IJB; they will be employed by one of the Parties and will be seconded to the IJB.

7.2 The Chief Officer will provide a strategic leadership role as principal advisor to and officer of the IJB and will be a member of the senior management teams of the Parties. The Chief Officer will lead the development and delivery of the Strategic Plan for the IJB and will be accountable to the IJB for the content of the directions issued to the Parties by the IJB and for monitoring compliance by the Parties with directions issued by the IJB.

7.3 The Chief Officer will report directly to the Chief Executives of both Parties. There will be a joint process for the regular performance reviews, support and supervision with both Chief Executives. Annual objectives for the Chief Officer will be agreed and the process will involve

the chairperson of the Integration Joint Board agreeing objectives with the Chief Officer relevant to their role with the Integration Joint Board as well as the Chief Executives of the Parties. The Chief Officer's performance against those annual objectives will be monitored through an agreed Performance Framework established by the Party which is their employer.

7.4 If an interim replacement for the Chief Officer of the IJB is required, in line with a request from the IJB to that effect (on the grounds that the Chief Officer is absent or otherwise unable to carry out their functions), the Chief Executives of the Parties will initiate a joint selection process, identifying a list of potential replacements; and selection of a suitable candidate will be undertaken against a set of agreed criteria. The interim replacement will be employed by one of the Parties and will be seconded to the IJB on an interim basis.

7.5 The Chief Officer will have operational responsibility for all of the functions delegated to the IJB with the following exceptions:

(a) the Chief Officer for NHS Lothian acute hospital services and directors responsible for the Western General Hospital, the Royal Infirmary of Edinburgh, St Johns Hospital and the Royal Edinburgh Hospital will provide delegated services on these hospital sites that will not be operationally managed by the Chief Officer.

(b) specific NHS Lothian functions that are managed on a pan-Lothian basis as a 'hosted service' which are solely the responsibility of NHS Lothian and not an IJB Delegated Function, which may be managed by one of the four chief officers in Lothian.

7.6 A group consisting of Directors responsible for hospital functions delegated to the IJB and the Chief Officers of the four IJBs in Lothian will be established to ensure close working arrangements between A) IJB Chief Officers, the Chief Officer of NHS Lothian acute hospital services and Hospital Site Directors and B) Chief Officers responsible for the management of a hosted service on behalf of the other three Lothian Chief Officers.

8 Workforce

8.1 The arrangements in relation to their respective workforces agreed by the Parties are:

(a) For staff managed by a line manager who is employed on different terms and conditions, the manager will observe the contract of employment and apply the employer's employment policies and procedures. Guidance will be available to assist the line manager. In addition the Parties will establish professional leadership lines of accountability to ensure clinical and professional standards are monitored and maintained;

(b) The Parties have agreed an Organisational Development Plan which is being implemented. There is a Human Resources and Organisational Group which includes Senior Managers and Trades Unions from both Parties.

8.2 The Parties have developed a Human Resources and Organisational Development Plan which supports the workforce through the integration process. This is a comprehensive plan which covers staff communication, staff engagement, staff and team development, leadership development and the training needs for staff that will be responsible for managing integrated teams. This plan will be reviewed annually to ensure that it takes account of the Strategic Plan of the IJB and the development needs of staff within the IJB.

8.3 The Human Resources and Organisational Development Plan will be monitored regularly and reviewed no less than once in any financial year.

8.4 The Parties will support the IJB to prepare a joint Workforce Development and Support Plan through the provision of professional, technical and support services described in Sections 5.4 and 6.1 of this Revised Scheme of Integration. The Workforce Development and Support Plan will sit alongside and be informed by the IJB's Strategic Plan.

9 Finance

9.1 This section describes the arrangements in relation to financial management and monitoring of integrated resources. It sets out the method for determining the resources to be made available by the Council and NHS Lothian to the Board. It also explains the financial governance and management arrangements, including budget variances, and the financial reporting arrangements between the Board, the Council and NHS Lothian

9.2 **Chief Finance Officer**

9.2.1 In relation to the preparation of its accounts and their audit, the Board is governed by the same legislation applying to local authorities and is required to make arrangements for the proper administration of its financial affairs; through the appointment of a proper officer for that purpose. The Board has appointed a Chief Finance Officer with this responsibility. The Chief Finance Officer will be employed by the Council or NHS Lothian and seconded to the Board. The holder of the post should be a member of a relevant professional accounting body, and the Board should have regard to the current Chartered Institute of Public Finance and Accountancy ("CIPFA") Guidance on the role.

9.2.2 In the event that the Chief Finance Officer position is vacant or the holder is unable to act, the Chief Officer shall secure, in consultation with the Board Chair, and through agreement with both the Council's Section 95 Officer and NHS Lothian's Director of Finance, an appropriate interim dedicated resource to discharge the role.

9.3 **Financial Management of the Board**

9.3.1 The Board is responsible for determining its own internal financial governance arrangements; and the Chief Finance Officer will be responsive to the decisions of the Board, and the principles of financial governance set out in this Scheme.

9.4 **Principles of Financial Governance**

9.4.1 The following principles of financial governance shall apply:

- NHS Lothian and the Council will work together in a spirit of openness and transparency; and
- NHS Lothian and the Council will work in partnership with the Board with the objective of agreeing sufficient funding of delegated functions in line with the financial elements of the Strategic Plan

9.5 **Financial Governance**

9.5.1 The Parties will contribute to the establishment of a Board budget. The Chief Officer will manage the Board budget.

9.5.2 The Parties are required to implement the Directions of the Board in carrying out the delegated functions in line with the Strategic Plan. The Parties will apply their established systems of financial governance to the payments they receive from the Board. NHS Lothian's Accountable

Officer and the Council's Section 95 officer have legally defined responsibilities and accountability for the financial governance of their respective bodies.

9.5.3 The Chief Officer in their operational role within NHS Lothian and the Council is responsible for the financial management of any Operational Budgets (as defined in section 9 of this Scheme) that may be delegated to them by the Parties, and is accountable for this to NHS Lothian's Chief Executive and the Council's Section 95 Officer.

9.5.4 The Board will develop and maintain its own financial regulations. The Chief Finance Officer will periodically review these financial regulations and present any proposed changes to the Board for its approval.

9.5.5 The Council will host the Board's Financial Accounts and will be responsible for recording the Board's financial transactions through its existing financial systems. The IJB can hold reserves. It is a matter for the Board to determine what its reserves strategy will be.

9.5.6 The Board's Chief Finance Officer is responsible for preparing the Board's accounts and ensuring compliance with statutory reporting requirements as a body under the relevant legislation.

9.5.7 As part of the financial year end procedures and in order to develop the year-end financial statements, the Chief Finance Officer will work together with NHS Lothian and the Council to coordinate an exercise agreeing the value of balances and transactions with Council and health board Finance teams. Each Party will provide information to this process on their recorded income, expenditure, receivable and payable balance with the Board. The Board's Chief Finance Officer will lead with the Parties on resolving any differences.

9.5.8 The Chief Finance Officer will also be responsible for preparing a medium-term financial plan to be incorporated into the Board's Strategic Plan. The Chief Finance Officer will liaise closely with NHS Lothian and the Council to develop integrated medium term financial planning and associated financial recovery plans taking account of assumptions around available funding and future service demands and service delivery models.

9.5.9 The Chief Finance Officer will also be responsible for preparing the annual financial statement that the Board must publish under section 39 of the Act, which sets out what the Board intends to spend in implementation of its Strategic Plan.

9.5.10 The Chief Finance Officer will be responsible for producing finance reports to the Board, ensuring that those reports are appropriate for the needs of the Board.

9.5.11 The Chief Finance Officer will liaise closely with the Council's Section 95 Officer and the health board's Director of Finance and their teams in order to discharge all aspects of their role.

9.6 Resources Delegated to the Board

9.6.1 The resources delegated to the Board fall into two categories: (i) payments for the delegated functions; and (ii) resources used in large hospitals that are set aside by NHS Lothian and made available to the Board for inclusion in its Strategic Plan.

9.6.2 Section 1(3)(e) of the Act requires that the Scheme must set out a method of determining payments that are to be made in respect of (i) above. Section 1(3)(d) of the Act requires the Scheme to set out a method of determining the amounts to be made available by NHS Lothian for us by the Board under (ii) above.

9.6.3 It is expected that the net difference between payments into and out of the Board will result in a balancing payment between the Council and NHS Lothian which reflects the effect of the Directions of the Board. The balancing payment will be reviewed throughout the year and depending on the expected value for the adjusting payment, it will be either made one-off prior to year-end or on a quarterly basis. Such payments would incorporate values previously treated as resource transfer.

9.7 Annual Budget Payments to the Board

9.7.1 The Council and NHS Lothian identify a core baseline Operational Budget for each function that is delegated to the Board. This will be used as the basis to calculate their respective payments into the Board budget each year. The previously agreed "resource transfer" payments from NHS Lothian will be part of the annual budget payment to the Board.

9.7.2 The Council and NHS Lothian have established financial planning processes which take into account the financial settlements they have received, and identified and assumed expenditure pressures, to arrive at opening annual budgets. These same processes will be applied to the core baseline Operational Budgets for the delegated functions in order to arrive at the annual payments to the Board.

9.7.3 The Council's Section 95 Officer and NHS Lothian's Director of Finance are responsible for preparing the budget contributions from their respective Party. The amounts to be paid will be the outcome of the above processes. They will consult with the Chief Officer and officers in both Parties as part of this process.

- The Council's Section 95 Officer and NHS Lothian's Director of Finance will each prepare a schedule outlining the detail and total value of the proposed payment from each party, and the underlying methodology and assumptions behind that payment. These draft schedules will identify any amounts included in the payments that are subject to separate legislation or subject to restrictions stipulated by third party funders. The schedules will also contain the detail and total value of set aside resources for hospital services, made under section 1(3) (d) of the Act.

- The Council's Section 95 Officer and NHS Lothian's Director of Finance will refer the draft schedules to the Chief Officer so that they may have an opportunity to formally consider it.

- The Council's Section 95 Officer and NHS Lothian's Director of Finance will thereafter present the final draft schedules to the Parties. This schedule must be agreed by NHS Lothian's Director of Finance, the Council's Section 95 Officer and the Chief Officer.

- The Council and NHS Lothian must approve their respective payments, in line with their governing policies

9.7.4 The Council's Section 95 Officer and health board's Director of Finance will liaise closely with the Chief Officer and Chief Finance Officer on the assumptions to be used on annual budget contributions and will have due regard to the impact of any service re-design activities that have been a direct consequence of the Board's Strategic Plan or Directions issued. Both the Council and NHS Lothian will provide indicative three year budget allocations to the Board, subject to annual approval through their respective budget setting processes.

9.7.5 The Parties will ensure the Chief Officer and Chief Finance Officer are actively engaged in their financial planning processes. The Chief Officer will be expected to feed into the planning processes with any intelligence that is relevant, e.g. the aims of the Strategic Plan, the effect of previous directions on activity and expenditure, projected demand led changes in activity and expenditure. NHS Lothian's Director of Finance, the Council's Section 95 Officer and the Chief Finance Officer will ensure a consistency of approach and consistent application of processes in considering budget assumptions and proposals.

9.8 **The set-aside of resources for use by the Board under section 1(3) (d) of the Act**

9.8.1 In addition to the payments to the Board, NHS Lothian will identify a set aside budget for delegated functions in large hospitals. The set aside budget for delegated hospital services will be based on an apportionment of the relevant health board budgets for the delegated hospital services (excluding overheads).

9.8.2 The core baseline budget for the set-aside functions in each Council area will be based on an appropriate methodology and agreed in partnership by NHS Lothian and Board.

9.9 **Hosted Services**

9.9.1 NHS Lothian carries out functions across four local authority areas. Some of the functions delegated to the Lothian IJBs are currently provided as part of a single Lothian-wide service, commonly referred to as “hosted services”.

9.9.2 The core baseline budget for the hosted services in each IJB area will be based on an appropriate methodology and agreed in partnership by NHS Lothian and Board.

9.10 **Due Diligence**

9.10.1 The Parties will share information on the financial performance over at least the previous two financial years of the functions and associated services delegated to the Board. This will allow the Parties to undertake appropriate reviews to gain assurance as to whether the services are currently being delivered sustainably within approved resources, and that the anticipated payments will be sufficient for the Board to carry out its integration functions.

9.10.2 If any such review indicates that the projected expenditure is likely to exceed the payments to the Board, then the relevant Party will be notified. The relevant Party will be required to take action to ensure that services can be delivered within the available Operational Budget

9.10.3 The Parties recognise that of the functions which are to be delegated to the Board, there are some where there is greater potential for the actual expenditure to vary significantly from projections. The Parties will identify what those functions are, and will ensure that information is provided to the Board so that it is aware of the issues, and is able to focus on those functions within their systems for risk management and financial reporting.

9.10.4 This process of due diligence will be informed by, amongst other things, the intelligence within the financial performance reports covering all integration functions that the Board will routinely receive.

9.11 **Process to agree payments from the Board to the Parties**

9.11.1 The Board will determine and approve, in accordance with the Strategic Plan, the payments to the Parties which will accompany its Directions to them for carrying out functions delegated to the Board. The Parties are required to implement the Directions of the Board in carrying out a

delegated function in line with the Strategic Plan, having agreed with the Board the resources required to deliver the said directions.

9.11.2 The Chief Finance Officer is responsible for providing the Board with appropriate information and advice, so that it may determine what those payments should be.

9.11.3 Directions from the Board to the Parties will take the form of a letter from the Chief Officer referring to the arrangements for delivery set out in the Strategic Plan and will include information on:

- the delegated function(s) that are to be carried out;
- the Outcomes to be delivered for those delegated functions; and
- the amount of and / or method of determining the payment to be made, in respect of the carrying out of the delegated functions.

9.11.4 Once issued, Directions can be amended or deleted or replaced by a subsequent Direction by the Board.

9.11.5 Where amounts paid to the Board are subject to separate legislation or subject to restrictions stipulated by third party funders, the Board must reflect these amounts in full, in determining the level of the payments to be made to the Parties in respect of the carrying out of the relevant function or functions. However, the Board is not precluded from increasing the resource allocated to the relevant services.

9.12 **Financial Reporting to the Board**

9.12.1 Budgetary control and monitoring reports will be provided to the Board as and when it requires. The reports will set out the financial position and forecast against the payments by the Board to the Parties in respect of the carrying out of integration functions and against the amount set aside by NHS Lothian for hospital services. These reports will present the actual and forecast positions of expenditure compared to budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.

9.12.2 NHS Lothian will provide information on the set-aside budgets which will be contained in financial reports to the Board.

9.12.3 Both Parties will provide the required information on budgetary performance from their respective finance systems, and this will be co-ordinated and consolidated by the Chief Finance Officer to provide reports to the Board on all the Board's delegated functions.

9.12.4 It is expected that as a minimum there will be quarterly financial reports to the Chief Officer and the Board.

9.13 **Process for addressing variance in the spending of the Board**

9.13.1 The Board is required to deliver its financial out-turn within available resources. Section 15 of this Scheme sets out the arrangements for risk management, and financial risk (within the Board and both Parties) will be managed in line with those arrangements.

9.13.2 The Parties will ensure that their respective budget monitoring and management systems will be applied to monitor and manage their expenditure in relation to delivery of integrated functions in accordance with Directions issued to them by the Board.

9.13.3 The manager leading this remedial action could be the Chief Officer in their operational capacity within the affected party.

9.13.4 In the event that such remedial action will not prevent the overspend, then the Chief Finance Officer will, together with the relevant Party, develop a proposed recovery plan to address the forecast overspend. The Chief Finance Officer will then present that recovery plan to the Board as soon as practically possible. The Board has to be satisfied with the recovery plan, and the plan is subject to its approval.

9.14 **Additional Payments by the Parties to the Board**

9.14.1 Where such a recovery plan is projected to be unsuccessful and an overspend occurs at the financial year end, and where there are insufficient available reserves held by the Board to meet the overspend, then the Parties may make additional payments to the Board.

9.14.2 The Chief Finance Officer and the Parties shall engage in discussion and negotiation about the amounts to be paid by each Party.

9.14.3 The Parties recognise that the delivery of delegated functions in accordance with the Strategic Plan depends on their co-operation between each other and with the Board and that all three parties must approach such discussions in good faith, recognising the pressures and constraints on their respective budgets and services. In such discussions the Parties recognise and accept that an overspend is at the risk of the Party incurring the overspend and the residual amount of overspend after usage of reserves must, in the absence of any other agreement, be met by that Party.

9.14.4 Recurring overspends will be considered as part of the following year's budget process. If a solution to the overspend cannot be agreed by the Parties, or is not agreed by the Board, then the dispute resolution mechanism in this Scheme may require to be implemented.

