Notice of Meeting and Agenda

Midlothian Integration Joint Board

Venue: **Virtual Meeting,**

Date: **Thursday, 14 October 2021**

Time: **14:00**

Morag Barrow
Chief Officer

Contact:

Further Information:

This is a meeting which is open to members of the public.

1 Welcome, Introductions and Apologies

2 Order of Business

Including notice of new business submitted as urgent for consideration at the end of the meeting.

3 Declaration of Interest

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

4 Minute of Previous Meeting

5 Public Reports

5.7	Midlothian Health & Social Care Partnership Winter Plan 2021/22 – Leah Friedman, Operational Business Manager.	337 - 398
5.8	Workforce Plan – Anthea Fraser, Practice Learning and Development Manager.	399 - 404
5.9	Vaccination Programme Update – Jamie Megaw, Strategic Programme Manager.	405 - 408
5.10	Chief Social Work Officer - Annual Report 2020-2021 – Joan Tranent, Chief Social Work Officer.	409 - 444

6 Private Reports

No private reports to be discussed at this meeting.

7 Date of Next Meeting

The next meeting of the Midlothian Integration Joint Board will be held on:

- 12 November 2021 at 1.30pm* - Development Workshop (Primary care and strategic plan)
- 9 December 2021 at 2.00pm - **Midlothian Integration Joint Board**

(* Please note carefully the change of time, which has previously be notified to Board Members)

Clerk Name:	Mike Broadway
Clerk Telephone:	0131 271 3160
Clerk Email:	mike.broadway@midlothian.gov.uk

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday 26 August 2021	2.00pm	Virtual Meeting held using Microsoft Teams.

Present (voting members):		
Carolyn Hirst (Chair)	Councillor Derek Milligan (Vice Chair)	Jock Encombe
Cllr Catherine Johnstone	Angus McCann	Cllr Jim Muirhead
Cllr Pauline Winchester		

Present (non-voting members):		
Morag Barrow (Chief Officer)	David King (Interim Chief Finance Officer)	Hamish Reid (GP/Clinical Director)
Wanda Fairgrieve (Staff side representative)	James Hill (Staff side representative)	Fiona Stratton (Chief Nurse)
Johanne Simpson (Medical Practitioner)	Fiona Huffer (Head of Dietetics)	Keith Chapman (User/Carer)
Lesley Kelly (Third Sector)		

In attendance:		
Mairi Simpson (Integration Manager)	Jill Stacey (Chief Internal Auditor)	Jamie Megaw (Strategic Programme Manager)
Roxanne King (Business Manager)	Debbie Crerar (Lead Physiotherapist)	Sandra Bagnall (Macmillan Programme Manager)
Sandra Wright (Clerk)		

Apologies:		
Tricia Donald	Grace Cowan (Head of Primary Care and Older Peoples Services)	

Midlothian Integration Joint Board

Thursday 26 August 2021

1. Welcome and Introductions

The Chair, Carolyn Hirst, in welcoming everyone to this virtual Meeting of the Midlothian Integration Joint Board, expressed her gratitude and thanks to outgoing Chair, Councillor Catherine Johnstone. She also extended a warm welcome back to David King who would be undertaking the role of Chief Finance Officer on an interim basis whilst Claire Flanagan was on maternity leave.

2. Order of Business

The order of business was confirmed as outlined in the agenda that had been previously circulated.

3. Declarations of interest

No declarations of interest were received.

4. Minute of previous Meetings

4.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on 17 June 2021 were submitted and approved as a correct record

4.2 The Minutes of Meeting of the MIJB Strategic Planning Group held on 19 May 2021 were submitted and noted.

4.3 The Minutes of Meeting of the Audit and Risk Committee held on 10 June 2021 were submitted and noted.

5. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.1 Lothian Strategic Development Framework (LSDF) – Update by Carolyn Hirst, Chair With reference to paragraph 4.2 of the Minutes of the Special Meeting held on 11 March 2021, when the Board had received a presentation from Rebecca Millar, Strategic Program Manager NHS Lothian regarding the strategic development framework which	Agreed that the Chair respond on behalf of the Midlothian IJB that in principle the Board endorsed the direction of travel, but require more time to work on its strategic plan to have a clearer understanding on how this will fit with the NHS Lothian strategic plan before a fuller response could be provided.	Chair	

Midlothian Integration Joint Board

Thursday 26 August 2021

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
looked at their planning strategy for the next 5 years, the Chair advised that she had received a letter asking the Midlothian IJB to endorse a number of 'fixed points' or assumptions underpinning the Framework and to provide clarity on some points relating to future IJB commissioning ambitions by no later than the end of August 2021. The Midlothian Strategic Planning Group had given some consideration to this at their meeting on 11 August – a paper and presentation which was provided to the SPG meeting would be circulated to all Board Members following today's meeting. The intention was to give further regard to the LSDF at a future Board meetings alongside the work on progressing the Board's Strategic Plan. The SPG's view had been that whilst broadly endorsing the fixed points, more time and information was needed before a response could be provided with respect to the detail requested about commissioning. Additionally, Scottish Government had recently published an NHS recovery plan. It set out key actions for the next 5 years aimed at addressing backlogs in health and increasing capacity by 10% by committing £10b in targeted investment for the recovery and renewal of the Scottish Health Service.			
5.2 Chief Officers Report This report provided a summary of the key service pressures and service developments which had occurred during the previous months across health	(a) Noted the issues and updates arising from the Chief Officers Report. (b) Agreed that Jock Encombe be appointed as a member of the Audit and Risk Committee.		

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Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
and social care as well as looking ahead at future developments. Having heard from the Chief Officer, Morag Barrow in amplification of her report, the Board discussed arrangements for the continuing used of Gorebridge Leisure Centre as a vaccination centre, particularly now that the Covid Booster and Seasonal Flu programme was underway. Members also gave consideration to the vaccination programme itself, in particular the inclusion of the younger age groups. With regards the likely impact that seasonal illness/covid would have on staff numbers, arrangements were in hand as part of the Winter Plan to ensure that, as far as it was possible to do so, services would continue to be provided safely. With regards to support for carers, Members were advised that H&SC continued to work closely with partners and also that a large scale survey led by Vocal was underway targeting unpaid carers. It was hoped that this would lead to the carer action group being re-establishing thereby ensuring carers' voices were heard. The report also provided updates on several other issues including: • 2022-25 Strategic Plan progress • Annual Report • Chief Finance Officer cover arrangements • IJB Self-evaluation progress • Workforce			

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Finally, approval was sought to appoint Jock Encombe as a member of the Audit and Risk Committee as a replacement for Mike Ash.			
5.3 MIJB Audit and Risk Committee Annual Report 2020-21 – Report by Chief Internal Auditor The purpose of this report was to provide Members with the MIJB Audit and Risk Committee Annual Report 2020/21 which set out how the Committee was performing against its remit based on self-assessments carried out in April 2021. The Chief Internal Auditor, Jill Stacey in presenting the Annual Report to the Board summarised some of the key findings and conclusions contained in the Report, which was designed to provide both assurance to the Board and actions for the Committee to improve its effectiveness. Following which she responded to Members questions and comments.	(a) Approved the MIJB Audit and Risk Committee Annual Report 2020/21; and (b) Noted the increased focus which would be put on risk.		
5.4 IJB Performance Management – Report by Morag Barrow, Chief Officer The purpose of this report was to request the use of MIJB general reserves to fund a fixed term Performance team to develop, implement and monitor performance against the MIJB Strategic Plan and Directions. The report advised that a significant amount of work had been commissioned to develop performance	(a) Agreed to the establishment of a performance group to report into the MIJB (non-statutory initially); and (b) Agreed to resource an additional Programme Manager and Data Analyst to develop, implement and monitor reporting to MIJB from the general reserves.		

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management and reporting infrastructure within the HSCP. This was to support data driven decision making around service development and transformation and also to support a more robust performance reporting overview to the MIJB. In order to develop performance reporting and monitoring further, it was requested that a separate Performance Group be established, supported by an additional Programme Manager, to develop the performance reporting structure for the monitoring of the MIJB Strategic Plan and annual Directions issued to NHS Lothian and Midlothian Council. The Board in considering the proposals detailed in the report discussed the potential use of reserves to drive forward projects to meet strategic ambition and also the need to ensure that the proposed development of a separate performance group did not detract from the Board's own performance monitoring responsibilities nor lead to an over reliance on performance information, to the detriment of such information being appropriately used to help inform good future decision making.			
5.5 Improving the Cancer Journey – Service Update – Report by Sandra Bagnall, Macmillan Programme Manager The purpose of this report was to share information on the progress made by Improving the Cancer Journey (ICJ) service, a Macmillan-funded programme for the Lothians, which went live in March 2021.	(a) Noted the progress made to date. (b) Noted the approach taken to align ICJ with an existing service in Midlothian. (c) Welcomed the monitoring and evaluation plans.		

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Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
The report explained that the service supported people's non clinical needs following a cancer diagnosis and was also open to carers. It currently brings funding of £295,000 into Midlothian, which has been used to secure two additional Practitioners to join Thistle's Wellbeing Service. In addition, a part-time Project Manager was employed and along with the Programme Manager, who support the planning, implementation and service monitoring and evaluation. The funding was secured for four years. Macmillan Programme Manager, Sandra Bagnall in speaking to the report provided the Board with an overview of the progress which had been made since going live in March 2021 and what this contributed to Midlothian. Referrals had increased, with 84% of people referred engaging with the service. Data shows that 70% of people were over the age of 60, with 70% female, under a half were in treatment with 16% having a palliative diagnoses.	(d) Noted the expectations for the service in the first year of operation.		
5.6 IJB Improvement Goal – Report by Jamie Megaw, Strategic Programme Manager The purpose of this report was to update the Board on progress towards achieving the current IJB performance goals and using OutNav to improve understanding of system impact on outcomes. Jamie Megaw was heard in amplification of the report and thereafter responded to Members questions and comments.	(a) Noted the performance against the IJB performance goals; (b) Noted progress to establish an outcomes-focused performance approach in the HSCP; and (c) Agreed to general practice being the subject of a future Development Workshop session.		

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Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
The Board in discussing the report, considered the impact of Covid on some services not just in practical terms but also it terms of the public's perceptions. One area which appeared to be affected more that most in this regard was GP practices, who although they had remained open throughout the pandemic were having to deal with a misconception that GPs were closed and face to face appointments were no longer provided. Certainly some aspects had changed, such as the way in which appointments were booked, however the fundamental service itself had not changed. The Board debated whether there was perhaps a communication issue, there being a feeling that mixed and inconsistent messages were not helping the situation. After further discussion, it was felt that this would probably be best dealt with at a Development Workshop session.			
5.7 Long Covid Support in Midlothian – Report by Debbie Crerar, Lead Physiotherapist The purpose of this report was to provide an update to the Board with regards to support for Long Covid in Midlothian. Debbie Crerar, advised that there were a number of different pathways in place in Midlothian where people could access support, but that numbers so far were relatively low. It was highlighted that this may	Noted the service provision for people with Long Covid in Midlothian.		

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Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
change in time, as the long term health impacts of Covid became clearer. This was therefore an ongoing piece of work that would continued to be developed linking in with other services as appropriate.			
5.8 Clinical and Care Governance Group - Report by Fiona Stratton, Chief Nurse The purpose of this report was to provide assurance to the Board regarding the Care and Clinical Governance arrangements within Midlothian Health and Social Care Partnership and to provide an update on the work of the Clinical and Care Governance Group. Chief Nurse, Fiona Stratton was heard in amplification of the report, highlighted in particular the work that had been undertaking at Midlothian Community hospital and the progress made with Lothian accreditation and care assurance standards, where the two wards undertaking there second round had improved their grades.	Noted and approved the contents of the report.		
5.9 The Mental Welfare Commission – Authority to Discharge: Report into decision making for people in hospital who lack capacity – Report by Mairi Simpson, Integration Manager The purpose of this report was to ensure that Board Members were aware of the actions being taken within Midlothian following the most recent Mental Welfare	(a) Noted the content of the report. (b) Noted the Action Plan and that updates on progress against the Plan would be brought to the Board.	Integration Manager	

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
Commission (MWC) report - Authority to Discharge: Report into decision making for people in hospital who lack capacity. The Board, having heard from Integration Manager Mairi Simpson, who responded to Members questions and comments, considered the report and Action Plan.			

6. Private Reports

No private business to be discussed at this meeting.

7. Any other business

Winter Planning: Noted that there was concern moving into the winter months of how services would cope with the normal winter challenges coupled with the ongoing pressure of Covid and that the Winter Plan would be the subject of a future report. As part of these plans the possible use of reserves on a non-recurring basis had been identified and with the Board's agreement in principle, the Chief Officer proposed bring forward a more detail report to the Special Board meeting on 9 September 2021.

After discussion, the Board agreed to support the principle of reserves being used in this way, subject to a more detailed report. In response to a further point regarding aids and adaptations referrals, the Chief Officer advised that steps were being taken to try and speed up the aids and adaptation process.

I**ndependent Review of Adult Social Care**: Noted that this, along with the newly developed handbook for IJB Members, would be discuss at the next Development Workshop session on 9 September 2021.

8. Date of next meeting

The next meetings of the Midlothian Integration Joint Board would be held on:

- Thursday 9 September 2021 2pm Special Midlothian Integration Joint Board/Development Workshop.
- Thursday 14 October 2021 2pm Midlothian Integration Joint Board

The meeting terminated at 16:19.

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday 9 September 2021	2.00pm	Virtual Meeting held using Microsoft Teams.

Present (voting members):		
Carolyn Hirst (Chair)	Cllr Derek Milligan (Vice Chair)	Tricia Donald
Cllr Jim Muirhead	Angus McCann	Cllr Catherine Johnstone
Cllr Pauline Winchester		

Present (non-voting members):		
Morag Barrow (Chief Officer)	David King (Interim Chief Finance Officer)	Fiona Stratton (Chief Nurse)
Wanda Fairgrieve (Staff side representative)	Fiona Huffer (Head of Dietetics)	Marlene Gill (User/Carer) (substitute for Keith Chapman)
Lesley Kelly (Third Sector)		

In attendance:		
Roxanne King (Business Manager)	Mairi Simpson (Integration Manager)	Andrew Henderson (DSO – Observing)
Mike Broadway (Clerk)		

Apologies:		
James Hill (Staff side representative)		

Midlothian Integration Joint Board

Thursday 9 September 2021

1. Welcome and introductions

The Chair, Carolyn Hirst, welcomed everyone to this virtual Special Meeting of the Midlothian Integration Joint Board.

Prior to the commencement of the formal business, the Board, having heard from the Chair, and Wanda Fairgrieve, both of whom paid warm tribute to Tom Waterson who had sadly passed away earlier in the day, paid its respects by observing a minute's silence.

2. Order of Business

The order of business was confirmed as outlined in the agenda that had been previously circulated.

3. Declarations of interest

No declarations of interest were received.

4. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
4.1 2020/21 Audited Annual Accounts – Report by Chief Officer. The purpose of this report was to present for the Board's approval the Audited Annual Accounts for 2020/21. The report explained that as a statutory body, the IJB was required to produce a set of annual accounts at the end of its financial year (31 March). These accounts were then reviewed by the IJB's external auditors who report their opinion of the IJB's annual accounts to the IJB's Audit and Risk Committee. The Independent auditors have given the accounts an 'unqualified' opinion which means that they meet the	(a). Noted the report of the Independent Auditor and requested the Chief Finance raise the issue of the need to endure the correct use of terminology and the Board's disappointment at amber rating for Value for Money; and (b). Approved the IJB's Annual Accounts 2020/21 and make appropriate arrangements for the document to be signed electronically.	Chief Finance Officer	

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Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
requirements of the regulations and give a fair and true view of the IJB's financial position in 2020/21. The accounts are required to be signed off by 30 September and signed by the Chair of the IJB, the Chief Officer of the IJB, the Chief Finance Officer of the IJB and the Independent Auditor. The Independent Auditors reported their views to the meeting of the IJB's Audit and Risk Committee on 2 September 2020. The IJB's Audit and Risk Committee was satisfied with the report of the Independent Auditor and recommended that the Annual Accounts are approved by the IJB. The Chief Finance Officer in presenting the Annual Accounts to the Board summarised the key findings and conclusions contained in the Annual Audit Report and made particular reference to plans to address issues around Financial Sustainability and Value for Money. He also made mention of the interchangeable used of the terms 'Integrated Joint Board' (IJB) and 'Health and Social Care Partnership' (HSCP), which given that they were two distinctly separate bodies was not always appropriate. There then followed a general discussion on the Annual Accounts during which both Morag Barrow and David King provided clarity on a number of issues in response to Members questions and comments. With regards the amber rating for Value for Money the Board expressed its disappointment that the			

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Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
decision to exercise powers granted by the Coronavirus (Scotland) Act 2020 to delay publication of the Annual Performance Report for 2020/21, had adversely impacted on this rating.			
4.2 Support to the 2020-21 Winter Plan – Report by Chief Officer. The purpose of this report was to seek the release of £756,000 from the IJB's general reserves to allow the Midlothian Health and Social Care partnership to appoint 20.00 WTE additional Healthcare Support workerd and 1.00 WTE additional admin member of staff. These staff would provide additional support to the HSCP's services during the winter. The report explained that every year, NHS Lothian working with its partners in the IJBs and the Councils prepared a Winter Plan. The Plan was designed to ensure that any additional pressures on the NHS that arise from winter and its impact on the population are matched with the appropriate additional resources. It was clear from early indicators that given the continuing impact of the Covid pandemic that this winter was likely to prove very challenging The Board, having heard from Chief Officer, Morag Barrow, acknowledged the difficulties to recruit on a temporary basis (a one-year contract) and welcomed the decision of NHS Lothian Gold Command to accept the financial risk of appointing these staff on a permanent basis. With regards whether the number involved would be enough to meet the anticipated	Agreed that the IJB will release c. £756,000 of funds from its general reserve over 2021/22 and 2022/23 to allow the HSCP to recruit the additional staff required.	Chief Officer	

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
requirements, the Chief Officer explained that the proposed number of staff was based on their best estimates,, and whilst due to the unprecedented nature of the situation it was impossible to be absolutely certain, the position would be kept under close review.			

5. Private Reports

There were no private reports for consideration at this meeting.

6. Any other business

The Board, having noted that this would be Fiona Huffer's last IJB meeting as she would shortly be taking up a new post in West Lothian, joined with the Chair in expressing their thanks to Fiona for all her hard work in support of the Midlothian Integration Joint Board over the years, and wishing her well in her new role.

7. Date of next meeting

The next meetings of the Midlothian Integration Joint Board would be held on:

- Thursday 14 October 2021 2pm Midlothian Integration Joint Board
- Thursday 11 November 2021 1.30pm* Development Workshop
  (Please Note Carefully the earlier start time)

(**Action: All Members to Note**)

The meeting terminated at 2.42pm.

Midlothian Strategic Planning Group

MS Teams

MINUTES

Wednesday 11 August 2021

IN ATTENDANCE: Carolyn Hirst (Chair), Anthea Fraser, Aileen Murray, David King, James Hill, Matthew Curl, Fiona Kennedy, Mairi Simpson, Dougie Harvie, Dania Wood, Grace Cowan, James Hill, Jamie Megaw, Jim Sherval, Kirsty McLeod, Simon Bain, Rebecca Miller, Lynne Douglas, Carly Mclean, Graham Kilpatrick, Jock Encombe, Lois Marshall, Marlene Gill, Lisa Cooke (Note Taker)

APOLOGIES: Joan Tranent, Fiona Stratton, Gillian Chapman, Wanda Fairgrieve, Morag Barrow, William Findlay, Fiona Huffer, Laura Hill

			ACTION
1	**Welcome and Introductions**	Carolyn Hirst welcomed members to the meeting. David King was welcomed as a new member. David is the Interim Chief Finance Officer while Claire Flanagan is on maternity leave.	
2	**Minutes of Last Meeting**	Minutes of meeting on 17 May 2021 were approved as accurate	**LM/LC**
3	**Action Log**	The action log was updated and shared with the group	
4	**Soapbox**	**The Soapbox section provides an opportunity for members to give a brief update to SPG on key areas of interest across the HSCP** **Vaccinations** JM provided the group with an update on vaccinations. It has been a very successful programme in Midlothian with a large number of the population now having received both vaccines. Gorebridge Leisure Centre and a venue in Penicuik will be used for Flu and COVID booster vaccines. GP practices will no longer offer flu vaccines. **Housing 2040, Care review, Proactive telecare** LD provide the group with an update on Housing 2040, Care review and Proactive telecare. LD shared the link Housing to 2040 https://www.gov.scot/publications/housing-2040-2/ for the group to review and feedback any questions. The National Care Service consultation was published on Monday.	**LD**

		Stride and Spring (Group programmes in Justice) KM provided the group with an update on Stride and Spring. Spring is a programme set up to support vulnerable women through weekly groups, support with health issues and access to a 12 weekly programme to increase confidence. Stride is a similar programme for men referred either from the justice service or directly from the courts.	**ALL**
5.	**Report on Progress**	**(I) Strategic Plan** LM circulated a paper in advance of the meeting to update the group on the development of the IJB Strategic Plan 2022 – 2025. She highlighted the workshops due to take place in October to discuss initial strategic plans. Group members to contact LM if they have not received the Doodle Poll for the IJB Workshops. CH asked group to respond to Doodle Poll, or nominate someone to attend on their behalf. CH also asked the group to suggest additional people and organisations that should be invited to the IJB Workshops to support informed discussions on each topic and send this to LM **(II) LSDF (NHS Lothian Strategic Development Framework)** RM circulated a paper in advance of the meeting and shared a presentation to provide an update on the framework. There was discussion on Appendix II: Point 1 "The citizen's home will be a key fixed point going forward, as a location at which care is provided." With members questioning the focus of this point. It was suggested that RM might wish to consider the 6 Strategic Aims developed by Midlothian IJB when reviewing this point. RM to circulate presentation and group to respond to RM regarding questions posed in paper and any other feedback regarding Appendix II **(III) Midlothian Interim Workforce Plan (for noting)** AF circulated a paper in advance of the meeting advising that the interim workforce plan is in place and now working on the next 3 year plan Group to contact AF if there are any questions around Interim or future 3 year plan	**ALL** **ALL** **ALL** **RM** **ALL** **ALL** **ALL**

		Unpaid Carers MS circulated a paper in advance of the meeting. The new contract to deliver support services to Unpaid Carers has been awarded to VOCAL with Red Cross supporting. The initial funding was £500,000 with £40,000 to short breaks. Since the initial funding was awarded a further £427,000 in additional funding has been granted by Scottish Government. Workshops have taken place to discuss areas for development and feedback collated however decision still being discussed. AM updated the group that overnight respite is still not available, as this was stopped due to the Covid-19 pandemic and has not restarted. AM and MS highlighted the impact that lack of respite is having on people and the range of consequences of this. AM highlighted the urgent need for this support to be offered. MS stated that a paper and discussion on this would be brought to the next SPG meeting by GC.	**GC/MS**
6.	**Developments for Discussion**	**(I) Home First** GC circulated a paper in advance of the meeting and shared two illustrative presentations with the group. LD asked what the key barriers were in Midlothian to the successful roll out of Home First. LD and GC to meet to discuss this. GC highlighted that a multidisciplinary planning group is being set up to support Home First and asked for members to join the group, or provide suggestions of who should join the group, to ensure a varied representation. CH welcomed this development. MC offered to join Home First Planning Group and share findings from TEC Pathfinder of key barriers identified within the partnership which may be of relevance for Home First.	**GC LD** **ALL**
6.	**AOCB**	CH to meet with MS to discuss future meetings All to note that September meeting is now 15th September. LC to send out future meeting dates for 2022 and 2023	**CH-MS**
7.	**Future Meetings**	**All future meetings below are via MS Teams** **Wed 15th September 2021 2-4pm (please note date change)** **Wed 17th November 2021 2-4pm**	

14th October 2021, 2.00pm

Chief Officer Report

Item number:	**5.1**

Executive summary

The paper sets out the key service pressures and service developments happening across Midlothian IJB over the previous month and looks ahead to the following 8 weeks.

Board members are asked to:

- *Note the issues and updates raised in the report*

Report

Chief Officer Report

1 Purpose

1.1 The paper sets out the key service pressures and service developments happening across Midlothian IJB over the previous month and looks ahead to the following 8 weeks.

2 Recommendations

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

- Note the updates highlighted by the HSCP Senior management team within the report.

3 Background and main report

3.1 **Chief Officer**

The Health and Social care system remains in a challenging position relating to workforce and demand. Workforce issues relate to covid absence, leave and general absence likely to relate to staff fatigue. The HSCP team continue to deliver exemplary care to our residents and have done throughout this pandemic. Staff wellbeing is a real focus, and the appointment of our Wellbeing Lead will drive this agenda forward over winter, and beyond. Thank you to all of the HSCP team.

3.2 **Clinical Director**

Primary care

All 12 GP practices remain open and proving patient service as they have done throughout the pandemic. All practices are reporting higher than usual call volumes. There is an IJB development session scheduled for 11/11/21 where it is intended to provide Board members with a more detailed account of the current situation, as well as offering a plan to address challenges.

Substance Use Service

Following long term absence, the HSCP have now advertised for a new Consultant Psychiatrist specialising in Addictions, with the interview date set for 16/11/21. This will provide a full establishment of medical cover and support continued development of mental health services locally.

General Adult Psychiatry

The HSCP have appointed a fourth Consultant in General Adult Psychiatry, Stuart Hunter started on 9th August and is based at Number 11 in Dalkeith. He will work primarily with the West Team in Midlothian looking after our patients both in the community and in-patients within the Royal Edinburgh Hospital.

Hamish Reid, Clinical Director – Hamish.reid@nhslothian.scot.nhs.uk

3.3 **Head of Adult Services**

Justice

The Midlothian Community Justice Outcome Improvement Plan 2020-2023 sets out 40 actions that Midlothian Community Justice Partnership will take forward over three years to deliver better outcomes for those affected by the justice system. One action contained within the plan is to 'Develop a trauma informed service that focuses on tailored, structured intervention and access to wraparound services for men on Community Payback Order (CPO) supervision'. The first step in designing the new holistic service (named Stride) was to consult with those individuals who would be most impacted by the service. One part of this was an online questionnaire devised to capture feedback from clients currently in the Justice system. This led to the development of a screening tool which indicates areas of therapeutic interventions. The Men's Group is facilitated by social workers (in Justice and Substance Misuse Service) and peer support workers with lived experience. All men on CPOs will be considered for this group work programme which aims to build emotional capacity, focus on positive outcomes and life choices and promote desistance.

Substance use

Substance Use Services are working to an assertive outreach model to those most at risk. Drug Related Deaths remain a concern, as do Alcohol Related Deaths. Work continues regarding Naloxone reach and the trialling of Buvidal, and there has been the recommencement of the Monday drop-in clinic. We are currently implementing the Medication Assisted Treatment standards.

Mental Health

Within Mental Health services, we are continuing to embed Primary Care Triage and the follow up model in each GP practice. We have a 1-year pilot for dual diagnosis bridging the gap between mental health and substance use and outreaching to our homeless accommodation in collaboration with the outreach model. We are currently redesigning our Intensive Home Treatment team ways of working in collaboration and partnership with the Third sector to provide same day access to mental health via a crisis and distress model – which will also complement the redesign of urgent care. A redesign of the autistic spectrum disorder pathway has reduced waiting times and we have also seen improved waiting times for psychological therapy. We are developing peer support work within No 11 across all services and are re-establishing some group activates across mental health and substance use services.

Learning and Development

The team are currently involved in supporting Care at Home with rapid recruitment, induction and training for new care staff. All posts in the Learning and Development team are now recruited to, with new staff coming into post over the next three months, including a new staff Wellbeing lead, 2 additional SVQ assessors.

Learning Disability

The key issue being faced in Learning Disability service area is the remobilisation of Day Services. Physical distancing guidance and transport availability are two key factors limiting Day Service capacity, but work is ongoing to maximise services and offer community-based alternatives to formal day services. Work has also been undertaken to consultation with stakeholders and complete the IJB Strategic Action Plans for Physical Disability & Sensory Impairment and Learning Disability & Autism.

Nick Clater, Head of Adult Services – nick.clater@midlothian.gov.uk

3.4 **Nursing**

Health Visiting

The Health Visiting service has recently benefited from the appointment of four newly qualified health visitors. The service currently carries less than 1.0 WTE vacancy which addresses IJB Directions regarding workforce and enables the provision of a more holistic and comprehensive service. Nursery Nurses are reorienting their work from assisting Health Visitors to undertake developmental reviews, to supporting parents where there are concerns around weaning, attachment, behaviour, sleep and toileting, and working with children and families whose needs are complex.

The service is not unaffected by the absence levels seen elsewhere, and the composition of the workforce results in a high level of maternity leave. Despite those factors, the reduced establishment gap has enabled the service to move from the pattern of targeted face to face visits required since the start of the Covid 19 restrictions, to restarting all previously delivered face to face contacts and, as part of progress towards the delivery of the Universal Health Visiting Pathway in its entirety, all Health Visitors are now offering the 13-15 month check. Work is underway to improve the interface with Children and Families Social Work teams and Mental Health and Substance Misuse Services to provide integrated and co-ordinated approaches to support parents and manage the risks presented to children growing up in some of the most vulnerable Midlothian families.

0-5-year Immunisation Team

The 0-5 years Immunisations Team is delivering seasonal flu vaccinations from a range of local and accessible sites. Uptake last year was 57% and the Immunisations Team and Health Visitors are telephoning families where children have not been brought to their flu immunisation appointment to offer drop in or alternative timed appointment with the aim of a much-improved uptake this year.

School Nursing

The Midlothian School Nursing team continues works across 4 school clusters with a focus on health screening, child protection, sexual health, mental health and wellbeing, and supporting children with additional and medical needs. The service is about to lose its current team manager to a promoted post. Plans are in place to recruit a new team manager and another vacancy which has arisen in the team. Temporary support is also being provided to support the delivery of the seasonal flu programme to school age children. Head teachers have been assured that they can still access the school nursing service, but that short term changes have been made to support the effective delivery of flu vaccination programme.

School Nursing is a priority area for Scottish Government funding, with plans in place to upscale and upskill of the service. Cohorts of experienced and new entrant school nurses will be fully funded and salaried to develop a significantly larger school nursing workforce across Lothian. The release and backfill of these nurses will present a challenge over the next 2 years, similar to that previously experienced in Health Visiting, but ultimately will produce a highly qualified workforce equipped to deliver the school nursing pathway.

Fiona Stratton, Chief Nurse – Fiona.stratton@nhslothian.scot.nhs.uk

3.5 **Midlothian Assurance**

As part of NHS Lothian Annual Assurance surveillance process, and the ongoing winter preparedness planning, the HSCP has reviewed and updated all Service resilience plans which were then submitted to NHS Lothian on 24th September. Annual assurance to Midlothian Council is also completed annually, with the last return submitted in July 2021.

A paper will be brought to the December IJB meeting to provide an overview to the Board on the assurance processes across the partnership for both NHS Lothian and Midlothian Council relating to resilience. Moving forward, a paper will be submitted annually to the IJB detailing the routine surveillance that the HSCP undertakes in relation to Risk and Resilience management to provide maximum assurance.

Roxanne King, Operational Business Manager – roxanne.king@nhslothian.scot.nhs.uk

3.6 **Older people and Primary care**

Seasonal Flu/Covid Booster Programme

The Seasonal Flu/COVID Booster Programme has commenced in Midlothian. The COVID Booster programme for eligible residents started on Monday 27th September. Vaccinations for care home residents, children under 5 and primary school children has also started. This is the first year when the Health and Social Care Partnership is leading the flu programme and has taken over this service from General Practices as part of the new GP contract. The majority of vaccinations will be provided from three venues: Gorebridge Leisure Centre, Midlothian Community Hospital and Eastfield Medical Practice. The Health and Social Care Partnership is also leading the ongoing COVID vaccination programme which includes Evergreen (1st and 2nd COVID doses), 12-15 years olds, 3rd dose for people who are immunosuppressed and the Booster programme.

There are now 64,592 residents in Midlothian who are fully vaccinated for COVID (1st and 2nd dose). This is 85% of the eligible cohort.

We commenced our Covid booster programme on the 27th September focusing on our stage 1 priority groups which include our care home residents. There has been 1,585 people in Stage 1 who have received their Booster vaccination. This is 7% in this cohort and reflects four days of activity.

We have also commenced our seasonal Influenza programme. 6,093 people in Midlothian have received a Seasonal Influenza vaccination. In this there are 3,900 people aged 70 or over which is 31% of this cohort. The Scottish Government target for this cohort is 90%.

For noting **Stage 1** (offered a third dose COVID-19 booster vaccine and the annual Flu vaccine, as soon as possible from September 2021):

- Immunosuppressed
- All Adults > 70
- All Adults >16 who are Clinically Extremely Vulnerable
- Frontline Health and Social Care Workers

Jamie Megaw, Strategic Programme Manager – Jamie.megaw@nhslothian.scot.nhs.uk

3.7 **Head of Older People and Primary Care**

Hospital Flow

Midlothian single point of access has strengthened our intermediate care clinical and non-clinical teams Implementation of new pathways and a shared Home First vision has enabled more Midlothian residents to be seen by the right person, at the right time, in the right place to prevent unnecessary EA/E attendance, reduce avoidable admissions, reduce length of stay, and facilitate flow through our system and reduce delays. With the creation of our Scottish Ambulance Service pathway for COPD patients we have been further enabled to provide appropriate care to patients who require emergency access to Respiratory Advanced Practice Physiotherapists as an alternative to A/E assessment and subsequent acute admission.