9.15 **Underspends**

9.15.1 As part of their normal financial management systems, the Parties conduct in-year reviews of financial performance, and occasionally this may lead to a forecast of an underspend at the year-end on one or more budgets. In the event that this happens within the Operational Budgets then the following shall apply:

- if the underspend is fortuitous and unrelated to any Board Direction then the underspend should be returned to the affected Party (through an adjustment to the payments to the Board)

- the Board will retain all other underspends.

9.15.2 The Board can hold reserves, as determined by its Reserves Policy.

9.16 **Treatment of variations against the amounts set aside for use by the Board**

9.16.1 A process will be agreed between NHS Lothian and the Board to manage any variations within the set-aside budget. This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the integrated payment as laid out above.

9.17 **Redetermination of payments (made under section 1(3) (e) of the Act) to the Board**

9.17.1 Redeterminations of payments made by the Parties for the carrying out of integration functions would apply under the following circumstances:

- Additional one off funding is provided to a Party or Parties by the Scottish Government, or some other body, for expenditure in respect of a function delegated to the Board

- The Parties, along with the Board, agree that an adjustment to the payment is required to reflect changes in demand and/or activity levels

9.17.2 In all cases full justification for the proposed change would be required and both Parties and the Board would be required to agree to the redetermination. The Parties would apply the process used to calculate the payment to the Board (described earlier) to the affected functions and the Strategic Plan would be required to be amended as necessary.

9.18 **Redetermination of set aside payments (made under section 1(3) (d)) to the Board**

9.18.1 This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the Operational Budgets as specified above.

9.19 **Use of Capital Assets**

9.19.1 The Board, NHS Lothian and the Council will ensure there is awareness of all capital assets which will be used in the delivery of the Strategic Plan.

9.19.2 Changes in use of capital assets will flow from the Strategic Plan and the Directions issued by the Board to the Parties. The Strategic Plan process will outline any implications or requirements for capital assets.

9.19.3 The Parties will ensure that their capital asset planning arrangements take due cognisance of the above implications and requirements.

9.19.4 The Chief Officer of the Board will consult with the Parties to identify the specific need for improvements/changes to assets owned by each which may be required in connection with the carrying out of integration functions. Where a capital investment need is identified, a business case will require to be developed. Any business case will set out how the investment will meet the strategic objectives set out in the Strategic Plan and identify the ongoing revenue costs/savings associated with implementation of the proposals.

9.19.5 The Board, the Council and NHS Lothian will work together to ensure assets required in connection with the carrying out of integration functions are used as effectively as possible and in compliance with the relevant legislation relating to use of public assets.

9.20 **Audit and Financial Statements**

Financial Statements and External Audit

9.20.1 The Act requires that the Board is subject to the audit and accounts provisions of a body under section 106 of the Local Government (Scotland) Act 1973. This requires audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations (section 12 of the Local Government in Scotland Act 2003, the Local Authority Accounts (Scotland) Regulations 2014 and other regulations under section 105 of the Local Government (Scotland) Act 1973). These will be proportionate to the limited number of

transactions of the Board whilst complying with the requirement for transparency and true and fair reporting in the public sector.

9.20.2 The Parties will agree a clear timetable for the preparation of the Board's annual accounts which will incorporate a process to agree any balances between the Board and the Parties. The reporting requirements for the annual accounts are as set out in legislation and regulations and are prepared following the CIPFA Local Authority Code of Practice.

9.20.3 As part of the financial year-end procedures and in order to develop the year-end financial statements, the Chief Finance Officer of the Board will annually co-ordinate an exercise agreeing the value of balances and transactions with the Council and health board finance teams. Each of the Parties will submit to the Chief Finance Officer their recorded income, expenditure, receivable and payable balance with the Board. The Parties' respective finance representatives will then work to resolve any differences arising.

9.20.4 The Board financial statements must be completed to meet the audit and publication timetable specified in the regulations (made under section 105 of the Local Government (Scotland) Act 1973).

9.20.5 The Accounts Commission will appoint the external auditors to the Board.

9.20.6 The financial statements will be signed in line with the governance arrangements for the Board and as specified in the Local Authority Accounts (Scotland) Regulations 2014, made under section 105 of the Local Government (Scotland) Act 1973.

9.20.7 In all forms of audit, the Parties are expected to comply with related requests and to aid the audit process.

10 Participation and Engagement

10.1 The Parties will support the Chief Officer, who will on behalf of the IJB, produce a strategy for engagement with, and participation by members of the public, representative groups or other organisations in relation to the decisions about the carrying out of integration functions as set out in this Section 10. The process to identify and provide support to the Chief Officer to develop the IJB's participation and engagement strategy is described in Section 5. As part of the process set out in Section 5 the Parties will:

(a) Make available to the IJB arrangements that are already established for consultation by one or both of the Parties. The IJB will consider a range of ways in which to connect with all stakeholders.

(b) Make available service/user participation and engagement teams to the IJB as this relates to function delegated within this Scheme.

(c) Make available communication support to allow the IJB to engage and participate.

10.2 The Parties expect that the IJB's participation and engagement strategy will be produced before the date the IJB approves the Strategic Plan for public consultation. When the IJB approves the Strategic Plan, Parties expect that IJB members must be satisfied that the Strategic Plan has had sufficient consultation and that the participation and engagement strategy has been followed.

10.3 The development of the participation and engagement strategy will be achieved using a collaborative response, involving the membership of the East Lothian Strategic Planning Group.

10.4 The Strategic Planning Group is expected to take both an advisory and active role in the undertaking of future participation and engagement around the implications of service development and re-design.

11 Consultation on this Scheme

11.1 A three stage approach was adopted to ensure sufficient involvement and consultation in the revision and further development of this Scheme:

Stage 1: Informing and Engaging:
Initial review was undertaken and revisions made by officers of the Parties with the involvement of a range of professionals within both Parties. This draft was approved for consultation by the Parties

Stage 2: Consultation
A formal internal and external stakeholder consultation was held from 2/5/22 – 29/5/22.

Stage 3: Response to the consultation
This Scheme was further developed by officers, guided by the consultation, and submitted for approval by the Parties to submit to Scottish Government.

11.2 Further details of the people and groups involved in the informing, engagement and consultation on this Scheme are set out in Annex 4.

12 Information-Sharing and data handling

12.1 There is an existing and long standing Pan-Lothian and Borders General Information Sharing Protocol, to which NHS Lothian, City of Edinburgh Council, the Council, Midlothian Council, West Lothian Council and Scottish Borders Council are all signatories and has been subject to previous modifications to comply with the Integration Scheme Regulations. This Protocol is subject to periodic review by a sub group on behalf of the Pan-Lothian Data Sharing Partnership and any resultant updates will be agreed and form the Protocol to support this Scheme. Any updated Protocol, following consultation, will be recommended for signature by Chief Executives of respective organisations, and the Chief Officers of the Integration Joint Boards, once they have been appointed by the IJB, on behalf of the Pan-Lothian Data Sharing Partnership.

12.2 Procedures for sharing information between the Council, the other local authorities within NHS Lothian area, NHS Lothian, and, where applicable, the IJB will be drafted as Information Sharing Agreements and procedure documents. This will be undertaken by a sub group on behalf of the Pan-Lothian Data Sharing Partnership, who will detail the more granular purposes, requirements, procedures and agreements for each of the Lothian IJBs and the functions respectively delegated to them. This will also form the process for amending the Pan-Lothian and Borders General Information Sharing Protocol.

12.3 The Council and NHS Lothian will continue to be Data Controller for their respective records (electronic and manual), and will detail arrangements for control and access. The IJB may require to be Data Controller for personal data if it is not held by either by the Council or NHS Lothian.

12.4 Arrangements for third party organisations access to records will be jointly agreed by all the Parties and the IJB prior to access.

12.5 Procedures will be based on a single point of governance model. This allows data and resources to be shared, with governance standards, and their implementation, being the separate responsibility of each organisation. Shared datasets governance will be agreed by all contributing partners prior to access.

12.6 Following consultation, Information Sharing Protocols and procedure documents will be recommended for signature by the Chief Executives of respective organisations, and the Chief Officers of the Lothian Integration Joint Boards.

12.7 The information sharing agreements and procedures have been established and shall be reviewed annually by the sub group of the Pan-Lothian Data Sharing Partnership, or more frequently if required. This will follow the process described in 12.2.

13 Complaints

The Parties agree the following arrangements in respect of complaints:

13.1 Any person will be able to make complaints either to the Council or to NHS Lothian. The Parties have in place well publicised, clearly explained and accessible complaints procedures, which allow for timely recourse and signpost independent advocacy services, where appropriate. There is an agreed emphasis on resolving concerns locally and quickly; as close to the point of service delivery as possible.

Complaints can be made to:

- the Council by:
  - telephone: 0131 653 5290
  - email: feedback@eastlothian.gov.ukonline: www.eastlothian.gov.uk
  - in writing: Customer Feedback Team, East Lothian Council, John Muir House, Haddington, EH41 3HA (or Freepost Plus, RSTG-AGEL-RJYH, Customer Feedback Team, East Lothian Council, John Muir House, Haddington, EH41 3HA) ; or
  - in person by visiting any Council office where feedback forms are available.

- NHS Lothian by:
  - Telephone: 0131 536 3370
  - Email: feedback@nhslothian.scot.nhs.uk
  - In writing to NHS Lothian Patient Experience Team, Waverley Gate, 2 – 4 Waterloo Place, Edinburgh, EH1 3EG.

13.2 There are currently different legislative requirements in place for dealing with complaints about health and social care. Complaints regarding the delivery of an integrated service will be made to, and dealt with by, the Party that delivers the integrated service, in line with their published complaints procedure, and consistent with any statutory complaints handling arrangements that apply. It is the responsibility of the Party initially receiving a complaint to make sure that it is routed to the appropriate organisation/individual, so that the person making the complaint only needs to submit a complaint once.

13.3 From 1 April 2017, the health and social work complaints handling procedures were aligned and therefore have the same stages and timescales, with the exception of timescale

extensions. Additionally, complaints about Social Work functions were merged into the Local Authority Model Complaint Handling Procedure in 2020 (now reflected in the updated East Lothian Council Complaints Handling Procedure). Joint working protocols have been adopted and will continue to be reviewed so that the process of making a complaint is as simple as possible and complaints about integrated services are responded to clearly, thoroughly and timeously. These joint working protocols will identify the lead organisation for each integrated service and will include the contact details of officers responsible for managing any complaints received.

13.4 When a complaint covers both health and social care functions, responsible officers within the Council and NHS Lothian will, where necessary, work together to make sure all parts of the complaint are investigated and responded to within established time limits and the complainant is correctly signposted to the options open to them if they remain dissatisfied. Wherever possible, there will be a joint response from the identified Party rather than separate responses.

13.5 At the end of the process, complainants are entitled to take their complaint to the Scottish Public Services Ombudsman. Where appropriate, complainants will also be advised of their right to complain to the Care Inspectorate and information held by the Council may be shared with the Care Inspectorate.

13.6 Responsibility for responding to the Scottish Public Services Ombudsman lies with the Party who dealt with the original complaint. Where necessary, officers responsible for complaints handling within the Council and NHS Lothian will work together to provide a full response to any Scottish Public Services Ombudsman enquiry that covers both health and social care functions.

13.7 The Chief Officer will have an overview of complaints made about integrated services and subsequent responses. Complaints about integrated services will be recorded and reported to the Chief Officer on a regular and agreed basis. Regular trend analysis of complaints and Outcomes will also be carried out as part of a wider quality assurance framework.

13.8 All independent contractors (General Practitioners, Community Pharmacists, Optometrists, opticians, General Dental Practitioners etc.) will be required to have a complaints procedure. Where complaints are received about the service provided by an independent contractor, the Party receiving the complaint will refer the complaint to the independent contractor in the first instance, either providing contact details or by passing the complaint on, depending on the preferred approach of the complainant. Complaints received about independent contractors will be recorded for contract monitoring purposes.

14 Claims Handling, Liability & Indemnity

14.1 The Parties and the IJB recognise that they could receive a claim arising from or which relates to the work undertaken on behalf of the IJB.

14.2 The Parties agree to ensure that any such claims are progressed quickly and in a manner which is equitable between them.

14.3 So far as reasonably practicable the normal common law and statutory rules relating to liability will apply.

14.4 Each Party will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.

14.5 Each Party will assume responsibility for progressing and determining any claim which relates to any building which is owned or occupied by them.

14.6 Each Party will assume responsibility for progressing and determining any claim which relates to any heritable property which is owned by them. If there are any heritable properties owned jointly by the Parties, further arrangements for liability will be agreed upon in consultation with insurers.

14.7 In the event of any claim against the IJB or in respect of which it is not clear which Party should assume responsibility then the Chief Officer (or their representative) will liaise with the Chief Executives of the Parties (or their representatives) and determine which Party should assume responsibility for progressing the claim.

14.8 If a claim is settled by either Party, but it subsequently transpires that liability rested with the other Party, then that Party shall indemnify the Party which settled the claim.

14.9 Claims regarding policy and/or strategic decisions made by the IJB shall be the responsibility of the IJB. The IJB may require to engage independent legal advice for such claims.

14.10 If a claim has a “cross boundary” element whereby it relates to another integration authority area, the Chief Officers of the integration authorities concerned shall liaise with each other until an agreement is reached as to how the claim should be progressed and determined.

14.11 The IJB will develop a procedure for claims relating to hosted services with the other relevant integration authorities. Such claims may follow a different procedure than as set out above.

14.12 Claims which pre-date the establishment of the IJB will be dealt with by the Parties through the procedures used by them prior to integration.

15 Risk Management

15.1 Integration Joint Board

15.1.1 Risk management processes will include risk monitoring, and a reporting process for the Parties and IJB via a Risk Register for the IJB. Risks will be continuously monitored and reported to the IJB.

15.1.2 The Parties will provide to the IJB sufficient support to enable it to fully discharge its duties in relation to risk management. This will be determined through the process described in Section 5.4.

15.1.3 The Parties anticipate that the IJB will also develop and agree its own risk management procedure in relation to carrying out of integration functions including reports, which will cover all of its activities.

15.1.4 The risk management procedure will include:-

(a) A statement of the IJB's risk appetite and associated tolerance measures;

(b) A description of how the system of risk management will work in practice, including procedures for the identification, classification, recording and reporting of risk, and the respective roles of the IJB and its officers. This will explain how the output from the risk management systems within NHS Lothian and the Council will inform the IJB's system of risk management;

(c) A description of how the IJB system of risk management is informed by other related systems of NHS Lothian and the Council, such as complaints management, health & safety, adverse events management, emergency planning and business resilience; and

(d) an agreement between NHS Lothian and the Council on the resources to be made available to support risk management.

15.1.5 The IJB risk register will not duplicate the detail of risk registers within NHS Lothian and the Council. However, the IJB will update its risk register should there be any emerging themes/risks which have a bearing on its activities.

15.2 **NHS Lothian and the Council**

15.2.1 Both Parties will continue to apply their existing policies and systems for risk management.

15.2.2 NHS Lothian covers four local authority areas, and there will be some 'hosted services' which one operational director manages on a Lothian-wide basis. The identification and management of risk for those hosted services will reflect the differing directions of the Lothian IJBs.

16 Dispute resolution mechanism

16.1 The Parties will commit to working well together, listening to each other and will always work to resolve any issues before they require the Dispute Resolution process to be actioned.

16.2 Where either of the Parties fails to agree with the other on any issue related to this Scheme or any of the duties, obligations, rights or powers imposed or conferred upon them by the Act (a 'Dispute'), then they will follow the process described below:

(a) The Chief Executives of NHS Lothian and the Council, and the Chief Officer, will meet to resolve the Dispute within 21 calendar days of being notified of the issue;

(b) If unresolved, NHS Lothian, the Council, and the Chief Officer, will each prepare a written note of their position on the Dispute and exchange it with the others within 14 calendar days of the meeting in (a) above;

(c) Within 14 calendar days of the exchange of written notes in (b) the Chief Executives and Chief Officer must meet to discuss the written positions;

(d) In the event that the issue remains unresolved, representatives of NHS Lothian and the Council will proceed to mediation with a view to resolving the Dispute.

16.3 Scottish Government will be informed by the chairperson of the IJB of the Dispute, the mediation process being followed and the agreed timeframe to conclude the mediation process. A copy of this correspondence will be sent to the Chair of NHS Lothian and the Leader of the Council.

16.4 The mediator will be external to the Parties and will be identified and appointed with the agreement of the Chair of NHS Lothian and the Leader of the Council and failing agreement within 21 calendar days shall be nominated by the Centre of Effective Dispute Resolution (CEDR) on the request of either Party.

16.5 The mediation will start no later than 21 calendar days after the date of the appointment of the mediator.

16.6 The Parties agree that the cost of the mediator will be met equally by NHS Lothian and the Council.

16.7 The timeframe to resolve the issue will be agreed prior to the start of the mediation process by the Chair of NHS Lothian and the Leader of the Council.

16.8 Where following mediation, the Dispute remains unresolved the Parties agree that the chairperson of the IJB shall write to the Scottish Ministers to provide notification that agreement cannot be reached. Scottish Government may then instruct the Parties how to proceed.

16.9 The Parties shall cooperate with each other to mitigate any adverse effect on service delivery pending resolution of the Dispute.

16.10 Nothing in this Scheme shall prevent the Parties from seeking any legal remedy or from commencing or continuing court proceedings in relation to the Dispute.

ANNEX 1

PART 1

Functions delegated by the NHS Lothian to the IJB

Set out below is the list of functions that are to be delegated by NHS Lothian to the IJB in compliance with the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014

Column A	*Column B*
The National Health Service (Scotland) Act 1978	
All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of—
	section 2(7) (Health Boards);
	section 2CB([2]) (Functions of Health Boards outside Scotland);
	section 9 (local consultative committees);
	section 17A (NHS Contracts);
	section 17C (personal medical or dental services);
	section 17I([3]) (use of accommodation);
	section 17J (Health Boards' power to enter into general medical services contracts);
	section 28A (remuneration for Part II services);
	Section 38 (care of mothers and young children)
	Section 38A (breastfeeding)
	Section 39 (medical and dental inspection, supervision and treatment of pupils and young persons)
	section 48 (provision of residential and practice accommodation);

([2]) Section 2CA was inserted by S.S.I. 2010/283, regulation 3(2) (as section 2CA) and re-numbered as section 2CB by S.S.I. 2013/292, regulation 8(2).

([3]) Section 17I was inserted by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2 and amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4. The functions of the Scottish Ministers under section 17I are conferred on Health Boards by virtue of S.I. 1991/570, as amended by S.S.I. 2006/132.

	section 55([4]) (hospital accommodation on part payment);
	section 57 (accommodation and services for private patients);
	section 64 (permission for use of facilities in private practice);
	section 75A([5]) (remission and repayment of charges and payment of travelling expenses);
	section 75B([6])(reimbursement of the cost of services provided in another EEA state);
	section 75BA ([7])(reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);
	section 79 (purchase of land and moveable property);
	section 82([8]) use and administration of certain endowments and other property held by Health Boards);
	section 83([9]) (power of Health Boards and local health councils to hold property on trust);
	section 84A([10]) (power to raise money, etc., by appeals, collections etc.);
	section 86 (accounts of Health Boards and the Agency);
	section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);
	section 98 ([11]) (charges in respect of non-residents); and

([4]) Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

([5]) Section 75A was inserted by the Social Security Act 1988 (c.7), section 14, and relevantly amended by S.S.I. 2010/283. The functions of the Scottish Ministers in respect of the payment of expenses under section 75A are conferred on Health Boards by S.S.I. 1991/570.

([6]) Section 75B was inserted by S.S.I. 2010/283, regulation 3(3) and amended by S.S.I. 2013/177.

([7]) Section 75BA was inserted by S.S.I. 2013/292, regulation 8(4).

([8]) Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 7) section 1(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.

([9]) There are amendments to section 83 not relevant to the exercise of a Health Board's functions under that section.

([10]) Section 84A was inserted by the Health Services Act 1980 (c.53), section 5(2). There are no amendments to section 84A which are relevant to the exercise of a Health Board's functions.

([11]) Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and

	paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);
	and functions conferred by—
	The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ([12]);
	The Health Boards (Membership and Procedure) (Scotland) Regulations 2001;
	The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000;
	The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004;
	The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018
	The National Health Service (Discipline Committees) Regulations 2006;
	The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006;
	The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009;
	The National Health Service (General Dental Services) (Scotland) Regulations 2010;
	The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011([13]);
Disabled Persons (Services, Consultation and Representation) Act 1986	
Section 7 (Persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002	

calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.S.I. 1991/570.

([12]) S.I. 1989/364, as amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/455; S.S.I. 2005/572 S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

([13]) S.S.I. 2011, to which there are amendments not relevant to the exercise of a Health Board's functions.

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003	
All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by—
	section 22 (Approved medical practitioners);
	section 34 (Inquiries under section 33: co-operation)([14]);
	section 38 (Duties on hospital managers: examination notification etc.)([15]);
	section 46 (Hospital managers' duties: notification)([16]);
	section 124 (Transfer to other hospital);
	section 228 (Request for assessment of needs: duty on local authorities and Health Boards);
	section 230 (Appointment of a patient's responsible medical officer);
	section 260 (Provision of information to patients);
	section 264 (Detention in conditions of excessive security: state hospitals);
	section 267 (Orders under sections 264 to 266: recall);
	section 281([17]) (Correspondence of certain persons detained in hospital);
	and functions conferred by—
	The Mental Health (Safety and Security) (Scotland) Regulations 2005([18]);

([14]) There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.
([15]) Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards under that Act.
([16]) Section 46 is amended by S.S.I. 2005/465.
([17]) Section 281 is amended by S.S.I. 2011/211.
([18]) S.S.I. 2005/464, to which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

	The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005([19]);
	The Mental Health (Use of Telephones) (Scotland) Regulations 2005([20]); and
	The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008([21]).
Education (Additional Support for Learning) (Scotland) Act 2004	
Section 23 (other agencies etc. to help in exercise of functions under this Act)	
Public Services Reform (Scotland) Act 2010	
All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by—
	section 31(Public functions: duties to provide information on certain expenditure etc.); and
	section 32 (Public functions: duty to provide information on exercise of functions).
Patient Rights (Scotland) Act 2011	
All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36([22]).
Carers (Scotland) Act 2016	Except functions conferred by—
	s.12 (duty to prepare young Carer statement)
	s.31 (duty to prepare local Carer strategy) Carers (Scotland) Act 2016

But in each case, subject to the restrictions set out in article 3(3) of the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 so far as they extend to the services detailed in Part 2 of Annex 1 of this Scheme.

([19]) S.S.I. 2005/467. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([20]) S.S.I. 2005/468. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([21]) S.S.I. 2008/356. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([22]) S.S.I. 2012/36. Section 5(2) of the Patient Rights (Scotland) Act 2011 (asp 5) provides a definition of "relevant NHS body" relevant to the exercise of a Health Board's functions.

PART 2

Services currently provided by NHS Lothian which are to be delegated

Interpretation of this Part 2 of Annex 1

In this part—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

"General Medical Practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 3 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018; and

"the public dental service" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

The functions listed in Part 1 of Annex 1 are delegated to the extent that they are exercisable in the provision of the following services:

Part 2A

Provision for people over the age of 18

The functions listed in Part 1 of Annex 1 are delegated to the extent that:

a) the function is exercisable in relation to the persons of at least 18 years of age;

b) the function is exercisable in relation to care or treatment provided by health professionals for the purpose of health care services listed at numbers 1 to 6 below; and

c) the function is exercisable in relation to the following health services:

1. Accident and Emergency services provided in a hospital.

2. Inpatient hospital services relating to the following branches of medicine—
   - general medicine;
   - geriatric medicine;
   - rehabilitation medicine;
   - respiratory medicine; and
   - psychiatry of learning disability.

3. Palliative care services provided in a hospital.

4. Inpatient hospital services provided by General Medical Practitioners.

5. Services provided in a hospital in relation to an addiction or dependence on any substance.

6. Mental health services provided in a hospital, except secure forensic mental health services.

7. District nursing services.

8. Services provided outwith a hospital in relation to an addiction or dependence on any substance.

9. Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

10. The public dental service.

11. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([23]).

12. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([24]).

13. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([25]).

14. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([26]).

15. Services providing primary medical services to patients during the out-of-hours period.

16. Services provided outwith a hospital in relation to geriatric medicine.

17. Palliative care services provided outwith a hospital.

18. Community learning disability services.

19. Mental health services provided outwith a hospital.

20. Continence services provided outwith a hospital.

21. Kidney dialysis services provided outwith a hospital.

22. Services provided by health professionals that aim to promote public health.

Part 2B

([23]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.

([24]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.

([25]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.

([26]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28), section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

NHS Lothian has also chosen to delegate the functions listed in Part 1 of Annex 1 in relation to the following services:

Provision for people under the age of 18

The functions listed in Part 1 of Annex 1 are also delegated to the extent that:

a) the function is exercisable in relation to persons of less than 18 years of age; and
b) the function is exercisable in relation to the following health services:

1. Primary Medical Services and General Medical Services (including GP Pharmaceutical services)
2. General Dental Services, Public Dental Services and the Edinburgh Dental Institute
3. General Ophthalmic Services
4. General Pharmaceutical Services
5. Out of Hours Primary Medical Services
6. Learning Disabilities
7. Health Visiting
8. School Nursing

ANNEX 2

PART 1A

Functions delegated by the Council to the IJB

Set out below is the list of functions that must be delegated by the Council to the IJB.

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A *Enactment conferring function*	*Column B* *Limitation*
National Assistance Act 1948([27])	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958([28])	
Section 3 (Provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968([29])	

([27]) 1948 c.29; section 48 was amended by the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 39, paragraph 31(4) and the Adult Support and Protection (Scotland) Act 2007 (asp 10) schedule 2 paragraph 1.

([28]) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1.

([29]) 1968 c.49; section 1 was relevantly amended by the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Children Act 1989 (c.41), Schedule 15; the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), schedule 10; S.S.I. 2005/486 and S.S.I. 2013/211. Section 4 was amended by the 1990 Act, Schedule 9, the Children (Scotland) Act 1995 (c.36) ("the 1995 Act"), schedule 4; the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ("the 2003 Act"), schedule 4; and S.S.I. 2013/211. Section 10 was relevantly amended by the Children Act 1975 (c.72), Schedule 2; the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 13; the Regulation of Care (Scotland) Act 2001 (asp 8) ("the 2001 Act") schedule 3; S.S.I. 2010/21 and S.S.I. 2011/211. Section 12 was relevantly amended by the 1990 Act, section 66 and Schedule 9; the 1995 Act, Schedule 4; and the Immigration and Asylum Act 1999 (c.33), section 120(2). Section 12A was inserted by the 1990 Act, section 55, and amended by the Carers (Recognition and Services) Act 1995 (c.12), section 2(3) and the Community Care and Health (Scotland) Act 2002 (asp 5) ("the 2002 Act"), sections 8 and 9(1). Section 12AZA was inserted by the Social Care (Self Directed Support) (Scotland) Act 2013 (asp 1), section 17. Section 13 was amended by the Community Care (Direct Payments) Act 1996 (c.30), section 5. Section 13ZA was inserted by the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 64. Section 13A was inserted by the 1990 Act, section 56 and amended by the Immigration and Asylum Act 1999 (c.33), section 102(2); the 2001 Act, section 72 and schedule 3; the 2002 Act, schedule 2 and by S.S.I. 2011/211. Section 13B was inserted by the 1990 Act sections 56 and 67(2) and amended by the Immigration and Asylum Act 1999 (c.33), section 120(3). Section 14 was amended by the Health Services and Public Health Act 1968 (c.46), sections 13, 44 and 45; the National Health

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	
Section 14 (Home help and laundry facilities.)	

Service (Scotland) Act 1972 (c.58), schedule 7; the Guardianship Act 1973 (c.29), section 11(5); the Health and Social Service and Social Security Adjudications Act 1983 (c.41), schedule 10 and the 1990 Act, schedule 9. Section 28 was amended by the Social Security Act 1986 (c.50), Schedule 11 and the 1995 Act, schedule 4. Section 29 was amended by the 1995 Act, schedule 4. Section 59 was amended by the 1990 Act, schedule 9; the 2001 Act, section 72(c); the 2003 Act, section 25(4) and schedule 4 and by S.S.I. 2013/211.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982([30])	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986([31])	
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000([32])	
Section 10 (Functions of local authorities.)	

([30]) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.

([31]) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.

([32]) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions
The Housing (Scotland) Act 2001([33])	
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002([34])	
Section 5 (Local authority arrangements for of residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003([35])	

([33]) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.
([34]) 2002 asp 5.
([35]) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	
Section 259 (Advocacy.)	
The Housing (Scotland) Act 2006([36])	
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007([37])	
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	
Section 6 (Duty to consider importance of providing advocacy and other.)	
Section 11 (Assessment Orders.)	

([36]) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.
([37]) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 14 (Removal orders.)	
Section 18 (Protection of moved persons property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	
Social Care (Self-directed Support) (Scotland) Act 2013([38])	
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013 .
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	

([38]) 2013 asp 1.

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A *Enactment conferring function*	*Column B* *Limitation*
The Community Care and Health (Scotland) Act 2002	
Section 4([39]) The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([40])	

In each case, so far as the functions are exercisable in relation to persons of at least 18 years of age.

Column A *Enactment conferring function*	*Column B* *Limitation*
Carers (Scotland) Act 2016	
Section 6 (Duty to prepare adult carer support plan)	
Section 21 (Duty to set eligibility criteria)	
Section 24 (Duty to provide support)	
Section 25 (Provision of support to carers: breaks from caring)	
Section 31 (Duty to prepare local carer strategy)	
Section 34 (Information and advice service for carers)	
Section 35 (Short breaks services statements)	

([39]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 62(3).
([40]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

PART 1B

In addition to the functions that must be delegated, the Council has chosen to delegate the following functions to the IJB.

Column A *Enactment conferring function*	*Column B* *Limitation*
Criminal Procedure (Scotland) Act 1995	
Sections 51(1)(aa), 51(1)(b) and 51(5) (Remand and committal of children and young persons in to care of local authority).	
Section 203 (Local authority reports pre-sentencing.)	
Section 234B (Report and evidence from local authority officer regarding Drug Treatment and Testing Order.)	
Section 245A (Report by local authority officer regarding Restriction of Liberty Orders.)	
Management of Offenders etc. (Scotland) Act 2005	
Section 10 (Arrangements for assessing and managing risks posed by certain offenders.)	
Section 11 (Review of arrangements.)	
Social Work (Scotland) Act 1968	
Section 27 (Supervision and care of persons put on probation or released from prison.)	
Section 27ZA (Advice, guidance and assistance to persons arrested or on whom sentence is deferred.)	

PART 2

Services currently associated with the functions delegated by the Council to the IJB

Set out below is an illustrative description of the services associated with the functions delegated by the Council to the IJB as specified in Part 1A and 1B of Annex 2.

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptions
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare
- Criminal Justice Social Work services including youth justice

ANNEX 3

Proposed Management Arrangements for functions delegated to the IJB

The provisions within this annex are not intended to create legally binding obligations. They are intended to be illustrative of the proposed management arrangements for the functions delegated to the IJB.

The IJB will issue directions to the Parties via its Chief Officer. Those directions will in the main require that the Chief Officer take forward the development of the IJB's Strategic Plan, and lead on ensuring that the plan is delivered. As the Chief Officer will not be personally managing all of the integration functions, ensuring the Strategic Plan is being delivered will include getting assurance from other chief officers (for hosted services – see below) and other managers in NHS Lothian and the four local authorities in Lothian.

The Chief Officer will have direct management responsibility for the following services:

- All Council services described in Annex 2, Part 2.
- All NHS Lothian services described in Annex 1, Part 2 with the exception of the following:

a) Hosted Services

There are NHS Lothian services for which it would not be suitable for the Chief Officer to have operational management responsibility. The factors contributing to determining these services are the degree of medical specialism of the service and scale of the service required for it to be safe, efficient and effective.

NHS Lothian carries out functions across four local authority areas. Some of the functions delegated to all four IJBs in the NHS Lothian boundary are provided as part of a single Lothian-wide service. Where an IJB is nominated by NHS Lothian to 'host' such a service via one of the Chief Officers of the Lothian IJB's in their role as Joint Director of NHS Lothian, this is commonly referred to as a "hosted service".

b) Acute Hospitals

Services provided on the three acute hospitals in NHS Lothian (Western General Hospital, Edinburgh Royal Infirmary, St Johns Hospital) will be managed by the Chief Officer for NHS Lothian acute hospital services and the relevant hospital site Director.