Our continued multidisciplinary focus on flow from both health and social care has enabled Midlothian delays to be maintained through an extremely challenging time of limited care capacity and care home availability. Expansion of our intermediate care teams has ensured that more people than ever have been able to be seen in the community at their time of need, as an alternative to hospital admission. For those who do require admission to hospital, our integrated teams are working closely with a hospital to identify Midlothian patients earlier in their hospital journey to aim to discharge home at the earliest and most appropriate opportunity.

All our teams are now data driven, with strong evidence that the work they are doing is making a positive difference to the lives of Midlothian residents.

Care at home

Midlothian has experienced significant pressures within our service over the last month. This being in line with the national challenges in workforce within Care at Home services. Despite this pressure Care at Home have worked hard to ensure packages of care have continued to be delivered.

The Scottish Government have issued guidance around an Assurance process for of Care at Home services, in a similar way to the assurance process within Care Homes, which has been in place since May 2020. The HSCP have formed a local assurance group, supporting a pan Lothian Director for NHS Lothian has responsibility for the Assurance across the system and will be supported locally by the Midlothian Chief Social Work Officer and HSCP Chief Nurse.

Grace Cowan, Head of Primary Care & Older People -
grace.cowan@nhslothian.scot.nhs.uk

3.8 **Public Health & Strategic Planning**

Midlothian IJB Strategic Plan 2022-25

Work is progressing to develop the IJB Strategic Plan 2022-25 and the corresponding Joint Needs Assessment. Workshops for IJB and Strategic Planning Group members planned for early October.

The Outcomes approach to Performance Management

At the IJB meeting on 11th February 2021, members were briefed and gave approval to the introduction of a new approach to performance management based on outcomes. Since then officers have been working with 'Matter of Focus' an organisation specialising in the development of this approach. The link Care Inspector from the Care Inspectorate, has also

been contributing to this work by highlighting the added benefit of ongoing self-evaluation and improvement to be realised from the approach.

At the IJB meeting on 26th August 2021, the IJB Performance Report provided an update on progress. The initial focus of working has been on learning how to map and gather a wide range of evidence about performance at a strategic level and more specifically in relation to the Frailty programme and the service provided at Number 11.

The intention had been to complete this phase of the work by September. Through a combination of the departure of three key members of staff in these areas of work and ongoing operational pressures alongside the labour-intensive nature of work involved in gathering evidence, this timescale has slipped. Nevertheless, good progress is being made:

a. In relation to Frailty, there is a wealth of convincing evidence to demonstrate the benefits of "*Building the infrastructure to provide tailored support to people identified as frail*".

b. In relation to Number 11, there is a range of evidence confirming clear progress in "*Working together to build a seamless service across mental health, drugs and alcohol and criminal justice*" despite the very different working environment that has existed throughout the pandemic.

The development of mapping at a strategic level is more complex. The objectives of the IJB have been broken into six interrelated work-streams or 'pathways': workforce; integration; using data and feedback; leadership, governance and finance; public engagement; and support for people to improve their health and wellbeing. In relation to the latter work-stream focussed on promoting good health, a range of quantitative and qualitative evidence has been identified to measure progress including feedback through *Care Opinion,* life expectancy data, prescribing rates for mental health issues, Public Health core suite indicators, and Scottish Survey responses for Midlothian.

The next phase of work is to compile analyses of these three work-streams in report format. Senior Management Team will consider these reports in November and, if agenda time allows, be presented to the IJB meeting in December. In the meantime, the next phase is about to get underway. This will include a particular focus on 'Home First' incorporating Intermediate Care services and the Midlothian Acute Services plan.

Health Inclusion Team

Midlothian HSCP has a Health Inclusion Team staffed by two Specialist Nurse Practitioners. The nurses work with people most vulnerable to poor health and health inequalities; this includes people with challenges related to mental health, substance misuse, homelessness and offending/criminal justice. It also includes gypsy/travellers, unpaid carers, people attending food banks and frequent attenders at the Emergency Department.
They support people to improve and manage their health and to access local services, such as drug treatment or welfare rights. Nurses provide an outreach service and offer time-limited self-management support. The Health Inclusion Team nurses are skilled in using health behaviour change, person centred approaches and deliver health needs assessments in community-based venues often linked to local services to improve reach and engagement.

The nurses visit each of Midlothian's homeless hostels every one or two weeks. They knock on resident's room door, offering the opportunity to speak to a nurse about their health and wellbeing. Every conversation is different and guided by what matters to the person. It can take a while for people to build up trust with the nurses. The nurses also provide support and advice to hostel staff when working with people with complex needs and can support people to access a wide range of local services. They also offer naloxone training, blood borne virus testing, sexual health assessments, contraception and STI testing.

Welfare Rights Support

Between April and September 2021, the HSCP Welfare Rights Service supported 452 people which generated £2,329,063.50 income for these Midlothian HSCP clients. This included 175 people with cancer who received support from the MacMillan Welfare Rights Advisor.

Third sector partners also provided welfare rights support, primarily two Citizen's Advice Bureaus but also third sector organisations such as the British Red Cross, VOCAL and some housing associations.

Midway

Midlothian HSCP recognises the need for staff to work differently to understand and empower the people they work with and have adopted 'The Midway' as an approach – where staff are facilitators, not fixers, shift power to the person, understand trauma and recognise inequality. Good Conversations training and bitesize programmes resumed after a pause in the early part of the pandemic. Staff are undertaking training so that anytime someone contacts a service, the focus is on their needs and what matters to them. Training paused due to Covid between March and Aug 2020. Between Aug 2020 and March 228 people attended. Bitesize topics included, Covid Debrief, Good Grief, Housing and Homelessness, Money worries and social security, weight stigma and intro to Good Conversations for use by Midlothian council managers

Training opportunities are made available across the Community Planning Partnership, for example training on health inequalities, health literacy, suicide prevention, and weight stigma. Midlothian continues to implement the Trauma Awareness Framework.

Midlothian Implementation of Neurological Pathway

Midlothian was successful in securing funding to develop a local pathway for people with a neurological condition, working in partnership with NHS Lothian and other services. A range of stakeholders attended a reference group on 2nd September to assist on the programme design and development. This work will be both data driven and will involve local people with lived experience. It will therefore provide a focus for two elements (population data management and citizen engagement) of Midlothian's Knowledge Exchange Programme (Scirocco) with European partners.

Potentially Preventable Admissions

Midlothian HSCP is undertaking focussed work on hospital admission avoidance. This includes a focus on Potentially Preventable Admissions (PPAs). Work across the HSCP and with acute hospital partners is currently underway around heart failure, cellulites and Type 2 Diabetes.

Mairi Simpson, Integration Manager – mairi.simpson@nhslothian.scot.nhs.uk

3.9 **Winter Planning for Health and Social Care: Scottish Government announcement on 5 October 2021**

The Cabinet Secretary announced a new investment of more than £300 million in recurring funding nationally, in Parliament on 5 October 2021. This is a described as a direct response to the intense winter planning and systems pressures work that has taken place over recent weeks. There are four key principles:

- Maximising capacity – through investment in new staffing, resources, facilities and services.

- Ensuring staff wellbeing – ensuring that they can continue to work safely and effectively with appropriate guidance and line-management and access to timely physical, practical and emotional wellbeing support.
- Ensuring system flow – through taking specific interventions now to improve planned discharge from hospital, social work assessment, provide intermediary care and increase access to care in a range of community settings to ensure that people are cared for as close to home as possible.
- Improving outcomes – through our collective investment in people, capacity and systems to deliver the right care in the right setting.

It is anticipated that further detail will be available by the date of the IJB Meeting. (Appendix 1 - letter from John Burns).

David King, Chief Finance Manager – david.king4@nhslothian.scot.nhs.uk

4 Policy Implications

4.1 The issues outlined in this report relate to the integration of health and social care services and the delivery of policy objectives within the IJBs Strategic Plan.

5 Directions

5.1 The report reflects the ongoing work in support of the delivery of the current Directions issued by Midlothian IJB.

6 Equalities Implications

6.1 There are no specific equalities issues arising from this update report.

7 Resource Implications

7.1 There are no direct resource implications arising from this report.

8 Risk

8.1 The key risks associated with the delivery of services and programmes of work are articulated and monitored by managers and, where appropriate, reflected in the risk register.

9 Involving people

9.1 There continues to be ongoing engagement and involvement with key stakeholders across the Partnership to support development and delivery of services.

10 Background Papers

AUTHOR'S NAME	Morag Barrow
DESIGNATION	Chief Officer
CONTACT INFO	0131 271 3402
DATE	06/10/21

Appendices:

1 – Letter from John Burns, NHS Scotland Chief Operating Officer

NHS Scotland Chief Operating Officer
John Burns

Director of Mental Wellbeing and Social Care
Donna Bell

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Scottish Government
Riaghaltas na h-Alba
gov.scot

Local Authority Chief Executives
Chief Officers
Chief Social Work Officers
COSLA
Chairs, NHS
Chief Executives, NHS
Directors of Human Resources, NHS
Directors of Finance, NHS
Nurse Directors, NHS

By email

Dear colleagues,

Winter Planning for Health and Social Care

We are writing to confirm a range of measures and new investment being put into place nationally to help protect health and social care services over the winter period and to provide longer term improvement in service capacity across our health and social care systems.

This new investment of more than £300 million in recurring funding, as set out by the Cabinet Secretary for Health and Social Care in Parliament today (05 October 2021), is a direct response to the intense winter planning and systems pressures work that has taken place over recent weeks with stakeholders, including with health boards, local authorities, integration authorities, trade unions and non-affiliated staff-side representatives.

All of our winter planning preparations are predicated on four key principles:

1. *Maximising capacity* – through investment in new staffing, resources, facilities and services.

2. *Ensuring staff wellbeing* – ensuring that they can continue to work safely and effectively with appropriate guidance and line-management and access to timely physical, practical and emotional wellbeing support.
3. *Ensuring system flow* – through taking specific interventions now to improve planned discharge from hospital, social work assessment, provide intermediary care and increase access to care in a range of community settings to ensure that people are cared for as close to home as possible.
4. *Improving outcomes* – through our collective investment in people, capacity and systems to deliver the right care in the right setting.

Collectively, these principles are designed to ensure the action we take now has a lasting and sustainable impact. We are not just planning to build resilience in our health and social care systems to see us through this winter; we are also building on the approach to recovery and renewal set out in the NHS Recovery Plan and through our continued efforts to improve social care support.

It is understood that collectively we continue to face significant demand across services and that current pressures are likely to further intensify over the winter period. We are grateful to you and your colleagues across the NHS, social work and social care who are working tirelessly to help us navigate through the on-going pandemic and to manage current demands.

You will already be aware that the NHS in Scotland will remain on an emergency footing until 31 March 2022. In connection with this, we are actively examining how we manage the volume of work connected with staff governance, staff experience and some on-going programmes of work over the winter period. This may include temporarily slowing or suspending some programmes – but this does not mean that the Scottish Government is no longer committed to completing those programmes. We are particularly mindful of the pressure on employer and staff time and wish to engage with you on how we manage work programmes that are not directly related to relieving winter service pressures, to enable us to support the objectives of maximising capacity and supporting staff wellbeing and, at the same time, progressing other Ministerial priorities.

The suite of new measures, and the actions now required of health boards, and in partnership with integration authorities and Local Authorities, is supported by significant new recurring investment. Further specific information on allocations to be made to individual areas will be provided to NHS Directors of Finance and IJB Chief Finance Officers in the coming days. Further discussions on Local Authority distribution mechanisms will take place urgently.

It is critical that we continue to work together to make progress at pace and we would like to offer our sincere thanks in advance for your collective efforts in implementing the suite of measures set out immediately below.

Multi-Disciplinary Working, including the recruitment of 1,000 Health and Care Support Staff

We are providing recurring funding to support the strengthening of Multi-Disciplinary Working across the health and social care system to support discharge from hospital and to ensure that people can be cared for as close to home as possible, reducing avoidable admissions to hospital. This includes up to £15 million for recruitment of support staff and £20 million to enhance Multi-Disciplinary Teams (MDTs) this year and recurring.

These MDTs should support with social work and care assessment, hospital-to-home and rapid response in the community. MDTs may encompass:

- Integrated assessment teams to discharge people from hospital with care and support in place, working in partnership with unpaid carers;
- Enabling additional resources for social work to support complex assessments, reviews and rehabilitation, as well as AWI work;
- Ensuring that people at home or in care homes have the most effective care and that care is responsive to changing needs;
- Rapid-response community MDTs to facilitate diversion away from GPs, Out of Hours services (OOH) and the Scottish Ambulance Service (SAS) into the community; and,
- Scaling up Hospital at Home to prevent or avoid admissions.

To further support this work, we are asking territorial health boards to recruit 1,000 new health care support workers, with a specific focus on Agenda for Change bands 3 and 4, immediately, to provide additional capacity across a variety of services both in the community and in hospital settings. Boards are also able to recruit to new band 2 roles in acute settings and to support progression of existing staff into promoted posts. These roles will support hospital services as well as support social care teams to enable discharge from hospital. Boards are asked to recruit staff to assist with the national programme of significantly reducing the number of delayed discharges.

It is essential that all of this increases capacity within local community systems and we are mindful that recruitment may inadvertently move staff from other sectors including Care at Home services and care homes. Decisions – including the decision to recruit new staff to MDTs – should be made in active consultation with H&SCP Oversight Groups, which have been stood up to manage community demand and the deployment of resources.

Boards should note that there will be a national recruitment campaign for social work and social care which will link in with activity being undertaken by Local Authorities.

Full details of the expected volume of staffing that each territorial board is expected to recruit, is set out at Annex A. It is expected that recruitment activity should be commenced immediately.

The Scottish Government has already provided £1 million of funding in-year across NHS Scotland to build capacity within recruitment teams and national health boards have offered to provide mutual-aid to territorial boards to manage new volume recruitment. Health boards have the flexibility to use recruitment agencies to assist with any aspect of the recruitment process.

NES has offered support with training and upskilling including residential fast-track induction in partnership with GJNH. This can take the form of developing 'Once for Scotland' induction and statutory and mandatory training at pace to allow mutual aid between boards on statutory and mandatory training and potential centrally coordinated Hub and Spoke training provision where boards would find this helpful.

Providing interim care

£40 million for 2021/22, and £20 million for 2022/23 has been provided to enable patients currently in hospital to move into care homes and other community settings, on an interim basis, to ensure they can complete their recovery in an appropriate setting. This is likely to be for a period of up to six weeks through an expedited process. Local teams will work with people and their families to explore options, maintaining choice and control. Multi-disciplinary teams will provide support to people in these interim settings to ensure they receive high quality, responsive healthcare and rehabilitation. Consent will, of course, be sought before discharge from hospital and safe clinical pathways, aligned with public health advice and guidance must be adhered to. Any placement is expected to be in their immediate locality or other suitable location. There will be no financial liability for the individual or their family towards the costs of the care home.

The offer of an interim placement should be made when the HSCP are unable to provide an appropriate care at home package immediately, or when the first choice care home is temporarily unavailable. A clear care plan for this period of interim care needs to be in place, with an agreed date for the placement to end, set out before the placement begins.

Expanding Care at Home capacity

£62 million for 2021/22, has been allocated for building capacity in care at home community-based services. This recurring funding should help to fulfil unmet need, and deal with the current surge in demand and complexity of individual needs, also helping to ease pressures on unpaid carers.

Therefore, this funding should be spent on:

i. **Expanding existing services**, by recruiting internal staff; providing long-term security to existing staff; Enabling additional resources for social work to support complex assessments, reviews and rehabilitation; commissioning additional hours of care; commissioning other necessary supports depending on assessed need; enabling unpaid carers to have breaks.

ii. **Funding a range of approaches to preventing care needs from escalating,** such as intermediate care, rehabilitation or re-enablement and enhanced MDT support to people who have both health and social care needs living in their own homes or in a care home.

iii. **Technology-Enabled Care (TEC),** equipment and adaptations, which can contribute significantly to the streamlining of service responses and pathways, and support wider agendas.

Social Care Pay Uplift

Up to £48 million of funding will be made available to enable employers to update the hourly rate of Adult Social Care Staff offering direct care. The funding will enable an increase from at least £9.50 per hour to at least £10.02 per hour, which will take effect from 1st December 2021. This funding is critical to support retaining and recruiting staff in the sector and to alleviate the immediate pressures in Social Care and NHS/ Community based health services.

COVID-19 Financial Support for Social Care Providers

The Scottish Government will continue to fund additional COVID-19 costs relating to remobilisation and adhering to public health measures, and the Social Care Staff Support Fund, until 31 March 2022. From 1 November 2021, the non-delivery of care and under-occupancy elements of financial support will only be available in exceptional circumstances where services are impacted for a sustained period due to COVID-19 outbreaks or following COVID-19 related Public Health guidance.

Nationally Coordinated Recruitment in Specialist Areas of Need

We know there are specific workforce shortages where Boards individually have struggled to achieve the numbers of workforce that they need. The Scottish Government is already providing marketing support for a nationally coordinated recruitment campaign for six Health Boards to deliver more midwives, predicated on a model developed for the nationally coordinated recruitment earlier this year of public health consultants, which was very successful.

In addition to this, we will make available national marketing support for Band 5 recruitment across the Health Boards. In particular, we will take forward a marketing campaign for Band 5 nurses working in community health and social care. We will request shortly from you the number of vacancies you aim to fill and will work with you to agree the next stages of this process.

We have also approved funding to extend the my jobs Scotland recruitment website until March 2022 to all third and independent sector organisations, which will mean that all social care vacancies can be advertised at no additional cost to providers on one platform. We will be running a national marketing campaign to attract more people to the sector, focusing on social media, working with schools and colleges and linking to the work we're doing with the SSSC and NES on career pathways and learning and development.

International Recruitment

We know international recruitment is a useful lever to alleviate pressures and as such are supporting Boards to increase the use of international recruitment through a number of measures. The Scottish Government has provided new recurring funding of £1 million to develop capacity within recruitment teams to support international recruitment. A readiness checklist for international recruitment has also been shared with boards to allow self-assessment and identification of priority areas for action.

The development of partnerships with a range of agencies such as Yeovil District Hospital Trust has been established to build a pipeline supply of international staff. A Memorandum of Understanding is available for use by Boards to engage the services of Yeovil District Hospital Trust. We now require that Boards nationally work towards the recruitment of at least 200 registered nurses from overseas by March 2022.

To support this, in year funding of £4.5 million has been identified to offset direct recruitment costs and can be used to support prospective candidates, including the provision of temporary accommodation for incoming recruits, and other reasonable out-of-pocket expenses.

We are also establishing OSCE training provision and training support in Scotland which will offer a comprehensive training programme either directly to Boards or as facility to train local trainers to prepare candidates to sit their OSCE exam to gain NMC registration. This will expedite the process of gaining NMC registration and significantly reduce the burden of training and preparing a candidate to Boards.

In addition, we are establishing the NHS Scotland Centre for Workforce Supply based in NES to identify further labour markets, build relationships with a range of recruitment agencies, promote the use in Scotland of Government to Government agreements for international recruitment and support Boards and candidates where appropriate with on-boarding.

We will make contact with Board HR teams in the coming weeks to receive an update on the use of the funding provided and the plan to accelerate readiness to commence international recruitment.

Professional Regulators' Emergency Covid-19 Registers

The Scottish Government's chief health professions officers, including the Deputy Chief Medical Officer, Deputy Chief Nursing Officer, Chief Allied Health Professions Officer and Chief Pharmaceutical Officer wrote on 27 September to remaining registrants on the professional regulators' emergency Covid-19 registers. This communication encourages registrants to apply for vacancies on the NHS Scotland Jobs website and, where relevant, to consider returning to service via Board staff banks.

This communication has been issued in anticipation of further challenges in the upcoming winter months, to encourage experienced professionals to return and support services in their area of expertise.

We hope that this approach of directing emergency registrants to live vacancies will attract suitable candidates to professional opportunities, based on your current and future staffing needs. Boards are asked to consider how retirees might be flexibly deployed. Many are unlikely to be able to return to full-time work, but can be deployed on a part-time basis, or via Board staff banks across areas of need.

Healthcare Students

The utilisation of the skills and experience of healthcare students has been an important step in addressing some of the workforce challenges. Whilst the Scottish Government does not believe it is appropriate to disrupt healthcare students' programmes through authorising full-time student deployment at this time, we do believe the deployment of healthcare students (apart from dental students) in appropriate part-time support roles will be beneficial to support boards' workforce capacity.

A national offer via an open letter has been made to healthcare students – including nursing, midwifery, AHP students and undergraduate medics – through their colleges and universities signposting them to the availability of 3 or 6 month Less Than Full Time Fixed Term Contracts (LTFTFTC), with their nearest health board.

A Director's Letter, reaffirming the policy arrangements set out in the Director's Letter 02/2021 will be issued and will provide further detail on the employment and deployment of students.

Wellbeing

Of significant importance is the wellbeing of our health and social care workforce, wherever they work, and this remains a key priority. We are working to ensure that the right level of support is offered across the system.

We are actively listening to colleagues to understand where the pressures are and what actions can be taken to mitigate the resulting impact on staff. Now, more than ever, it is critical that staff look after staff wellbeing and take the rest breaks and leave to which they are entitled, as well as being given time to access national and local wellbeing resources at work.

We are committed to ensuring we collectively provide the strategic leadership and oversight of staff wellbeing. An immediate priority is to address people's basic practical and emotional needs, and we are also developing further practical support measures and additional resources for Boards as you respond to winter pressures.

In support of that ongoing engagement, £4 million is being made available in this financial year to help staff with practical needs over the winter, such as access to hot drinks, food and other measures to aid access to rest and recuperation, as well as additional psychological support. £2 million of this funding will be made available immediately, with the remainder being allocated following the conclusion of ongoing discussions with staff-side representatives and employers to understand how the investment can best support staff welfare needs.

Finally, we appreciate the pressure our services are facing and once again reiterate our gratitude for the hard work and dedication of all our colleagues across the health and social care sector for all they do to support us through this challenging period.

Yours sincerely,

John Burns
Chief Operating Officer,
NHS Scotland

Donna Bell
Director of Mental Wellbeing
and Social Care

Annex A

Volume of Staffing – NRAC Share

Allocations by Territorial Board 2021-22		
	Target share	**NRAC Share**
NHS Ayrshire and Arran	7.38%	74
NHS Borders	2.13%	21
NHS Dumfries and Galloway	2.99%	30
NHS Fife	6.81%	68
NHS Forth Valley	5.45%	54
NHS Grampian	9.74%	97
NHS Greater Glasgow & Clyde	22.21%	222
NHS Highland	6.59%	66
NHS Lanarkshire	12.27%	123
NHS Lothian	14.97%	150
NHS Orkney	0.50%	5
NHS Shetland	0.49%	5
NHS Tayside	7.81%	78
NHS Western Isles	0.67%	7

Midlothian Health & Social Care Partnership

Thursday 14 October 2021 at 2pm

Proposed Meeting Schedule and Development Workshops Dates for 2022 and 2023

Item number:	**5.2**

Executive summary

The purpose of this report is to set the dates for the meetings and development workshops of the Midlothian Integration Joint Board for 2022 and 2023.

Board members are asked:

- ***To approve the Meeting Schedule and Development Workshops dates 2022 and 2023; and***
- ***To note the approach for Service Visits for the Members of the Midlothian Integration Joint Board.***

Report

Proposed Meeting Schedule and Development Workshops Dates for 2022 and 2023

1. Purpose

To set the dates for meetings and development workshops of Midlothian Integration Joint Board for 2022 and 2023 as prescribed by the Midlothian Integration Joint Board Standing Orders – 5.2.

2. Recommendations

2.1 To approve the Meeting Schedule and Development Workshops dates for 2022 and 2023 as set out in **Appendix** to the report.

2.2 To note the approach for Service Visits for the Members of the Midlothian Integration Joint Board as set out in the report.

3. Background and Main Report

3.1 The proposed schedule follows the current existing pattern of Board meetings and Development Workshops held on alternative months, with quarterly Audit & Risk Committee meetings and Special Board meetings in March and September to consider the budget and annual accounts respectively.

3.2 The proposed schedule of meetings for 2022 and 2023 is shown in detail in the Appendix hereto.

3.3 Members are reminded that the facility exists under Standing Orders for special meetings to be called if and when required.

3.4 Other issues Members may wish to take into account in considering the proposed schedule are that following the successful switch to virtual meetings as a result of the global Coronavirus pandemic that all Meetings should continue to be held virtually wherever possible, with appropriate arrangements being made where applicable for the access of the public and press to attend.

3.5 Any Service Visits will continue to be scheduled as required or at the request of Members of the Midlothian Integration Joint Board.

4. Policy Implications

4.1 There are no policy implications arising from any decisions made in this report.

5. Equalities Implications

5.1 There are no equalities issues arising from any decisions made in this report.

6. Directions

6.1 There are no implications on Directions arising from any decisions made in this report.

7. Resource Implications

7.1 There are no direct resource implications arising from any decisions made in this report.

8. Risk

8.1 The availability of the schedule of meeting dates contributes to the mitigation of risk by:

- facilitating forward planning for meetings;
- contributing to the governance framework which allows the Board to conduct its business; and
- providing a timetable to which Officers can work to ensure that reports are submitted timeously.

9. Involving People

9.1 There are no implications for involving people as a result of this report.

10. Background Papers

10.1 There are no background papers in relation to the content of this report

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DATE	23 July 2021

Appendices: Proposed Meeting Schedule and Development Workshops Dates 2022 and 2023.

Midlothian Integration Joint Board

Midlothian Health & Social Care Partnership

Proposed Meeting Schedule and Development Workshops Dates 2022 and 2023

Day/Date	Time	Meeting
2021		
Thursday 26th August 2021*	2pm	MIJB Board
Thursday 2nd September 2021*	2pm	MIJB Audit and Risk Committee
Thursday 9th September 2021*	2pm	Special MIJB Board (Annual Accounts)/ Development Workshop
Thursday 14th October 2021*	2pm	MIJB Board
Thursday 11th November 2021*	2pm	Development Workshop
Thursday 2nd December 2021*	2pm	MIJB Audit and Risk Committee
Thursday 9th December 2021*	2pm	MIJB Board
2022		
Thursday 13th January 2022	2pm	Development Workshop
Thursday 10th February 2022	2pm	MIJB Board
Thursday 3rd March 2022	2pm	MIJB Audit and Risk Committee
Thursday 17th March 2022	2pm	Special MIJB Board (Budget/Directions)/ Development Workshop
Thursday 14th April 2022	2pm	MIJB Board
Thursday 12th May 2022	2pm	Development Workshop
Thursday 2nd June 2022	2pm	MIJB Audit and Risk Committee
Thursday 16th June 2022	2pm	MIJB Board
Summer Recess		
Thursday 25th August 2022	2pm	MIJB Board
Thursday 1st September 2022	2pm	MIJB Audit and Risk Committee
Thursday 15th September 2022	2pm	Special MIJB Board (Annual Accounts)/ Development Workshop
Thursday 13th October 2022	2pm	MIJB Board
Thursday 10th November 2022	2pm	Development Workshop
Thursday 1st December 2022	2pm	MIJB Audit and Risk Committee
Thursday 15th December 2022	2pm	MIJB Board

2023

Thursday 12th January 2023	2pm	Development Workshop
Thursday 9th February 2023	2pm	MIJB Board
Thursday 2nd March 2023	2pm	MIJB Audit and Risk Committee
Thursday 16th March 2023	2pm	Special MIJB Board (Budget/Directions)/ Development Workshop
Thursday 13th April 2023	2pm	MIJB Board
Thursday 11th May 2023	2pm	Development Workshop
Thursday 1st June 2023	2pm	MIJB Audit and Risk Committee
Thursday 15th June 2023	2pm	MIJB Board
Summer Recess		
Thursday 24th August 2023	2pm	MIJB Board
Thursday 7th September 2023	2pm	MIJB Audit and Risk Committee
Thursday 21st September 2023	2pm	Special MIJB Board (Annual Accounts)/ Development Workshop
Thursday 12th October 2023	2pm	MIJB Board
Thursday 9th November 2023	2pm	Development Workshop
Thursday 7th December 2023	2pm	MIJB Audit and Risk Committee
Thursday 21st December 2023	2pm	MIJB Board

* Meeting dates already approved but included for completeness.

Service Visits

Further service visits will be scheduled as required or at the request of members of the Midlothian Integration Joint Board.

14 October 2021, 2.00pm

Development of services for citizens with learning disabilities, and rehabilitation after severe and enduring mental illness

Item number:	**5.3**

Executive summary

This report seeks approval from the Midlothian Integration Joint Board for the Initial Agreement for the development of inpatient facilities at the Royal Edinburgh Hospital. Specifically, these facilities will support citizens with Learning Disabilities and those with rehabilitation needs following severe and enduring mental illness.

The programme of work to develop these services is focussed on delivering new support and services for citizens in these categories and in providing care closer to home. This is genuinely transformational work and a major plank of the MIJB's strategic direction.

These Initial Agreements suggest that the revenue costs for MIJB are neutral, and that the capital costs are for NHSL to consider. This latter cannot be done until the four Lothian IJBs have all approved the strategic case contained within the IAs.

Board members are asked to:

Approve the attached Initial Agreements.

Report

Development of services for citizens with learning disabilities, and rehabilitation after severe and enduring mental illness

1 Purpose

1.1 To seek MIJB approval for the attached Initial Agreements supporting the development of services for citizens with either learning disabilities or rehabilitation needs after severe and enduring mental illness.

2 Recommendations

2.1 As a result of this report what are Members being asked to:-

Note the strategic case outlining how services will change over the next 5 years;

Note that this case delivers on strategic aspirations of the MIJB;

Approve the case and **agree** that NHSL's Finance and Resources Committee consider the capital and revenue aspects.

3 Background and main report

3.1 The development of services for people with a range of conditions under the banner of "mental illness" has been a focus of public sector work for the last century in the western world. In particular, the direction of travel has been away from the antediluvian, asylum-based model of "protecting" the general populace and towards a truer understanding of the nature of these conditions.

It should be noted at this point that "mental illness" in this section is used in its broadest sense as a shorthand, but it is fully acknowledged that people with learning disabilities do not meet many definitions of "mental illness"

3.2 This direction of travel has also shown that people being treated and supported closer to home, in a "normalised" environment, have better long-term outcomes than those kept in institutions.

3.3 This developing approach has also shown that there can be advantages in utilising the skills of those with "lived experience", and with a focus on care, rather solely relying on a medicalised model of treatment.

3.4 Over the last 30 years, this has seen the number of people housed in old “asylums” reduced drastically, and this applies within the Lothians as much as anywhere else in the UK.

3.5 NHS Lothian is the main provider of inpatient services for people with mental illnesses, but some Midlothian residents may have to leave the Lothians altogether for treatment. This can last for multiple years.

3.6 NHS Lothian has long sought to replace large sections of the inpatient faciltiies it has for East Lothian, Edinburgh, and Midlothian residents. This includes some 19th-century buildings clearly not suitable for modern care and treatment. Over the last ten years NHSL has managed to move forward this desire to reprovide services and was successful in opening the new Royal Edinburgh Building in 2016 to provide acute adult mental health services, and specialist Robert Fergusson specialist rehabilitation facility.

3.7 Midlothian HSCP teams have worked with NHSL over the last 5 years, and with partner HSCP teams, to design a new model of care for people with learning disabilities and for those with rehabilitation needs after severe and enduring mental illness, including models for low-secure care.

3.8 The output of this work is in the appended Initial Agreements. Board members will note the detailed strategic case which expands on the argument advanced above, and which lays out the changes in provision which will result. Midlothian HSCP teams have identified the bed base expected to be required in both Initial Agreements based on current demand patterns.

3.9 Overall, these cases see a significant reduction in the overall bed-base for the Lothians. This is a true interpretation, but this is secondary to the way in which the new models will support more people living independent, supported, lives with more appropriate care in future, rather than being housed in institutions.

3.10 This series of changes are genuinely transformational and will not be easy to deliver, but the cases presented illustrate how these will be delivered.

4 Policy Implications

4.1 These cases fit with the general policy direction of the MIJB, in providing more care closer to home.

5 Directions

5.1 These cases deliver in part on the requirements of Direction 11 on Mental Health. Specifically, “Work with other Lothian IJBs to agree plans for pan-Lothian and hosted mental health service provision 2022-25 by November 2021.”

6 Equalities Implications

6.1 These proposals significantly reduce inequalities for cohorts of individuals with severe and enduring mental illness and/or learning disabilities.

7 Resource Implications

7.1 Revenue implications are currently expected to be neutral. Capital implications are for NHSL.

8 Risk

8.1 There are similar risks to any and all large capital projects, and these are described in the Initial Agreements.

9 Involving people

9.1 As noted, Midlothian HSCP teams have been involved throughout the development of these IAs.

10 Background Papers

10.1

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DATE	6th October 2021

Appendices:
Initial Agreements x2

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

NHS Lothian

Initial Agreement

Project Owner: Nickola Jones

Project Sponsor: Alex McMahon

Date: 14/05/2021

Version: 1.13

Version History

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

Contents

1. Executive Summary

1.1 Purpose

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

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

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

1.2 Background and Strategic Context

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

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

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

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

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

1.3 Need for Change

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

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

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

1.4 Investment Objectives

The investment objectives for this case are to:

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

1.5 The Preferred Option(s)

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

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

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

1.6 Readiness to proceed

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

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

1.7 Conclusion

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

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

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

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

2. The Strategic Case

2.1 Existing Arrangements

Intellectual Disability Wards

What is a Learning Disability?