ANNEX 4

Initial Integration Scheme Consultation

Further details of the people and groups involved in the engagement and consultation on the original East Lothian Integration Scheme are set out below:

Public and Staff consultation from December 17th 2014 to February 17th 2015 with responses received from:

- Members of the public
- Members of staff in East Lothian Council
- Clinical and non-clinical staff in NHS Lothian
- Third Sector Organisations and representative bodies

The members and organisations on the following groups and committees were consulted on the original Integration Scheme:

East Lothian Council Corporate Management Team
East Lothian Council
East Lothian Council's Audit and Governance Committee
East Lothian Health and Social Care Partnership Shadow Board
East Lothian Health and Social Care Partnership Shadow Strategic Planning Group
East Lothian Area Partnerships
NHS Lothian Corporate Management Team
NHS Lothian Board
NHS Lothian Strategic Planning Group
NHS Lothian Strategic Programme Managers
NHS Lothian Healthcare Governance committee
Lothian Area Clinical Forum
All staff of East Lothian CHP and East Lothian Council's Adult Wellbeing department
East Lothian Partnership forum
East Lothian joint planning groups
TSI (STRiVE) for all third sector members
East Lothian independent sector care at home and care home providers
Scottish Care
Carers of East Lothian
East Lothian Council Strategic Housing Department (including RSLs within East Lothian)
All General Practitioners in East Lothian
All Community Pharmacists in East Lothian
All Optometrists in East Lothian
All General Dental Practitioners in East Lothian
Press release and use of social media
Advert in East Lothian Courier Newspaper
Lothian Medical Committee
East Lothian Community Planning Partnership
MSPs (including all list MSPs)
Local MP
Midlothian, West Lothian, City of Edinburgh and Scottish Borders Councils
NHS Borders
Scottish Government Policy Department
Joint Improvement Team

Revised Joint Integration Scheme

Details of the people and groups involved in the engagement and consultation on the revised (2023) East Lothian Integration Scheme are set out below:

Public and Staff consultation from April 2/5/22 – 29/5/22.

The following organisations, groups and committees were consulted on the revised integration scheme:

East Lothian Council Corporate Management Team
East Lothian Council
East Lothian Council's Audit and Governance Committee
East Lothian Integration Joint Board
East Lothian HSCP Management Team
East Lothian Health and Social Care Partnership Strategic Planning Group
East Lothian Area Partnerships/Connected Communities
NHS Lothian Corporate Management Team
NHS Lothian Board
NHS Lothian Strategic Programme Managers
NHS Lothian Healthcare Governance Committee
Lothian Area Clinical Forum
All staff of East Lothian Health and Social Care Partnership
East Lothian Partnership Forum
East Lothian Joint Planning Groups
Third Sector Interface (TSI) (Volunteer Centre East Lothian) for all third sector members
East Lothian independent sector care at home and care home providers
Scottish Care
Carers of East Lothian
East Lothian Council Strategic Housing Department (including RSLs within East Lothian)
All General Practitioners in East Lothian
All Community Pharmacists in East Lothian
All Optometrists in East Lothian
All General Dental Practitioners in East Lothian
Press release and use of social media
Advert in East Lothian Courier Newspaper
Lothian Medical Committee
GP Sub-committee
East Lothian Partnership
MSPs (including all list MSPs)
Local MP
Midlothian, West Lothian, City of Edinburgh and Scottish Borders Councils
NHS Borders
NHS Borders Integration Joint Board
Scottish Government Policy Department(s)

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 21 September 2023

BY: Chief Officer

8

SUBJECT: ELCH Ward 5 Orthopaedic Rehabilitation

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1 PURPOSE

1.1 The purpose of this report is to inform IJB members of the development of NHS Lothian's use of Ward 5 of East Lothian Community Hospital (ELCH) for the provision of in-patient orthopaedic rehabilitation as part of its Orthopaedic Recovery Plan. The Ward opened to the first 8 patients week beginning 4 September 2023.

2 RECOMMENDATIONS

The IJB is asked to**:**

2.1 Note the development by NHS Lothian for orthopaedic rehabilitation in-patient provision at ELCH.

2.2 Note the positive impact of this development for East Lothian residents and for ELCH, and that funding will be through the Elective Recovery Programme, with no direct financial implications for the East Lothian IJB.

3 BACKGROUND

3.1 The Covid-19 pandemic significantly impacted NHS Lothian surgical waiting lists due to postponements and cancellations of non-urgent procedures. A backlog of elective surgical cases developed and patient waiting times increased, potentially affecting healthcare outcomes. Increased health and social care needs are seen for patients on waiting lists creating additional demand on community resources.

3.2 The development of in-patient orthopaedic rehabilitation provision at ELCH is part of NHS Lothian's Orthopaedic Recovery Plan. The plan is funded through the Elective Recovery Programme and focuses on two primary initiatives:

- Expansion of unscheduled orthopaedic rehabilitation capacity
- Ringfencing of elective orthopaedic capacity

Together it is estimated that these initiatives will result in an increase of elective arthroplasty (hips and knees) of approximately 800 procedures per year across the Lothians, prorated to an estimated 465 for fiscal year 2023/24 under current assumptions.

3.3 Provision at ELCH is for elective orthopaedic patients from across the Lothians transferred from the Edinburgh Royal Infirmary post-operatively once medically stable.

3.4 The provision has a number of benefits:

- Supporting the acute sector in addressing the backlog of elective surgical cases and reducing waiting times for Lothian patients, including East Lothian patients.

- Reducing waiting times, helping to prevent patients' conditions deteriorating and health and social care needs escalating whilst awaiting surgery. This results in better outcomes for individuals, as well as preventing further growth of pressure on community resources, including care at home services.

- Enabling East Lothian patients to benefit from post operative in-patient rehabilitation closer to home, making access and visiting, easier, and supporting local planning and provision for discharge.

- ELCH is designed as a rehabilitation hospital, making it well placed to provide this type of provision. This development provides an opportunity for the hospital to become a 'centre of excellence' for orthopaedic rehabilitation.

4 ENGAGEMENT

4.1 Governance for the project is provided by a Project Board with membership from NHS Lothian Acute, East Lothian HSCP, Edinburgh HSCP, Midlothian HSCP, and West Lothian HSCP. This has resulted in excellent collaboration between the HSCPs and Acute teams to develop the proposal and work towards delivery.

5 POLICY IMPLICATIONS

5.1 The plan supports delivery of:

Strategic Objective 1 – 'Develop services that are sustainable and proportionate to need' (by contributing to key priorities 'planning for an ageing population' and 'supporting the acute sector').

Strategic Objective 4 – 'Enable people to have more choice and provide care closer to home'.

6 INTEGRATED IMPACT ASSESSMENT

6.1 The subject of this report is being progressed through the Integrated Impact Assessment process. This will be a collaboration between all Partnership stakeholders and the Acute, reflecting potential impact in all areas. Edinburgh Acute are lead author of the IIA.

7 DIRECTIONS

7.1 There is no impact on existing Directions.

8 RESOURCE IMPLICATIONS

8.1 Funding is through the Elective Recovery Programme, with no impact / implications for the East IJB budget. Costs are predominantly PAYS (staffing), in the order of £2.5m per annum. Additional ward operational costs of £92k are also funded.

8.2 As additional capacity, the ward will be staffed through recruitment as per 8.1.

Description	Band	WTE
Nursing	7	2.00
Nursing	6	3.00
Nursing	5	11.50
Nursing	4	3.00
Nursing	3	17.00
Nursing	2	1.50
AHP (PT)	6	1.00
AHP (OT)	6	1.00
AHP (PT & OT)	5	2.00
AHP (PT & OT)	3	2.00
Medical	Consultant	0.40
Medical	Clinical Fellow	1.00
Porter	3	1
Domestics	3	3.6
Pharmacy	7	0.70
Pharmacy	4	1.00

8.3 Recruitment has been challenging in all healthcare professions recently, however Medical, AHP, Porters, Domestics, and Pharmacy are able to recruit new establishment to meet this additional demand.

Nursing held a recruitment fair in July and successfully recruited a number of staff. Further nursing recruitment is ongoing. To mitigate this pressure the ward initially opened with 8 beds, allowing launch with a smaller establishment. Ward rehabilitation capacity is expected to increase to 12 beds by end of September, and 16 beds by mid- October, based on recruitment forecasting.

9 BACKGROUND PAPERS

9.1 None.

AUTHOR'S NAME	Guy Whitehead
DESIGNATION	Physiotherapy Clinical Lead
CONTACT INFO	Guy.Whitehead@nhslothian.scot.nhs.uk
DATE	12 September 2023

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 21 September 2023

BY: Chief Officer

9

SUBJECT: East Lothian Inreach Project at Royal Infirmary of Edinburgh

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1 PURPOSE

1.1 To update the IJB on ongoing development and delivery of the Inreach Programme.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Note the positive evaluation of Phase 1 of the Inreach Project and the agreement to continue delivery until March 2024.

3 BACKGROUND

3.1 The East Lothian (EL) Inreach model aims to shape and direct the pathways of all EL residents presenting or admitted to the Royal Infirmary Edinburgh (RIE). The model aims to ensure that residents are identified at the earliest point in their patient journey with a focus on optimising patient journey and reducing length of stay (LOS).

3.2 An enhanced Inreach approach has been implemented with a team of EL therapists based within the RIE, undertaking assessments of EL patients. At the core of this model are the close links with the wider East Lothian Health & Social Care Partnership (ELHSCP) and a commitment to support acute staff in navigating EL discharge pathways. This includes fostering an ethos of Partnership responsibility and transfer of risk to the HSCP, in order to explore all available opportunities to support hospital discharge.

3.3 Phase 1 of the project case managed 347 patients, completing 2300 interventions, and facilitated 320 discharges. The project evidenced mitigated costs of £518,760 achieved through an average of 11 bed days

saved over 120 patients by improvements in the Discharge to Assess pathway.

3.4 Phase 2 (Q1) of the project has case managed a further 382 patients, completing 1795 interventions, and facilitated 166 discharges.

4 ENGAGEMENT

4.1 N/A

5 POLICY IMPLICATIONS

5.1 Development of the Inreach Project supports a number of the IJB's strategic priorities for 2022-2025, including Strategic Objective 1 'Develop services that are sustainable and proportionate to need' and Delivery Priority 'Supporting the acute sector'.

6 INTEGRATED IMPACT ASSESSMENT

6.1 No IIA required at this stage due to this being a time-limited project, this has been discussed and agreed with East Lothian Rehabilitation Services IIA Lead.

7 DIRECTIONS

7.1 ELHSCP are determining the introduction of a direction for this piece of work.

8 RESOURCE IMPLICATIONS

8.1 Financial – Additional funding sourced from repurposed Scottish Government Unscheduled Care funding (£300,000).

8.2 Personnel – this was initially provided through existing resource, however, subsequently some additional recruitment was completed and at the beginning of Phase 2 the staff was as shown in the table below.

Description	Band	WTE	Cost (£K)
Occupational Therapy Team Lead	7	1	£63,468
Advanced Practice Occupational Therapist	7	1	£63,468
Physiotherapy Team Lead	7	1	£63,468
Occupational Therapist	6	1	£57,267
Occupational Therapist	5	2	£46,558 x2 = £93,116
Occupational Therapy Assistant Practitioner	4	1	£33,908
Total			**£374,695**

8.3 Other – Nil

9 BACKGROUND PAPERS

9.1 East Lothian RIE Inreach Final Report (Oct 22-Mar 23)

AUTHOR'S NAME	Laura Rowlinson
DESIGNATION	Clinical Lead Physiotherapist and Digital & Informatics Lead, East Lothian Rehabilitation Service
CONTACT INFO	Laura.rowlinson@nhslothian.scot.nhs.uk
DATE	12/09/23

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East Lothian RIE Inreach

November 2022
–
March 2023

Rebecca Knipe – Clinical Lead Occupational Therapist

Laura Rowlinson – Clinical Lead Physiotherapist and Digital & Informatics Lead

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Introduction & Background

The current health and social care system has been under unprecedented and sustained extreme pressures and is no longer sustainable in its current model of service delivery. There is a global shortage of health and social care workforce (Crooks, 2023), significant increase in waiting lists (with 1 in 9 people on a waiting list in Scotland) and a limited hospital and care resource (Carey-Whitehead, 2023).

A fundamental change in service delivery and existing pathways is essential to meet the requirements of the Scottish population.

The challenges outlined above are reflected within NHS Lothian and in planning for Winter 22/23 all Partnerships were asked to review what they could do, to support their residents and ease pressure on the acute hospitals. An enhanced Health and Social Care Partnership (HSCP) approach was required where Partnerships assist in the navigation of discharge pathways and with this the intention to transfer responsibility, and therefore risk to the HSCP for seeking all available opportunities to support early hospital discharge.

Allied Health Professionals (AHPs) are well-placed to address some of the challenges around unscheduled care, assessing and using high clinical reasoning skills to identify patients who can be discharged home directly from the front door or at the earliest point within the patient journey. It is estimated that 70% of patients referred to Occupational Therapists (OTs) at the front door can be discharged directly home (James, 2017).

East Lothian Health and Social Care Partnership (ELHSCP) has a reputation for developing home first pathways and having an agile workforce able to adapt to meet the changing needs of the population, ensuring people receive the right care, at the right time. ELHSCP residents admitted to acute sites, particularly those over 65, are often known to local services, where it was identified that comprehensive Partnership assessment could positively influence the discharge plan at an early point, utilising local knowledge, expertise and integrated team working. Furthermore, the East Lothian Hub and Flow Team identified an increasing prevalence of Request for Service's (RFS's) from acute clinicians were lacking in essential information, consideration of alternative options and limited or poor family communication. (See Appendix 1 for additional challenges identified).

ELHSCP proposed an enhanced Partnership model with daily Activity Huddles chaired by Senior Managers and an Inreach model based at the Royal Infirmary of Edinburgh (RIE) to allow East Lothian AHPs to complete comprehensive assessments and rehabilitation of East Lothian Residents. The Inreach would be delivered by the East Lothian Rehabilitation Services (ELRS) with continual collaboration with all the ELHSCP services.

The RIE Inreach model supports the priorities of the NHS Lothian USC programme focused on Discharge without Delay and is in accordance with the refreshed National Framework for Unscheduled Care (Scottish Government, 2022). This collaborative approach would improve pathways through hospital settings and reduce length of stay by optimising flow and aligning capacity and demand. Working with patients, families and/or carers, it will ensure patients are treated in their home where appropriate.

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Executive Comments

Calum Campbell, Chief Executive of NHS Lothian

"As we continue to see the increasing challenges on demand, we need to respond differently looking at alternative and novel systems of approach. The activities undertaken by East Lothian's AHP service, are a fantastic example of how they can show their support to the wider HSCP system, by developing and delivering an alternative approach to assessment.

It not only challenged risk using local knowledge, but also improved the performance, creating capacity and importantly delivered better outcomes for patients. It was clearly an incredible team effort, worthy of praise and recognition."

Alison Macdonald, NHS Lothian Executive Director of Nursing, Midwifery and Allied Health Professionals

"In delivering this project East Lothian has used their well-established AHP team to access the full range of services available across the community to meet the needs of our patients. It is through these kinds of project that we can see the true value of integration across our professional groups. East Lothian's approach benefits from the knowledge Partnerships bring, to how our patients live day to day. I'd like to commend them on this patient centred approach to care."

Fiona Wilson, Chief Officer of East Lothian Health and Social Care Partnership

"East Lothian HSCP has a strong history of developing innovative pathways to prevent admission and support discharge. This project has looked at opportunities for improvement, by incorporating AHP Inreach at the front end and a strong skilled multi-agency team working alongside them, to support the best pathway for patients. Not only was this development balanced on risk, it also focused on delivering an asset based approach. Our commitment is to strengthen this development further, identifying opportunities to improve performance, with the potential to cultivate wider system change."

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East Lothian Rehabilitation Services

East Lothian Rehabilitation Services (ELRS) was well positioned to respond to this request. ELRS at design is an agile, integrated, and collaborative team. With an innovative and data-driven ethos, the service was able to reallocate workforce within existing resources to support East Lothian therapists to clinically work within the RIE to provide comprehensive assessment and discharge planning of East Lothian (EL) residents.

ELRS work across multiple sites within East Lothian and have a high level of remote and virtual communication and time management skills. There is a strong ethos of auditable practice with bi-annual notes and outcome measure audits completed. In addition, there is a comprehensive training, supervision, and Continual Professional Development structure. All these factors supported ELRS to be able to respond to this new requirement not only in a timely manner, however with professionalism and enthusiasm.

The impact of moving resource was identified, with the expected increased community waiting lists and potential for reduced Discharge to Assess (D2A) capacity. Priority "RAG (Red-Amber-Green)" rating was implemented on existing workstreams, and the Single Point of Contact Phoneline cover was provided by Band 7 / 8a's to increase clinical capacity within the community, ensuring the continual delivery of a flexible service to respond to facilitating discharge requests.

ELRS has a collaborative and visible management structure, which allows for quick decision making and provides a supportive staffing structure. Furthermore, ELRS AHPs already had close links with the EL Hub / Flow Team and Social Work teams, across both inpatient and community. These elements provide essential foundations to develop and implement the Inreach model on.