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

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

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

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

How many people have an intellectual disability?

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

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

What does the existing inpatient service do?

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

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

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

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

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

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

Model of Care

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

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

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

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

In general, unless the individual has the ability to consent to a voluntary period as an inpatient, all patients must meet the psychiatric criteria to require a period of detention under the Mental Health (Care and Treatment) (Scotland) Act 2003. All patients who are detained have an allocated Mental Health

Officer (MHO), and all patients have access to NHS Lothian funded Advocacy.

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

The key functions that the intermediate teams provide are:

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

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

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

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

Current Ward Establishment

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

Current capacity is as follows:

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

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

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

Length of Stay

Lengths of stay in the Intellectual disability service are often measured in years, rather than days or months, with low turnover of patients in units, small numbers of admissions and discharges annually

through a small number of beds. These long lengths of stay mean that the inpatient units are “home” for patients for several years. The lengths of stay range from 6 months to 10 years.

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

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

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

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

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

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

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

2.2 Drivers for Change

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

Intellectual Disability Wards

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

Inappropriate Physical Environment

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

receiving care and staff delivering it.

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

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

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

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

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

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

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

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

Lack of Therapeutic/General Space

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

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

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

- 'A kitchen I could use myself would be good for making snacks and meals'
- 'I'd like to be able to make some of my own food. I'd like to have more things to do'
- 'I think a kitchen for patients to use would be good – to keep up your skills and learning new ones making snacks and drinks and meals. I'd like more opportunities to keep active and fit and looking after myself'
- 'I'd like to have a kitchen that I could use to learn how to cook and make meals'

It is extremely challenging to do 1:1 interventions with patients as it is usually inappropriate to conduct therapeutic interventions within a patient bedroom, and the other spaces are communal and therefore not private. Often this means that OT and Psychological interventions do not happen. Additionally, being able to associate certain spaces with certain activities is often important when supporting people with learning disabilities due to the nature of their condition. There is a requirement for certain sensory elements to be associated with a certain room, for example their being a bed and dark curtains in the place you go to sleep. This room being used for a purpose other than sleeping can be damaging to patients' understanding of what activity happens where, which can lead to further distress. Additionally, another challenge is access to washing machines. Generally, patients are supported to do their own washing if they are able to as this is an activity they will be doing when they go home,

however, some people with an intellectual disability have specific preferences relating to their clothes, and some like to wash clothes every night to be ready to wear again the next morning. There is currently no access to washing machines on the wards. These factors in combination make the lack of therapeutic space detrimental to patient care and increases their length of stay due to an inability to practice skills required for going home.

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

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

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

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

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

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

Lack of Storage

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

Staff Morale and Development

The current environment is damaging to staff morale and wellbeing. Staff often feel that they are

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

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

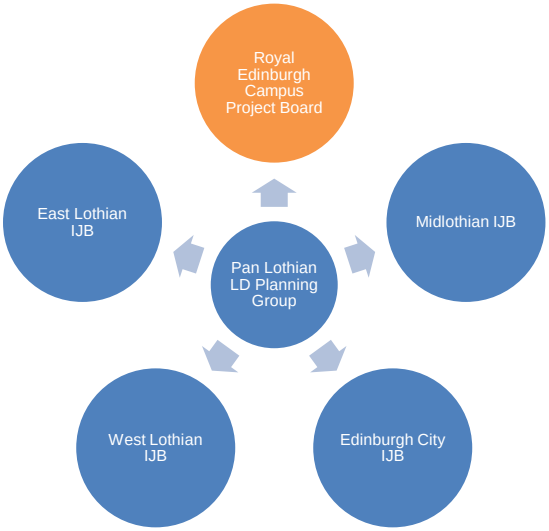
The needs for change are summarised as follows:

- The Austin Smith Lord report describes that the buildings in which LD services are currently situated are not fit for purpose. Of particular importance for LD patients is robustness and space, a lack of which can lead to a higher level of restrictions for patients and a lack of dignity. Despite multiple upgrades to current accommodation, they continue to fall short of the needs of service users
- The shift in resource stated in this proposal will mean that those with longer term needs will be cared for in the community, however, those who will require hospital based care will therefore have more challenging needs and will require a robust, high quality, safe inpatient environment, which is also safe for staff to deliver care from
- NHS Lothian's Property and Asset Management Strategy states that the Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant
- There is likely to be increased demand for the service alongside population growth. This service development, alongside the development of sufficient community services, will support a high quality inpatient service for this population
- Current LD accommodation is located across multiple sites meaning service delivery is more fragmented and high numbers of staff are required
- People want a safe place to live that is a 'home' rather than a hospital. There is currently not enough funding to provide alternative care in a community setting. Reducing the inpatient beds will release funding to enable people with LD currently living in hospital to move back to a community setting

A Joint Vision for the Future

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

reported through members to their respective IJBs as well as to the Royal Edinburgh Campus Project Board.



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

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

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

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

Integration Authority	Current IP	Planned Discharges		Future IP or OOA	Planned beds
		2021	2022		
East Lothian	2	0	1	1	2
Edinburgh	33	20	2	11	10

Midlothian	1	0	0	1	1
West Lothian	10	1	9	0	2
Totals	**46**	**21**	**12**	**13**	**15**

Table 1: Planned LD Discharges

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

Edinburgh

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

East Lothian

- Within East Lothian, a new short break provision at Hardgate Court has been developed to support those with more complex needs. This includes an adjoining flat/safe space which can be used in crisis/emergency situations where 24 hours care can be provided utilising internal day services staff in an outreach role.
- In addition, East Lothian are currently developing an Autism Hub in Musselburgh which will provide care at home and housing support for individuals with Autism. The aim of the hub is to offer a community based accommodation whilst developing a hub of support, information and advice to other providers, professionals and unpaid carers.
- East Lothian are also in the process of developing an enhanced LD service bringing together the ELCLDT and SW staff in to one team to provide specialist health and social care support to adults with Learning Disabilities.

West Lothian

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

Midlothian

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

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

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

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

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

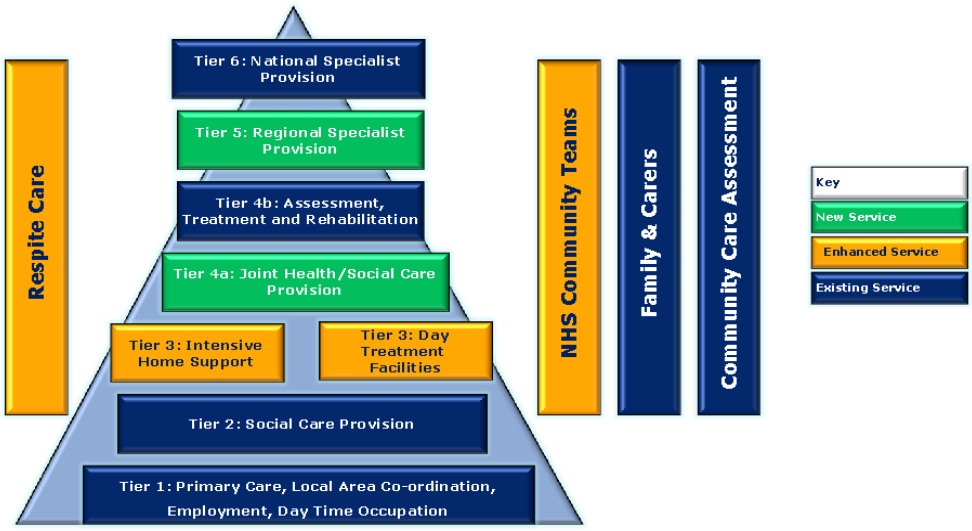
- Primrose Lodge – will be taken over by Midlothian for conversion to a 4 bedded complex physical health facility
- Glenlomond – located directly on the outskirts of the main Royal Edinburgh Campus, potential for future use is being considered by current REAS services
- Camus Tigh – located in Broxburn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

Future Model of Care

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

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

Chart 1: LD Service Tiers



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

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

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

Alignment with National and Local Strategy

The Keys to Life is the Scottish Government's ten year learning disability strategy for 2013 – 2022. It takes a human rights approach to addressing inequalities experienced by many people with learning disabilities. The national 2018-2020 Implementation Framework presents four strategic objectives - A Healthy Life, Choice and Control, Independence and Active Citizenship - to support local partnerships frame priority areas for action. This proposal is aligned with the strategic ambition to: 'Support services that promote independent living, meet needs and work together to enable a life of choices, opportunities

and participation. Health and social care support services are designed to meet - and do meet - the individual needs and outcomes of disabled people.' (The Keys for Life Implementation Framework 2019-2021). The Keys to Life states: '*The need for people with learning disabilities to live independently, having the same choice, control and protection as all other citizens of Scotland in terms of the age-appropriate support they receive, is more relevant than ever'.* This proposal supports the realisation of this strategy by shifting the balance of care away from hospital based services and towards community services. It does this by reducing bed numbers and transferring resources but also by proposing that a new facility is built to meet the specific needs of people with an intellectual disability when they are admitted to hospital. This will mean that people who are admitted receive the best possible care that enables them to be discharged home or to a homely setting as quickly as possible. This proposal has been developed in partnership with health and social care providers and is supported by extensive community plans.

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

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

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

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

The Lothian Hospitals Plan describes the Royal Edinburgh Hospital as one of the four key strategic planning priorities for NHS Lothian alongside the 4 Lothian IJB's and Borders IJB. The 4 Lothian IJB's strategic plans state the intention to support the re-design of the REH campus alongside the

[2] https://keystolife.info/

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

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

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

development of broader care pathways for people with an intellectual disability. This broader piece of work is focused on ensuring people have access to treatment outwith an acute hospital environment when possible, which requires reducing numbers of acute beds and increasing investment in community service. The reduction in bed numbers described in this IA aids the realisation of these local aims.

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

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

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

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

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

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

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

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

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

- Additional costs, nursing costs and ward environmental adaptations to safeguard and manage young people in adult and paediatric ward settings.

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

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

The NIDAIPU 4 bedded unit is being included in the wider IA for Adult Intellectual disability wards in NHS Lothian because there are economies of scale by both commissioning the building services together and also recruiting and retaining staff. There may also be opportunities for enhanced gym and outdoor space for the 4 bedded unit since it will be co-located with the adult unit. There would be careful consideration on how any shared space would be used given the vulnerability of the young people being cared for within the unit.

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

Table 1: Summary of the Need for Change

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
Local and national strategies aim to ensure people have access to treatment out with an acute hospital environment when possible, which requires reducing numbers of acute beds and increasing investment in community service	The organisation is currently not meeting the strategic goals of the four Lothian IJBs. Therefore the proposal set out within this IA is to reduce the number of beds within the adult learning disabilities service and transfer investment into community services.	The intention to commission new facilities for people with learning disabilities on the REH campus is stated in the plans of the 4 Lothian IJBs. There is pan-Lothian agreement on this proposal. Reduction in acute hospital beds is required to transfer resource to community alternatives.
There is currently a lack of space for therapeutic activities, including therapeutic interventions, space to practice skills for discharge and space to spend time with family	Poorer outcomes for patients who are admitted to hospital because there is a lack of space to deliver therapeutic activities which would provide them with skills required to be discharged. Patients may also struggle to maintain good links with family and friends as there is no space in the inpatient unit to meet with them.	Patients continue to receive care in environments which do not enhance their treatment and recovery. They may lose some ability to maintain key relationships which may be important to their recovery.

Existing buildings are not fit for purpose and the majority cannot efficiently be converted into single bedroom/bathroom ward accommodation	The organisation is failing to meet requirements such as having single, en-suite rooms. Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older.	The redevelopment is required now to provide a safe, financially sustainable and high quality environment to those requiring inpatient care for a long term mental health illness
The existing buildings are not safe for staff to deliver care from due to their size and configuration	The organisation is at risk of placing higher levels of restrictions on patients with an intellectual disability and of buildings being unsafe for staff to deliver care from	Staff are under continued pressure to deliver care in a challenging environment. This makes the work highly stressful, which can lead to higher rates of sickness absence and staff turnover
Existing buildings have poor energy efficiency	Current facilities incur high facilities costs and have poor energy efficiency which is not aligned with the national aim to decrease carbon footprint	Spending on energy is higher than it could be because it is not efficient or sustainable
There are significant workforce challenges, particularly within nursing	High vacancy rate across mental health services	The proposed bed reduction in Adult LD will enable the recruitment of staff for the new 4 bedded NIDAIPU facility. The LD campus will help to attract and retain staff
There is no NIDAIPU in Scotland	Young people over the age of 12 are inappropriately admitted to the wrong hospital settings. Historically they often travelled to England for treatment, however due to reduced capacity in England they stopped accepting referrals from Scotland therefore we no longer have access to these beds.	A SLWG have concluded that a specialist inpatient unit is required for Scotland and this should be located on the Royal Edinburgh Hospital Campus

2.3 Investment Objectives

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

Table 2: Investment Objectives

Effect of the need for change on the organisation	What has to be achieved to deliver the necessary change? (Investment Objectives)

Poorer outcomes for patients who are admitted to hospital because there is a lack of space to deliver therapeutic activities which would provide patients with skills required to be discharged. Patients may also struggle to maintain good links with family and friends as there is no space in the inpatient unit to meet with them.	Provide adequate space for the delivery of therapeutic activities and spending time with family
The organisation is failing to meet requirements such as having single, en-suite rooms.	Establish a high quality, safe and robust inpatient services which meet care standards such as providing en-suite bathrooms
Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older.	
The organisation is at risk of placing higher levels of restrictions on patients with an intellectual disability and of buildings being unsafe for staff to deliver care from	Establish an inpatient environment which provides adequate space for care which enables staff to deliver care in the least restrictive way possible
Current facilities incur high facilities costs and have poor energy efficiency which is not aligned with the national aim to decrease carbon footprint	Have a facility which meets the current standards for energy efficiency and sustainability
High vacancy rate across mental health services	Realistic and sustainable workforce model using the whole multidisciplinary team (MDT)
Young people and their families sometimes have to travel to England for treatment. This is both challenging for the young people and their families in terms of practicalities of visiting and support as well as being less clinically effective as the young person is further from home and therefore their day to day meaningful activities	Development of a dedicated inpatient unit in Scotland.
Young people are being cared for in inappropriate settings such as adult wards. This means that both the staff caring for them and the environment in which they are being cared for are not fit for purpose.	Development of an initial specialist inpatient unit of 4 beds on the Royal Edinburgh Hospital campus, negating the need to use adapted adult LD environments for this service user group.
Adult intellectual disability beds are being used to care for young people, reducing the capacity within the adult LD service which may lead to a delay in admission for an adult requiring hospital care.	
Young people with learning disabilities are being admitted to inappropriate environments which do not have the facilities to meet their educational needs.	Development of an appropriate educational space within the 4 bedded specialist unit, supported by the right educational support.
Young people are being admitted to facilities which are far from their parents and that have no facilities for parents to stay overnight.	Development of dedicated space for young people and their families, including provision for overnight stays for parents.

There is no dedicated centre for excellence for care of young people with learning disabilities in Scotland. This means that there are inconsistent pathways for this group when an inpatient admission is required.	Develop a centre for excellence on both community and inpatient care for young people with learning disabilities. This means that referral for admission to the national unit is only made when there is no other community based option. It will also be a consistent centre for advice and outreach to support community teams.

2.4 Benefits

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

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

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

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

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

2.5 Strategic Risks

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

Table 3: Strategic Risks

- Unable to meet demand;
- Unable to recruit and retain staff;
- Unable to manage the needs of all patients' needs within the space available;
- Inappropriate level of restrictions due to building layout and configuration;
- Inability to meet needs of young adultsi.e. 16 to 18yrs old;
- Number and frequency of adverse events is unacceptable; and
- Lack of sufficient time and resource to plan for new model and redevelopment.

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

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

2.6 Constraints and Dependencies

The key constraints to be considered are:

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

The key dependencies to be considered are:

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

3. Economic Case

3.1 Do Minimum/baseline

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

Table 4: Do Minimum

Strategic Scope of Option	Do Nothing
Service provision	Learning disabilities inpatient services would continue to be delivered from unsuitable accommodation as described in the 'Current Model of Care' section above

Service arrangements	Intellectual disability services would continue to be delivered by NHS Lothian from the REH and other sites across Lothian
Service provider and workforce arrangements	NHS Lothian would continue to provide staff and services at a higher staffing level than would be required in a bespoke facility
Supporting assets	Standard maintenance work as required to maintain existing standard (backlog maintenance on REH site is circa £16 million)
Public & service user expectations	People receiving care within the intellectual disability wards would continue to receive care in poor quality environments. They may experience a higher level of restriction as a result, leading to poorer clinical outcomes for them as well as having the potential to cause them more harm during their stay in hospital

3.2 Engagement with Stakeholders

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

Table 5: Engagement with Stakeholders

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

Staff/Resources	Staff affected by this proposal include all of the multidisciplinary team required to deliver care within the proposed wards. Their involvement in its development includes being involved with developing the clinical brief.	Staff representatives were consulted on the final version of this Initial Agreement by [*method*], on [*date*]. Their feedback was [*outline*] which has been incorporated into this proposal by [*outline any direct changes*].
Other key stakeholders and partners	Other key stakeholders identified for this proposal include health and social care partnerships, IJBs and hub. Their involvement in the development of this proposal includes being members of the Project Board.	Confirmed support for this proposal has been gained through the IA being presented to the four Lothian IJBs following support from the Project Board.

3.3 Long-listed Options

The table below summarises the long list of options identified:

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

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

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

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

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

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

   There is a piece of unused land in close proximity to the current adult intellectual disability facilities which can be used to build a bespoke CAMHS Leaning disabilities inpatient unit with sufficient capacity to include the required additional facilities such as family room, educational

suite and the potential to consider shared therapy suites as appropriate. There is also space on site which could be used to build a new, high quality, robust facility for adult LD.

Table 6: Long-listed options

Strategic Scope of Option	Option 2 - Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU	Option 3 - Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU	Option 4 – New Build for both services on REH site
Service provision	Reduction in LD bed numbers to 17. Creation of 4 beds for NIDAIPU.	Reduction in LD bed numbers to 17. Creation of 4 beds for NIDAIPU.	Reduction in LD bed numbers to 17. Creation of 4 beds for NIDAIPU.
Service arrangements	NHS Lothian staff would deliver inpatient LD care on the REH site. Move to a new model of care of 'assess to admit' rather than 'admit to assess'	NHS Lothian staff would deliver inpatient LD care on the REH site. Move to a new model of care of 'assess to admit' rather than 'admit to assess'.	NHS Lothian staff would deliver inpatient LD care on the REH site. Move to a new model of care of 'assess to admit' rather than 'admit to assess'.
Service provider and workforce arrangements	NHS Lothian will continue to be the service provider.	NHS Lothian will continue to be the service provider.	NHS Lothian will continue to be the service provider.
Supporting assets	May have some provision for enhanced therapeutic space, but this will depend on availability of space	May have some access to enhanced therapeutic space to improve treatment and patient care	Treatment would be delivered in a high quality environment with the least restrictions possible, with access to therapeutic space for treatment and socialisation

Strategic Scope of Option	Option 2 - Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU	Option 3 - Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU	Option 4 – New Build for both services on REH site
Public & service user expectations	Public and service user expectations would be partially met as existing accommodation would be improved and would be supported by a model of care which prioritises keeping people at home or in a homely setting wherever possible	Public and service user expectations would be partially met as existing accommodation would be improved and would be supported by a model of care which prioritises keeping people at home or in a homely setting wherever possible	Public and service user expectations would be met as there would be a top spec intellectual disabilities campus supported by a model of care which prioritises keeping people at home or in a homely setting wherever possible

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

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

1.1.1 Initial Assessment of Options

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

Table 7: Assessment of options against investment objectives

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

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

3.4 Short-listed Options and Preferred Way Forward

Shortlisted options

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

Table 8: Short Listed Options

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

Non-financial benefits assessment

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

The results of the benefits assessment are summarised below:

Table 9: Results of Non-Financial Benefits Assessment

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

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

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

Indicative costs

The table below details the indicative whole life costs associated with each of the shortlisted options.

For further detail around the determination of the costs see the Financial Case.

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

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

Table 10: Indicative Costs of Shortlisted Options

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

Overall assessment and preferred way forward

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

Table 11: Economic Assessment Summary

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

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

criteria for achievement from this project.

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

3.5 Design Quality Objectives

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

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

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

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

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

4. The Commercial Case

4.1 Procurement Strategy

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

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

4.2 Timetable

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

Table 12: Project Timetable

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

5. The Financial Case

5.1 Capital Affordability

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

Table 13: Capital Costs

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

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

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

also need replaced/upgraded in a 'Do Minimum' scenario.

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

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

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

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

Table 14: Inflation& Programme Extension Sensitivity Analysis

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

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

5.2 Revenue Affordability

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

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

Table 15: Annual Revenue Costs

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

- Community places have been worked up at individual client level by HSCP managers responsible for commissioning.
- For Inpatient costs, a detailed bottom up exercise has been conducted with the Chief Nurse/General Manager and Clinical Nurse Manager based on nursing requirements forthe commissioned level of beds. HSCP commissioners have confirmed they are not supportive of any changes (increases or decreases) to current levels of staff for support services i.e. AHPs, Psychology.
- NSS NSD Funding is equivalent to the estimated costs of the 4 bed NIDAIPU service. The costs of the nationally commissioned service will be funded through the established process of top

slicing territorial boards their NRAC share of the total revenue costs of the service.

- The NHS Lothian share of the NIDAIPU service is estimated at £400k. There are currently no adolescent beds in NHS Lothian therefore there is no funding that can be released to offset the NHS Lothian share of the national costs.
- At the April 2021 Corporate Management Team meeting, members supported including the NHS Lothian contribution of the national costs in the financial plan. Therefore funding of £400k has been assumed in this financial model to offset the NHS Lothian share of the NIDAIPU service.
- NHS Borders income is based on the costs of the two beds they have commissioned.
- West Lothian income is the funding associated with 2 clients currently placed out of area who are to return to community placements (costs of community placements are also included).
- All specialist support teams are assumed to continue in their current form
- Non pays costs are based upon the current William Fraser and Islay ward non costs (LD inpatient wards on REC)
- Depreciation is based on a useful life of 29 years for Option 2 and 3, and 50 years for Option 5 and assumed to be funded from the existing NHS Lothian Depreciation funding allocation. Depreciation excluded in Option 1 as already forms part of Depreciation cost for the Royal Edinburgh Buildings.

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

There are 33 planned discharges from hospital associated with the learning disability redesign. As described above the cost implications are two fold – the costs of community teams being in place before people are discharged and whilst community costs will happen immediately the release from NHS budgets will occur in phases as beds or facilities are closed. The estimated double running costs associated with the adult learning disability redesign are shown below in table 15 by financial year:

Table 15: Double Running Costs

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

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

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

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

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

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

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

5.3 Overall Affordability

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

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

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

6 The Management Case

6.1 Readiness to proceed

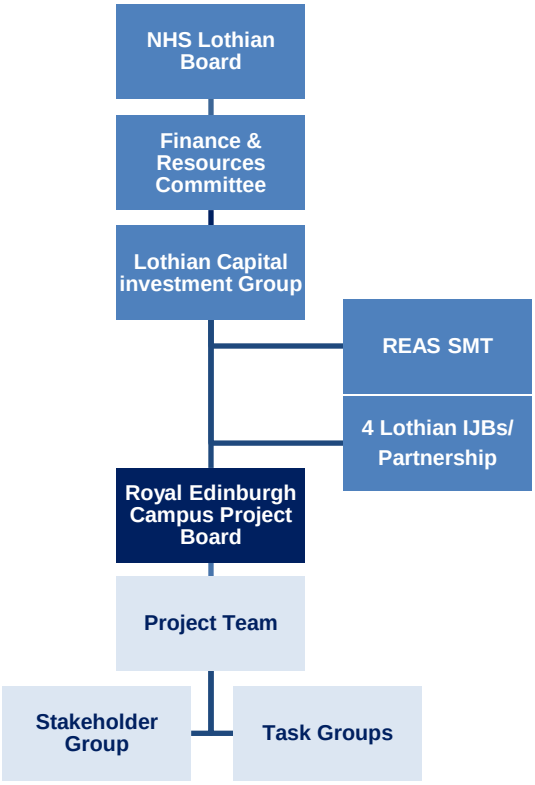
A benefits register and initial high level risk register for the project are included in Appendix 2: Benefits Register and Appendix 3: Risk Register. Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects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

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

6.2 Governance support for the proposal

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

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



6.3 Project Management

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

Table 14: Project Management Structure

Role	Individual	Capability and Experience
Project Sponsor and Programme Management Board Chair	Professor Alex McMahon Executive Director, Nursing, Midwifery and Allied Healthcare Professionals Executive Lead, REAS and Prison Healthcare	Starting his career as a qualified nurse in 1986, Alex has worked in both the public and private sectors, including time with the Royal College of Nursing and as Nursing Advisor for Mental Health and Learning Disabilities in the Scottish Government. In 2009 he received an Honorary Chair from the University of Stirling for his work in mental health and nursing. Alex chairs the REH Programme Management Board and is ultimately responsible for the project and its overall business assurance i.e. ensuring that it remains on target to deliver the outcomes that will achieve the anticipated business benefits and that it is delivered within its agreed budget and timescale tolerances

Role	Individual	Capability and Experience
Senior User and Programme Management Board Deputy Chair	Tracey McKigen, Services Director, Royal Edinburgh and Associated Services	As Senior User Tracey is accountable for ensuring that requirements have been clearly defined in the Clinical Brief and that the proposed development is fit for purpose and fully meets user needs. Following the principles of PRINCE2, the Senior User has primary responsibility for quality assurance and represents the interests of all those who will use and operate the new facilities. As REAS Service Director, Tracey has a deep understanding of the clinical and support needs of the services delivered from the REH. She has also held a number of other senior management roles in the NHS
Strategic Programme Manager	Nickola Jones, Strategic Programme Manager	Previous experience of NHS capital projects
Project Manager	Steve Shon, Senior Project Manager, Capital Planning	Steve has worked within NHS Capital Planning since 1998 managing and co-ordinating all aspects of the procurement of major new health facilities, from preparation of business cases through to commissioning. In terms of procurement, he has been involved in traditional, D&B, and PFI schemes and is now working on Hub developments, including the redevelopment of the Royal Edinburgh Hospital. Previous projects have ranged from small Learning Disabilities houses, through Care of the Elderly facilities, to the redevelopment of the State Hospital at Carstairs
Capital Finance Support	Laura-Jane Smith	Experience supporting capital investment projects
Finance Business Partner	Hamish Hamilton	Previous experience at Senior Manager level in similar projects

Role	Individual	Capability and Experience
Service Lead	Andrew Watson	Associate Medical Director for the Royal Edinburgh Hospital and Associated Services
Service Lead	Karen Ozden	Chief Nurse for the Royal Edinburgh Hospital and Associated Services
Partnership Representative	To be confirmed	Dependant on appointee

The project's external advisers are:

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

7 Conclusion

The strategic assessment for this proposal (included in

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

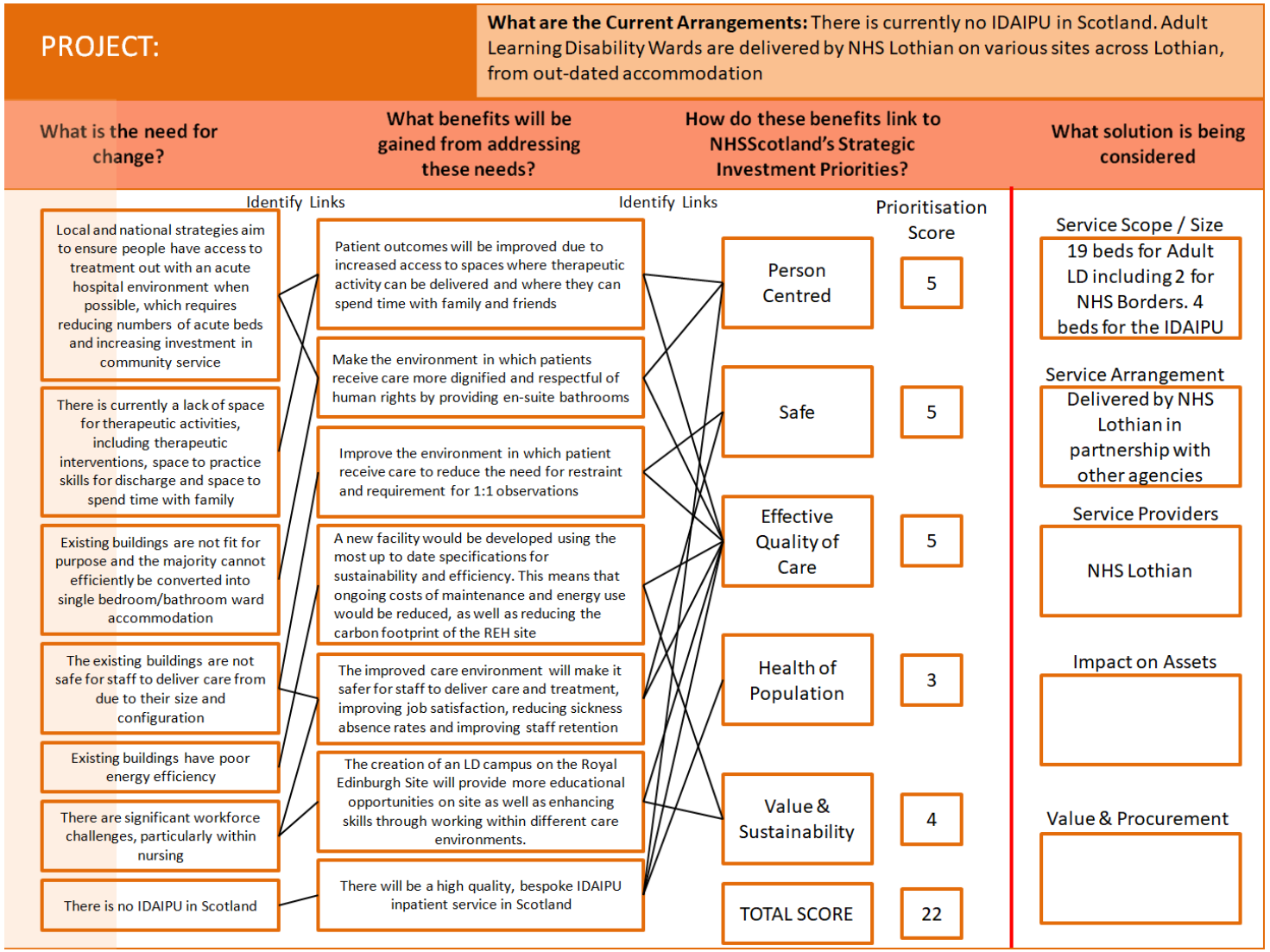
This case clearly describes the need for improved accommodation for those with intellectual disability and mental health needs in NHS Lothian, it also describes the case for providing a bespoke 4 bedded facility for adolescents with these needs across Scotland, as requested by the Scottish Government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

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

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

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

Appendix 1: Strategic Assessment



Appendix 2: Benefits Register and Non-Financial Benefits Assessment

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

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

Appendix 3: Risk Register

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

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

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

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

Included as attachment due to file size.

Appendix 5: Pictures of NHS Lothian Current Intellectual Disability Wards

Included as attachment due to file size.

Benchmark | **REH Phase 2 Intellectual Disabilities Facilities** | **AEDET Refresh** v1.1 Feb 2016

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	0		
A.02	The design facilitates the care model	1	1	
A.03	Overall the design is capable of handling the projected throughput	1	3	
A.04	Work flows and logistics are arranged optimally	1	1	
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1	3	
A.06	Where possible spaces are standardised and flexible in use patterns	1	2	
A.07	The design facilitates both security and supervision	1	1	
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	2	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	3	
A.10	The benchmarks in the Design Statement in relation to building USE are met	0		

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	4	
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1	1	
B.03	The approach and access for ambulances is appropriately provided	1	3	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	3	
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	3	
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	3	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	3	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	1	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	0		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	1	
C.02	The ratio of usable space to total area is good	1	2	
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	2	
C.04	Any necessary isolation and segregation of spaces is achieved	1	1	
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	3	
C.06	There is adequate storage space	1	1	
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	4	
C.08	The relationships between internal spaces and the outdoor environment work well	1	3	
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	0		

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	1	
D.02	The building and grounds are easy to clean and maintain	1	2	
D.03	The building and grounds have appropriately durable finishes and components	1	2	
D.04	The building and grounds will weather and age well	1	3	
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	1	
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	1	
D.07	The design minimises maintenance and simplifies this where it will be required	1	1	
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	0		

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	0	YES
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	0	YES
E.03	The engineering systems are energy efficient	1	0	YES
E.04	There are emergency backup systems that are designed to minimise disruption	1	0	YES
E.05	During construction disruption to essential services is minimised	1	0	YES
E.06	During maintenance disruption to essential healthcare services is minimised	1	2	YES
E.07	The design layout contributes to efficient zoning and energy use reduction	1	0	YES

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0	0	YES
F.02	Temporary construction work is minimised	0	0	YES
F.03	The impact of the building process on continuing healthcare provision is minimised	0	0	YES
F.04	The building and grounds can be readily maintained	0	0	YES
F.05	The construction is robust	0	0	YES
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	0	0	YES
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	0	0	YES
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	0	0	YES
F.09	The construction contributes to being a good neighbour	0	0	YES
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	0	0	YES

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1	2	
G.02	The building and grounds are interesting to look at and move around in	1	2	
G.03	The building, grounds and arts design contribute to the local setting	1	2	
G.04	The design appropriately expresses the values of the NHS	1	1	
G.05	The project is likely to influence future designs	1	3	
G.06	The design provides a clear strategy for future adaptation and expansion	1	3	
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	1	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	0		

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1	2	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	1	
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1	3	
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	3	
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	3	
H.06	The design maximises the site opportunities and enhances a sense of place	1	2	
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0		

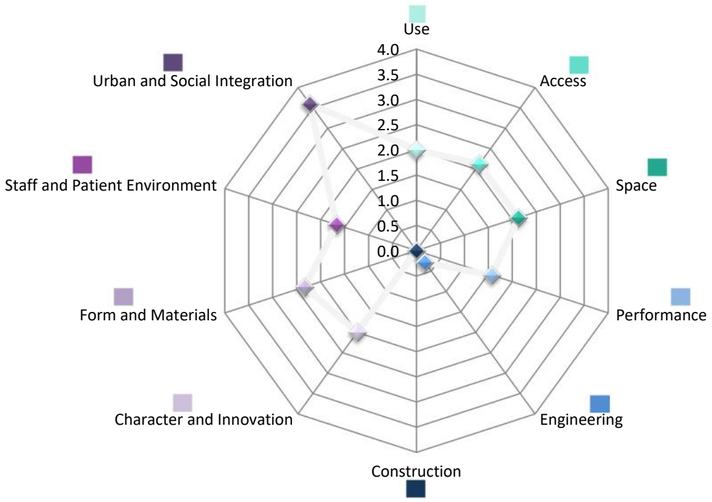
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1	1	
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	1	
I.03	The design maximises the opportunities for access to usable outdoor space	1	3	
I.04	There are high levels of both comfort and control of comfort	1	2	
I.05	The design is clearly understandable and wayfinding is intuitive	1	1	
I.06	The interior of the building is attractive in appearance	1	2	
I.07	There are good bath/ toilet and other facilities for patients	1	1	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1	1	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	3	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	0		

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	4	
J.02	The facility contributes positively to its locality	1	3	
J.03	The hard and soft landscape contribute positively to the locality	1	3	
J.04	The overall design contributes positively to neighbourhood and is sensitive to passers-by	1	4	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1	4	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	0		

AEDET Refresh Benchmark Summary



	Benchmark
Use	2.0
Access	2.1
Space	2.1
Performance	1.6
Engineering	0.3
Construction	0.0
Character and Innovation	2.0
Form and Materials	2.3
Staff and Patient Environment	1.7
Urban and Social Integration	3.6

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

REH Phase 2 Intellectual Disabilities Facilities

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
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	D.08	
	E.01	
	E.02	
	E.03	
	E.04	
	E.05	
	E.06	
	E.07	
	F.01	F.01 to F.10 - Not Applicable
	F.02	
	F.03	
	F.04	
	F.05	
	F.06	
	F.07	
	F.08	
	F.09	
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	I.03	
	I.04	
	I.05	
	I.06	
	I.07	
	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

Target | **REH Phase 2 Intellectual Disabilities Facilities** | **AEDET Refresh** v1.1 Feb 2016

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	2	6	
A.02	The design facilitates the care model	2	6	
A.03	Overall the design is capable of handling the projected throughput	2	5	
A.04	Work flows and logistics are arranged optimally	1	5	
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2	6	
A.06	Where possible spaces are standardised and flexible in use patterns	2	6	
A.07	The design facilitates both security and supervision	2	5	
A.08	The design facilitates health promotion and equality for staff, patients and local community	2	5	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	4	
A.10	The benchmarks in the Design Statement in relation to building USE are met	2	5	

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	4	
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1	4	
B.03	The approach and access for ambulances is appropriately provided	1	4	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	4	
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	2	5	
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	2	5	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	4	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	4	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2	5	

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	5	
C.02	The ratio of usable space to total area is good	1	5	
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	5	
C.04	Any necessary isolation and segregation of spaces is achieved	1	5	
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	5	
C.06	There is adequate storage space	1	6	
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	2	6	
C.08	The relationships between internal spaces and the outdoor environment work well	2	5	
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2	5	

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	6	
D.02	The building and grounds are easy to clean and maintain	1	5	
D.03	The building and grounds have appropriately durable finishes and components	2	6	
D.04	The building and grounds will weather and age well	1	4	
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	2	5	
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	4	
D.07	The design minimises maintenance and simplifies this where it will be required	1	5	
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2	5	

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	4	
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	4	
E.03	The engineering systems are energy efficient	1	4	
E.04	There are emergency backup systems that are designed to minimise disruption	1	4	
E.05	During construction disruption to essential services is minimised	1	5	
E.06	During maintenance disruption to essential healthcare services is minimised	1	6	
E.07	The design layout contributes to efficient zoning and energy use reduction	1	4	

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	1	4	
F.02	Temporary construction work is minimised	1	4	
F.03	The impact of the building process on continuing healthcare provision is minimised	1	4	
F.04	The building and grounds can be readily maintained	1	4	
F.05	The construction is robust	1	4	
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1	4	
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1	4	
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1	4	
F.09	The construction contributes to being a good neighbour	1	4	
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1	4	

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1	5	
G.02	The building and grounds are interesting to look at and move around in	1	5	
G.03	The building, grounds and arts design contribute to the local setting	1	4	
G.04	The design appropriately expresses the values of the NHS	1	4	
G.05	The project is likely to influence future designs	1	4	
G.06	The design provides a clear strategy for future adaptation and expansion	1	5	
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	5	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2	5	

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	2	6	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	4	
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1	5	
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	4	
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	4	
H.06	The design maximises the site opportunities and enhances a sense of place	1	4	
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2	5	

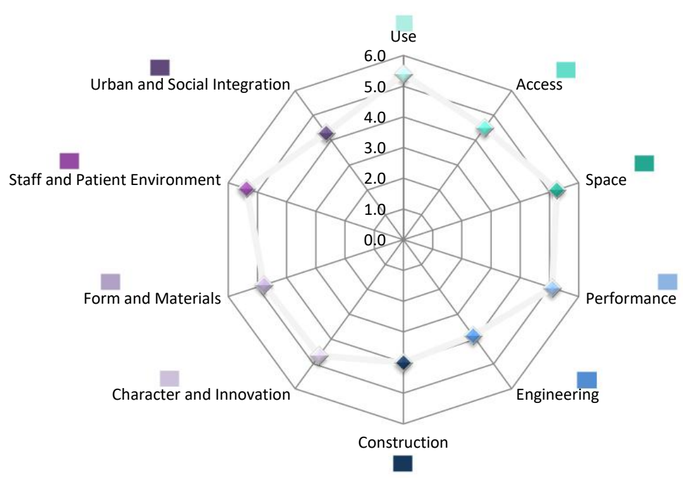
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	2	6	
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	6	
I.03	The design maximises the opportunities for access to usable outdoor space	2	6	
I.04	There are high levels of both comfort and control of comfort	1	6	
I.05	The design is clearly understandable and wayfinding is intuitive	1	5	
I.06	The interior of the building is attractive in appearance	1	5	
I.07	There are good bath/ toilet and other facilities for patients	2	5	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	2	5	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	2	5	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2	5	

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	4	
J.02	The facility contributes positively to its locality	1	4	
J.03	The hard and soft landscape contribute positively to the locality	1	4	
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1	4	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1	4	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2	5	

AEDET Refresh Target Summary



	Target
Use	5.4
Access	4.5
Space	5.3
Performance	5.1
Engineering	3.9
Construction	4.0
Character and Innovation	4.7
Form and Materials	4.8
Staff and Patient Environment	5.4
Urban and Social Integration	4.3

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

REH Phase 2 Intellectual Disabilities Facilities

	Ref	Note
	A.01	
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	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	2		
A.02	The design facilitates the care model	2		
A.03	Overall the design is capable of handling the projected throughput	2		
A.04	Work flows and logistics are arranged optimally	1		
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2		
A.06	Where possible spaces are standardised and flexible in use patterns	2		
A.07	The design facilitates both security and supervision	2		
A.08	The design facilitates health promotion and equality for staff, patients and local community	2		
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1		
A.10	The benchmarks in the Design Statement in relation to building USE are met	2		

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1		
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1		
B.03	The approach and access for ambulances is appropriately provided	1		
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1		
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	2		
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	2		
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1		
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1		
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1		
C.02	The ratio of usable space to total area is good	1		
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1		
C.04	Any necessary isolation and segregation of spaces is achieved	1		
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1		
C.06	There is adequate storage space	1		
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	2		
C.08	The relationships between internal spaces and the outdoor environment work well	1		
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2		

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1		
D.02	The building and grounds are easy to clean and maintain	1		
D.03	The building and grounds have appropriately durable finishes and components	2		
D.04	The building and grounds will weather and age well	1		
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	2		
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1		
D.07	The design minimises maintenance and simplifies this where it will be required	1		
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2		

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1		
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1		
E.03	The engineering systems are energy efficient	1		
E.04	There are emergency backup systems that are designed to minimise disruption	1		
E.05	During construction disruption to essential services is minimised	1		
E.06	During maintenance disruption to essential healthcare services is minimised	1		
E.07	The design layout contributes to efficient zoning and energy use reduction	1		

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	1		
F.02	Temporary construction work is minimised	1		
F.03	The impact of the building process on continuing healthcare provision is minimised	1		
F.04	The building and grounds can be readily maintained	1		
F.05	The construction is robust	1		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1		
F.09	The construction contributes to being a good neighbour	1		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1		

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1		
G.02	The building and grounds are interesting to look at and move around in	1		
G.03	The building, grounds and arts design contribute to the local setting	1		
G.04	The design appropriately expresses the values of the NHS	1		
G.05	The project is likely to influence future designs	1		
G.06	The design provides a clear strategy for future adaptation and expansion	1		
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1		
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2		

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	2		
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1		
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1		
H.04	The external materials and detailing appear to be of high quality and are maintainable	1		
H.05	The external colours and textures seem appropriate and attractive for the local setting	1		
H.06	The design maximises the site opportunities and enhances a sense of place	1		
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2		

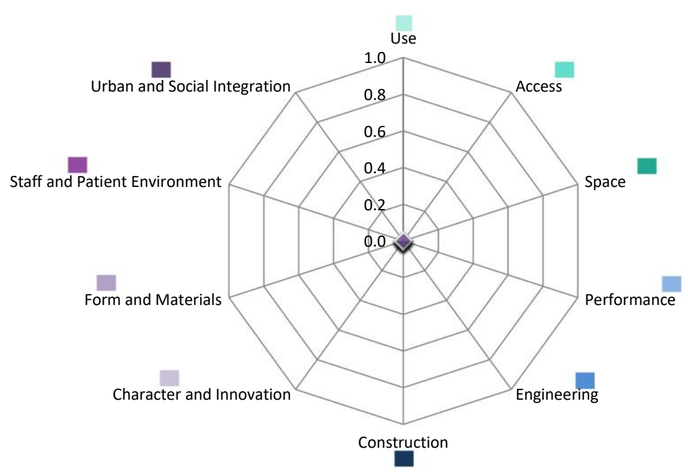
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	2		
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1		
I.03	The design maximises the opportunities for access to usable outdoor space	2		
I.04	There are high levels of both comfort and control of comfort	1		
I.05	The design is clearly understandable and wayfinding is intuitive	1		
I.06	The interior of the building is attractive in appearance	1		
I.07	There are good bath/ toilet and other facilities for patients	2		
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	2		
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	2		
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2		

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1		
J.02	The facility contributes positively to its locality	1		
J.03	The hard and soft landscape contribute positively to the locality	1		
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1		
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1		
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2		

AEDET Refresh OBC Summary



Target		Progress	
		Prev	Curr
5.4	Use	5.4	0.0
4.5	Access	4.5	0.0
5.3	Space	5.3	0.0
5.1	Performance	5.1	0.0
3.9	Engineering	3.9	0.0
4.0	Construction	4.0	0.0
4.7	Character and Innovation	4.7	0.0
4.8	Form and Materials	4.8	0.0
5.4	Staff and Patient Environment	5.4	0.0
4.3	Urban and Social Integration	4.3	0.0

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

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Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Outline Business Case Stage

1. AEDET OBC to be recorded near end of OBC Stage and must be submitted for NDAP
2. The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3. The note section to be completed to provide further briefing information
4. If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5. Boards may add project specific criteria. A note must be provided stating the reason for this.
6. Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	2		
A.02	The design facilitates the care model	2		
A.03	Overall the design is capable of handling the projected throughput	2		
A.04	Work flows and logistics are arranged optimally	1		
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2		
A.06	Where possible spaces are standardised and flexible in use patterns	2		
A.07	The design facilitates both security and supervision	2		
A.08	The design facilitates health promotion and equality for staff, patients and local community	2		
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1		
A.10	The benchmarks in the Design Statement in relation to building USE are met	2		

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1		
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1		
B.03	The approach and access for ambulances is appropriately provided	1		
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1		
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	2		
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	2		
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1		
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1		
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1		
C.02	The ratio of usable space to total area is good	1		
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1		
C.04	Any necessary isolation and segregation of spaces is achieved	1		
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1		
C.06	There is adequate storage space	1		
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	2		
C.08	The relationships between internal spaces and the outdoor environment work well	1		
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2		

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1		
D.02	The building and grounds are easy to clean and maintain	1		
D.03	The building and grounds have appropriately durable finishes and components	2		
D.04	The building and grounds will weather and age well	1		
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	2		
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1		
D.07	The design minimises maintenance and simplifies this where it will be required	1		
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2		

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1		
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1		
E.03	The engineering systems are energy efficient	1		
E.04	There are emergency backup systems that are designed to minimise disruption	1		
E.05	During construction disruption to essential services is minimised	1		
E.06	During maintenance disruption to essential healthcare services is minimised	1		
E.07	The design layout contributes to efficient zoning and energy use reduction	1		

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0		
F.02	Temporary construction work is minimised	0		
F.03	The impact of the building process on continuing healthcare provision is minimised	1		
F.04	The building and grounds can be readily maintained	1		
F.05	The construction is robust	1		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1		
F.09	The construction contributes to being a good neighbour	1		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1		

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1		
G.02	The building and grounds are interesting to look at and move around in	1		
G.03	The building, grounds and arts design contribute to the local setting	1		
G.04	The design appropriately expresses the values of the NHS	1		
G.05	The project is likely to influence future designs	1		
G.06	The design provides a clear strategy for future adaptation and expansion	1		
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1		
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2		

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	2		
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1		
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1		
H.04	The external materials and detailing appear to be of high quality and are maintainable	1		
H.05	The external colours and textures seem appropriate and attractive for the local setting	1		
H.06	The design maximises the site opportunities and enhances a sense of place	1		
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2		

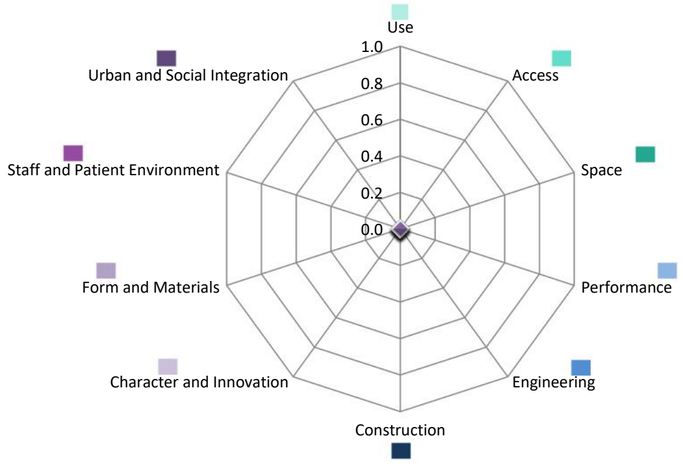
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	2		
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1		
I.03	The design maximises the opportunities for access to usable outdoor space	2		
I.04	There are high levels of both comfort and control of comfort	1		
I.05	The design is clearly understandable and wayfinding is intuitive	1		
I.06	The interior of the building is attractive in appearance	1		
I.07	There are good bath/ toilet and other facilities for patients	2		
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	2		
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	2		
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2		

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1		
J.02	The facility contributes positively to its locality	1		
J.03	The hard and soft landscape contribute positively to the locality	1		
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1		
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1		
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2		

AEDET Refresh FBC Summary



Target		Progress Prev	Progress Curr
5.4	Use	0.0	0.0
4.5	Access	0.0	0.0
5.3	Space	0.0	0.0
5.1	Performance	0.0	0.0
3.9	Engineering	0.0	0.0
4.0	Construction	0.0	0.0
4.7	Character and Innovation	0.0	0.0
4.8	Form and Materials	0.0	0.0
5.4	Staff and Patient Environment	0.0	0.0
4.3	Urban and Social Integration	0.0	0.0

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
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Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Full Business Case Stage

1. AEDET FBC to be recorded near end of FBC (or SBC) Stage and must be submitted for NDAP
2. The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3. The note section to be completed to provide further briefing information
4. If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5. Boards may add project specific criteria. A note must be provided stating the reason for this.
6. Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	2		
A.02	The design facilitates the care model	2		
A.03	Overall the design is capable of handling the projected throughput	2		
A.04	Work flows and logistics are arranged optimally	1		
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2		
A.06	Where possible spaces are standardised and flexible in use patterns	2		
A.07	The design facilitates both security and supervision	2		
A.08	The design facilitates health promotion and equality for staff, patients and local community	2		
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1		
A.10	The benchmarks in the Design Statement in relation to building USE are met	2		

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1		
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1		
B.03	The approach and access for ambulances is appropriately provided	1		
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1		
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	2		
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	2		
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1		
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1		
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1		
C.02	The ratio of usable space to total area is good	1		
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1		
C.04	Any necessary isolation and segregation of spaces is achieved	1		
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1		
C.06	There is adequate storage space	1		
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	2		
C.08	The relationships between internal spaces and the outdoor environment work well	1		
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2		

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1		
D.02	The building and grounds are easy to clean and maintain	1		
D.03	The building and grounds have appropriately durable finishes and components	2		
D.04	The building and grounds will weather and age well	1		
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	2		
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1		
D.07	The design minimises maintenance and simplifies this where it will be required	1		
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2		

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1		
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1		
E.03	The engineering systems are energy efficient	1		
E.04	There are emergency backup systems that are designed to minimise disruption	1		
E.05	During construction disruption to essential services is minimised	1		
E.06	During maintenance disruption to essential healthcare services is minimised	1		
E.07	The design layout contributes to efficient zoning and energy use reduction	1		

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0		
F.02	Temporary construction work is minimised	0		
F.03	The impact of the building process on continuing healthcare provision is minimised	1		
F.04	The building and grounds can be readily maintained	1		
F.05	The construction is robust	1		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1		
F.09	The construction contributes to being a good neighbour	1		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1		

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1		
G.02	The building and grounds are interesting to look at and move around in	1		
G.03	The building, grounds and arts design contribute to the local setting	1		
G.04	The design appropriately expresses the values of the NHS	1		
G.05	The project is likely to influence future designs	1		
G.06	The design provides a clear strategy for future adaptation and expansion	1		
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1		
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2		

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	2		
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1		
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1		
H.04	The external materials and detailing appear to be of high quality and are maintainable	1		
H.05	The external colours and textures seem appropriate and attractive for the local setting	1		
H.06	The design maximises the site opportunities and enhances a sense of place	1		
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2		

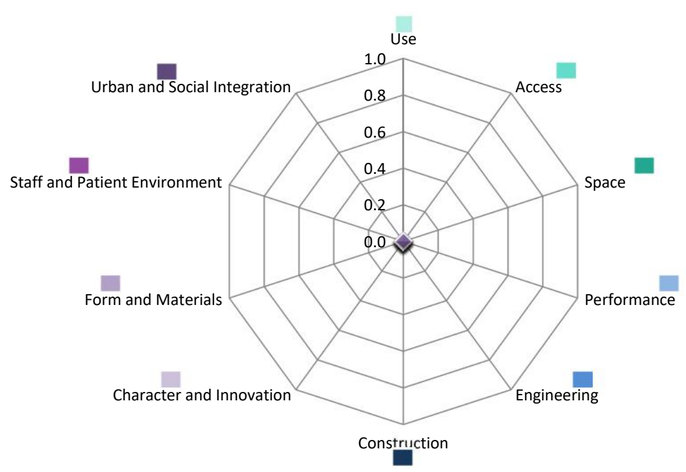
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	2		
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1		
I.03	The design maximises the opportunities for access to usable outdoor space	2		
I.04	There are high levels of both comfort and control of comfort	1		
I.05	The design is clearly understandable and wayfinding is intuitive	1		
I.06	The interior of the building is attractive in appearance	1		
I.07	There are good bath/ toilet and other facilities for patients	2		
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	2		
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	2		
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2		

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1		
J.02	The facility contributes positively to its locality	1		
J.03	The hard and soft landscape contribute positively to the locality	1		
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1		
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1		
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2		

AEDET Refresh POE Summary



Target		Progress	
		Prev	Curr
5.4	Use	0.0	0.0
4.5	Access	0.0	0.0
5.3	Space	0.0	0.0
5.1	Performance	0.0	0.0
3.9	Engineering	0.0	0.0
4.0	Construction	0.0	0.0
4.7	Character and Innovation	0.0	0.0
4.8	Form and Materials	0.0	0.0
5.4	Staff and Patient Environment	0.0	0.0
4.3	Urban and Social Integration	0.0	0.0

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
	A.08	
	A.09	
	A.10	
	B.01	
	B.02	
	B.03	
	B.04	
	B.05	
	B.06	
	B.07	
	B.08	
####	B.09	
	C.01	
	C.02	
	C.03	
	C.04	
	C.05	
	C.06	
	C.07	
	C.08	
	C.09	
	D.01	
	D.02	
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	I.03	
	I.04	
	I.05	
	I.06	
	I.07	
	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Post Occupation Evaluation Stage

1 AEDET POE to be set approx 1-2 years after occupation and must be submitted for NDAP Post Project Evaluation
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

AEDET Refresh v1.1 Feb 2016

REH Phase 2 Intellectual Disabilities Facilities

Summary

Category	Benchmark	Target	OBC	FBC	POE
Use	2.0	5.4	0.0	0.0	0.0
Access	2.1	4.5	0.0	0.0	0.0
Space	2.1	5.3	0.0	0.0	0.0
Performance	1.6	5.1	0.0	0.0	0.0
Engineering	0.3	3.9	0.0	0.0	0.0
Construction	0.0	4.0	0.0	0.0	0.0
Character and Innovation	2.0	4.7	0.0	0.0	0.0
Form and Materials	2.3	4.8	0.0	0.0	0.0
Staff and Patient Environment	1.7	5.4	0.0	0.0	0.0
Urban and Social Integration	3.6	4.3	0.0	0.0	0.0

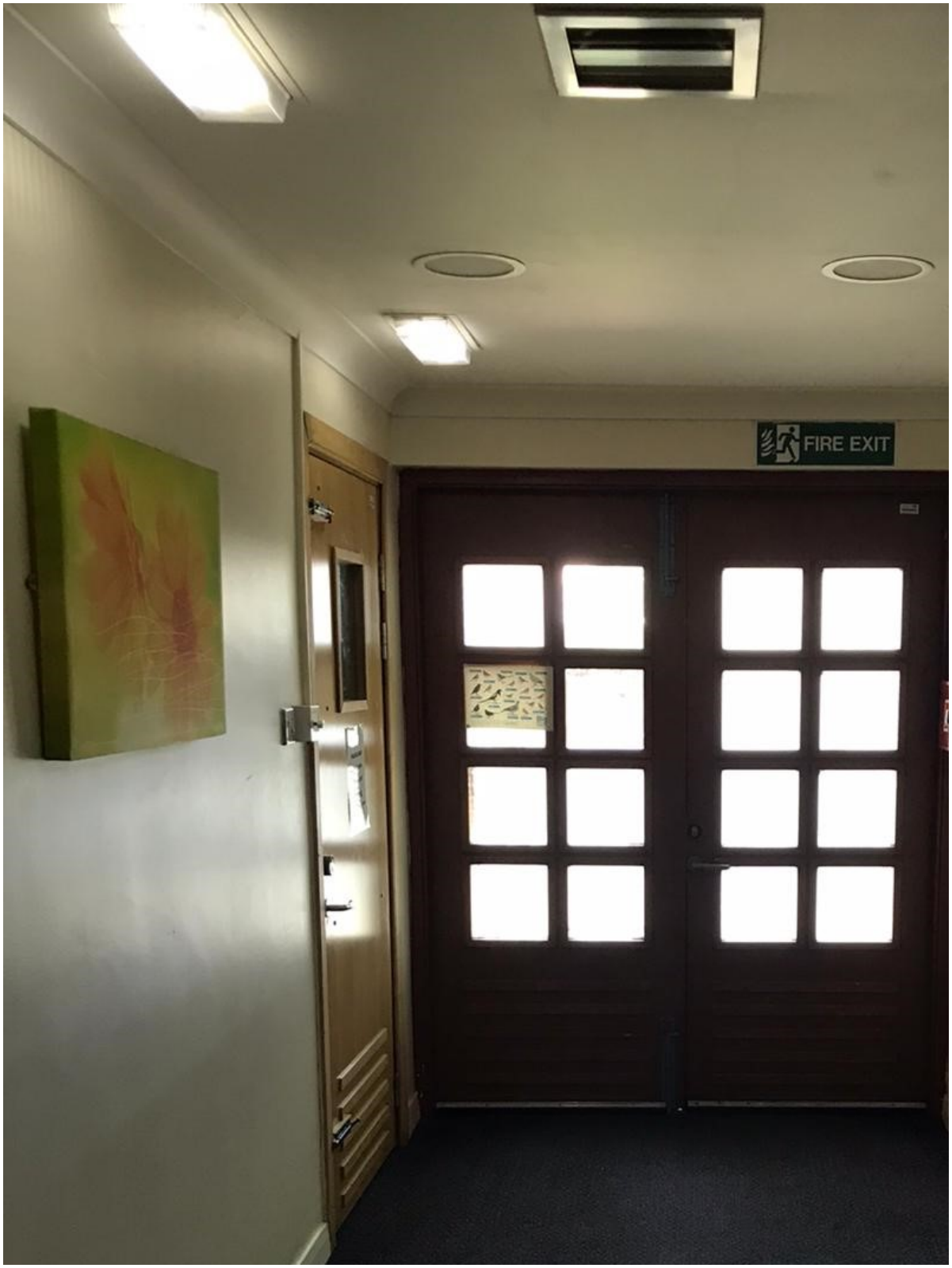
NHS National Services Scotland

Health Facilities Scotland

Summary Progress

Corridors with bedrooms straight from them:


Fire
exit
THANK
YOU

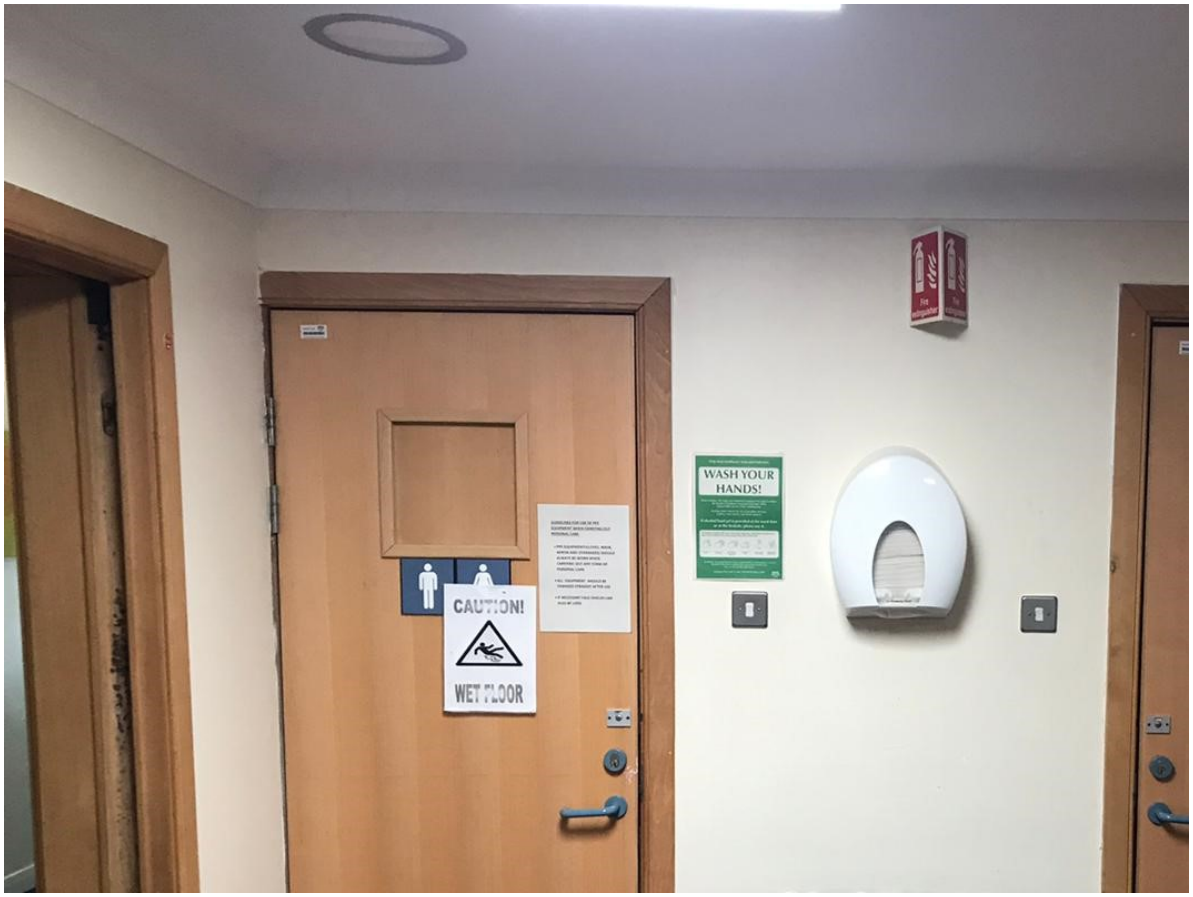


Doo


KEEP LEFT
RANNOCHMOR

Seclusion Room Door

Shared bathrooms with insufficient space for privacy and dignity:


WASH YOUR HANDS!
CAUTION!
WET FLOOR

Insufficient and lack of space for patient activities – including practicing activities of daily living