'ELRS is a successful service due to its ethos of evidence-based and data-driven service design and adhering to and implementing operational policies, auditable practice, and comprehensive training within all service pathways.

The Inreach model could be described as the 'arrow point' of ELRS, and the service was able to implement this model due to the multi-agency and collaborative approach utilised within ELHSCP.

Innovation is a key priority within ELRS and there is active development of enhancing digital choice options available and utilising current and emerging technologies.

I am very proud to be the General Manager of this innovative service.'

Lesley Berry, General Manager East Lothian Rehab Service and Chief AHP.

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The Inreach Model & Aims

The East Lothian Inreach model aims to shape and direct the pathways of all EL residents presenting or admitted to the acute hospitals (RIE and Western General Hospital (WGH)). Ensuring patients are identified at the earliest point in their journey with a focus on optimising their journey and reducing length of stay (LOS).

Additionally, the aim to ensure the appropriate patients are listed for an East Lothian Community Hospital (ELCH) bed in a timely manner and supporting these patients to continue to receive rehabilitation and avoid being "prioritised out".

A primarily remote EL Inreach model was commenced on the 15th August 2022 at the WGH, this was alongside the daily multi-agency flow huddle which commenced 11th July 2022. However, as it became apparent that most of EL patients and delays were within the RIE, the model was reviewed and adapted to be implemented in the RIE. The updated model consisted of a small team of OTs and Physiotherapists (PTs) who would be clinically working at the RIE Monday to Friday, assessing and rehabilitating EL residents.

The Inreach team aim was to work with acute AHPs and the Discharge Hub on:

- Tracking EL patients, from presenting at the front door (A&E).
- Assist and guide acute AHPs on EL Pathways
  - Determining appropriate patients for an ELCH bed or opportunities for innovation (e.g. lifestyle monitoring kits) and utilising 3rd sector organisations, daycentres etc. reducing formal care package requirements where possible.
- Addressing rehabilitation gaps by escalating where people may not be optimised in their treatment goals. Identifying opportunities for Home First at every point.
- Influence risk thresholds, balanced with those applied in ELCH and EL community and grow confidence in the inpatient OT's assurance in the community approach.
- Inform the EL Daily Activity Huddle to ensure optimal length of stay.
- Utilising the proven model of highest skillset being present at the point of triage, the role of the APOT presence at the front door:
  - to support advanced clinical decision making and conversations around direct discharge options to EL.
  - to explore options around Safe Home referral, follow up for EL patients

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The Project

Resource

The project team consists of Occupational Therapists, Physiotherapists and Assistant Practitioners, working Monday – Friday within the RIE. In addition to the clinical staff there was appropriate Clinical Leadership assigned to the project. This was to support the team in a new environment, allowing higher level decisions to be made quickly and support the data gathering and evaluation of the project.

The staffing reallocated to this project from within existing ELRS resource varied throughout the project to be agile to meet the high demand for East Lothian led case management in the RIE. Additional resource was reallocated and student AHP staff were recruited through collaboration with Queen Margaret University and the NHS Lothian Staff Bank to meet the increasing demand.

The current total costing of the clinical team is shown below (as off the end of project March 2023 and costed using Paycost table for 21/22, mid-point +1 and inclusive of employer's costs):

For further details on Staffing throughout the project refer to Appendix 2 – Resource.

Description	Band	WTE	Cost(£k)
Occupational Therapist (Team Lead)	7	1.0	£63,468
Occupational Therapist (APOT)	7	1.0	£63,468
Physiotherapist (Team Lead)	7	1.0	£63,468
Occupational Therapist	6	1.0	£53,855
Occupational Therapist	5	2.0	£86,562
Assistant Practitioner (OT)	4	1.0	£33,908
Total			£364,729

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Activity

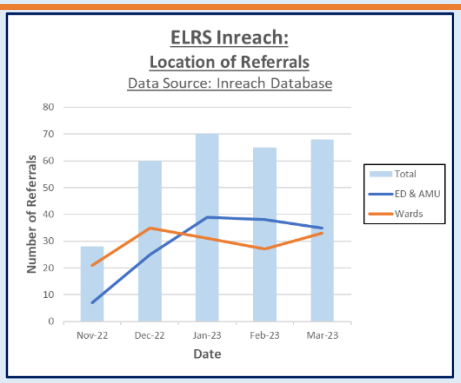
The East Lothian Inreach team case managed 347 patients and completed 2300 interventions. (See Appendix 3 – Additional Graphs). The patient demographics were 88% of patients were 65+ years and 12% <65 years (see Appendix 5 – LAS Project Evaluation for further details). It would be beneficial to have comparative data from the acute of patient demographics and AHP activity.

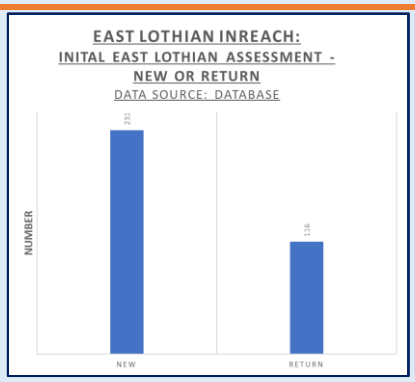
There were 231 patients who had not been assessed by a RIE OT or PT prior to being referred to the Inreach team, these referrals were described as "New". There were 116 patients who had been assessed by a RIE OT or PT prior to being referred to the Inreach team, these referrals were described as "Return".

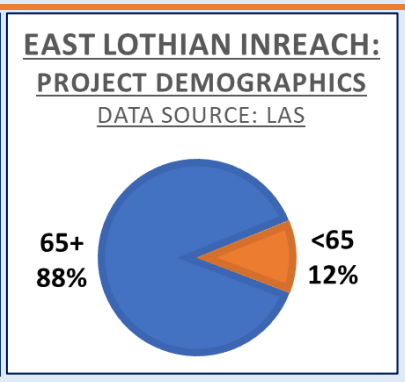
The first graph below summarises the pattern of referrals from A&E compared to the Wards. The first stage of the project focused on the back door and therefore more referrals were from the wards, whereas as the project progressed the requirement for increased presence in A&E was evident and there was an increase in A&E referrals. The team have worked to capacity at times having to decline new referrals.

The team saw patients across 19 different specialties and 35 wards. The patient specialty receiving the largest number of interventions was Medicine of the Elderly (38%). General Medicine and Orthopaedics received the next largest number of interventions (24% and 11% respectively). A further 7% of interventions were completed in A&E.

Occupational Therapy interventions were 54% direct patient contact and 46% non-direct patient contact. Physiotherapy interventions were 65% direct patient contact and 35% non-direct patient contact. (See Appendix 1 – Additional Graphs)







Discharges

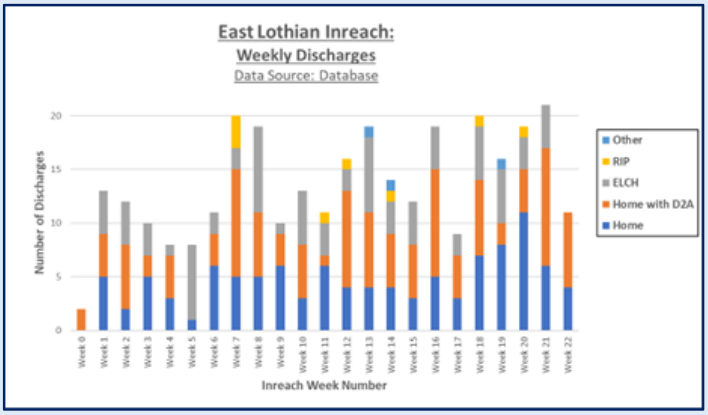
The project facilitated 320 discharges from the RIE. (See Appendix 1 – Additional Graphs).

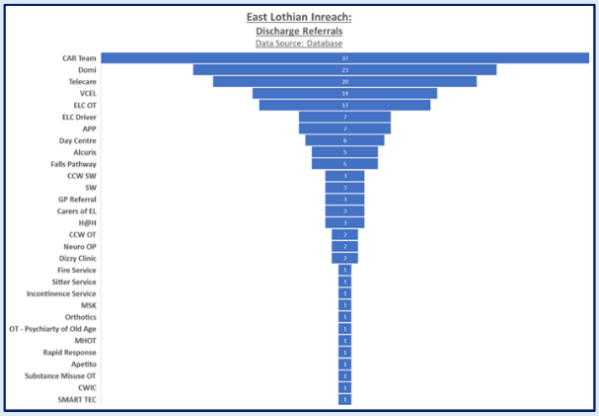
	Number of Discharges	Percentage (%)
ELCH	79	25
Home	110	34
Home with D2A	120	38
Other	3	1
RIP	8	3
Grand Total	**320**	

East Lothian specialist knowledge was utilised to refer to a wide range of EL services to support timely and effective discharge planning avoiding care where possible. The team through high levels of communication across ELHSCP were aware of the worsening situation in the community regarding the availability of care, as per the end of March there was 1,238 hours of unmet care in EL (data provided by ELHSCP).

The project facilitated the discharge of 120 patients with the D2A service. This service can facilitate earlier discharge by supporting patients' home who have ongoing OT or PT assessment and rehabilitation goals. Within the 120 patients 36 patients were referred to additional services at time of discharge, supporting a comprehensive discharge. A total of 64 referrals were made to 24 different services.

Across the project the team utilised 31 different services and completed a total of 296 referrals including 120 D2A referrals. The other 176 referrals included 37 referrals to Care Assessment and Review (CAR) Team, this team review the need for Care when a patient is at home with the aim to reduce care requirements by utilising specialist equipment, digital options and completing rehabilitation. There were also 23 Community Physiotherapy (Domi), 20 Telecare, 14 Volunteer Centre East Lothian (VCEL) and 13 Community Occupational Therapist (ELC OT) referrals completed.





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Discharge To Assess (D2A)

Prior to the Inreach project the average length of stay (LOS) for a patient discharged from the RIE with D2A was 16 days and the RIE discharged on average 5 patients a week with D2A (over the 6-month baseline period). There were 7 patients referred to D2A from A&E during the baseline period. When LOS is reviewed excluding discharges from A&E, average LOS is 17 days.

During the project the RIE therapists continued to discharge on average 4 patients a week with an average LOS of 16 days with D2A. However, in addition to these discharges the project discharged on average 5 patients a week with an average LOS 5 days.

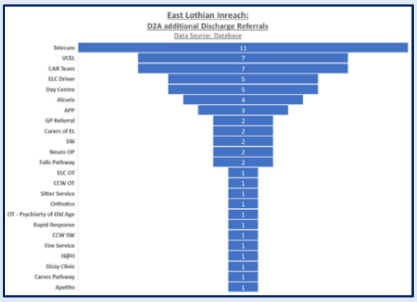
- *Mitigated project costs: 11 bed days saved over 120 patients (£518,760).*
- *Annual mitigated costs supporting increase system capacity: 3,168 bed days (£1,245,024)*

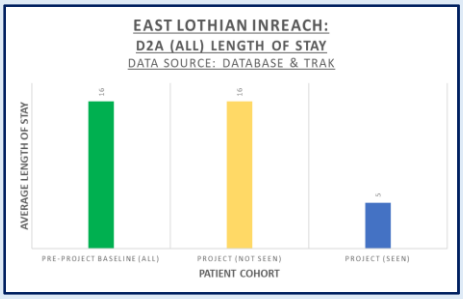
This significant reduction in LOS can be explained by the increase D2A referrals from A&E. During the project 12% of D2A referrals were from A&E compared to the baseline period where only 5% of D2A referrals from the RIE came from A&E. However, it should be noted that during the project D2A referrals from the RIE A&E team have increased to 10% of their referrals however, average LOS has remained 16 days.

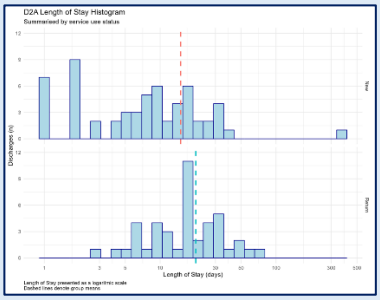
On further review of the D2A data it can be evidenced that if the project team were to complete the initial assessment of the patient, "New", these D2A patients had an average LOS of 11 days. In comparison to an average LOS of 20 days if the acute therapists completed the first assessment and the project was subsequently referred the patient, "Return".

This LOS data comparison excludes discharges from A&E. The improvement in LOS, particularly when EL complete the first assessment, evidences the importance of having an EL specialist assessment completed at the earliest stage of a patient's journey. These patient's assessment and rehabilitation being overseen by an EL Inreach team results in effective and timely D2A discharge planning.

Baseline data and comparable data is from ELRS Capacity Database, RIE have not been able to provide any comparable data. See Appendix 4 – full D2A statistics and Appendix 5 – LAS.







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Accident & Emergency (A&E)

During the project there were 61 assessments in A&E, 35 patients (57%) were discharged directly home from A&E and 45 patients (74%) were discharged home from A&E or Acute Medical Unit (AMU) following Inreach OT or PT assessment.

A further 14 (23%) patients were assessed by Inreach team and discharged or deemed safe for a facilitate

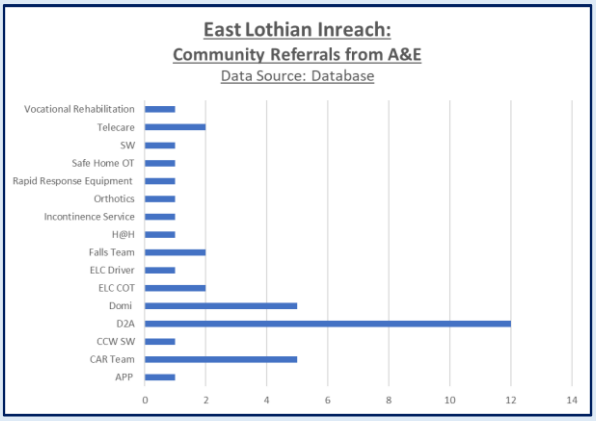
d discharge, however, were admitted. Out of these 14 patients, three were admitted due to transport issues.

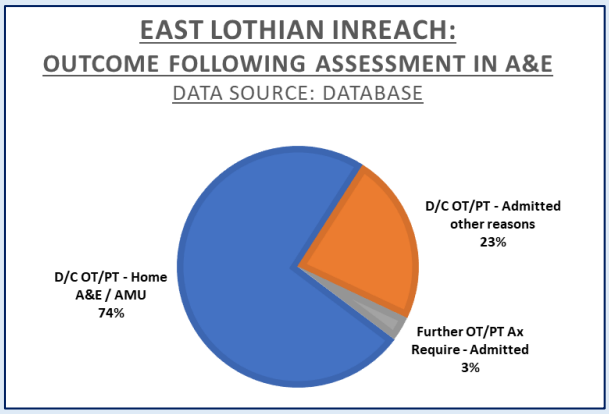
The Inreach team were able to utilise their local expertise to support discharges directly from A&E, there were 38 onward referrals to 16 different EL services, as shown in the graph below. The RIE completed an A&E process map for before the project and this identified they had 7 community services they referred to including D2A, prevention of admissions, package of care, voluntary sector, and community alarm services. Unfortunately, at the time of writing this report the final process map had not been shared by the acute.

Reviewing the 45 patients who were discharged from A&E or AMU the pie chart below displays the discharge destinations. The Inreach team were able to support 31 patients home without requiring D2A, to achieve this local expertise was utilised to refer these patients to 10 different community services (excluding D2A), totalling 21 referrals for these 31 patients.

See Whole System Flow section for HSCP level review.

At time of writing this report Acute Project reports had not been shared to provide further comparable data.





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Feedback

ELHSCP, ELRS and the clinical project team value the importance of feedback from all staff. The staff feedback questionnaire was launched through Jisc on 10th March 2023 and ran until 24th March. It was sent electronically to all OT and PT staff (qualified and non- qualified) and all Consultants and Doctors. In addition, hard copies were provided on the wards to support ward staff to complete.

In total 31 online and 7 paper questionnaires were completed, resulting in a total of 38 responses. Staff feedback came from clinicians working within the specialities that the project had the most clinical input with and referrals from, those being, MOE (36.8%), ED/AMU (15.8%) and Orthopaedics (15.8%). Full summary of the online questionnaire feedback attached in Appendix 6, any identifiable staff information has been removed to maintain anonymity.