Super
L2
Non-Biological
Laundry Powder
100
DISSOLV-A-WAY
Electrolux
BOSCH

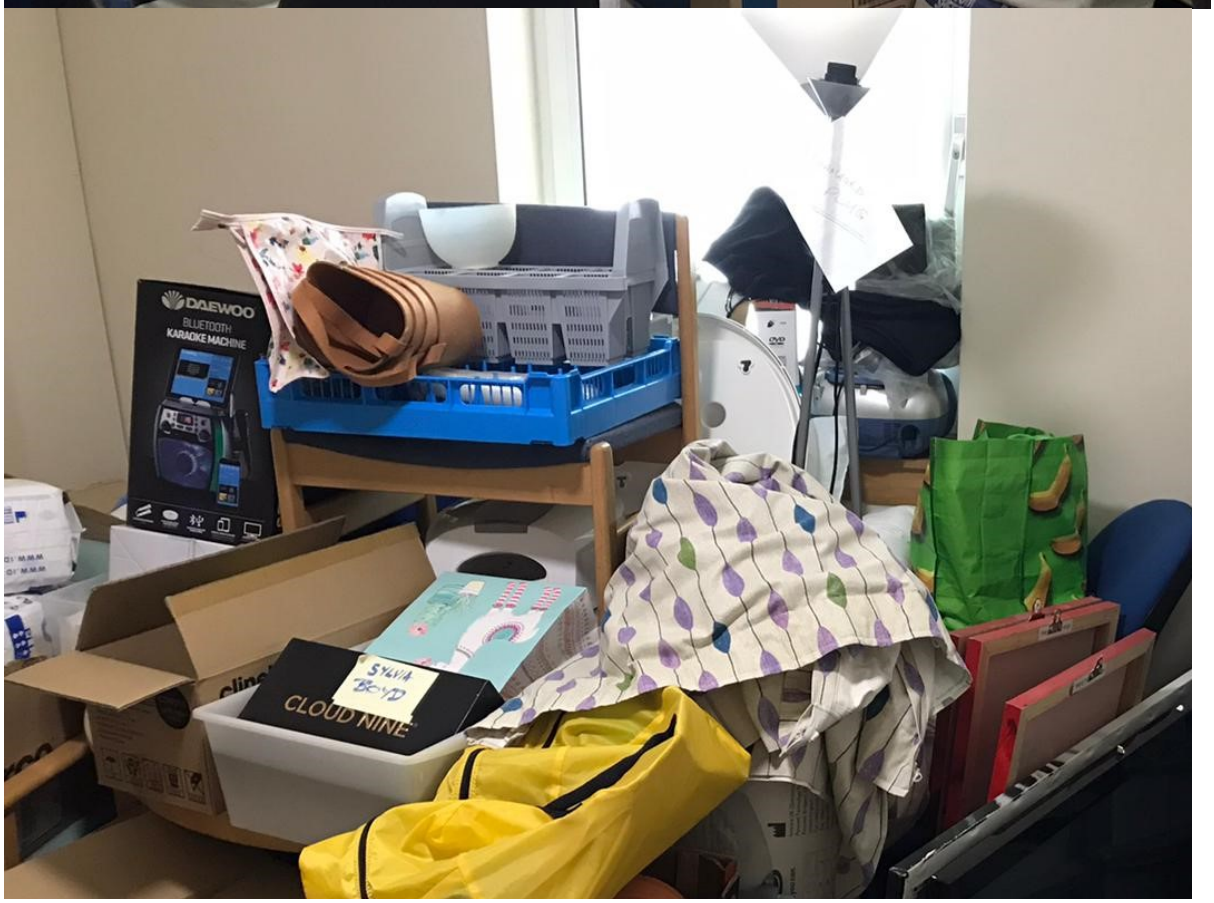

COLOUR CODED CUTTING BOARDS
RAW MEAT
RAW FISH
SALAD & FRUIT
VEGETABLES
OVEN GLOVES

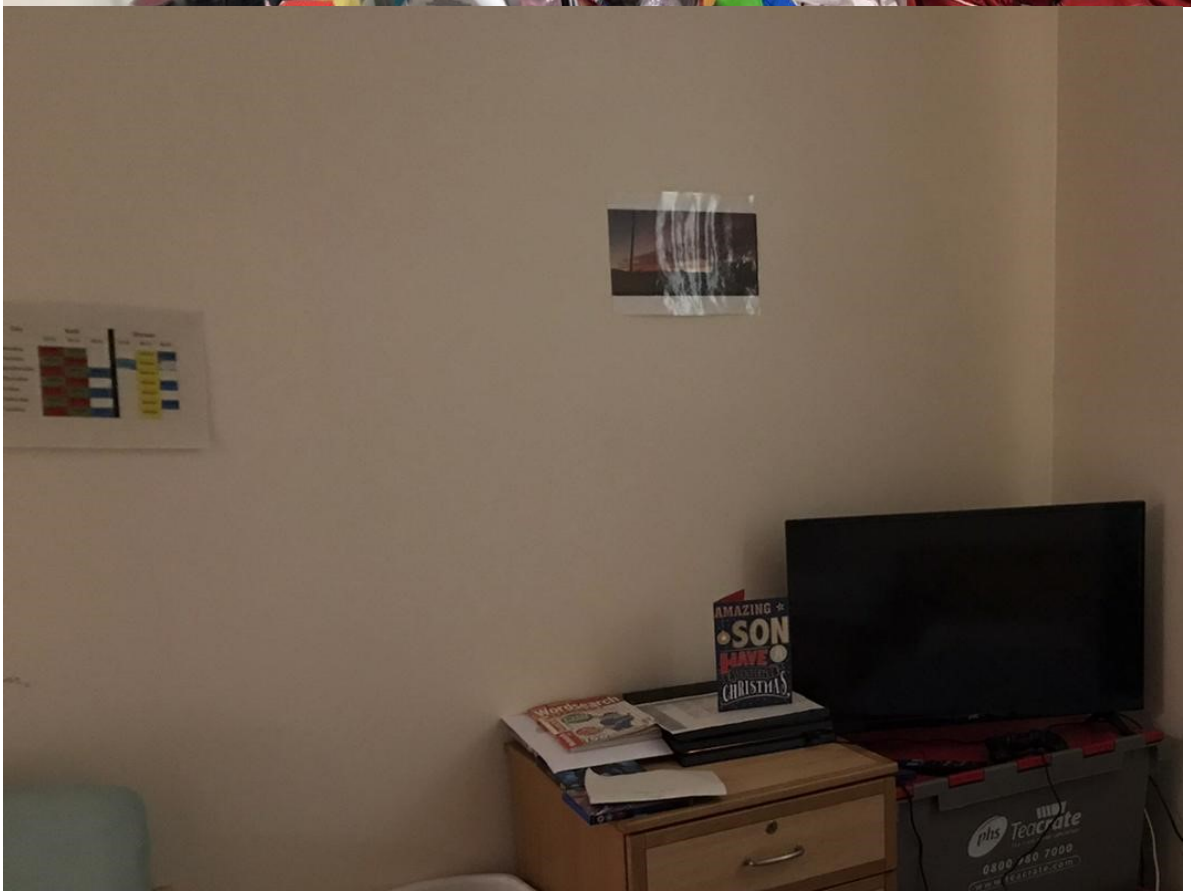
Poor and lack of staff space


NOTICE
CAN ALL STAFF PLEASE ENSURE ALL MOBILES ARE KEPT IN LOCKERS
12
5
2
16


Lyreco
BUDGET
Lyreco
Lyreco
BUDGET

Lack of storage for patient belongings




AMAZING
SON
CHRISTMAS

Dark Shared Living Spaces

Treatment Room

Integrated Mental Health Rehabilitation and Low Secure Centre

NHS Lothian

Initial Agreement

Project Owner: Nickola Jones

Project Sponsor: Alex McMahon

Date: 13/05/2021

Version: 1.17

Version History

Version	Date	Author(s)	Comments
1.0	13/05/2021	Nickola Jones	Initial draft, pulling together progress to date
1.1	18/09/2021	Mike Holligan/Andy Wills	Review and update case
1.2	19/05/2021	Andy Wills/Mike Holligan	Review and update case
1.3	24/05/2021	Mike Holligan/Andy Wills	Review and update case
1.4	28/05/2021	Nickola Jones	Review and update case
1.5	01/06/2021	Andy Wills/Mike Holligan	Review and update case
1.6	03/06/2021	Mike Holligan	Editing and Formatting of document changes
1.7	10/06/2021	Andy Wills/Mike Holligan	Review and update case
1.8	14/06/2021	Nickola Jones	Review and update case
1.9	15/06/2021	Mike Holligan	Review and update case
1.10	16/06/2021	Nickola Jones/Steve Shon	Review and update case
1.11	21/06/2021	Nickola Jones/Steve Shon	Review and update case
1.12	21/06/2021	Laura Smith/Hamish Hamilton	Updates to Economic Case & Financial Case
1.13	06/07/2021	Nickola Jones	Review and Update case based on feedback from REAS SMT and REH Project Board
1.14	19/07/2021	Nickola Jones	Review and update case
1.15	20/07/2021	Nickola Jones and Laura Smith	Review and update case, update of financial sections of case
1.16	22/07/2021	Nickola Jones	Review and update case
1/17	05/09/2021	Nickola Jones	Review and update case following Edinburgh IJB feedback

Contents

1. Executive Summary

1.1 Purpose

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

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

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

1.2 Background and Strategic Context

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

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

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

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

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

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

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

1.3 Need for Change

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

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

1.4 Investment Objectives

The Investment Objectives for this case are:

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

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

1.5 The Preferred Option(s)

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

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

Option Appraisal	Option 1	Option 2	Option 3	Option 4
Weighted benefits points	245	610	745	1000
NPV of Costs (£k)	118,340	198,898	209,600	269,714
Cost per benefits point (£k)	483	326	281	270
Rank	**4**	**3**	**2**	**1**

1.6 Readiness to proceed

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

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

1.7 Conclusion

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

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

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

2. The Strategic Case

2.1 Existing Arrangements

Adult Mental Health Low Secure

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

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

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

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

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

Adult Mental Health Rehabilitation

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

Who might need a mental health rehabilitation service?

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

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

People may have these difficulties because:

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

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

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

When are people referred to rehabilitation services?

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

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

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

What are the aims of mental health rehabilitation?

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

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

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

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

What treatments and support are provided?

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

Treatments may include:

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

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

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

Current Ward Establishment

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

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

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

Patient Activity 2018 - 2021

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

2.2 Drivers for Change

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

Low Secure

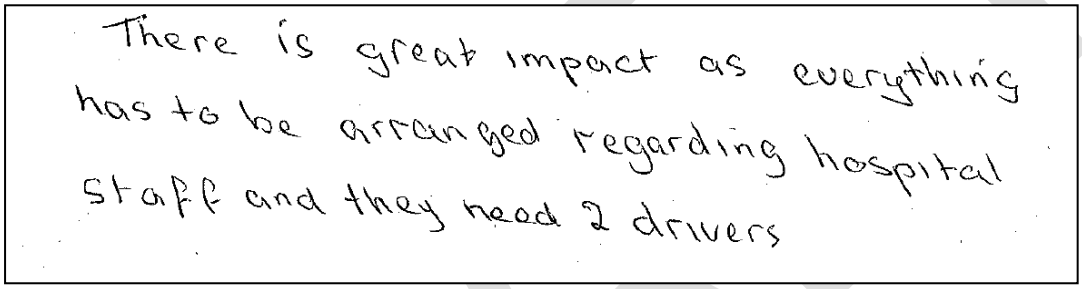
There is currently no low secure provision in the Lothian area. Patients are receiving care far from home which means that connecting with family members becomes even more challenging than it would be normally for this patient group. In addition to this, out of area low secure placements currently cost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

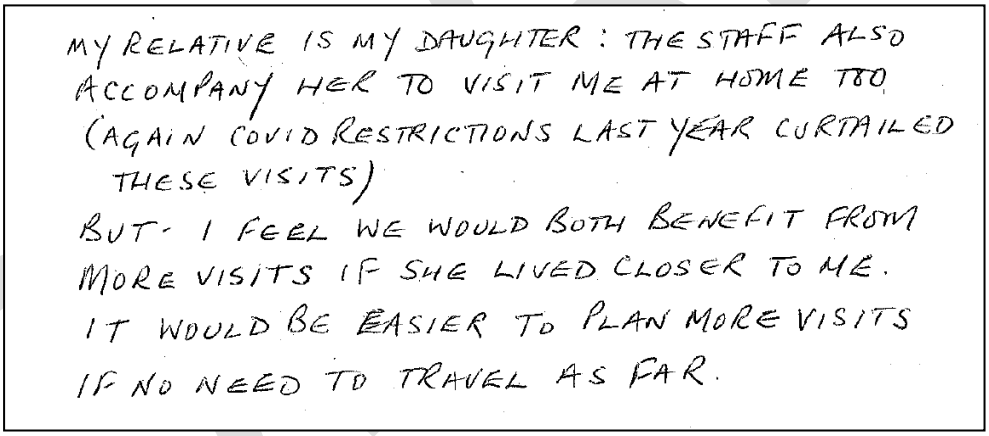
[4] Royal College of Psychiatrists – 'Mental Health Rehabilitation Services' https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-rehabilitation-services

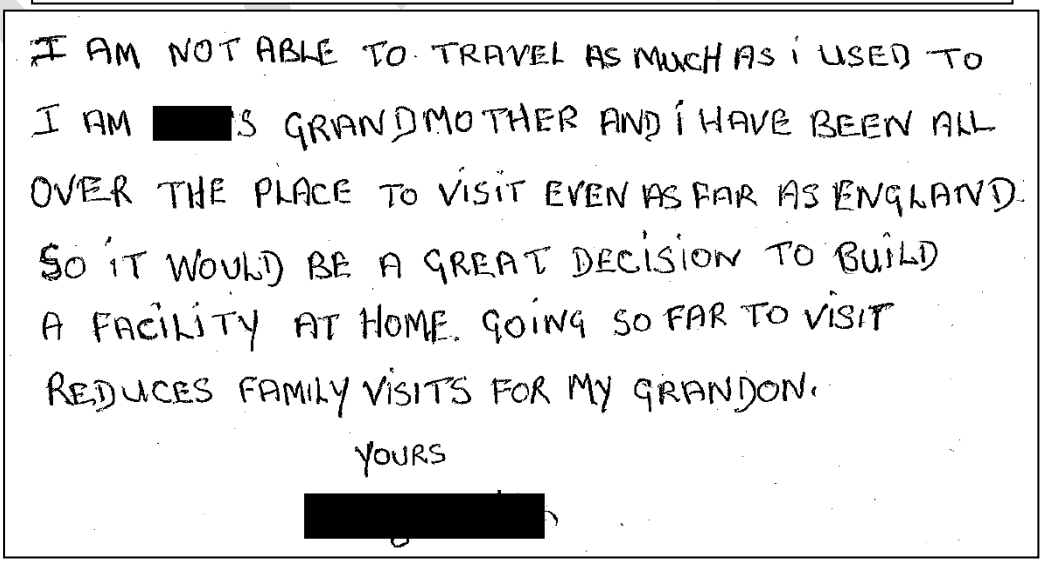
An exercise to gain feedback from patient's currently receiving low secure care out of area and their families was conducted in early 2021. Some of the quotes from this exercise are listed below, which clearly demonstrate some of the challenges currently experienced:

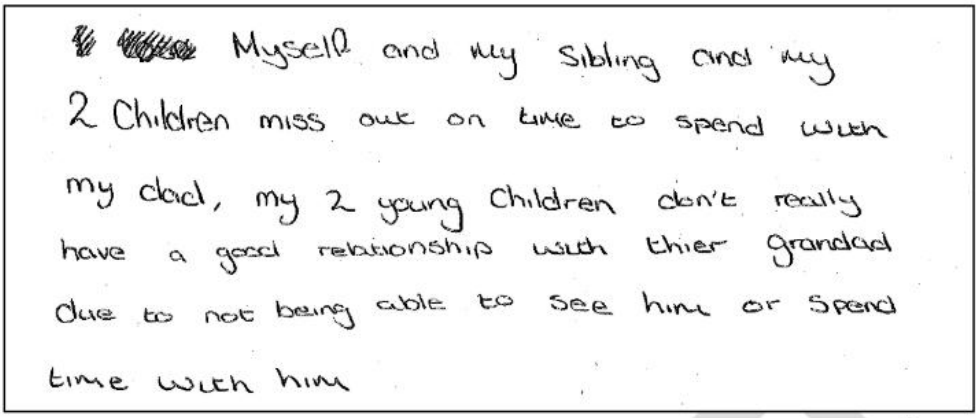
> *'I am from here, why do I need to be sent away? That is not going to make be better'* Low Secure Patient
>
> *'I have not seen my third grandson since he was born, if I was in Edinburgh I would have the chance to meet with him.'* Low Secure patient
>
> *'The day it was decided that my son had to move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

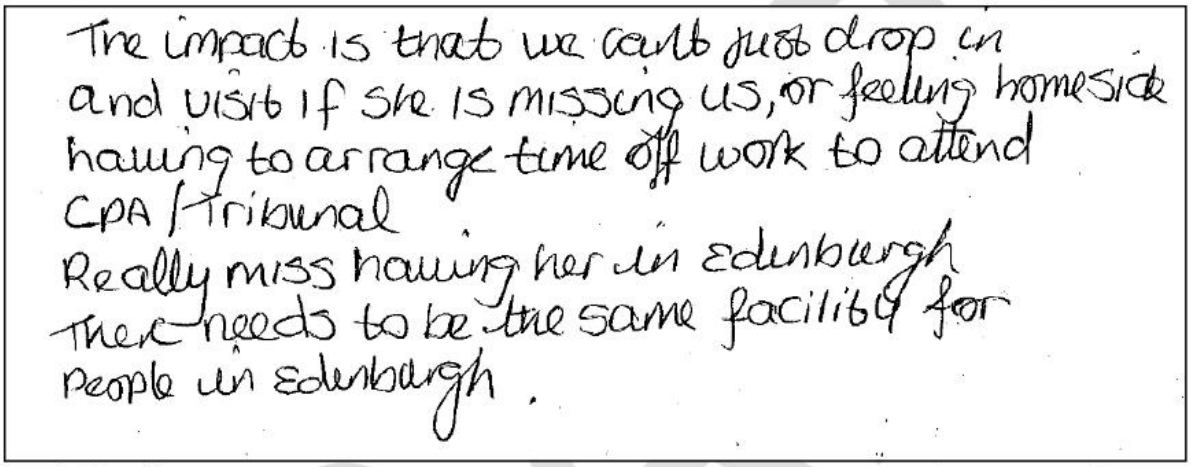
Some of the written responses are shown below:

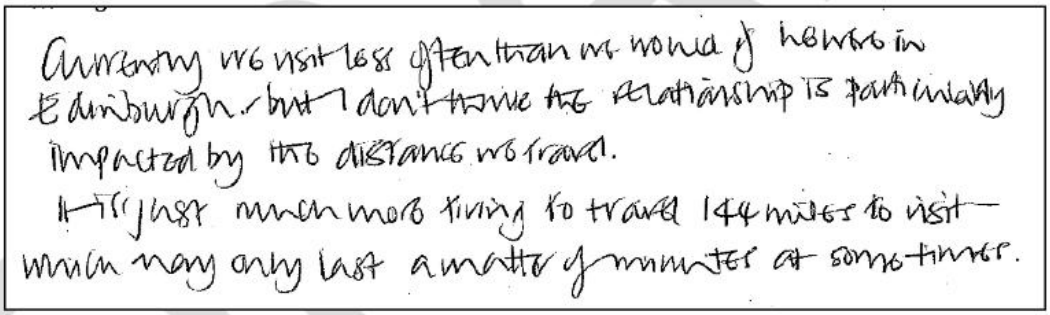

There is great impact as everything has to be arranged regarding hospital staff and they need 2 drivers


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


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


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


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


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

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

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

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

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

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

Mental Health Rehabilitation

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

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

Shared bathroom and shower facilities

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

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

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

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

Shared Living Spaces

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

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

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

Access to Outdoor Space

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

Wheelchair Accessibility

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

Storage of Belongings

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

Lighting and Temperature

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

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

Physical Structure

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

Lack of Therapeutic Space

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

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

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

Combined Treatment room and Dispensary

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

A Vision for the Future

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

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

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

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

Proposed Bed Numbers

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

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

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

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

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

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

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

Alignment with National and Local Strategy

National Strategy

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

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

2. *National Health and Wellbeing Outcomes Framework 2015*

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

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

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

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

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

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

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

4. *National Clinical Strategy for Scotland*

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

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

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

5. *2020 Vision*

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

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

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

7. *Public Health Priorities for Scotland*

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

8. *The Sustainable Development Strategy for NHS Scotland*

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

Local Strategies

1. *NHS Lothian Hospitals Plan*

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

2. *NHS Lothian Quality Strategy*

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

distracted by environmental concerns.

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

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

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

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

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

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

6. *Property and Asset Management Strategy*

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

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

7. *AEDET*

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

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

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

Table 1: Summary of the Need for Change

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

2.3 Investment Objectives

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

Table 2: Investment Objectives

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

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

2.4 Benefits

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

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

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

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

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

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

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

lower incidence of items going missing.

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

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

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

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

2.5 Strategic Risks

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

Table 3: Strategic Risks

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

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

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

2.6 Constraints and Dependencies

The key constraints to be considered are:

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

The key dependencies to be considered are:

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

3. Economic Case

3.1 Do nothing/baseline

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

Table 4: Do Nothing

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

3.2 Engagement with Stakeholders

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

Table 5: Engagement with Stakeholders

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

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

3.3 Long-listed Options

The table below summarises the long list of options identified:

1. **Do minimum**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 6: Long Listed options (not discounted above)

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

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

Initial Assessment of Options

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

Table 7: Assessment of options against investment objectives

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

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

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

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

3.4 Short-listed Options and Preferred Way Forward

3.4.1 Shortlisted options

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

Table 8: Short Listed Options

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

3.4.2 Non-financial benefits assessment

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

The results of the benefits assessment are summarised below:

Table 9: Results of Non-Financial Benefits Assessment

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

#	Benefit	Weight (%)	Option 1	Option 2	Option 3	Option 4
	clinical staff, patients, and carers will assist in the reduction of violence and aggression, self harm behaviours, missing persons and use of illicit substances					
4	The creation of a mental health rehabilitation and low secure service on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments	5	0	6	7	10
5	The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention	15	4	6	7	10
6	Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends and the improved ability of staff supported by improved access to health technology which provides continuity of care in one setting	15	4	6	7	10
7	A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site	5	0	3	6	10
Total Weighted Benefits Points		**100**	**245**	**610**	**745**	**1,000**

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

3.4.3 Indicative costs

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

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

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

Table 10: Indicative Costs of Shortlisted Options

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

3.4.4 Overall assessment and preferred way forward

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

Table 11: Economic Assessment Summary

Option Appraisal	Option 1	Option 2	Option 3	Option 4
Weighted benefits points	245	610	745	1000
NPV of Costs (£k)	118,340	198,898	209,600	269,714
Cost per benefits point (£k)	483	326	281	270
Rank	**4**	**3**	**2**	**1**

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

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

3.5 Design Quality Objectives

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

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

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

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

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

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

3 The Commercial Case

4.1 Procurement Strategy

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

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

4.2 Timetable

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

Table 12: Project Timetable

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

4 The Financial Case

5.1 Capital Affordability

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

Table 13: Capital Costs

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

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

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

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

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

Inflation

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

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

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

Table 14: Inflation & Programme Extension Sensitivity Analysis

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

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

5.2 Revenue Affordability

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

Table 14: Incremental Revenue Costs

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

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

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

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

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

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

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

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

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

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

5.3 Overall Affordability

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

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

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

5 The Management Case

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

6.1 Readiness to proceed

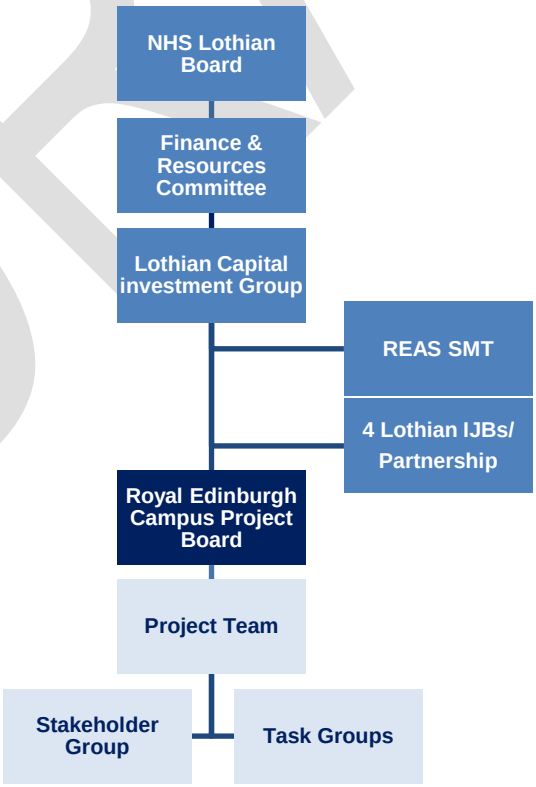
A benefits register and initial high level risk register for the project are included in Appendix 3: Benefits Register and Appendix 4: Risk Register. Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects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

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

6.2 Governance support for the proposal

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

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



6.3 Project Management

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

Table 15: Project Management Structure

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

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

The project's external advisers are:

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

6 Conclusion

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

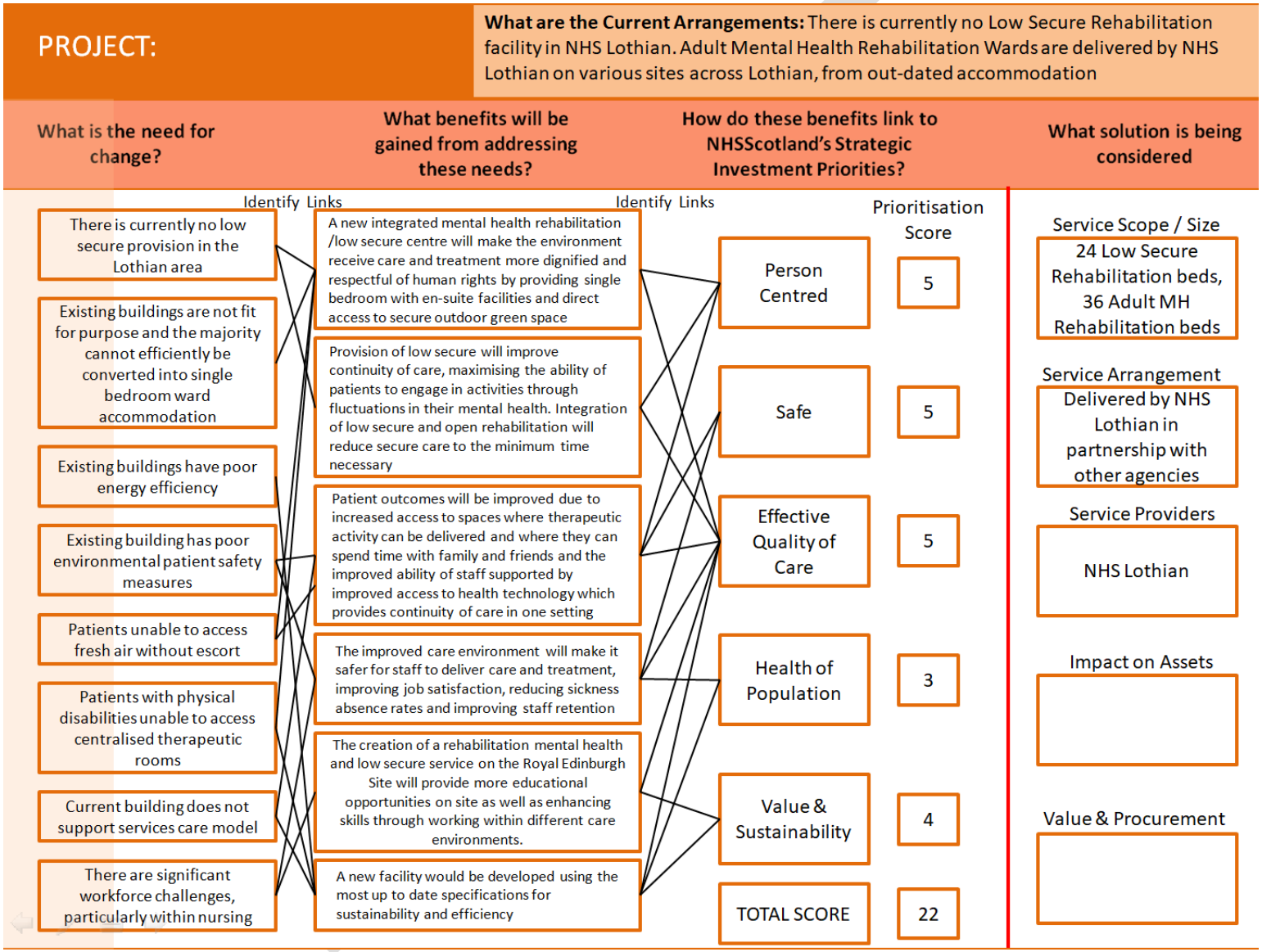
At the centre of this case is a desire to provide the best quality of care to those who require mental health care in NHS Lothian. Having to receive care out of area is detrimental to our patient's wellbeing and recovery, as is receiving care in a poor quality environment. Additionally, staff should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

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

Appendix 1: Pictures of Current Mental Health Rehabilitation Wards

Provided as a separate document due to file size.

Appendix 2: Strategic Assessment



Appendix 3: Benefits Register and Non-Financial Benefits Assessment

Benefits Register

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

Non Financial Benefits Assessment

#	Benefit	Weighting (%)	Option 1	Option 2	Option 3	Option 4
1	A new integrated mental health rehabilitation /low secure centre will make the environment in which patients receive care and treatment more dignified and respectful of human rights by providing single bedroom with en-suite facilities and direct access to secure outdoor green space	25%	3	5	6	10
2	Low secure care will be provided in NHS Lothian, preventing patients from having to recieve care out of area. Provision of low secure facilities will improve continuity of care, maximising the ability of patients to engage in activities through fluctuations in their mental health	25%	0	8	10	10
3	A well-designed building which has had input from clinical staff, patients, and carers will assist in the reduction of violence and aggression, self harm behaviours, missing persons and use of illicit substances	10%	5	6	7	10
4	The creation of a mental health rehabilitation and low secure service on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments	5%	0	6	7	10
5	The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention	15%	4	6	7	10
6	Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends and the improved ability of staff supported by improved access to health technology which provides continuity of care in one setting	15%	4	6	7	10
7	A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site	5%	0	3	6	10
	Total Weighted Benefits Points		**245**	**610**	**745**	**1,000**

Appendix 4: Risk Register

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

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

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

Provided as a separate document due to file size.

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	0		
A.02	The design facilitates the care model	1	1	
A.03	Overall the design is capable of handling the projected throughput	1	3	
A.04	Work flows and logistics are arranged optimally	1	1	
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1	2	
A.06	Where possible spaces are standardised and flexible in use patterns	1	1	
A.07	The design facilitates both security and supervision	1	1	
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	1	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	1	
A.10	The benchmarks in the Design Statement in relation to building USE are met	0		

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	4	
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1	1	
B.03	The approach and access for ambulances is appropriately provided	1	3	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	3	
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	2	
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	1	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	4	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	1	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	0		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	1	
C.02	The ratio of usable space to total area is good	1	2	
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	2	
C.04	Any necessary isolation and segregation of spaces is achieved	1	1	
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	1	
C.06	There is adequate storage space	1	1	
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	4	
C.08	The relationships between internal spaces and the outdoor environment work well	1	1	
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	0		

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	1	
D.02	The building and grounds are easy to clean and maintain	1	2	
D.03	The building and grounds have appropriately durable finishes and components	1	2	
D.04	The building and grounds will weather and age well	1	2	
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	2	
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	1	
D.07	The design minimises maintenance and simplifies this where it will be required	1	1	
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	0		

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	0	YES
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	0	YES
E.03	The engineering systems are energy efficient	1	0	YES
E.04	There are emergency backup systems that are designed to minimise disruption	1	0	YES
E.05	During construction disruption to essential services is minimised	1	0	YES
E.06	During maintenance disruption to essential healthcare services is minimised	1	2	YES
E.07	The design layout contributes to efficient zoning and energy use reduction	1	0	YES

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0	0	YES
F.02	Temporary construction work is minimised	0	0	YES
F.03	The impact of the building process on continuing healthcare provision is minimised	0	0	YES
F.04	The building and grounds can be readily maintained	0	0	YES
F.05	The construction is robust	0	0	YES
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	0	0	YES
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	0	0	YES
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	0	0	YES
F.09	The construction contributes to being a good neighbour	0	0	YES
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	0	0	YES

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1	2	
G.02	The building and grounds are interesting to look at and move around in	1	2	
G.03	The building, grounds and arts design contribute to the local setting	1	1	
G.04	The design appropriately expresses the values of the NHS	1	1	
G.05	The project is likely to influence future designs	1	1	
G.06	The design provides a clear strategy for future adaptation and expansion	1	1	
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	1	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	0		

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1	1	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	1	
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1	1	
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	2	
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	1	
H.06	The design maximises the site opportunities and enhances a sense of place	1	1	
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0		

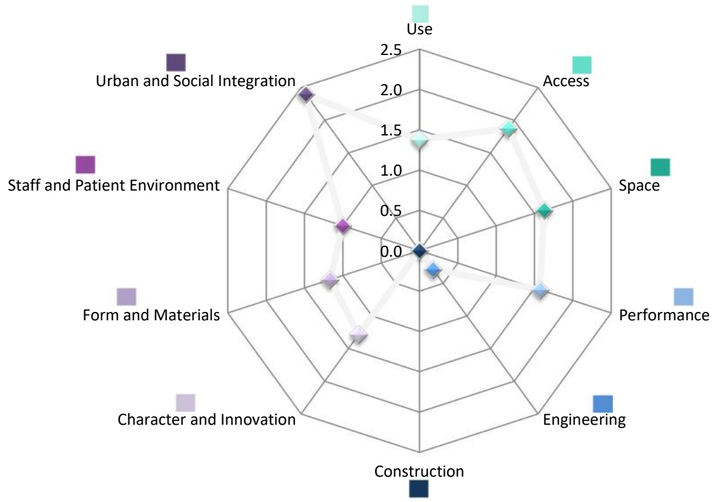
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1	1	
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	1	
I.03	The design maximises the opportunities for access to usable outdoor space	1	1	
I.04	There are high levels of both comfort and control of comfort	1	1	
I.05	The design is clearly understandable and wayfinding is intuitive	1	1	
I.06	The interior of the building is attractive in appearance	1	1	
I.07	There are good bath/ toilet and other facilities for patients	1	1	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1	1	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	1	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	0		

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	3	
J.02	The facility contributes positively to its locality	1	3	
J.03	The hard and soft landscape contribute positively to the locality	1	3	
J.04	The overall design contributes positively to neighbourhood and is sensitive to passers-by	1	2	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1	1	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	0		

AEDET Refresh Benchmark Summary



	Benchmark
Use	1.4
Access	1.9
Space	1.6
Performance	1.6
Engineering	0.3
Construction	0.0
Character and Innovation	1.3
Form and Materials	1.2
Staff and Patient Environment	1.0
Urban and Social Integration	2.4

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

REH Phase 2 60-bed MH Rehabilitation and Low Secure Unit

Benchmark

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
	A.08	
	A.09	
	A.10	
	B.01	
	B.02	
	B.03	
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	C.09	
	D.01	
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	D.08	
	E.01	
	E.02	
	E.03	
	E.04	
	E.05	
	E.06	
	E.07	
	F.01	F.01 to F.10 - Not Applicable
	F.02	
	F.03	
	F.04	
	F.05	
	F.06	
	F.07	
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	I.06	
	I.07	
	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Target

REH Phase 2 60-bed MH Rehabilitation and Low Secure Unit

AEDET Refresh v1.1 Feb 2016

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	0	6	
A.02	The design facilitates the care model	1	4	
A.03	Overall the design is capable of handling the projected throughput	1	4	
A.04	Work flows and logistics are arranged optimally	1	4	
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1	4	
A.06	Where possible spaces are standardised and flexible in use patterns	1	4	
A.07	The design facilitates both security and supervision	1	4	
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	4	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	4	
A.10	The benchmarks in the Design Statement in relation to building USE are met	2	5	

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	4	
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1	4	
B.03	The approach and access for ambulances is appropriately provided	1	4	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	4	
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1	4	
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	4	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	4	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	4	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2	5	

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	4	
C.02	The ratio of usable space to total area is good	1	4	
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	4	
C.04	Any necessary isolation and segregation of spaces is achieved	1	4	
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1	4	
C.06	There is adequate storage space	1	4	
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	4	
C.08	The relationships between internal spaces and the outdoor environment work well	1	4	
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2	5	

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	4	
D.02	The building and grounds are easy to clean and maintain	1	4	
D.03	The building and grounds have appropriately durable finishes and components	1	4	
D.04	The building and grounds will weather and age well	1	4	
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	4	
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	4	
D.07	The design minimises maintenance and simplifies this where it will be required	1	4	
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2	5	

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	4	
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	4	
E.03	The engineering systems are energy efficient	1	4	
E.04	There are emergency backup systems that are designed to minimise disruption	1	4	
E.05	During construction disruption to essential services is minimised	1	4	
E.06	During maintenance disruption to essential healthcare services is minimised	1	4	
E.07	The design layout contributes to efficient zoning and energy use reduction	1	4	

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	1	4	
F.02	Temporary construction work is minimised	1	4	
F.03	The impact of the building process on continuing healthcare provision is minimised	1	4	
F.04	The building and grounds can be readily maintained	1	4	
F.05	The construction is robust	1	4	
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1	4	
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1	4	
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1	4	
F.09	The construction contributes to being a good neighbour	1	4	
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1	4	

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1	4	
G.02	The building and grounds are interesting to look at and move around in	1	4	
G.03	The building, grounds and arts design contribute to the local setting	1	4	
G.04	The design appropriately expresses the values of the NHS	1	4	
G.05	The project is likely to influence future designs	1	4	
G.06	The design provides a clear strategy for future adaptation and expansion	1	4	
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1	4	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2	5	

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1	4	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	4	
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1	4	
H.04	The external materials and detailing appear to be of high quality and are maintainable	1	4	
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	4	
H.06	The design maximises the site opportunities and enhances a sense of place	1	4	
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2	5	

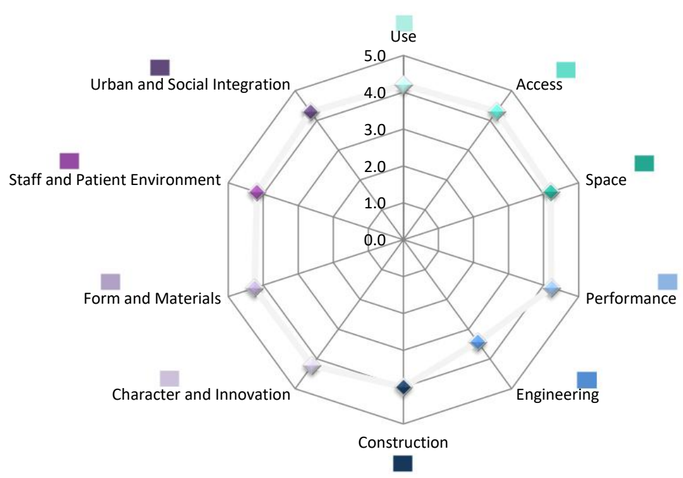
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1	4	
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1	4	
I.03	The design maximises the opportunities for access to usable outdoor space	1	4	
I.04	There are high levels of both comfort and control of comfort	1	4	
I.05	The design is clearly understandable and wayfinding is intuitive	1	4	
I.06	The interior of the building is attractive in appearance	1	4	
I.07	There are good bath/ toilet and other facilities for patients	1	4	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1	4	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	4	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2	5	

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	4	
J.02	The facility contributes positively to its locality	1	4	
J.03	The hard and soft landscape contribute positively to the locality	1	4	
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1	4	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1	4	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2	5	

AEDET Refresh Target Summary



	Target
Use	4.2
Access	4.3
Space	4.2
Performance	4.2
Engineering	3.4
Construction	4.0
Character and Innovation	4.2
Form and Materials	4.3
Staff and Patient Environment	4.2
Urban and Social Integration	4.3

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

REH Phase 2 60-bed MH Rehabilitation and Low Secure Unit

Target

	Ref	Note
	A.01	
	A.02	
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	I.08	
	I.09	
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	J.04	
	J.05	
	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	0		
A.02	The design facilitates the care model	1		
A.03	Overall the design is capable of handling the projected throughput	1		
A.04	Work flows and logistics are arranged optimally	1		
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1		
A.06	Where possible spaces are standardised and flexible in use patterns	1		
A.07	The design facilitates both security and supervision	1		
A.08	The design facilitates health promotion and equality for staff, patients and local community	1		
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1		
A.10	The benchmarks in the Design Statement in relation to building USE are met	2		

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1		
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1		
B.03	The approach and access for ambulances is appropriately provided	1		
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1		
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1		
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1		
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1		
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1		
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1		
C.02	The ratio of usable space to total area is good	1		
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1		
C.04	Any necessary isolation and segregation of spaces is achieved	1		
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1		
C.06	There is adequate storage space	1		
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1		
C.08	The relationships between internal spaces and the outdoor environment work well	1		
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2		

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1		
D.02	The building and grounds are easy to clean and maintain	1		
D.03	The building and grounds have appropriately durable finishes and components	1		
D.04	The building and grounds will weather and age well	1		
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1		
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1		
D.07	The design minimises maintenance and simplifies this where it will be required	1		
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2		

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1		
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1		
E.03	The engineering systems are energy efficient	1		
E.04	There are emergency backup systems that are designed to minimise disruption	1		
E.05	During construction disruption to essential services is minimised	1		
E.06	During maintenance disruption to essential healthcare services is minimised	1		
E.07	The design layout contributes to efficient zoning and energy use reduction	1		

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	1		
F.02	Temporary construction work is minimised	1		
F.03	The impact of the building process on continuing healthcare provision is minimised	1		
F.04	The building and grounds can be readily maintained	1		
F.05	The construction is robust	1		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1		
F.09	The construction contributes to being a good neighbour	1		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1		

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1		
G.02	The building and grounds are interesting to look at and move around in	1		
G.03	The building, grounds and arts design contribute to the local setting	1		
G.04	The design appropriately expresses the values of the NHS	1		
G.05	The project is likely to influence future designs	1		
G.06	The design provides a clear strategy for future adaptation and expansion	1		
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1		
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2		

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1		
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1		
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1		
H.04	The external materials and detailing appear to be of high quality and are maintainable	1		
H.05	The external colours and textures seem appropriate and attractive for the local setting	1		
H.06	The design maximises the site opportunities and enhances a sense of place	1		
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2		

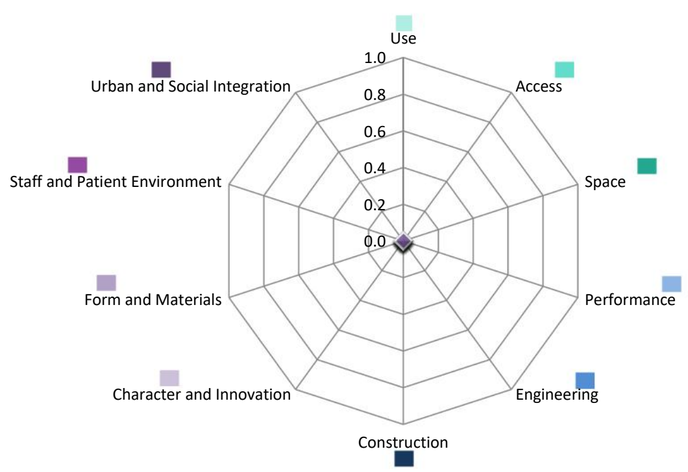
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1		
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1		
I.03	The design maximises the opportunities for access to usable outdoor space	1		
I.04	There are high levels of both comfort and control of comfort	1		
I.05	The design is clearly understandable and wayfinding is intuitive	1		
I.06	The interior of the building is attractive in appearance	1		
I.07	There are good bath/ toilet and other facilities for patients	1		
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1		
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1		
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2		

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1		
J.02	The facility contributes positively to its locality	1		
J.03	The hard and soft landscape contribute positively to the locality	1		
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1		
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1		
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2		

AEDET Refresh OBC Summary



Target		Progress	
		Prev	Curr
4.2	Use	4.2	0.0
4.3	Access	4.3	0.0
4.2	Space	4.2	0.0
4.2	Performance	4.2	0.0
3.4	Engineering	3.4	0.0
4.0	Construction	4.0	0.0
4.2	Character and Innovation	4.2	0.0
4.3	Form and Materials	4.3	0.0
4.2	Staff and Patient Environment	4.2	0.0
4.3	Urban and Social Integration	4.3	0.0

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
	A.08	
	A.09	
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	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Outline Business Case Stage

1 AEDET OBC to be recorded near end of OBC Stage and must be submitted for NDAP
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	0		
A.02	The design facilitates the care model	1		
A.03	Overall the design is capable of handling the projected throughput	1		
A.04	Work flows and logistics are arranged optimally	1		
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1		
A.06	Where possible spaces are standardised and flexible in use patterns	1		
A.07	The design facilitates both security and supervision	1		
A.08	The design facilitates health promotion and equality for staff, patients and local community	1		
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1		
A.10	The benchmarks in the Design Statement in relation to building USE are met	2		

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1		
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1		
B.03	The approach and access for ambulances is appropriately provided	1		
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1		
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1		
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1		
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1		
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1		
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1		
C.02	The ratio of usable space to total area is good	1		
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1		
C.04	Any necessary isolation and segregation of spaces is achieved	1		
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1		
C.06	There is adequate storage space	1		
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1		
C.08	The relationships between internal spaces and the outdoor environment work well	1		
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2		

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1		
D.02	The building and grounds are easy to clean and maintain	1		
D.03	The building and grounds have appropriately durable finishes and components	1		
D.04	The building and grounds will weather and age well	1		
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1		
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1		
D.07	The design minimises maintenance and simplifies this where it will be required	1		
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2		

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1		
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1		
E.03	The engineering systems are energy efficient	1		
E.04	There are emergency backup systems that are designed to minimise disruption	1		
E.05	During construction disruption to essential services is minimised	1		
E.06	During maintenance disruption to essential healthcare services is minimised	1		
E.07	The design layout contributes to efficient zoning and energy use reduction	1		

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0		
F.02	Temporary construction work is minimised	0		
F.03	The impact of the building process on continuing healthcare provision is minimised	1		
F.04	The building and grounds can be readily maintained	1		
F.05	The construction is robust	1		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1		
F.09	The construction contributes to being a good neighbour	1		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1		

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1		
G.02	The building and grounds are interesting to look at and move around in	1		
G.03	The building, grounds and arts design contribute to the local setting	1		
G.04	The design appropriately expresses the values of the NHS	1		
G.05	The project is likely to influence future designs	1		
G.06	The design provides a clear strategy for future adaptation and expansion	1		
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1		
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2		

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1		
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1		
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1		
H.04	The external materials and detailing appear to be of high quality and are maintainable	1		
H.05	The external colours and textures seem appropriate and attractive for the local setting	1		
H.06	The design maximises the site opportunities and enhances a sense of place	1		
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2		

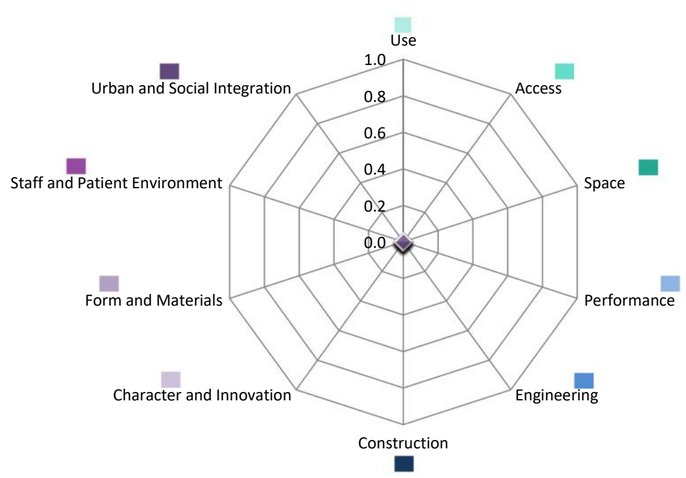
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1		
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1		
I.03	The design maximises the opportunities for access to usable outdoor space	1		
I.04	There are high levels of both comfort and control of comfort	1		
I.05	The design is clearly understandable and wayfinding is intuitive	1		
I.06	The interior of the building is attractive in appearance	1		
I.07	There are good bath/ toilet and other facilities for patients	1		
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1		
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1		
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2		

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1		
J.02	The facility contributes positively to its locality	1		
J.03	The hard and soft landscape contribute positively to the locality	1		
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1		
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1		
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2		

AEDET Refresh FBC Summary



Target		Progress Prev	Progress Curr
4.2	Use	0.0	0.0
4.3	Access	0.0	0.0
4.2	Space	0.0	0.0
4.2	Performance	0.0	0.0
3.4	Engineering	0.0	0.0
4.0	Construction	0.0	0.0
4.2	Character and Innovation	0.0	0.0
4.3	Form and Materials	0.0	0.0
4.2	Staff and Patient Environment	0.0	0.0
4.3	Urban and Social Integration	0.0	0.0

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
	A.08	
	A.09	
	A.10	
	B.01	
	B.02	
	B.03	
	B.04	
	B.05	
	B.06	
	B.07	
	B.08	
	B.09	
	C.01	
	C.02	
	C.03	
	C.04	
	C.05	
	C.06	
	C.07	
	C.08	
	C.09	
	D.01	
	D.02	
	D.03	
	D.04	
	D.05	
	D.06	
	D.07	
	D.08	
	E.01	
	E.02	
	E.03	
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	F.07	
	F.08	
	F.09	
	F.10	
	G.01	
	G.02	
	G.03	
	G.04	
	G.05	
	G.06	
	G.07	
	G.08	
	H.01	
	H.02	
	H.03	
	H.04	
	H.05	
	H.06	
	H.07	
	I.01	
	I.02	
	I.03	
	I.04	
	I.05	
	I.06	
	I.07	
	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Full Business Case Stage

1. AEDET FBC to be recorded near end of FBC (or SBC) Stage and must be submitted for NDAP
2. The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3. The note section to be completed to provide further briefing information
4. If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5. Boards may add project specific criteria. A note must be provided stating the reason for this.
6. Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

Health Facilities Scotland

NHS National Services Scotland

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	0		
A.02	The design facilitates the care model	1		
A.03	Overall the design is capable of handling the projected throughput	1		
A.04	Work flows and logistics are arranged optimally	1		
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	1		
A.06	Where possible spaces are standardised and flexible in use patterns	1		
A.07	The design facilitates both security and supervision	1		
A.08	The design facilitates health promotion and equality for staff, patients and local community	1		
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1		
A.10	The benchmarks in the Design Statement in relation to building USE are met	2		

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1		
B.02	There is adequate parking for visitors/ staff cars/ disabled people	1		
B.03	The approach and access for ambulances is appropriately provided	1		
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1		
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	1		
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1		
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1		
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1		
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2		

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1		
C.02	The ratio of usable space to total area is good	1		
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1		
C.04	Any necessary isolation and segregation of spaces is achieved	1		
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	1		
C.06	There is adequate storage space	1		
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1		
C.08	The relationships between internal spaces and the outdoor environment work well	1		
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2		

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1		
D.02	The building and grounds are easy to clean and maintain	1		
D.03	The building and grounds have appropriately durable finishes and components	1		
D.04	The building and grounds will weather and age well	1		
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1		
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1		
D.07	The design minimises maintenance and simplifies this where it will be required	1		
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2		

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1		
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1		
E.03	The engineering systems are energy efficient	1		
E.04	There are emergency backup systems that are designed to minimise disruption	1		
E.05	During construction disruption to essential services is minimised	1		
E.06	During maintenance disruption to essential healthcare services is minimised	1		
E.07	The design layout contributes to efficient zoning and energy use reduction	1		

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0		
F.02	Temporary construction work is minimised	0		
F.03	The impact of the building process on continuing healthcare provision is minimised	1		
F.04	The building and grounds can be readily maintained	1		
F.05	The construction is robust	1		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1		
F.09	The construction contributes to being a good neighbour	1		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1		

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1		
G.02	The building and grounds are interesting to look at and move around in	1		
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G.05	The project is likely to influence future designs	1		
G.06	The design provides a clear strategy for future adaptation and expansion	1		
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	1		
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2		

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1		
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1		
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	1		
H.04	The external materials and detailing appear to be of high quality and are maintainable	1		
H.05	The external colours and textures seem appropriate and attractive for the local setting	1		
H.06	The design maximises the site opportunities and enhances a sense of place	1		
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2		

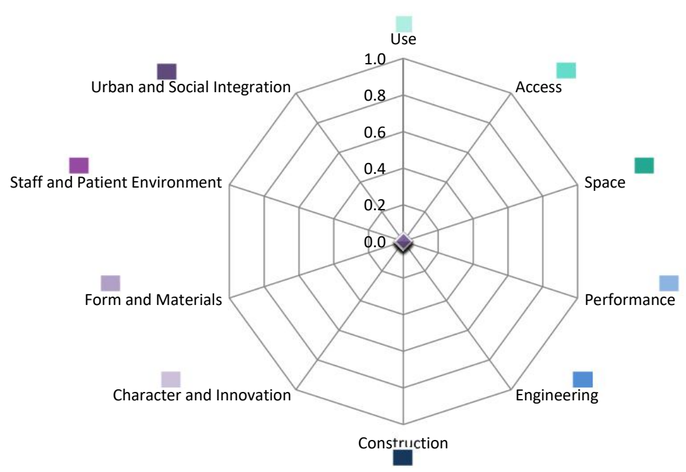
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	1		
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	1		
I.03	The design maximises the opportunities for access to usable outdoor space	1		
I.04	There are high levels of both comfort and control of comfort	1		
I.05	The design is clearly understandable and wayfinding is intuitive	1		
I.06	The interior of the building is attractive in appearance	1		
I.07	There are good bath/ toilet and other facilities for patients	1		
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	1		
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1		
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2		

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1		
J.02	The facility contributes positively to its locality	1		
J.03	The hard and soft landscape contribute positively to the locality	1		
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers- by	1		
J.05	There is a clear vision behind the design, its setting and outdoor spaces	1		
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2		

AEDET Refresh POE Summary



Target		Progress	
		Prev	Curr
4.2	Use	0.0	0.0
4.3	Access	0.0	0.0
4.2	Space	0.0	0.0
4.2	Performance	0.0	0.0
3.4	Engineering	0.0	0.0
4.0	Construction	0.0	0.0
4.2	Character and Innovation	0.0	0.0
4.3	Form and Materials	0.0	0.0
4.2	Staff and Patient Environment	0.0	0.0
4.3	Urban and Social Integration	0.0	0.0

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
	A.08	
	A.09	
	A.10	
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	B.08	
####	B.09	
	C.01	
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	C.06	
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	I.04	
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	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Post Occupation Evaluation Stage

1 AEDET POE to be set approx 1-2 years after occupation and must be submitted for NDAP Post Project Evaluation
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

AEDET Refresh v1.1 Feb 2016

REH Phase 2 60-bed MH Rehabilitation and Low Secure Unit

Summary

Category	Benchmark	Target	OBC	FBC	POE
Use	1.4	4.2	0.0	0.0	0.0
Access	1.9	4.3	0.0	0.0	0.0
Space	1.6	4.2	0.0	0.0	0.0
Performance	1.6	4.2	0.0	0.0	0.0
Engineering	0.3	3.4	0.0	0.0	0.0
Construction	0.0	4.0	0.0	0.0	0.0
Character and Innovation	1.3	4.2	0.0	0.0	0.0
Form and Materials	1.2	4.3	0.0	0.0	0.0
Staff and Patient Environment	1.0	4.2	0.0	0.0	0.0
Urban and Social Integration	2.4	4.3	0.0	0.0	0.0

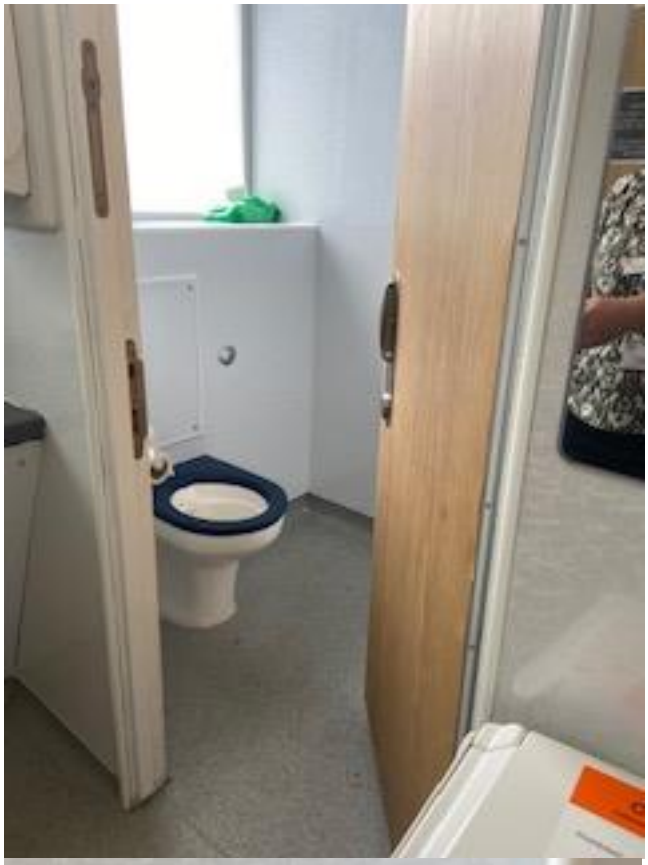
NHS National Services Scotland

Health Facilities Scotland

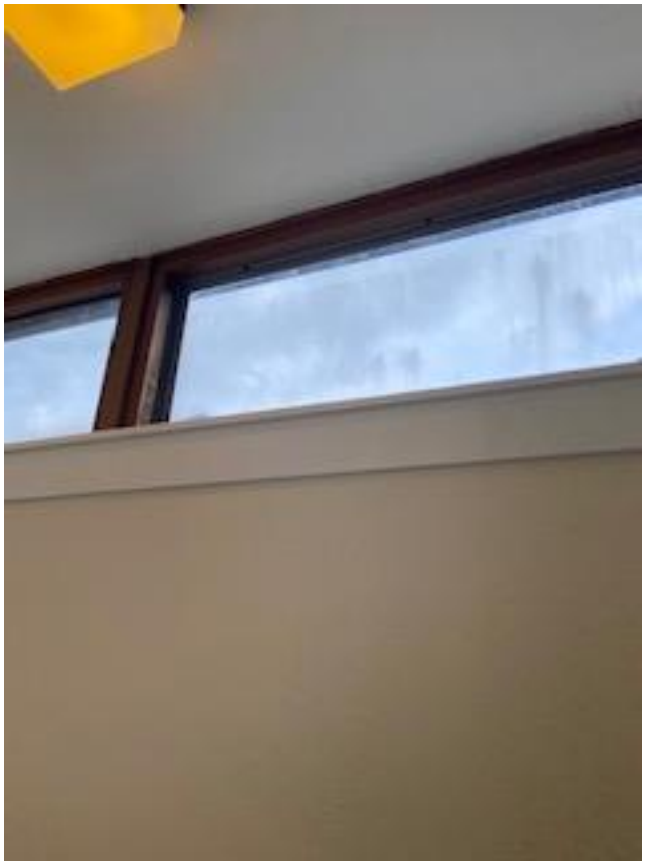
Appendix 6 – Pictures of Current Rehabilitation Wards

Treatment and Dispensory Room

Toilets




PLEASE WASH
YOUR HANDS



Windows

Family Room

Door to Ward

Damage to Walls/Flooring

Lift

14th October 2021, 2.00pm

Financial Position August 2021, financial out-turn 2021/22 and financial planning 2022/23 – 25/26

Item number:	**5.4**

Executive summary

The IJB has a budget for the current financial year of c. £150m . This report lays out the current (August 2021) expenditure against this budget by the IJB partners (an overspend of c. £ 429k), lays out the projected out-turn for the financial year 2021/22 (projected to be break-even) and considers the use of the IJB's general reserve in year. The IJB is required to prepare a balanced financial plan and this report then considers the current position and examines the progress in driving this work forward

Board members are asked to:

1. *Note the financial position at August 2021*
2. *Note the projected out-turn position for 2021/22*
3. *Note the deployment of the earmarked reserves in 2021/22*
4. *Agree the applications of the general reserve*
5. *Support the further development of the IJB's five year financial plan*

Report

Financial Position August 2021, financial out-turn 2021/22 and financial planning 2022/23 – 25/26

1 Purpose

1.1 This paper has six objectives :-

- Update the IJB on its current (month 5) financial position
- Inform the IJB of the current projected out-turn for 2021/22
- Note the deployment of the earmarked reserves in 2021/22
- Agree the applications of the general reserve
- Consider the current issues and the future the financial challenges in 22/23 and beyond
- Discuss the current progress towards the production of a five year, balanced financial plan

2 Recommendations

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

- Note the financial position at August 2021
- Note the projected out-turn position for 2021/22
- Note the deployment of the earmarked reserves in 2021/22
- Agree the applications of the general reserve
- Support the further development of the IJB's five year financial plan

3 Background and main report

3.1 Background and Context

At August 2021, the IJB has a budget of c. £149.6m for 21/22. This position has moved on from the opening balances that were agreed by the IJB at its March 2021 meeting. Appendix 1 reconciles the opening budget for 21/22 to the current position. Further resources, if required to support Covid pressures will be made available by the Scottish Government.

3.2 August 2021 Position

Although the IJB is not a board of management and relies on its partners to manage the operational delivery of the services that have been delegated to the IJB, its useful to have an update on the current financial position as that is the baseline for the forecast for the current financial year and also an indication of financial pressures within the system. That said, Midlothian Council do not provide

a monthly YTD financial position (although detailed information is available to the management teams) instead they update their year-end forecast. NHS Lothian have provided the following position for month 5 –

	Mid Lothian IJB Annual Budget '000	Mid Lothian IJB YTD Budget £'000	Mid Lothian IJB YTD Actual £'000	Mid Lothian IJB YTD Variance £'000
NHS Services				
Core	69,202	23,611	24,001	(390)
Hosted	13,724	5,407	5,316	91
Acute	19,009	7,382	7,513	(130)
NHS Services	**101,935**	**36,400**	**36,829**	**(429)**

That is an overspend of £439k at the end of August 2021. There being three main pressures within that position –

- An overspend within the MLCH (Rossbank Ward) – management action is underway to resolve this pressure
- An overspend within the prescribing budget – an element of the IJB's uplift (the current use of which has still to be agreed) will support this position
- Pressures within the Set Aside budget – largely within the Junior Doctors budget lines. Discussions are on-going with Acute colleagues to understand this position and to action a resolution.

3.3 Projected out-turn position 2021/22

Both partners have provided the IJB with an updated outturn forecast. Midlothian Council have forecast an overspend of c. £88k for Adult Social care and NHS Lothian (having taken account of the IJB's uplift as discussed above) are projecting an overspend of c. £165k on delegated services . Both these positions make the assumption that additional costs incurred by the IJB as a result of the Covid pandemic will be covered by the Scottish Government.

However, the current out-turn projection by the partners for the IJB (c. £253k of an overspend) is, based on previous experience, manageable by the operational management teams and, at this time, a break-even position for the IJB is forecast for 2021/22. Neither Midlothian Council nor NHS Lothian has made any provision to increase the resources allocated to the IJB - that is they expect a breakeven position to be secured.

3.4 Use of the IJB's Reserves

At the end of March 2021, the IJB had c. £12.9m of reserves of which c. £5.5m was the Covid reserve. The Covid reserve will be used to support the partners as appropriate in 21/22 with the reserves available to the IJB operationally being c. £7.4m of which £4.7m is held in the general reserve with the remainder being funds carried forward from previous periods for agreed projects.

Appendix 2 shows the reserves balances as 31/3/21 and lays out the in year use of the carried forward balances (the earmarked reserves).

The IJB has a reserves strategy which was agreed at its February 2017 meeting. This policy discussed the use of the general reserve and set a target value of 2% of the total budget. That would be, based on the budget above but excluding the Covid funding, c. £2.9m. The balance on the general reserve at 31/3/21 was £4.7m which is clearly in excess of this target. The IJB has already agreed to use £756k of the general reserve over the winter of 2021/22 to provide an additional 20 WTE healthcare support workers and is funding further project management resource but even after this disbursement the IJB's general reserve will be in excess of its target balance. It is proposed that additional resources above the 2% target are considered to be used in future periods as required to support the production of a balanced long term financial plan.

3.5 Potential financial pressures – 22/23 onwards

There are three major areas of challenge :-

3.5.1 Further impact of the Covid Pandemic

In 20/21, the IJB used £4.5m of support from the Scottish Government to underpin the additional costs incurred by its partners due to the impacts of the Covid pandemic. There are two underlying issues which now require to be developed :-

- On the presumption that no further funds are available in 2022/23 to support Covid costs what is the financial impact on the current operations of the partners ? Appendix 3 shows the totality of this risk in financial terms, discussion are underway with partners and the Scottish Government around the management of this position.

- What is the financial impact on health and social care services for the delivery of post pandemic services ?
  Both partners are considering this position but, at this time, no further financial forecasts are available and until these are available its difficult to prepare a financial forecast for the IJB

3.5.2 Pay Awards and other staff settlements

Within the NHS system, pay awards are generally recognised as part of an uplift to the Health Board's base budget. However, the uplift only applies to the base recurring budget and services funded from other allocations (for example PCIF or Action 15) do not have any uplift applied and therefore any pay award generates a financial pressure therein.

Councils do not, generally, get an uplift to recognise the full financial impact of pay awards and the Scottish Government's requirements for 'fair work' and the appropriate pay for staff employed by third party provides of social care services also has a further inflationary impact on these costs. Whilst negotiations for the 2021 pay uplifts have yet to be concluded the offers currently being discussed exceed the uplift that Councils received to their core funding as part of the 2021/22 local government settlement and may bring a further pressure to the system

As employers both NHS and the Council will face an increased NIC employer cost as a result if the 1.25% increase in employer NIC rates to fund social care

investment. This is part of the UK governments plan to provide additional resources to both Health and Social Care but will also increase the cost base of the services provided by the IJB's partners. This is discussed further below.

3.5.3 Demographic Pressures

Midlothian's population growth is the highest of any council area in Scotland and this generates additional demand on both the Health and Social Care services. While the Scottish Government distribution methods that recasts the share of the total resources available for both health and social care take account of population movements they do not react sufficiently swiftly to population increases in operational terms. For local government there is also a floor mechanism which gives a degree of protection to Councils' with reducing populations which is self funded by reducing the allocation to growing councils There is also the question of how any additional resources are to be distributed amongst the services that the partners provide. This is not a new issue and colleagues will be aware that it has been discussed previously.

3.6 Opportunities

It should be recognised that a range of additional investments has been made available to the IJB over the past few years – Change Fund, Integrated Care Fund, additional Delayed Discharge funding, Action 15, SCF, PCIF, Carers, etc and these investments have supported the IJB's transformational model. It's worth considering if these investments have indeed delivered the benefits that was intended. This consideration has been raised with the SPG and further work is on-going to review the costs/benefits of all the investments.

There are two further pieces of work underway which should provide additional resources which can then be incorporated into the IJB's financial plans :-

- NHS Recovery plan

  On 25th August 2021 the Scottish Government published its NHS recovery plan which sets out key ambitions and actions to be developed and delivered now and over the next 5 years in order to address the backlog in care and meet ongoing healthcare needs for people across Scotland.

- UK Government plans for additional resources for the NHS and Social Care in England. The Barnet consequentials of which are estimated at £1.1 bn, the use of which will be decided by the Scottish Government

3.7 Further development of the IJB's Financial Plan

The IJB is required to prepare a financial plan that articulates (in financial terms) how it will achieve its Strategic Plan. In principle this plan should be multi-year (ideally over the period of the Strategic Plan) and be balanced – that is break-even year on year. For the last two financial years, the IJB's external Auditors have flagged up their concerns about 'financial stability' – by which they mean the lack of a balanced multi-year financial plan and the CO and the CFO have undertaken to progress the development of such a plan as a matter of urgency.

3.7.1 Financial Strategy

The IJB has prepared a detailed finance strategy to provide a framework for the development of the financial plan. This can be seen at https://www.midlothian.gov.uk/info/1347/health_and_social_care/200/health_and_social_care_integration under 'Finance Strategy 2019-22'. It's recommended that colleagues read this document since this document lays out, in detail, how the financial plan will be developed.

3.7.1 Most recent Financial Plan Update

At its December 2020 meeting, an updated financial projection for the next four financial years was presented to the IJB. This showed a pre-Covid forecast (extracted from both partners financial forecasts) and projected financial gaps ranging from £3.8m in 21/22 to £11.0m in 24/25. It was noted that these were pre-Covid forecasts, that the current Covid crisis was hindering development work and that actions to close these gaps were being developed.