Key results:

1. Understood aim of Project –
   Yes (81.6%), No (10.5%), Unsure (7.9%).

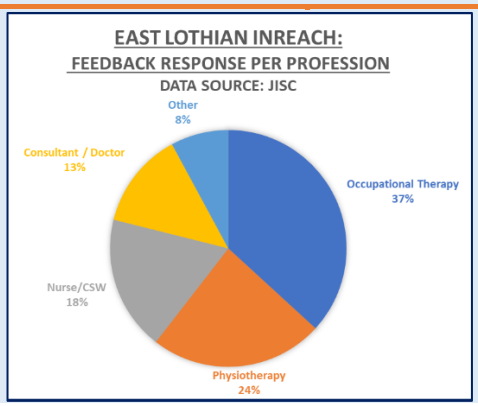
2. Experience with the EL Inreach team

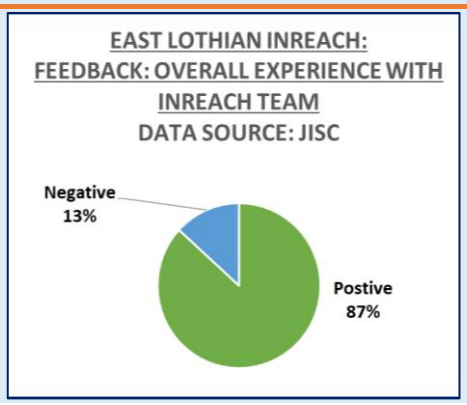
Questions	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree
Approachable	66%	18%	11%	5%	0%
Good Communicators	32%	50%	8%	8%	3%
Knowledgeable of EL Service	71%	26%	3%	0%	0%

"Very friendly and approachable team,

it is so great to have them in the RIE"

3. Key Themes were identified, including the following (for full review see appendix 7)
   - Differing use of Trak
   - Referrals to D2A
   - Initial Introduction of Project and Team
   - Communication between Inreach and acute teams
   - Clinical focus area of project
   - Added capacity vs EL Specific Knowledge
   - Screening of EL Patients





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Whole System Flow

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East Lothian Activity in the RIE, ELCH Activity & ELRS Activity

Although the Inreach project is a small resource within a much large health system, over time it is anticipated that the improvements in pathways and outcomes for patients will be reflected in the whole system flow.

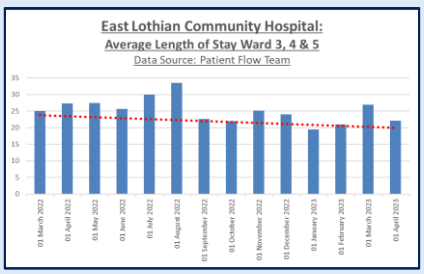
Total Occupied Bed Days (TOBD), delayed discharges and A&E activity has been monitored throughout the project.

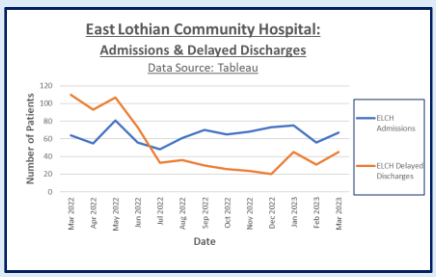
During the project there were 1,595 East Lothian admissions to the RIE – 65+ years, unplanned admissions. (Data Source: Tableau – Activity Trends by Hospital – accessed 11/04/23). Over the project the team case managed 347 patients thus 22% of these admissions.

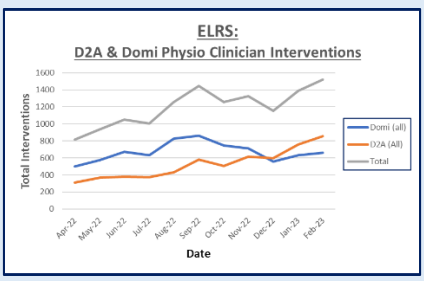
Variable	October	November	December	January	February	March
Mean LOS of Hospital Discharges	8.6	8.6	9.1	9.1	9.6	8.3
Hospital Admissions	254	288	302	264	221	266
Hospital Transfers Out	39	53	51	48	42	43
TOBD	2307	2459	2798	2581	2216	2153
Death	18	17	21	25	13	16

In addition, activity within ELCH has been monitored, including number of transfers in, discharges and LOS. The below graph displays an improving average LOS across Wards 3, 4 and 5.

ELRS activity is shown in the graph below. The reduction in Domi interventions is reflective of the RAG rating being implemented and with this there was an increase in the Domi waiting list, RAG rating was removed in March. However, the graph evidences that the process put into place to support the pressures on the acute sites to facilitate more discharges have been successful in releasing capacity to this workstream and total community interventions have increased during the project.







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Total Occupied Bed Days for Delayed Discharges (TOBD for DD)

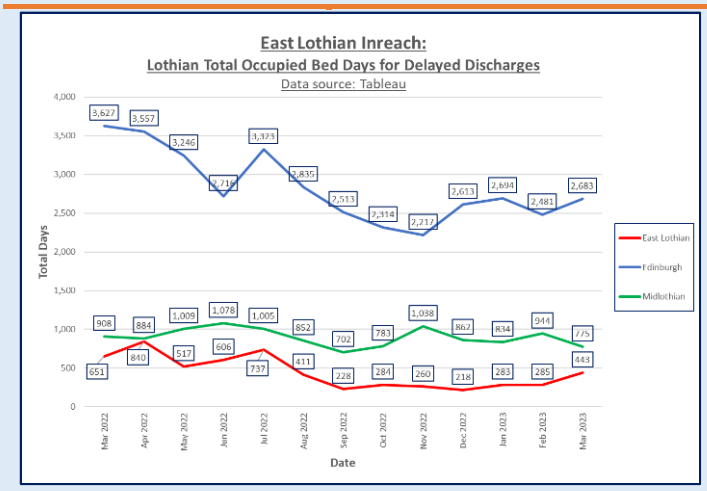
Delayed Discharges is a key area ELHSCP are reviewing and actively working to reduce within the context of a care crisis in the community. All patients recorded as a Delayed Discharge are discussed at the daily integrated Activity Huddle to ensure all avenues have been investigated to facilitate discharges wherever possible. These patients may not be known to the Inreach project team, however, they will often be following the meeting liaise with acute colleagues or actively take on the management of these patients dependent on the daily discussions.

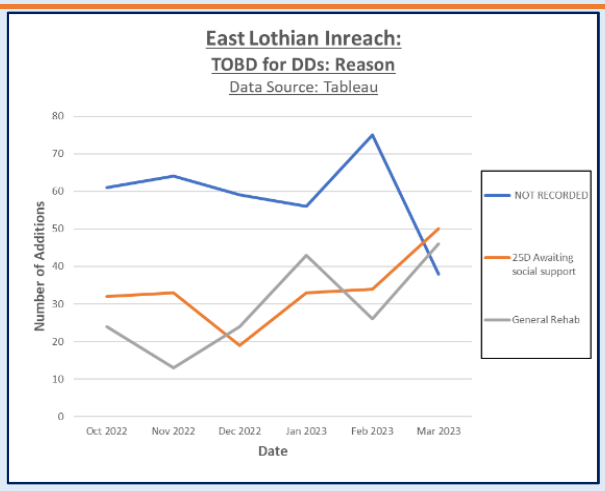
The highest proportion of ELHSCP DDs are “Not recorded”, “25D awaiting social support” and “General Rehab”. (See Appendix 1 – Additional Graphs)

At the initial phase of the project there was a focus on the “back door” to “pull” patients out utilising the specialist knowledge of the Inreach Team. During this period there was a reduction in TOBD for DDs. As the project progressed capacity was continuously reallocated to meet competing demands from the front door and back door.

Over the final month of the project there was an increase in TOBD for DDs and on reviewing the reasons for DDs there was a large increase in “General Rehab” DDs from 67 in October to 135 in March and a large increase in “25D awaiting social support” from 46 in October to 120 in March. This is reflective of the lack of care provision, the reduction in access to interim beds and reduction in ward 5 beds (8 were closed in March). The Inreach team will continue to ensure patients active to them receive ongoing rehabilitation whilst awaiting transfer, this however, will impact on the teams capacity to accept new referrals.

East Lothian TOBD for DDs remain the lowest when compared to Edinburgh and Midlothian HSCP.





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Accident & Emergency (A&E)

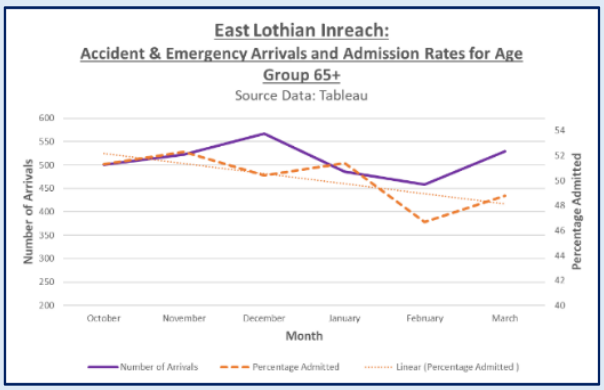
During the project the team have increased their presence in A&E as this is identified as a key area where patients can be supported home with the correct services. This can prevent unnecessary hospital admission, especially as this often results in care packages being lost and lengthy waits for care to be recommenced.

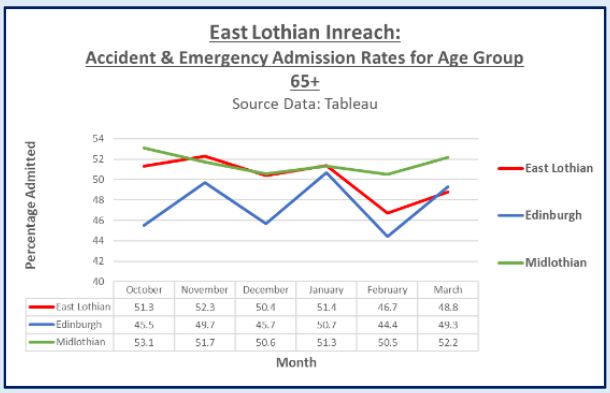
The key data that is being monitored is the number of arrivals to A&E and the percentage of patients 65+ years who are subsequently admitted.

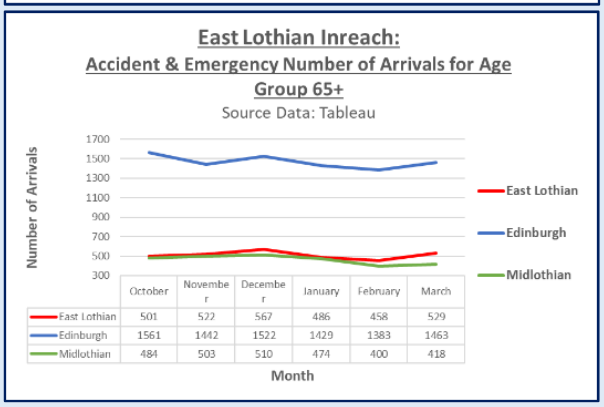
During the project East Lothian arrivals at A&E have ranged from 458 to 529 per month with the highest numbers in December and March. The percentage of patients requiring admission has reduced from 51.3% in October to 48.8.% in in March. It can be seen in the graph below there is a positive trendline in the reduced percentage of patients being admitted even when arrivals at A&E have increased.

See Appendix 3 Additional Graphs for trends from April 2020-March 2023.

East Lothian	October	November	December	January	February	March
Number of Arrivals	501	522	567	486	458	529
Percentage Admitted	51.3	52.3	50.4	51.4	46.7	48.8







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Readmissions

Readmission data review was completed by Lothian Analytic Services (LAS) and a full report can be found in Appendix 5.

Baseline readmission data was reviewed for the specialities of General Medicine and Medicine of the Elderly, and for patients 65+ years following an unplanned admission. These metrics were chosen on review of the demographics of patients seen in the project. This baseline data was reviewed across East Lothian, Edinburgh and Midlothian and at 7 days, 28 days and 90 days percentage readmitted.

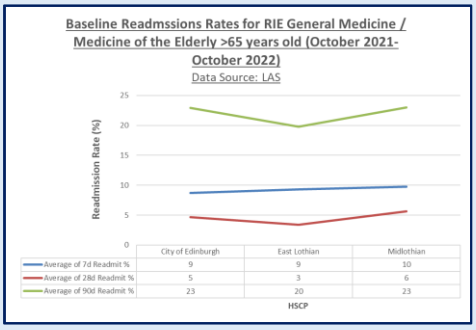
Baseline data evidence that East Lothian has the lowest percentage readmitted across all three categories as shown in the graph below.

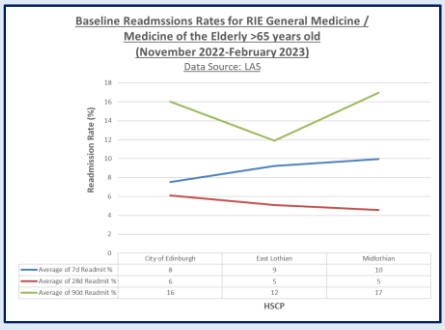
Review of data from the project period evidence that East Lothian has remained consist with percentage readmitted. Edinburgh has a 1% lower average percentage admitted at 7 days and otherwise East Lothian has continued to have the lowest percentage readmitted when reviewed again Edinburgh and Midlothian, across the three categories.

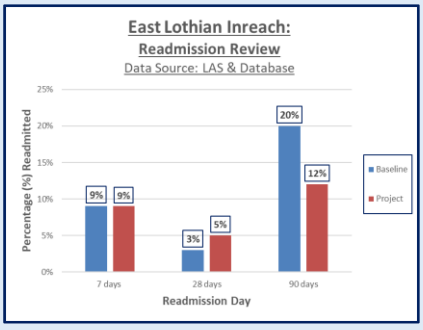
Thus showing, that although there has been an increased number of patients facilitated home at an early point in their journey, with the right support in place these patients have remained home, with no change in percentage of patient being readmitted.

Cohort	7 days	28 days	90 days
Baseline	9%	3%	20%
Project	9%	*5%	*12%

*The current percentage readmitted at 28 days and 90 days is included, however, the analysis will need to be re-run 28 days and 90 days following the last day of the data (28th April and 29th June).







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Case Studies & Patient Feedback

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Case Study 1

OUTCOMES	Barthel
Start:	*55*
End:	*70 (improved)*

Background:

- 88 year old Female
- Admitted to hospital following a fall
  - Resulting in left hip pain
  - Confined to bed for 2 weeks preadmission
- PMH:
  - OA
  - Prediabetes
  - CKD

Key Dates:

Admitted to RIE:	05/01/2023
Referred to EL Inreach Team:	17/01/2023
Desired Discharge Date:	18/01/2023
Actual Discharge Date:	22/01/2023

**Medical Staff kept patient in for TVN review rather than refer to community and daughter not wanting to support over weekend.*

Challenges:

- Consultant unavailable for discussion and junior doctor unable to make decision re discharge plan without discussion with consultant so had to wait until following day to discuss.
- Medical staff reluctant to refer to tissue viability in community therefore remained in hospital to await this.

Successes:

- Prevented unnecessary transfer to ELCH
- Patient straight home without wait for POC assessment
- Prevented further AHP professional involvement through holistic PT approach
- Prevented OT involvement through EL PT being involved, arranging care review and equipment provision.

Situation:

- Handed over patient by MOE PT on 17th Jan
- for maintenance until transfer to ELCH
- last reviewed on 13th.

Input:

- Assessment carried out, patient close to baseline mobility of WZF and supervision
- Discussion with daughter at initial assessment who was keen to take patient home.
- Daughter assists with all ADL's at baseline.
- Medical staff requested patient remained on ward for TVN review
- Liaised with NS and DN's – hospital bed and nimbus mattress ordered on rapid response

Sign posting/ referrals:

- CAR Team referral for assessment of POC in community.
- Domi PT referral to progress outdoor mobility
- CAS referral to allow easy escalation of falls/patient becoming unwell due to history of long period of bed rest following fall.
- Equipment provision with rapid response for hospital bed.

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Case Study 2

Key Dates

Admitted to RIE:	06/12/2023
Referred to EL Inreach Team:	06/12/2023
Desired Discharge Date:	06/12/2023
Actual Discharge Date:	06/12/2023

Background:

- 71 year old Female
- Admitted to hospital due to back pain.
- PMH:
  - COPD
  - AF
  - Electrolyte derangement secondary to anorexia
  - Osteoporotic fractures
  - Hereditary haemochromatosis - homozygous C282Y
  - Anorexia Nervosa
  - Chronic hyponatraemia with element of SIADH
  - History of alcohol excess

Situation:

- Lives alone (bungalow);
- Has supportive family however patient beginning to separate herself from them as she feels they are too involved.
- BD POC on admission however patient previously had TDS POC for meal prep due to malnutrition and patients lack of motivation.
- Current input from Domi PT, Alcohol Liaison Nurse and EL POA.

Input:

- Transfer, mobility, strength, ROM and balance assessment completed in ED.
- Pain was limiting factor. Liased with medical staff in ED about H@H follow up.
- Checked Mosaic and TRAK for all services involved.