3.6.2 Forecasting bias

Financial forecasts for future years tend to show financial gaps. Efficiency schemes are rarely sufficiently developed to project their future impact, projections are generally based on assumptions of fully staffed services and the impact of any transformation work being developed by the IJB may not be taken into account.

3.6.3 What needs to be done

The partners, having updated the financial forecasts to take account of the impact of Covid, will provide a revised set of financial forecasts to the IJB. It is accepted that building in the impact of Covid will be difficult so any forecasts will have to be clearly caveated. It's likely that this work will generate the usual set of financial gaps.

The IJB requires to be presented with a set of 'balancing actions' which will be a mixture of operational efficiency plans and the assumed impact of any transformational programmes developed through the SPG. The IJB needs to be able to make clear decisions regarding any such proposals and then issue the appropriate directions.

3.6.4 Actions

Much of this is discussed in the finance strategy document but will include:-

- Further engagement with the SPG – the SPG should be the engine of transformational change. Thus any transformational programme will have to consider what financial or resource impact it will have on the IJB's overall budgetary position.
- Engage the partners to -
  - Identify efficiency plans in Set Aside and Hosted
  - Ensure that the impacts of transformation programmes are understood by Set Aside and Hosted management teams to Identify actions that can be taken collaboratively with the other IJBs
- Identify HSCP efficiency plans both for current year and future years

- Consider current operational Overspends – action to manage current overspends and proposals to manage future overspend.

4 Policy Implications

4.1 There are no policy implications from this report, however policies may require to be revised arising from any operational or transformation proposals to balance the IJB's financial plan.

5 Directions

5.1 There are no implications on directions from this report.

6 Equalities Implications

6.1 There are no equalities implications from this report

7 Resource Implications

7.1 There are no resource implications from this report.

8 Risk

8.1 The risks raised by this report are already included within the IJB risk register, any further risks arising from any proposals will be included in the register as required.

9 Involving people

9.1 The IJB's meetings are recorded and available to the public and all of its papers are available on the internet.

10 Background Papers

10.1 IJB's Financial Strategy – link above

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DATE	September 2021

Appendices:
Appendix 1 – Reconciliation – current IJB budget to offer letters agreed
Appendix 2 – Disbursement of Reserves
Appendix 3 – Covid Exit analysis

Appendix 1

Reconciliation from Budget Offer to Month 5 Budget

Midlothian IJB Budget for 2021/22	£000's Council	£000's NHS	£000's Total
Opening Offer @ March 2021 (recurrent IJB baseline)	47,724	78,030	125,754
GMS		16,810	
Scottish Government Allocations		2,115	
COVID Funding		3,598	
Additional Resources from Financial Plan		1,382	
Budget at Month 5	47,724	101,935	149,659

Appendix 2 – Reserves Analysis

	Opening Balance	Held by Midlothian Council	Held by NHSiL	Closing Balance	Notes
	£000's	£000's	£000's	£000's	£000's
COVID Funding	5,492	-4238	-1254	0	Analysis shows where reserves are being held at start of 21-22. Funding will be allocated to partners based on actual spend incurred
Local Programmes	926	-69	-857	0	
Primary Care Investment Fund	342		-342	0	
MELDAP	326	-54	-272	0	
Community Support Fund	312	-312		0	
Technology Enabled Care (SG funding)	274	-57	-217	0	
Integrated Care Fund	218	-218		0	
Wellbeing Service	189	-189		0	
Action 15	102		-102	0	
EGIERDA Project (Big Lottery funding)	79	-79		0	
Autism Strategy (SG funding)	12	-12		0	
Total Earmarked Reserves	**8,272**	-5228	-3044	**0**	
General Reserves	4,721		-577	**4,144**	includes £315k for 5 months of £756k FYE for Additional Carers as posts still at recruitment stage
Total Reserves	**12,993**	-5228	-3621	**4,144**	

Appendix 3 – Services in Midlothian Partnership with COVID EXIT PLANS

Covid Services /Expenditure	**21/22 Est Cost £**	**21/22 WTE's**	**Exit Plan** *(Update of arrangements to withdraw extra staff/service)*	**Exit Trigger** *(set out any criteria that needs to be met in order to implement the Exit Plan)*
Additional Care at Home posts	£345,000	10.00	Funding received from NHSL Gold or staff put on redeployment as per NHSL Gold agreement	Recommendation from NHSL Gold Command
Discharge to asses Expansion	£880,000	19.84	No Exit plan for the local decision to enhance team (£661k) Funding received from NHSL Gold (£219k) or staff put on redeployment as per NHSL Gold agreement	Recommendation from NHSL Gold Command
Flow HUB - 7 day working	£137,000	2.00	Funding received from NHSL Gold or staff put on redeployment as per NHSL Gold agreement	Recommendation from NHSL Gold Command
Hospital at Home expansion	£160,000	2.00	Funding received from NHSL Gold or staff put on redeployment as per NHSL Gold agreement	Recommendation from NHSL Gold Command
Home first expansion	£158,000	5.00	Funding received from NHSL Gold or staff put on redeployment as per NHSL Gold agreement	Recommendation from NHSL Gold Command
Opening of an additional ward in MCH	£957,500	36.20	Funding received from NHSL Gold or staff put on redeployment as per NHSL Gold agreement	Recommendation from NHSL Gold Command

Local Flow Hub	£139,000	3.00	No exit, plan to continue	
Care Home Team Exp	£166,000	3.60	No exit, plan to continue	
Volunteer Coordinator	£46,000	1.00		
Community Respiratory Team Exp	£316,000		No exit, plan to continue. Team plan to tackle patients with respiratory issues (inc long Covid)	
Old Bonnyrigg Wards	£20,000	N/A		
MCH Works	£150,000	N/A		
Total ML Partnership Prefund Value	**£3,474,500**	**82.64**		

Note – Significant sums were also expended to support Social Care Providers in Midlothian

Thursday 14th October 2021, 2.00pm

Draft Annual Performance Report 2020-21

Item number:	**5.5**

Executive summary

The IJB are required by Scottish Government and the 2014 Joint Working Act to publish an Annual Performance Report.

The attached draft Midlothian Annual Performance Report provides information on the health and wellbeing of the people of Midlothian and an assessment of performance in meeting the 9 national outcomes. It also describes the financial performance of the Partnership and the quality of health and care services delivered during 2020-21.

Board members are asked to:

- **Approve the content of the attached draft Annual Performance Report**

Draft Annual Performance Report 2020-21

1 Purpose

1.1 The attached draft Midlothian Annual Performance Report provides information on the health and wellbeing of the people of Midlothian and an assessment of performance in meeting the 9 national outcomes. It also describes the financial performance of the IJB and the quality of health and care services delivered during 2020-21.

2 Recommendations

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

Approve the content of the attached draft Annual Performance Report

3 Background and main report

3.1 The IJB are required by Scottish Government and the 2014 Joint Working Act to publish an annual report detailing key achievements of the previous financial year and an assessment of performance against the national core suite of integration indicators and in meeting the 9 national outcomes.

3.2 The purpose of the performance report is to provide an overview of performance of the IJB in planning and carrying out integrated functions and is produced for the benefit of the IJB, Partnerships and their communities.

3.3 In recognition of the impact of COVID-19 on the planning and delivery of Health and Social Care, Scottish Government offered IJBs the option to extend the date of publication of Annual Performance Reports through to November 2021 through the Coronavirus Scotland Act (2020) Schedule 6, Part 3.

3.4 At the meeting on 17th June 2020 the Midlothian IJB agreed to delegate authority to Morag Barrow, Chief Officer, to publish the Annual Report by 31 July 2021, in line with the reporting timeframes set by Scottish Government, and to bring the report for formal IJB approval at the meeting in August 2021.

3.5 While it was the preference of the HSCP that this report was completed and published in line with original timeframes, due to the need for further clarity and exploration of the data then received from Public Health Scotland at the end of June it was agreed to postpone publication until this data was available. This was agreed at the IJB meeting on the 26th of August.

3.6 The 20/21 National Core Suite of Integration Indicators were received from Public Health Scotland at the end of June and are included in the report, along with the Midlothian IJB performance against MSG indicators.

3.7 Information on the number of responses for the Health and Care Experience Survey (which is used to give the data indicators 1-9) was requested from Public Health Scotland to support understanding of this data. This information has been included in the draft Annual Performance Report.

3.8 Information on the confidence intervals was also requested from Public Health Scotland to further support interpretation of the data. This was received on the 4th of October and has now been included in the report. For a number of the indicators there are large differences in the confidence intervals for the national data compared to Midlothian, with the Midlothian data having much larger confidence intervals. The confidence intervals show the degree of uncertainty around the survey response; results with larger confidence intervals have a high degree of uncertainty.

3. As the report covers April 2020 to March 2021 in sharing our activities and achievements over the year we have aimed to reflect the impact of Covid whilst still giving a balance in reporting of both Covid and non-Covid related activities.

4 Policy Implications

4.1 IJBs have a legal obligation to produce an annual performance report in line with the The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 and the Scottish Government Guidance: Health and Social Care Integration Partnerships: reporting guidance.

4.2 This includes reporting on the national Core Suite of Integration Indicators provided by Public Health Scotland, using these to support reporting on how well we are progressing the 9 national health and wellbeing outcomes which apply to integrated health and social care.

4.2 This Midlothian Annual Performance Report complies with all the requirements with the exception of a breakdown of spend per locality. Systems to facilitate a robust report on this are not yet in place.

5 Directions

5.1 This report does not relate to any specific directions.

6 Equalities Implications

6.1 There are no equalities implications arising from this report.

7 Resource Implications

7.1 There are no resource implications arising from this report.

8 Risk

8.1 IJBs, have a legal obligation to produce an annual performance report which meets the requirements set by Scottish Government. Not complying will pose legislative risks and it will be more difficult for the IJB to undertake its duties related to accountability and good governance

9 Involving people

9.1 The report highlights the involvement of users of services in the development and recommissioning of services

10 Background Papers

10.1

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Appendices: Midlothian IJB Annual Performance Report




Midlothian
Health & Social Care



Midlothian Integration Joint Board ANNUAL PERFORMANCE REPORT 2020/21

Contents

Foreword

This report shares our performance around planning and delivering health and social care services. It covers the period 1st April 2020 to 31st March 2021. It shows how we have done over the past year in improving the quality and experience of health and social care services for people and communities in Midlothian.

COVID
The pandemic brought many challenges and disruption to the Health and Social Care Partnership (HSCP), our partners and the communities we serve. There was increased anxiety and pressure on many service users, unpaid carers and staff.

Our priority was the safety of clients, communities and staff. It was important to be innovative and support people effectively and safely. As well as managing changes to existing services, the HSCP provided care and treatment to people who had contracted COVID-19 and their families. It provided personal protective equipment and staff testing support to partner agencies.

Partners
The last year has highlighted the importance of working with local communities and involving them at all levels. Our third sector and independent partners remain crucial and we will continue to work with these strong and innovative sectors.

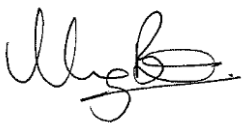
Improving outcomes for people
The level of service transformation in the HSCP over the last year demonstrates innovation, flexibility and a focus on sustainable change to improve outcomes for people. This report includes example of service transformation. As a partnership we aim to work with people and make a positive difference to their health and wellbeing – as a result we have increased our focus on performance and our ability to demonstrate that our services are contributing to improved outcomes for people.

Data
This report includes results from a 2 yearly survey to a small number (2.5% for Midlothian) of people aged 17 or over in 2019. This showed that 93.3% of adults in Midlothian are able to look after their health well or very well. However further work is required to ensure services are coordinated and people have positive experiences.

This report also includes information from Public Health Scotland. This showed that our performance related to use of acute hospitals has improved but again more work is required, for example, people getting home from hospital promptly.

New Strategic Plan
During 2021-22 we will continue to reshape our services to support people to stay well and at home as far as possible. We will continue to involve people in developing our next 3-year Strategic Plan. We will continue to manage finances well and demonstrate good governance.

I would like to thank our staff, the IJB Board and our partners for all their work over the year.



Morag Barrow,
Chief Officer,
Midlothian Integration Joint Board

HOW DID WE DO?

Health & Wellbeing Outcomes

The Scottish Government set 9 National Health and Wellbeing Outcomes to improve the quality and experience of health and social care services. This report shows how we are working towards these.

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

Outcome 2 – Living in the Community
People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 3 – Positive Experiences and Dignity
People who use health and social care services have positive experiences of those services, and have their dignity respected.

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

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

Outcome 6 – Carers
People who provide unpaid care are supported to look after their health and wellbeing

Outcome 7 - Safe from Harm
People using health and social care services are safe from harm.

Outcome 8 – Workforce
People who work in health and social care services are engaged with their work and improve information, support, care and treatment they provide.

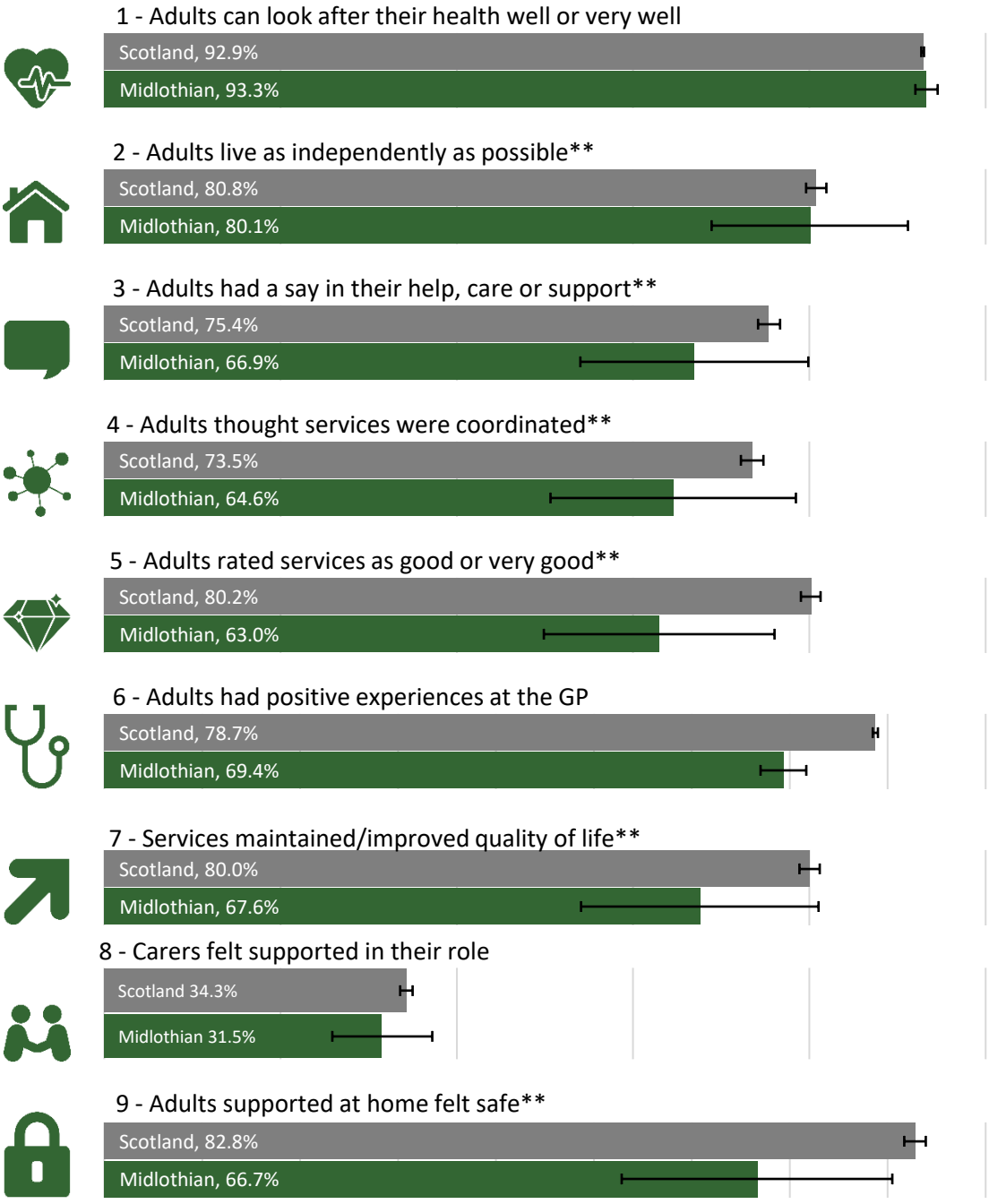
Outcome 9 – Resources
Resources are used effectively and efficiently.

National Performance Indicators

We use National Performance Indicators to measure how we are meeting the outcomes. These are from the Health and Care Experience (HACE) Survey and Public Health Scotland.

**2,060 people from Midlothian contributed to the HACE survey, however for indicators 2,3,4,5,7, 9 under 60 responses were received as only people receiving NHS Lothian and Midlothian Council funded health and social care services were surveyed. Results for 2019/20 should not be directly compared to previous years due to changes in methodology.

Confidence intervals have been added to indicators 1- 9 to show the degree of uncertainty around the survey response; results with larger confidence intervals have a high degree of uncertainty. The black bars show the range within which there is a 95% confidence that the true result will be found. This should be taken into account when considering these results.



Results from Previous Years

1 - % of Adults can look after their health well or very well

	13/14	15/16	17/18	19/20
Scotland	94.0	95.0	93.0	92.9
Midlothian	94.9	93.5	91.7	93.3

2- % of Adults live as independently as possible**

	13/14	15/16	17/18
Scotland	83.0	83.0	81.0
Midlothian	82.6	78.0	86.3

3- % of Adults had a say in their help, care or support**

	13/14	15/16	17/18
Scotland	83.0	79.0	76.0
Midlothian	84.9	84.4	79.7

4 - % of Adults thought services were coordinated**

	13/14	15/16	17/18
Scotland	78.0	75.0	74.0
Midlothian	76.8	71.3	70.8

5 - % of Adults rated services as good or very good**

	13/14	15/16	17/18
Scotland	83.0	81.0	80.0
Midlothian	83.5	73.1	71.3

6 - % of Adults had positive experiences at the GP

	13/14	15/16	17/18	19/20
Scotland	85.0	85.0	83.0	78.7
Midlothian	77.7	78.6	75.8	69.4

7 - % of Services maintained/improved quality of life**

	13/14	15/16	17/18
Scotland	85.0	83.0	80.0
Midlothian	80.2	82.3	73.1

8 - % of Carers felt supported in their role

	13/14	15/16	17/18	19/20
Scotland	43.0	40.0	37.0	34.3
Midlothian	44.5	39.4	32.1	31.5

9 - % of Adults supported at home felt safe**

	13/14	15/16	17/18
Scotland	85.0	83.0	83.0
Midlothian	76.8	80.7	79.5

Hospitals

12 - Emergency Admission rate per 100,000 of the population

	15/16	16/17	17/18	18/19	19/20	2020
Scotland	12,295	12,229	12,210	12,279	12,522	11,111
Midlothian	11,602	10,923	11,599	11,153	12,666	11,295

13 - Emergency Bed Rate per 100,000 of the population

	15/16	16/17	17/18	18/19	19/20	2020
Scotland	127,563	125,948	123,388	120,155	118,288	102,961
Midlothian	122,683	122,772	122,160	120,976	113,821	104,076

14 – Emergency readmission into hospital within 28 days (rate per 1,000 discharges)

	15/16	16/17	17/18	18/19	19/20	2020
Scotland	98	101	103	103	105	115
Midlothian	104	109	114	110	109	120

19- Number of days of people 75+ spend in hospital when ready to be discharged per 1,000 population

	15/16	16/17	17/18	18/19	19/20	20/21
Scotland	915	841	762	793	774	488
Midlothian	835	971	1,422	1,323	966	678

20 - % health and care resource spent on hospital stays after an emergency admission

	15/16	16/17	17/18	18/19	19/20	2020
Scotland	23.2	23.4	24.1	24.1	24.1	21.2
Midlothian	21.7	21.8	22.9	23.9	23.0	20.8

Community

15 - % of the last 6 months of life spent at home or in a community setting

	15/16	16/17	17/18	18/19	19/20	2020
Scotland	87.0	87.3	88.0	88.0	88.4	90.0
Midlothian	84.6	85.5	87.3	85.9	86.5	88.6

16 - Falls rate per 1,000 of the population aged 65 or over

	15/16	16/17	17/18	18/19	19/20	2020
Scotland	21.1	21.4	22.2	22.5	22.8	21.7
Midlothian	21.1	18.7	20.2	17.9	23.9	25.9

17 - Proportion (%) of care services rated good or better by the care inspectorate

	15/16	16/17	17/18	18/19	19/20	20/21
Scotland	82.9	83.8	85.4	82.2	81.8	82.5
Midlothian	85.0	75.7	89.0	87.0	83.3	79.8

18 - % Adults with intensive care needs receiving care at home

	2015	2016	2017	2018	2019	2020
Scotland	61.2	61.6	60.7	62.1	63.1	62.9
Midlothian	64.9	68.8	69.8	67.7	61.0	56.8

11 - Premature Mortality Rate per 100,000 people

	2015	2016	2017	2018	2019	2020
Scotland	441	440	425	432	426	457
Midlothian	396	400	389	409	425	397

If data has not been published for 2020/21 we have included data from Jan – Dec 2020. Public Health Scotland recommends this use of calendar year data to improve consistency between Health and Social Care Partnerships.

Ministerial Steering Group Targets

The Scottish Government's Ministerial Strategic Group (MSG) have additional targets.

Updated targets for 2020/21 were developed by the HSCP, agreed by the Midlothian IJB and submitted to Scottish Government in February 2020. Our targets are measured against a baseline from 2017/18.

MEASURE	2017-18	2018-19	2019-20	2020-21	STATUS	PERFORMANCE
Reduce emergency admissions into hospital from Midlothian by 5% (all ages)	9,028	8,841	10,139	8,733*	Not achieved	*2020 Calendar year 3.26% reduction from baseline
Reduce number of unscheduled hospital bed days: acute specialties by 10% (all ages)	63,019	62,372	59,798	53,546*	Achieved	*2020 Calendar year 15% reduction from baseline
Decrease in the use of unscheduled geriatric long-stay beds (all ages)	12,734	13,551	12,806	12,802*	Not achieved	*2020 Calendar year 0.53% increase from baseline
Decrease in the use of unscheduled mental health beds (all ages)	14,843	15,162	12,847	12,706*	Achieved	*2020 Calendar year 14.4% decrease from baseline
Maintain Emergency Department Attendance at baseline level (all ages)	29,382	29,688	30,804	24,518	Below baseline	16.55% reduction
Reduce occupied bed days as a result of delayed discharge (all reasons) by 20% (age 18+)	12,295	12,934	10,412	7,150	Achieved	41.85% reduction from baseline
Increase percentage of time spent in community in last six months of life	87.3%	85.9%	86.5%	No data	Not achieved	0.8 percentage point change
Balance of Care - Increase the proportion of people over the age of 65 living in the community (supported and unsupported)	96.4%	96.5%	96.7%	No data	Achieved	0.3 percentage point change

SOURCE: Public Health Scotland Integration Performance Indicators June 2021 (Integration-performance-indicators-v1.42 MSG)

Notes

- Where noted the calendar year 2020 is used as a proxy for 2020/21 due to the national data for 2020/21 being incomplete. We have done this following guidance from Public Health Scotland.
- Figures presented will not take into account the full impact of COVID-19 during 2020/21. In particular the reduction in emergency department attendance is likely due to the fact that in 2020 there was a national lockdown because of COVID-19 and therefore may not reflect a true improvement in performance.

WHAT DID WE DO?

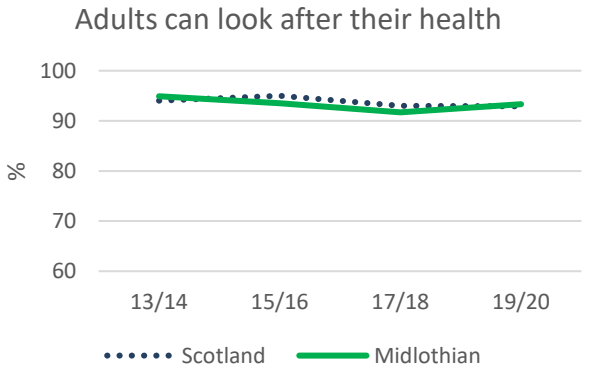
1 – Health & Wellbeing

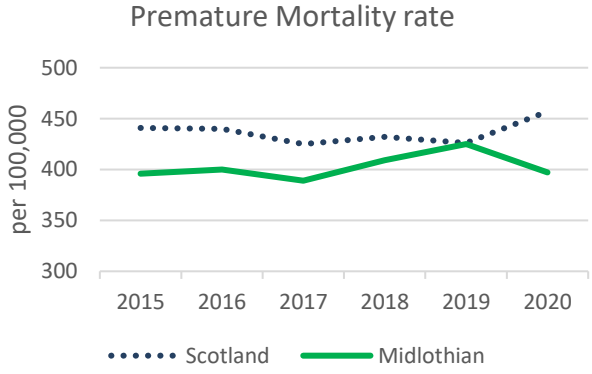
This outcome is aimed at making sure people are able to look after and improve their own health and wellbeing and live in good health for longer. We are moving money to a range of services that support people to do this including classes to help reduce the risk of falling, services to support people dealing with grief and services that provide support to people at home to help them avoid a hospital admissions.

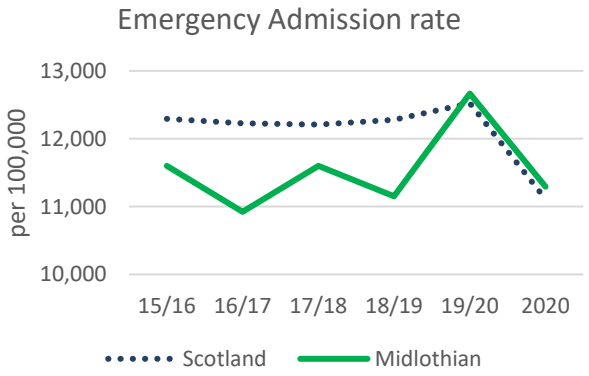
Empowering communities and individuals to manage their health and wellbeing can be challenging because of the difficulties some people face, including poverty and long term health conditions.

How we measure this outcome – yearly trends:

These are the national indicators used by Scottish Government to measure our progress towards this outcome.







New Beginnings

New Beginnings is a six week course for people who are bereaved. Due to Covid-19 the course was redesigned by the Health in Mind team working with the Thistle foundation so it could be delivered online.

The first online course was successful with 9 participants. One person said “I have found that hearing others’ stories has helped me a lot. I felt very alone before the group and I’ve learned to open up and share how I’m feeling rather than bottling it up.”

Reduce the risk of falling

Sport and leisure services joined the Health and Social Care Partnership during the year.
Together with Ageing Well and Midlothian Active Choices, they have worked with physiotherapy and Occupational Therapy services to support people at risk of falling.

By encouraging people to take part in Strength and Balance classes and short walking sessions they hope to improve people’s mobility and independence of and reduce their risk of falling.

Resilience Art Project

Children and young people shared their experiences of coping during COVID-19 through artwork using the ‘5 ways to wellbeing’.

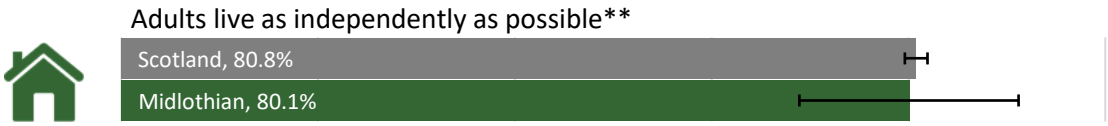
152 pieces of art from 13 schools was exhibited across Midlothian in a woodland trail and online gallery, along with Information on support available.

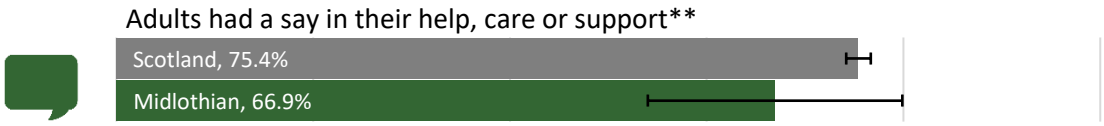
2 – Living in the Community

This outcome is aimed at ensuring people can live independently and at home or in a homely setting in their community. To support this, we continued to plan and build new specialist housing to meet people's care and support needs. We worked with third sector partners to help support people at home during the national lockdown, and we also continued to develop our support to help people get back home from hospital promptly.

How we measure this outcome – yearly trends:

These are the national indicators used by Scottish Government to measure our progress towards this outcome.





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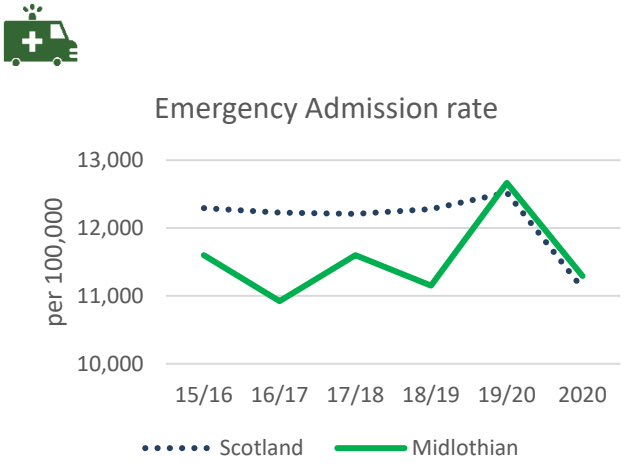
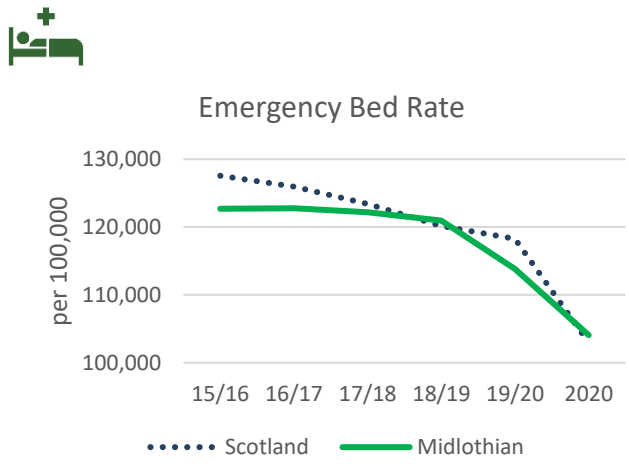
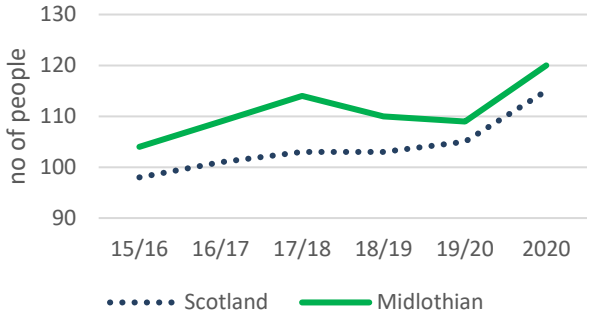
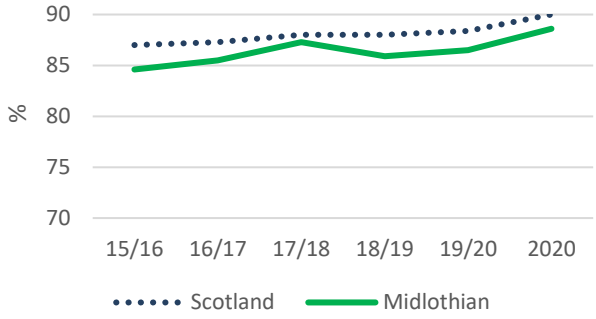




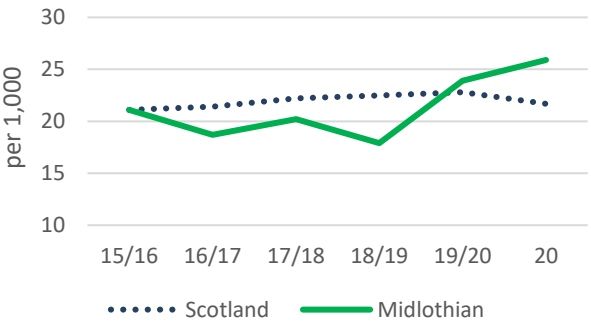
Readmission into hospital in 28 days



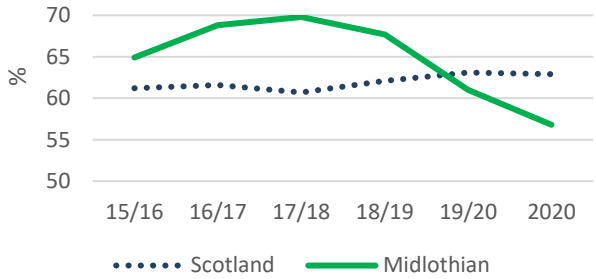
Last 6 months of life spent at home



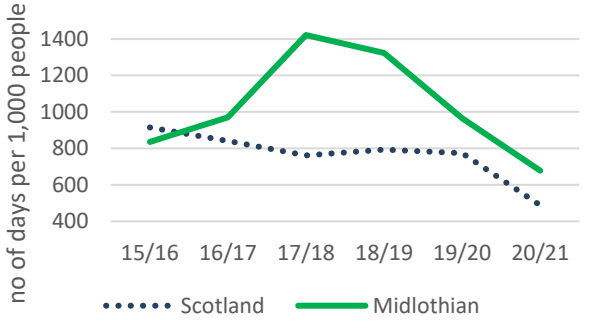
Falls rate (65+)



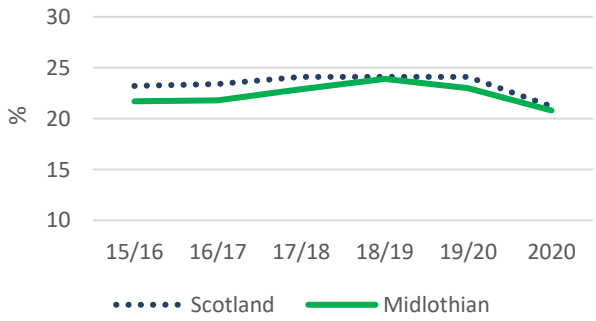
Adults with Intensive care needs recieving care at home



Delayed discharge (75+)



% spend after emergency admission



Extra Care Housing

Extra Care Housing allows people to access social care support while living in their own tenancy.