Sign posting/ referrals:

- Follow up form H@H for pain management
- CAR Team referral to review POC
- Email sent to Domi PT involved
- Increased POC back to its previous level (TDS)

Successes

- Due to EL Inreach Team PT/OT knowing the patient form the community there was a lot of important information already known.
- EL Inreach Team also able to check Mosaic for additional information on input and services.
- Direct contact with Domi PT to ensure suitable follow up available.
- Discharge was successfully supported by H@H and Domi PT, with no readmission.
- Care and Review Team follow up was very appropriate for this lady as her care has been insufficient for some time, it also allowed us to send the patient home to await her care as we knew someone was going in to specifically assess if her care is sufficient.

Challenges

- H@H were initially unable to support with pain management.

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Case Study 3

Background:

- 66 year old Female
- Presented to ED for Biers block post fall.
- Admitted to hospital following reduced mobility secondary to cerebellar ataxia. Has found balance "off" for a number of months with sensation of leaning back regularly.
  - ❖ Resulting in left wrist fracture.
- PMH:
  - ❖ Cerebellar ataxia

Key Dates

Admitted to RIE:	09/01/2023
Referred to EL Inreach Team:	09/01/2023
Desired Discharge Date:	09/01/2023
Actual Discharge Date :	09/01/2023

Situation:

- Lives with husband
- Husband supports with all transfers and ADL's.
- Carrying out precarious transfers at baseline for long time
- Minimal support in community

Input:

- Assessed in ED
- Mobility assessment – precarious
- Reviewed previous Neuro PT notes to compare assessment to previous function.
- Discussion with patient and husband re risks of admission v risk of discharge with community support.
  - Agreed DC home safest route to establish safe set up in own environment and establish good community support networks

Challenges:

- Difficulty assessing complex patient in ED without normal bed height access.
- Difficulty in busy environment with precarious mobility

Successes:

- Able to pick up on orthotics referral to reduce further falls risk
- Able to be well informed at point of assessment due to awareness of previous input from ELRS.
- Patient able to go home as per wish
- Prevented likely admission due to complexity of mobility and background condition

Sign posting/ referrals

- Referred to D2A
- Referred to orthotics
- Sign posted to carers of East Lothian – declining referral at point of assessment

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Case Study 4

Key Dates

Admitted to RIE:	06/01/2023
Referred to EL Inreach Team:	09/01/2023
Desired Discharge Date:	20/01/2023*
Actual Discharge Date:	25/01/2023*

**delayed discharge – tested positive for COVID Medical team made the decision to delay D/C*

Background:

- 88 year old Female
- De-conditioned, low mood, lost confident become house bound.
- Admitted to hospital following: GP referral - cough + vomiting + reduced PO intake + suprapubic pain, ++ carer stress as family felt patient was not coping at home & required a 4 times per day POC
- PMH:
  - ❖ AF, hearing aids, BPPV, NSTEMI, malignant neoplasm of ascending colon right hemicolectomy and anastamosis, diverticulosis, unstable angina, HTN, migraine

Situation:

- Lives alone bungalow
- Family live locally who visit daily for social support, provide shopping and make meals if required ++ daughter stress as they feel mum depends on them a lot
- No PoC
- Lost confidence and developed anxiety after husband pasted away
- Stopped going out for walks or attending local activity groups

Input:

- Meal prep practice in the Kitchen
- Personal Care toileting Practice to promote Independence
- Ongoing mobility practice to build patients confidences
- Washing & Dressing Ax with ongoing practice
- Checked Mosaic and TRAK for all services involved

Sign posting/ referrals

- D2A, Alcuris, Telecare
- Volunteers of East Lothian, Day centre
- Increase POC to OD

Challenges:

- Delayed discharge due to testing positive for COVID
- Family ++ stressed and felt mum was depending on them a lot prior to admission family felt patient would benefit from a 4 x per day POC

Successes:

- Patient progressed to near full independence
- EL Inreach Team knowing what East Lothian services were on offer for patient OTAP was able to refer patient to day centre to start weekly attendance the same week patient was discharged home
- EL Inreach Team also able to check Mosaic for additional information on current input and services.
- Discharge was successfully supported D2A with no readmission
- OTAP knowledge with Alcuris & Telecare enable the family to view and see how mum was managing at home without them having to visit daily

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Patient Feedback

The Inreach Team used the ELRS Patient Feedback Questionnaire that has been approved by NHS Lothian Patient Experience Team. All results are hosted through the ELRS digital platform.

Patient feedback was collated by clinicians either face to face with patients or family members at point of discharge or via telephone call if patients had been discharged prior to completion of Patient Feedback Questionnaire. To date clinicians have completed 73 Patient Feedback Questionnaires.

Key Themes:

- Receiving **regular** Physiotherapy and Occupational Therapy input was beneficial
- Input from Physiotherapy and Occupational Therapy made recovery much easier
- Provision of equipment / aids supported timely discharge home
- East Lothian provided a great inpatient service and community follow up
- Good communication re. discharge planning with patient and families

See below for Patient Quotes.

'Seen by OTAP one day and got home the next day, very happy as I wanted to get home ASAP'

'Great service and follow up that East Lothian offer'

'Kept me up to date with discharge planning and provided me and my husband with all relevant info which led to fast discharge and got me home to my dogs quickly'

'Waited on RIE PT Team to review me for 2days before I could be discharged home'

'East Lothian OT Team have been great, got me home quickly after my fall'

'Well set up going home'

'OTs and PTs were very patient and caring'

'Reassurance given at each stage was beneficial'

'Great follow up service with D2A'

'My POC was held whilst I had a short stay in the RIE'

'Everything has been wonderful, PT was very knowledgeable and helped me progress my walking and hand movement'

'Got home quickly from RIE with follow up, rather than going to ELCH for rehab'

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Summary & Recommendations

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Summary

East Lothian Rehabilitation Service has been able to successfully respond to the request from the acute to support the extreme and sustained pressures facing the acute sites. ELRS was able to be responsive due to their core values, robust structures, and data-driven approach to service delivery across multiple existing pathways.

The Inreach model was implemented in conjunction with the existing Multi-agency Daily Activity Huddles and existing effective and efficient methods of information sharing within ELHSCP including third sector.

Within existing resources ELRS was able to reallocate a small resource of staff to the RIE. Workstreams were revised to enhance capacity for facilitating earlier discharges from the acute and ELCH to support whole system flow. Urgent work was prioritised, and routine work was monitored via RAG rating between December - March.

The Inreach project case managed 347 patients, which equated to 22% of EL unplanned 65+ admissions to the RIE. They worked across 19 different specialities, 35 wards and supported 320 discharges. The project referred to 31 different EL services on discharge and completed a total of 296 onward referrals.

During the project an average of 9 patients were discharged per week with D2A compared to 5 patients during the baseline period. In addition, the average LOS improved from 16 days from the baseline period to 5 days for patients seen by the Inreach team. This equates to annual mitigated costs of £1,245,024.

The Inreach team completed 61 assessments in A&E and 74% were discharged home from A&E or AMU. These patients were referred on to 16 different services, totally 38 onward referrals. Without the acute providing comparative data, finalised process pathways and project reports conclusion cannot be drawn. However, from a shared draft pathway it was reported the acute A&E team refer to 7 EL services.

Feedback received from RIE staff reported 87% of staff had a positive experience with the Inreach team. On reviewing the comments, the team were well received in the acute. However, other comments highlighted perceived issues, for example with communication and the use of Trak as the primary method. This alongside other feedback highlighted significant differences in culture.

Whole system flow is being monitored and at this early-stage readmissions rate has remained at 9%. Although initially there was an improvement in TOBD for DDs, March saw this number increase, in conjunction with bed closures in ELCH, reduced interim beds and reduced care availability. A further period is required to continue to review this data and the impact of Inreach model.

To meet the demand within the acute site for EL led case management the Inreach team has provided an agile and flexible service across the whole of the RIE. This approach has been adopted to best meet the needs of EL patients however, due to the small Inreach resource this influences the ability to measure the impact of the project.

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Recommendations

It is recommended that additional funding (£297, 638.50 – from EL Unscheduled Care Funding) is used to allow the continual delivery of this test of change for one further year. This would allow for further data evaluation and impact to be measured and reported, and resource returned to ELRS inpatient and community teams.

At the end of the additional year one of the two Outcomes proposed below will be agreed by senior management within the Acute, ELHSCP and senior NHS Lothian management.

Outcome 1:

- The Inreach project demonstrates successful outcomes for EL patients and positive impact on whole system flow therefore, resource would be transferred from the acute / set-aside to EL.
- Within the year the Inreach project will develop the following.
    - Enhanced EL model in A&E.
    - Agreement of all pathways and processes for EL and RIE staff.
    - Process implementation in line with EL capacity and working patterns.

Outcome 2:

- The RIE will evidence how they can meet the identified needs of the EL population – Inreach project will cease.
- The RIE will be able to evidence the following.
    - Use of a full range of EL discharge pathways and services.
    - Attendance at daily multi-agency activity huddle.
    - Improved pathways within D2A and EL whole system flow.

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Appendixes

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Appendix 1: Challenges Identified by Flow Team

It was identified from the flow huddle that frequently:

- People are added as a health or social delay without discussion with EL, where earlier intervention could have prevented the delay.
- Planned date of discharge (PDD) is not always used to provide clarity on the ready for discharge date from an early point.
- People are prioritised out from receiving rehabilitation when they are listed for a rehabiltation bed, which results in deconditioning and a longer length of stay overall.
- Activity meetings have highlighted discrepancies in acute MDT feedback regarding patients function and need for ELCH bed.
- There were opportunities to support earlier conversations around a multi-disciplinary PDD. Similarly, conversations around risk management, 'moving on' and community options could be more effective if supported by teams with ELHSCP specific knowledge who will often know the patient and their family.
    - AHP/SW assessment could be brought forward in the patient journey.
    - Acute teams are not clear on the options within EL, resulting in a different assessment of need, and threshold for managing risk.
    - Patients are listed for OT/PT when there may be no clear indication of need, resulting in delayed discharges awaiting AHP input that may not be required.

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Appendix 2 – Resource

Initial SBAR (August 2022) presenting the ELHSCP In-Reach Plus RIE model proposed a staffing compliment (from existing resource) off 1x Advanced Practitioner OT, 1x Team Lead OT, 1x B6 OT, 1x B6 PT and 1x B4 Assistant Practitioner, costing £268,554 (costed using 21/22 Payscale).

The project commenced in October 2022 with the following staffing, 1x Clinical Lead OT, 0.4x Clinical Lead PT, 1x Team Lead OT, 1x B6 OT, 1x B6 PT and 1x B4 Assistant Practitioner, costing £298,908.40. The decision to change the staffing compliment, increasing senior management was to support the team in a new and potentially challenging environment and to allow higher level decisions to be made quickly and to support the data gathering and evaluation of the project. (From existing resource and costed on 21/22 Payscale).

In the second month of the project capacity was increased further as clinical demand was not being met. ELRS Inpatient Team Lead OT was moved to the project (0.6 WTE) and the Staffbank was utilised to employ OT and PT students as B4 Assistant Practitioners, 2.45WTE B4 Assistant Practitioners. Annual costing would be a further £121,155.40. (21/22 payscale used.) Please note 0.45WTE Assistant Practitioner PT worked with team for one month only and the 2.0WTE B4 Assistant Practitioners are now on the Staffbank as Band 5 OTs and continue to work within the project. Staffbank employees have been funded through existing vacancy monies.

The increased capacity allowed the In-reach team to have more of a presence at ED/AMU, data available at the end of this report. The use of students from Staffbank allowed the continuation of outcome measurement completion and gathering of Patient Feedback, alongside increased rehab capacity at backdoor for EL patients. As staffing resource was moved to allow the RIE Inreach to commence, ELRS community and inpatient teams have been negatively impacted, this was expected to happen when the project was undertaken using existing resource. Initial SBAR (August 2022) presenting the ELHSCP Inreach Plus RIE model proposed a staffing compliment off. (From existing resource and costed using 21/22 Payscale):

Description	Band	WTE	Cost (£K)
Occupational Therapists (Team Lead and APOT	7	2.0	£63,468 x 2 = £126,936
Occupational Therapist	6	1.0	£53,855
Physiotherapist	6	1.0	£53,855
Assistant Practitioner	4	1.0	£33,908
Total			**£268,554**

The project commenced in October 2022 with the staffing shown in the table below. (From existing resource and costed on 21/22 Payscale)

Description	Band	WTE	Cost(£k)
Clinical Lead Occupational Therapist	8a	1.0	£67,016
Clinical Lead Physiotherapist	8a	0.4	£26,806.40
Occupational Therapist (Team Lead)	7	1.0	£63,468
Occupational Therapist	6	1.0	£53,855
Physiotherapist	6	1.0	£53,855
Assistant Practitioner (OT)	4	1.0	£33,908
Total			**£298,908.40**

In the second month of the project, capacity was increased further as clinical demand was not being met. Inpatient Team Lead OT was moved to the project and the Staffbank was utilised to employ OT and PT students. Costing below, 21/22 payscale used. Please note Assistant Practitioner PT worked with team for one month only and the Staffbank employees were funded through existing vacancy monies.

Description	Band	WTE	Cost (£K)
Occupational Therapist (Team Lead)	7	0.6	£38,080.80
Assistant Practitioner (OT)	4	2.0	£33,908 x 2 = £67,816
Assistant Practitioner (PT)	4	0.45	£15,258.60
Total			**£121,155.40**

To enable the project to continue, maintaining the level of delivery and improvement for 1 more year and to return staffing resource back to the ELRS inpatient and community teams in which resource was taken within the first 6months, the following is a breakdown of how funding would be used. (Costed using Paycost table for 22/23, mid-point +1 and inclusive of employers costs).

Description	Band	WTE	Cost (£K)
Occupational Therapist	6	1.0	£57,267
Occupational Therapist	5	2.0	£93,116 (£46,558 x2)
Occupational Therapist	4	1.0	£36,853
Physiotherapist	7	1.0	£8,565 (difference between B6 point 2 - B7 point 1)
Physiotherapist	5	1.0	£46,558
Physiotherapist	4	2.0	£55,279.50 (£36,853 + £18,426.50) (1.0 for 6months only)
Total			**£297,638.50**

This would be achieved through utilising current recruitment cycles where possible. While these people would be recruited permanently, we would use natural staff turnover to support any cost pressure if the project was not funded after 1 year. Within this, there is an opportunity to permanently recruit 2 newly qualified OTs (currently working within Inreach project through Staff bank), recruit B4 OTA from recent interviews (person identified), recruit a B6 OT from upcoming B6 OT interviews, fund 1 B5 PT over-established from recent interviews and act up current B6 PT to B7 to provide PT Team leadership for Inreach team. Evaluation will continue throughout the next year, discussing if the In-reach project continues and annual costs this would incur.

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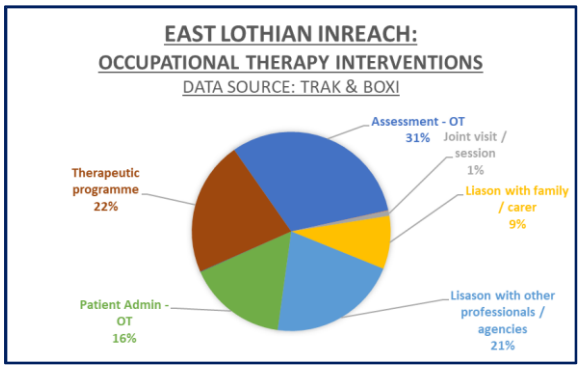
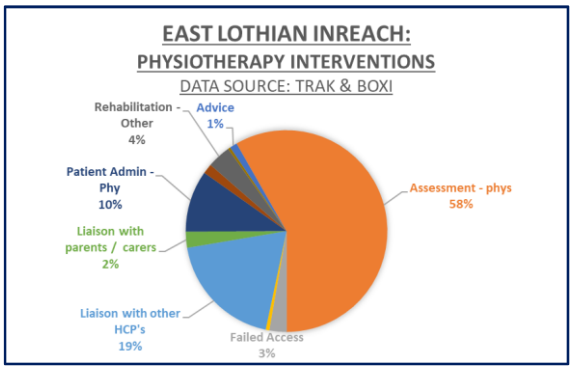
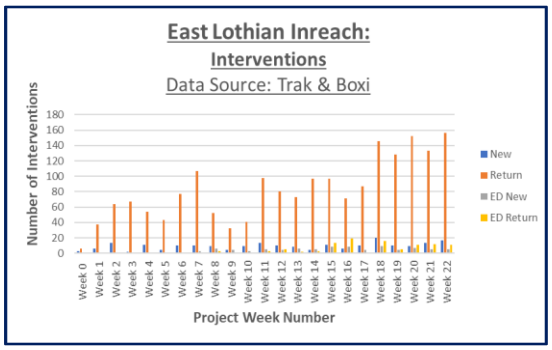
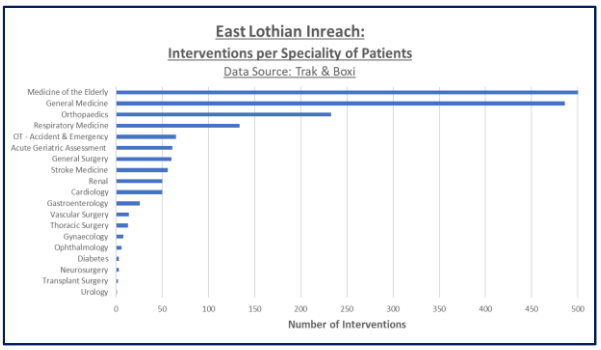
Appendix 3: Additional Graphs

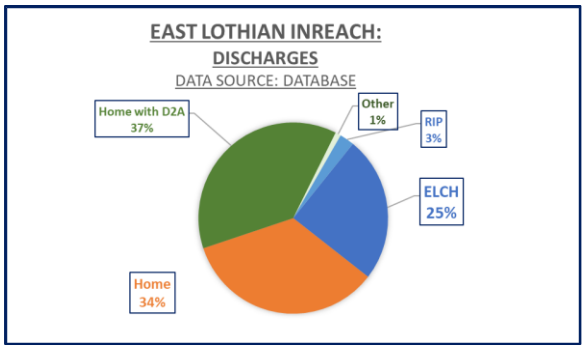
The main body of this report was not able to include all relevant graphs, therefore additional key graphs can be reviewed in this section, which support the discussions within the main body of the report.

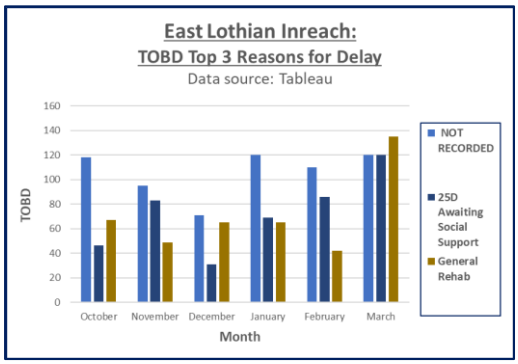


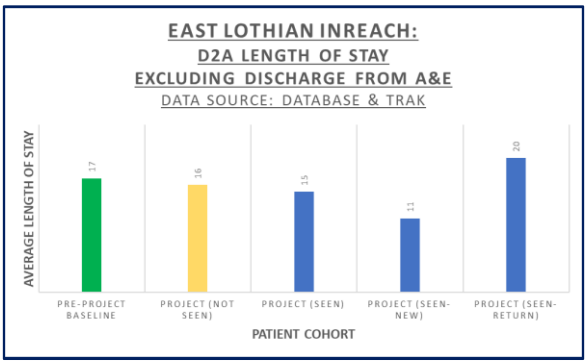












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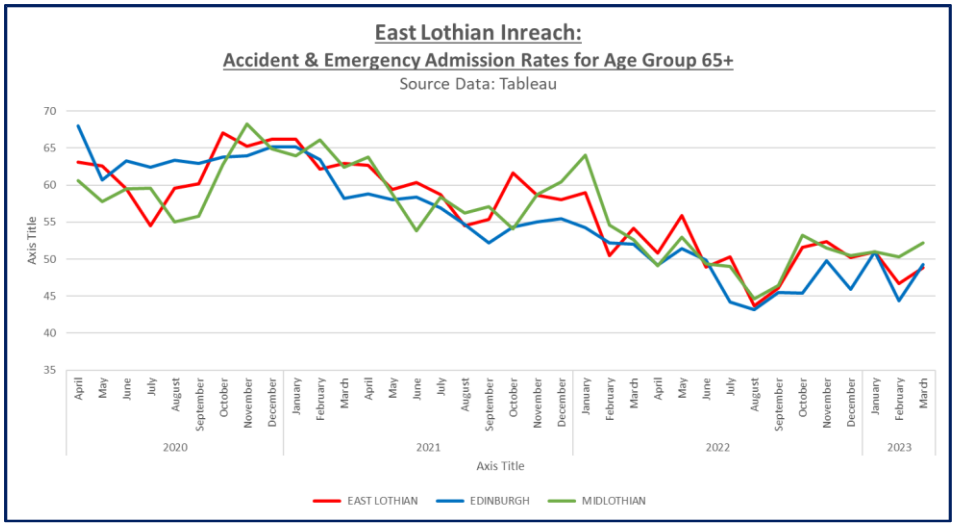

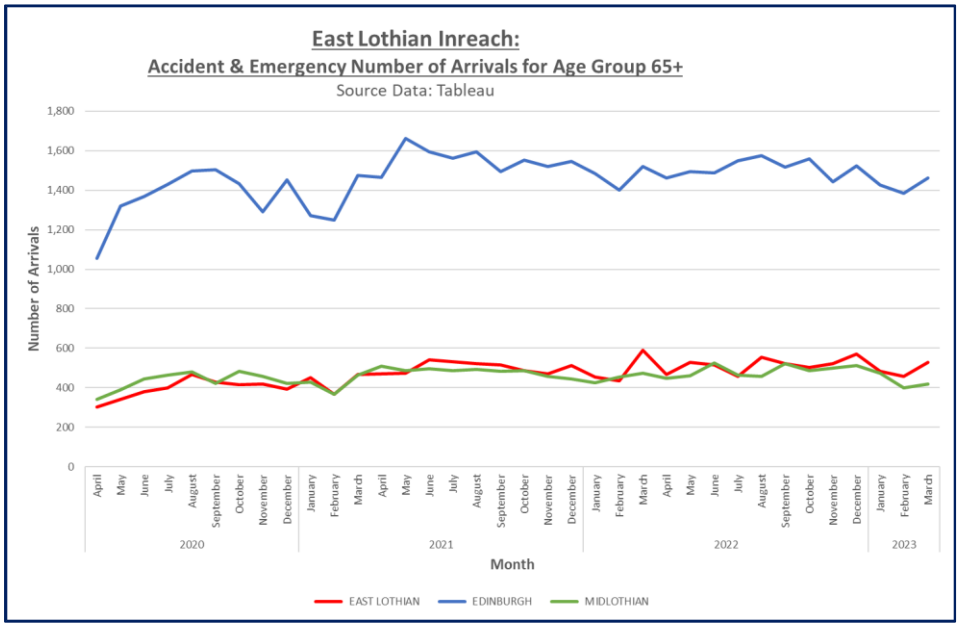

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Appendix 4: D2A data

The table below displays full D2A LOS analysis for Baseline and Project period cohorts of patients.

Patient Cohort	Exclude ED D/C	Number of Patients	Duration (weeks)	Average per Week	Mean LOS	Median LOS
Pre-Project Baseline (All)		138	26	5	16	12
Pre-Project Baseline (ED only)		7	26	0	0	0
Pre-Project Baseline	Exclude ED D/C	131	26	5	17	12
Project (NOT Seen)	Exclude ED D/C	81	22	4	16	10
Project (Seen)		120	22	5	5	4
Project (Seen-New)		74	22	3	3	2
Project (Seen-Return)		46	22	2	7	4
Project (Seen)	Exclude ED D/C	103	22	5	15	11
Project (Seen-New)	Exclude ED D/C	57	22	3	11	10
Project (Seen-Return)	Exclude ED D/C	46	22	2	20	11
Project (Seen-ED)		14	22	1	0	0

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Appendix 5: LAS Project Evaluation

Lothian Analytic Services completed a comprehensive evaluation of LOS and D2A. The LAS report compliments this report and it is recommended that is it reviewed alongside this report.

East Lothian Inreach Project Analytical Rep

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Appendix 6: Staff Feedback

To review full staff feedback access document here.

Questionnaire Feedback - 38 (1).pd

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Appendix 7: Staff Feedback Key Themes

Within the main body of the presentation there was discussion around the key themes from the staff feedback form. Further detail and ELRS responses have been included here for review.

1. Trak – within the feedback it was noted that EL Inreach team use Trak as a 'notice board' and that this is 'not communication'.
    a. From an EL perspective, this is what Trak should be utilised for, Trak is a safe and timely way of sharing confidential patient information across MDT members, it is more effective and time efficient way of communication as it means everyone involved in the patients care has access to the same information and it is not information that is passed through word of mouth that can be altered/misinterpreted. EL complete regular audits of all clinician notes to ensure high quality of notes are documented and also to ensure staff are meeting clinical governance standards. Documentation of notes is part of HCPC adherence for all AHPs.
    b. The EL Inreach team use Trak but have also been happy to update any AHP handovers or Nursing handovers e.g. the brain on Trak with updates so that those attending MDTs / Rapid Rundowns have access to the most up to date EL Inreach team information. To be time efficient, as the Inreach team cover all wards and specialities across the RIE they do not attend MDTs or Rapid Rundowns, unless specifically requested or beneficial due to discussion for example around a complex patient.
2. Referrals to D2A – feedback suggested the feeling that EL Inreach team referrals were being accepted over RIE therapists, and a 'lack of trust' in the assessment of RIE therapists.
    a. From data captured by EL, there is no evidence that higher numbers of RIE referrals were declined, prior to Inreach commencement the average RIE D2A referrals were 5 per week, this has remained similar throughout the project with the average RIE D2A referrals being 4 per week. Further D2A data is included in the main body of this report. From data collated by EL D2A throughout the duration of the project only one D2A was declined in December due to capacity, with other referrals being signposted to other EL services if did not meet D2A criteria.
    b. Further comment on D2A referrals advised the feeling that EL D2A was harder to refer too than other localities – EL have worked with RIE clinicians closely, providing the referral forms showing the info that will be asked and also doing education on the EL service structures. EL follow a 'true' D2A model, in which assessment is completed by OT and/or PT on day of discharge (or within 24hours of discharge), the patient has clear outstanding assessment and goals to achieve on discharge and therefore the team are very much facilitating the discharge. The reason EL work this way is to ensure the best use of finite resource, e.g. by information gathering we can ensure the right clinician follows the patient up at the right time. EL have structures in place such as Community OT and Domi PT pathways which are more appropriate for patients requiring follow up but not on day of discharge.
3. Initial introduction of team and aim of project not shared
    a. Unfortunately there was a delay on the acute side in sharing of information at the start of the project, the EL Inreach Team had completed an SBAR and had a clear evaluation matrix prior to starting the project which had been shared.

4. Communication
    a. Unfortunately when the EL Inreach Team started there was no dedicated office space allocated, this made communication difficult for the team but also for those trying to reach the team. This took 3months to be resolved, during this time the Inreach team worked hard to maintain communication, sharing work phone numbers etc but this was difficult to manage with A/L or sickness etc. Bleeps were ordered but took time to arrive. Now the team have a dedicated space, office phone and bleeps communication is much easier.
5. 'Just added capacity' – feedback that EL Inreach Team provided additional capacity only.
    a. From the gathering of data that the team undertook throughout the project the evidence shows that with specific EL knowledge, onwards referrals were made to 31 different EL pathways, whereas when the RIE completed an A&E process map for before the project and this identified they had 7 community services they referred to including D2A, prevention of admissions, package of care, voluntary sector, and community alarm services. Furthermore, the LOS savings EL Inreach Team incurred by using D2A at an earlier stage also highlights benefits of EL knowledge of community pathways and patients.
6. ED/AMU focus more so than back door wards
    a. Initially the team focused (in October and November) on the back door delays, this was due to EL patients being 'prioritised out', due to staff capacity. As with any test of change the focus changed during the project to allow for evaluation of impact at ED/AMU, with the aim of using EL knowledge to turn pts around before they became a delay. Due to Inreach Team being small, capacity shifted to ED/AMU but the Inreach Team did maintain a presence at backdoor, supporting where possible.
7. Picking up pts 'who were ready to go', 'already had RIE AHP input' or handing patients back when Ao2
    a. The Inreach Team generally only took on patients from back door who were referred by the acute AHPs or those raised at the 930 Activity Huddles as being prioritised out due to RIE AHP capacity but requiring OT/PT. Also, due to capacity the ED pts and majority of AMU patients picked up by the Inreach Team were via referral. However, an agreement was in place from RIE Senior Management at the start of the project that if EL Inreach Team screened a patient they could pick up as they felt appropriate, all picking up of EL patients via the Inreach Team was done with clear communication with AHPs in that area and documented clearly on Trak.
    b. The Inreach team were unable to get involved with many patients who were assistance of 2 due to capacity, but if the team did become involved no patients were handed back to RIE therapists due to being Ao2. There was acknowledgement that the team would benefit from extra PT capacity and this has been actioned by recruitment of a B5 PT going forward and with future plans for a B4 PTA. Where capacity allowed the OTs in the Inreach Team tried to provide input to patients who were Ao2 still with PT, with the aim of identifying earlier those requiring further rehab at ELCH or who may get home direct from the RIE, this is something that RIE therapists did not have capacity to do.
8. Screening duplication
    a. Screening of EL patients was done as capacity allowed, often the priority was using time effectively by prioritising clinical. Going forward the team would be keen to put processes in place, allowing EL therapists to screen EL patients at certain points (within the working day each week). Due to working hours and no weekend cover, this would need to be done jointly and with agreement from the RIE acute therapists.

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Appendix 8 – Data Source Information

To ensure transparency and reproducibility of data the following table provides detailed description of data source and additional information.

Graph Title	Data Source	Dashboard (if applicable)	Filters (if applicable)	Date data accessed
TOBD Top 3 Reasons for Delay	Tableau	Delayed Discharges	Months: October 2022 – March 2023 Hospital: RIE HSCP: East Lothian Show Me TOBD by Reason and Month	
TOBD for Delayed Discharges	Tableau	Delayed Discharges	Months: October 2022 – March 2023 Hospital: RIE HSCP: East Lothian, Edinburgh and Midlothian Show Me: TOBD by HSCP and Month	
TOBD for Delayed Discharges **Specialty - General Medicine & Medicine of the Elderly**	Tableau	Delayed Discharges	Months: October 2022 – March 2023 Hospital: RIE Speciality: General Medicine or Medicine of the Elderly HSCP: East Lothian, Edinburgh and Midlothian Show Me: TOBD by HSCP and Month	
Accident & Emergency Arrivals and Admission Rates for Age Group 65+	Tableau	Activity Trends for A&E	April 2020 – March 2023 Hospital: RIE HSCP: East Lothian, Edinburgh and Midlothian Show Me: Percentage Admitted by Month and HSCP	
Accident & Emergency Number of Arrivals for Age Group 65+	Tableau	Activity Trends for A&E	pril 2020 – March 2023 Hospital: RIE HSCP: East Lothian, Edinburgh and Midlothian Show Me: Number of Arrivals by Month and HSCP	
Baseline Readmission Rates for RIE General Medicine / Medicine of the Elderly >65 years old	LAS		East Lothian HSCP Specialty: General Medicine and Medicine of the Elderly 65 years and older	

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Appendix 9 – SBAR and Evaluation Matrix

SBAR - ELHSCP In-Reach Plus RIE V4

Core Evalutation Matrix.docx

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Acknowledgements, References & Additional Information

Acknowledgments

There has been many people involved in this project excluding the authors and ELHSCP management team and we would like to take this opportunity to thank them.

The clinical team; Jenny Goldie, Nicola Bissett, Corey Weir, Katie McBrierty, Hayley McKenzie, Noreen Barry and Helena McHugh. Analytic support was provided from Bradley Roy in LIST to develop daily patient reports and Rob Chan Seem in LAS to support provide final evaluation.

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Additional Information

Data within this report may differ from data presented in previous Inreach Project reports. This is due to the development and improvement in datasets throughout the project. Only data included within this report should be referenced.

This report utilises an average bed day cost of £393 in line with Acute reports. This differs from average bed day cost utilised in previous reports that used the cost of £545 as provided by the Finance team. This figure was agreed with the Acute Management team 28th February 2023.

The Royal Infirmary of Edinburgh Occupational Therapy and Physiotherapy services have limited comparable datasets due to reported poor compliance of staff to complete Contacts Processing within TrakCare or limited access to up to date and accurate data. The acute teams collate limited paper statistics and instead collate increased data during specific projects to complete their project evaluations as not robust baseline data. At the time of writing this report the specific project reports which had been agreed to be shared from the acute had not been shared. Therefore, this report was not able to complete comparable analysis.

All Graphs within this report are in picture format and therefore not editable. If further information is required on any area of this report, please contact the authors. No part of this report should be repurposed without consent from the authors and ELHSCP Management Team.

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