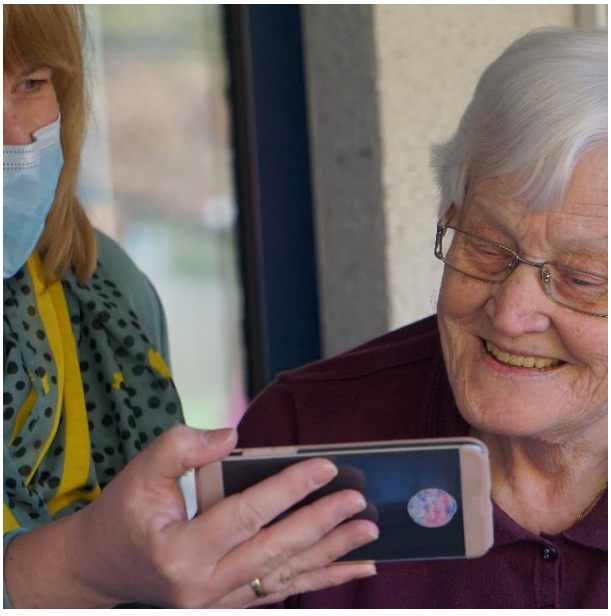
Building work was underway on 3 sites to provide 106 Extra Care Housing units.

In addition planning consent was awarded for 40 Extra Care flats and 8 Extra Care bungalows in Dalkeith.

Support through COVID

The Red Cross developed new ways of working and formed many new partnerships over the COVID pandemic to support as many people as possible.

Activities included delivering food and library books to people who were housebound, making over 5,000 welfare calls to elderly people, replacing hearing aid batteries, presenting a Radio show and creating activity packs with exercise programmes.



Supporting people with Frailty

The HSCP, GPs and Third Sector groups worked together to support people with moderate and severe frailty. They used GP data to create a 'Frailty Index' that could identify patients that may benefit from proactive support.

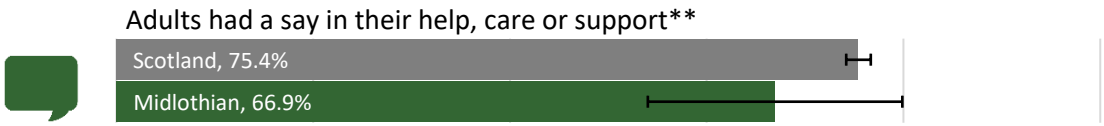
Once identified a person living with frailty was contacted and invited to receive care from the Primary Care frailty team who could offer longer, more holistic appointments, often at home. People who received this specialised and proactive support had less emergency admissions to hospital.

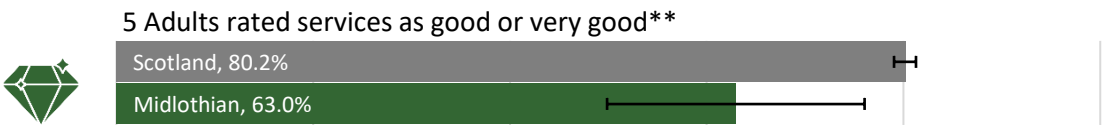
3– Positive Experiences & Dignity

This outcome is aimed at ensuring people who use health and social care services have positive experiences and have their dignity respected. Due to the impact of COVID our GP services developed new ways of providing primary care services including online, by phone and by email. Our GP practice teams also expanded with more specialist services located in practices such as physiotherapists, pharmacists and mental health nurses which allows people to be seen quicker and have a better experience.

How we measure this outcome – yearly trends:

These are the national indicators used by Scottish Government to measure our progress towards this outcome.





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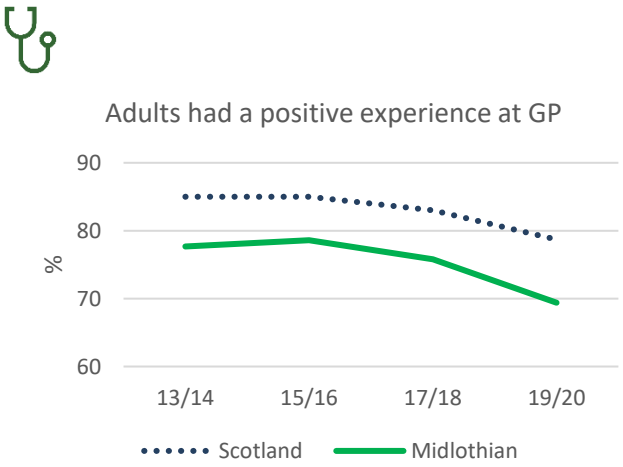
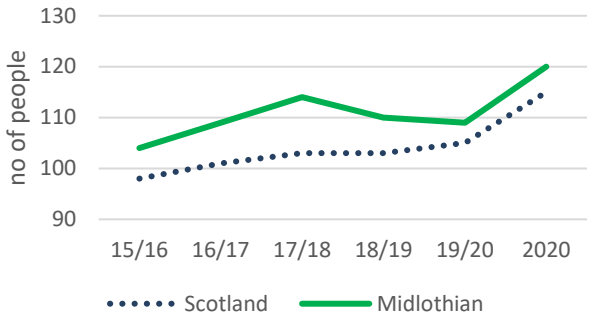
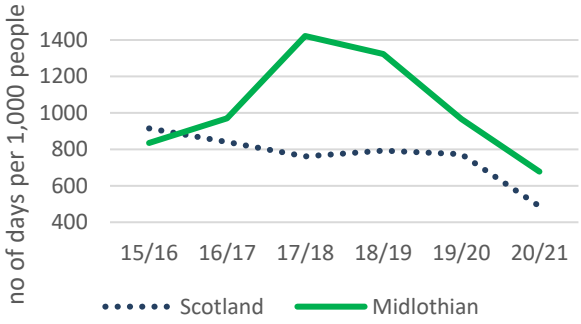


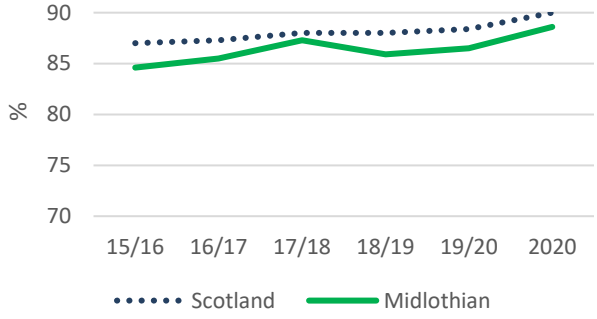
Readmission into hospital in 28 days

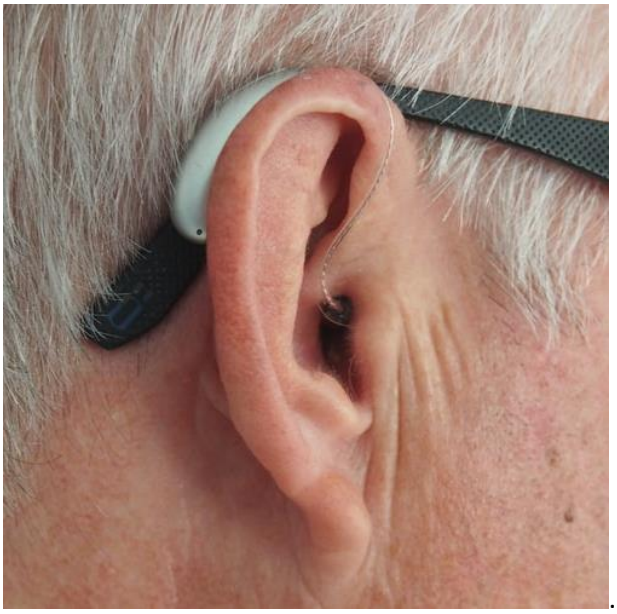


Delayed discharge (75+)



Last 6 months of life spent at home





Sensory Champions

Audiology run hearing aid repair clinics at Midlothian Community Hospital but due to COVID it was not possible for people to attend the clinics in person.

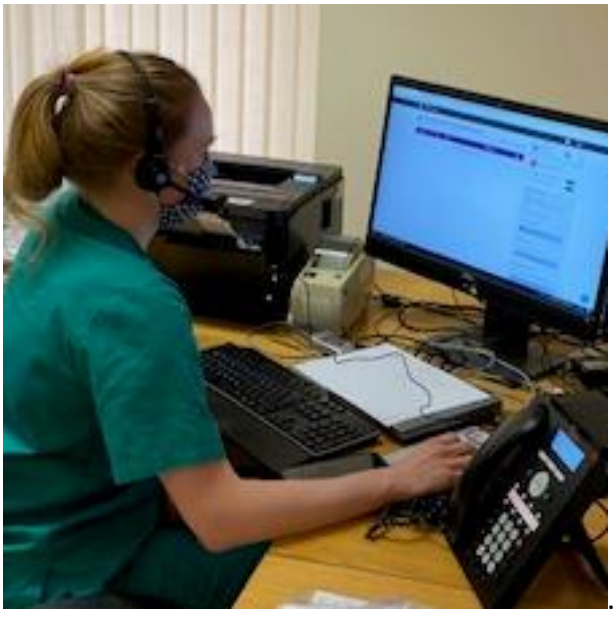
To address this a scheme was put in place where local volunteers collected hearing aids from individuals in advance of the clinic and delivered them back after the clinic. This support has been appreciated as it is minimises the length of time people are without working hearing aids.

Mental Health Nurses

Primary Care Mental Health Nurses are now in all 12 GP practices.

People can ask their GP to refer them, and in some GP practices patients can book to see the nurses directly via the reception team.

As well as providing direct support to people, they can link people to other community based support that support mental health such as Health in Mind, Women's Aid and volunteering programmes.



Remote GP consultations

COVID has speeded up ways to make it easier to access support from a doctor.

Most practices now offer consultations via the telephone, video or email in the first instance so that people don't have to travel to their surgery if they don't need to.

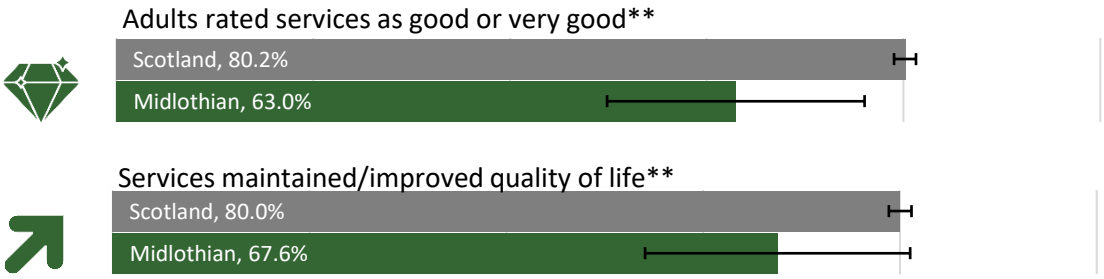
Where a physical examination adds value, people are seen face to face for that part of the consultation.

4 – Improved Quality of Life

This outcome is aimed at ensuring health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. Due to the lockdown our day services developed a range of new ways to keep in touch and provide support. We also continued to develop our falls service to quickly help people who have fallen and offer support to help prevent falls.

How we measure this outcome – yearly trends:

These are the national indicators used by Scottish Government to measure our progress towards this outcome.



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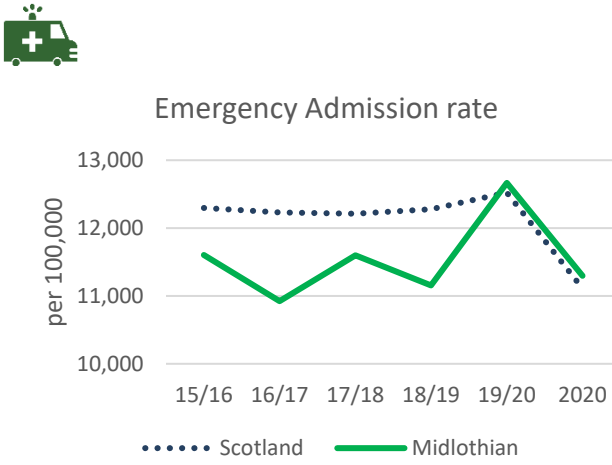
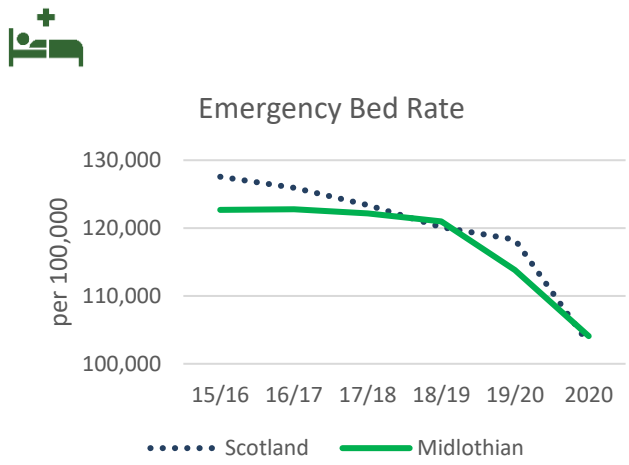
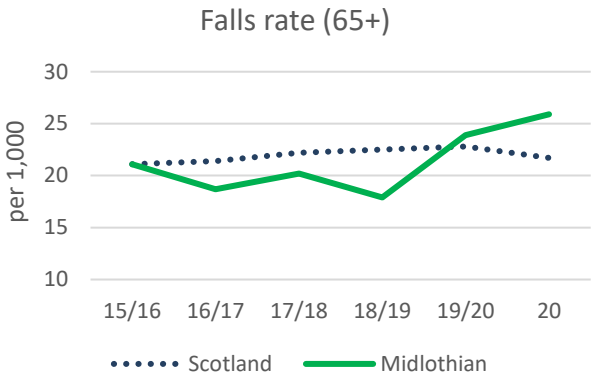
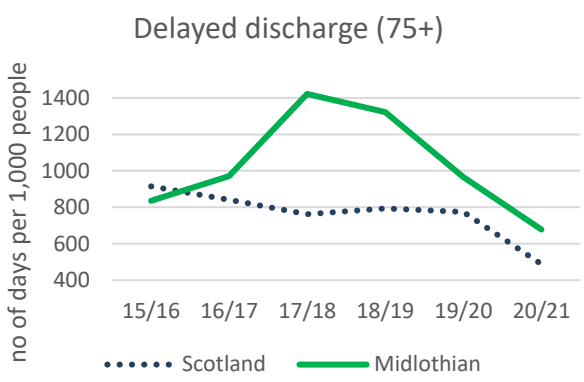





Falls rate (65+)
per 1,000
30
25
20
15
10
15/16
16/17
17/18
18/19
19/20
20
Scotland
Midlothian


Delayed discharge (75+)
no of days per 1,000 people
1400
1200
1000
800
600
400
15/16
16/17
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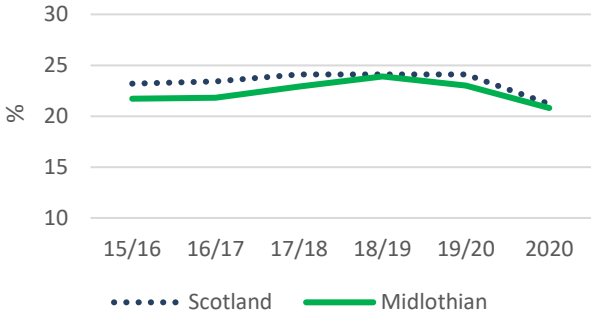
18/19
19/20
20/21
Scotland
Midlothian


% spend after emergency admission
%
30
25
20
15
10
15/16
16/17
17/18
18/19
19/20
2020
Scotland
Midlothian

Day Services – response to COVID

Day services for older people maintained regular contact with clients, offering essential support.

St David's phoned clients daily, helping with shopping and prescriptions. They delivered activity packs, including knitting and jigsaws.
Broomhill staff visited clients at their doorstep to provide support and delivered meals
Grassy Riggs kept in touch with people and during summer months encouraged people to host "garden bubble socials".

Artlink TV – Thursday Live!

Before lockdown, every Thursday a different entertainer would visit Cherry Road Learning Centre in Bonnyrigg.

When visits to the centre were no longer possible, Thursday Live! went online. Performers filmed themselves at home, and videos were streamed to Artlink TV on YouTube , so that anyone could watch them at home.

Artists familiar to Thursday Live! tailored performances to an audience who they knew well – and people could watch recordings of their videos multiple times.

Vaccination Programme

For some people attending a regular clinic for a vaccination can be difficult or anxiety provoking. So Learning Disability Nurses, the Vaccination Team at the Community Hospital, Social Workers, Support Providers, and families and carers worked together to organise a Learning Disability Vaccination Programme with an adapted clinical environment and a supportive and individual approach to accommodate people's needs.

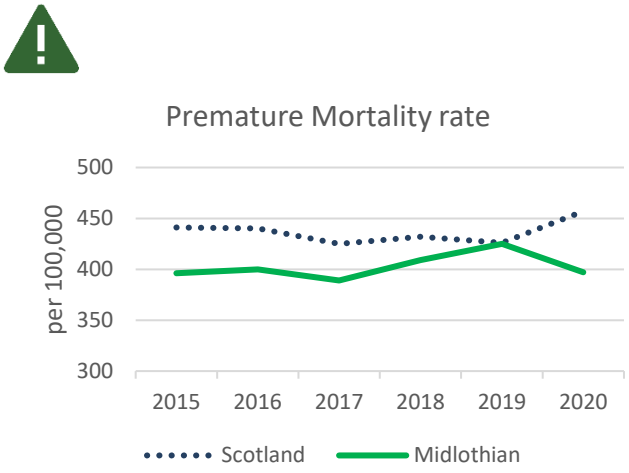
137 people received their first dose in early March and 135 their second in May.

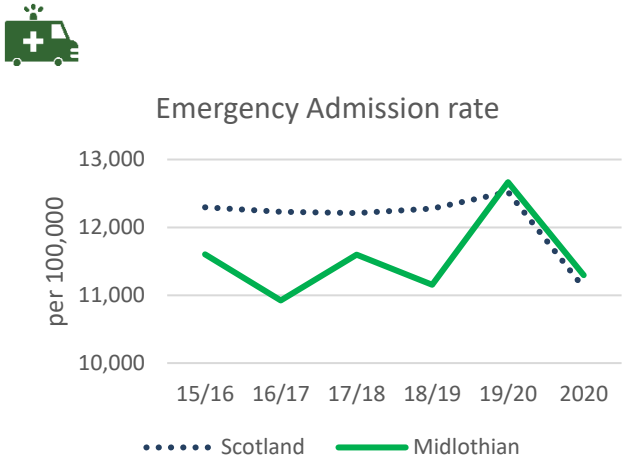
5 – Reduced Inequality

This outcome is aimed at ensuring that health and social services contribute to reducing health inequalities. Inequalities are avoidable and unfair differences in people's health across social and population groups. We adapted our services, and provided technological support to ensure we could continue to reach those most at risk.

How we measure this outcome – yearly trends

These are the national indicators used by Scottish Government to measure our progress towards this outcome.





Digital Response to COVID

Substance Misuse Services used phone, video platforms and essential 1 to 1 meetings to continue to provide care throughout COVID.

Across Midlothian and East Lothian, MELDAP provided 381 phones, 37 tablets and 553 digital top ups to assist those most at risk to keep in contact with treatment and support agencies.

Money in your pocket

The Welfare Rights Service supported people receiving a HSCP service to access £4,282,119,239.

This included 239 people with cancer who received support from the MacMillan Welfare Rights Advisor.

Third sector partners also provided welfare rights support including Citizen's Advice and the Red Cross.

Community Inclusion

The team adapted to ensure they could continue to offer essential support to vulnerable people and Carers throughout the pandemic.

They offered telephone and video health and wellbeing appointments and continued to offer face to face appointments where essential. They visited homeless accommodations regularly, knocking on each resident's door and offering them the opportunity to speak to a nurse.

6 – Support for Carers

This outcome is aimed at ensuring people who provide unpaid care are supported to look after their health and wellbeing.

Midlothian has approximately 9,000 unpaid carers and it is crucial we recognise the significant impact and effect their caring role can have on them, and offer support to sustain their role as long as they wish to do so. Many of these carers are not actively known to our services and we continue to try and reach these hidden carers.

We appreciate that the restrictions and worry caused by the pandemic increased the pressure on carers. We are grateful to third sector partners such as VOCAL Midlothian and Alzheimer's Scotland for the support offered.

How we measure this outcome – yearly trends:

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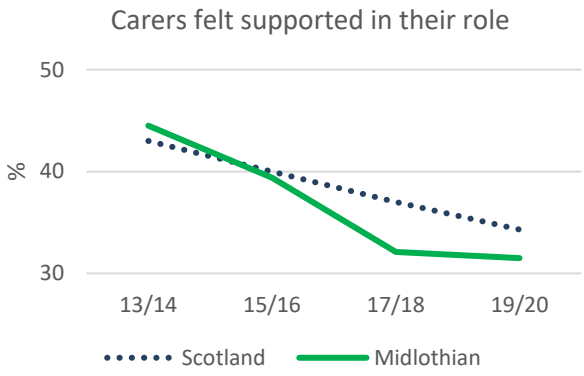


Local Data/Evidence

1,623 carers received an adult carer support plan of their care needs during 2020-21 (VOCAL and Adult Social Care combined). This more than doubled from the previous year.

2,278 carers received 1 to 1 support by VOCAL during 2020-21. This was an 18.71% increase from the previous year.

316 carers accessed short breaks through VOCAL Wee Breaks Service during 2020-21.
Penicuik CAB continued to offer surgeries and support to carers receiving support from VOCAL.

Additional carer income generated through contact with Penicuik CAB in 2020-21 was **£415,208.**

Recommissioning Carer Services

During 2020/21 we consulted with carers, the public, HSCP and Third Sector staff on what services should look like.

The review identified aims and priorities around carer support and services and used these to re-commission local services that will begin in July 2021 and be in place for 3 years.

Designing & Delivering Services

We worked in partnership and involved carers in decisions and arrangements around providing support to the people they care for and for themselves (as carers).

We had a carers' planning group and also involve carers within our wider processes, service commissioning and delivery, and strategic decisions which will impact on them and the care they provide.

Support during COVID

During the pandemic we recognised unpaid carers as Key Workers and issued guidance and PPE.

We worked with Third sector partners to send out Identification Letters.

As normal "short break" opportunities and respite support wasn't available, we put in place funding to support different and creative breaks from caring and discussed alternative ways to use SDS budgets.

7 – Safe from harm

This outcome is aimed at ensuring that people using health and social care services are safe from harm. All services must aim to keep people safe from harm and prevent avoidable risks. There is a strong link between substance misuse, community justice and mental health and the Number 11 Hub in Dalkeith improves collaboration between these services.

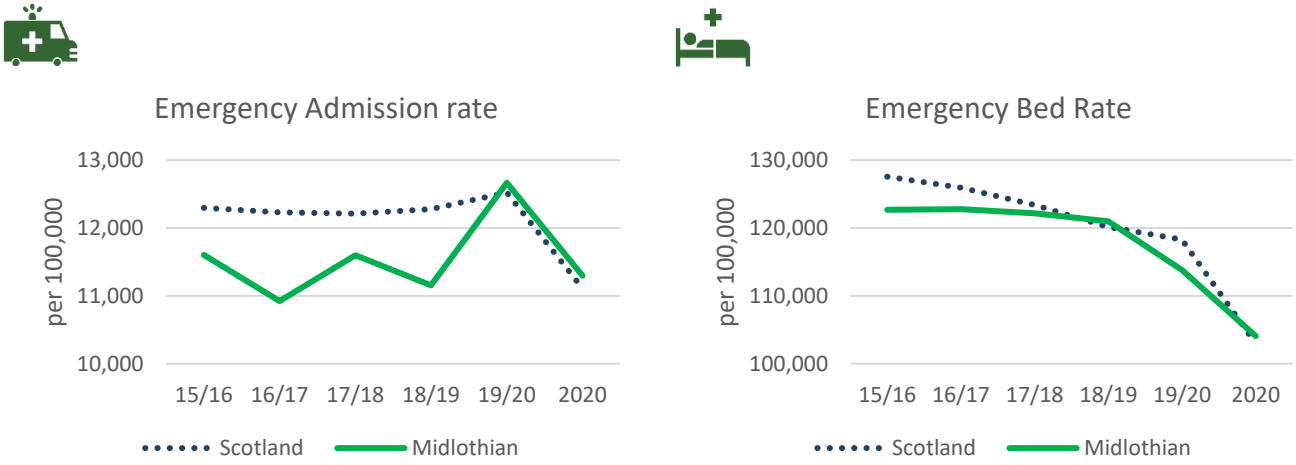
We adapted our training methods due to the impact of COVID so to ensure we were still able to deliver essential high quality training and assessment to all staff.

How we measure this outcome – yearly trends:

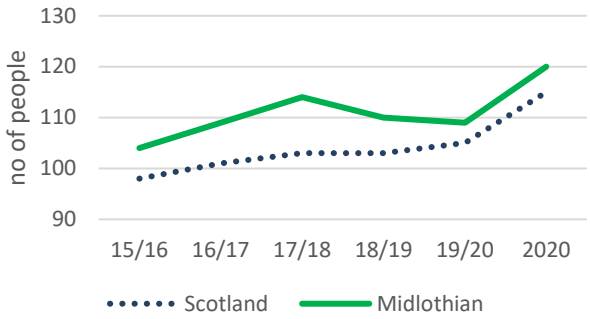
These are the national indicators used by Scottish Government to measure our progress towards this outcome.

Adults supported at home felt safe**

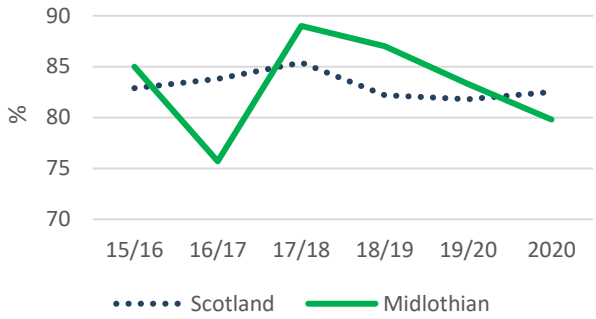
** Due to changes in the 2019/20 survey wording, this indicator is no longer comparable to previous years.



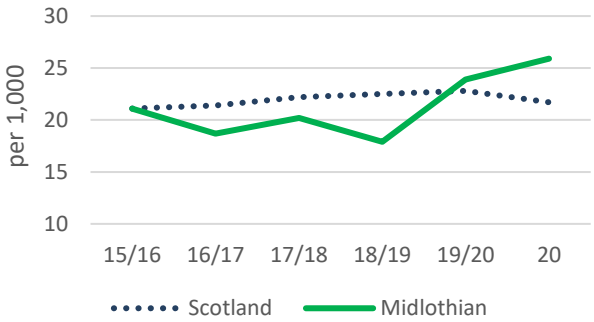
Readmission into hospital in 28 days



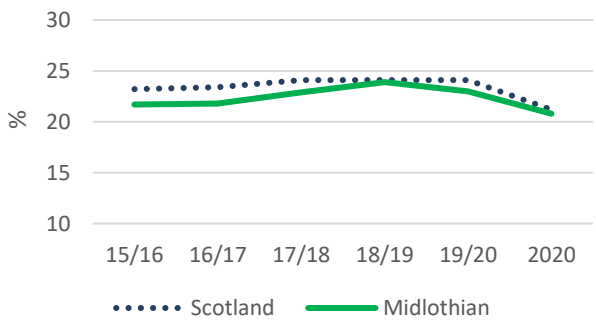
Care services rated good or better



Falls rate (65+)



% spend after emergency admission



COVID & Gender Based Violence

In Midlothian there was a 29% increase in the number of women referred to our specialist domestic abuse referral pathway following a police incident, from 244 to 315.

The impact of the COVID pandemic led to increased waiting lists for services for domestic abuse. Guidance for domestic abuse was developed in collaboration with Midlothian Council Housing and Homelessness Services and specialist services.

Care at Home

In November and December 2020 we asked people for feedback on Care at Home Services. Over 200 people took part. **88% of people said they always feel safe** "…**having the same carers are good for me and give me security and confidence because they know me and I know them**"

Some of the other ways people said that the care at home services promoted privacy and safety were through using a key safe, locking the door, and encouraging the person to say if something wasn't right.

Staff Training during COVID

The Practice Learning and Development team continued to deliver training and assessment to a range of staff.

They had to adapt their methods of training and assessment due to COVID and a number of courses moved to e-learning including dementia awareness, medication management and infection control.

Moving and handling training continued to be delivered in person, but was adapted to ensure social distancing and infection control measures were met.

8 – Workforce

This outcome is aimed at ensuring 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.

We have developed a comprehensive staff training programme which allows staff to have a "Good Conversation" with people to support self-management. The Midway includes training in trauma, health inequalities and health literacy.

How we measure this outcome:

We measure this outcome through our staff surveys.

1,191 staff work in Midlothian Health and Social Care Partnership. The majority are full time, with 975.41 full-time equivalent staff across the partnership. The largest percentage of the workforce are 45-60 years.

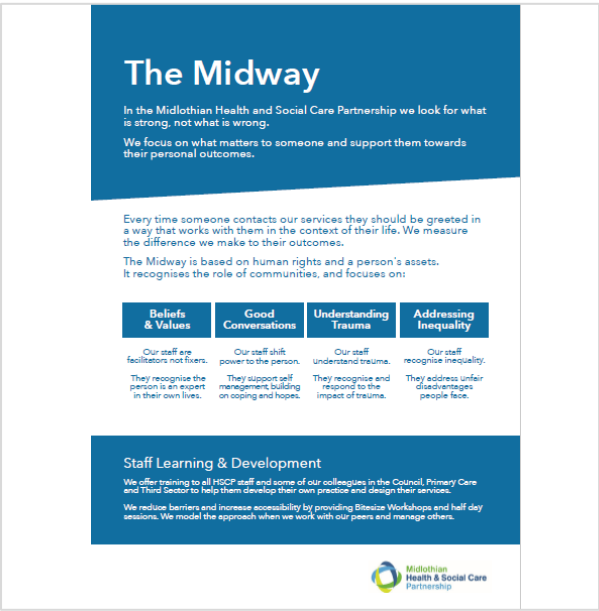
The number of staff employed by NHS and working for the HSCP has increased by 39 to 649 (compared to the previous two years). The full-time equivalent figure has increased from 486 in 2019 to 525 in 2020 with 49% of staff working full time and 51% part time. The gender split is 90% female and 10% male with 74% of the male workforce working full time and 44% of the female workforce working full time.

The number of staff employed by Midlothian Council in March 2021 and working within the HSCP has increased to 542 in 2021 with 450 full-time equivalent staff. This compares to 534 employees (441 full-time equivalent) in 2020 - an increase but not as significant as for NHS employees. 87% (471) staff were female and 13% (71) were male. Within the council employed staff in the HSCP there is a significant difference in the gender split regarding part or full time contracts with nearly 50% of female staff working part–time and 80% of male staff working full time.

The HSCP conducted a staff survey in January 2021 to understand what matters in relation to health and wellbeing.

The HSCP engaged staff to develop a new workforce plan. Key themes that emerged were:

- realistic career opportunities
- an increase in transition awards to enable staff to progress their career in a more supportive way when seeking alternative carer pathways.
- improved support/guidance and induction for team leaders/first line managers to enable them to become effective leaders to support front line staff. This was specifically around HR polices – improved briefings on these and in particular more effective and consistent approach of sickness absence polices to support staff to be well at work.
- Staff, in particular front line staff, needing to be listened to, respected and valued



The MidWay Approach

We trained staff so that anytime someone contacts our services, the focus in on their needs and what matters to them, and what their personal circumstances are.

We have trained and developed 228 staff so that our staff are facilitators not fixers, shift power to the person, understand trauma, recognise inequality We call this “The Midway”.

Care Home Support

During the pandemic the HSCP provided support to all care homes. This included support to access routine COVID tests.

This helped the homes identify staff with Covid-19 who were not showing symptoms but might have spread the virus without knowing they were infected.

9 – Effective & efficient use of resources

This outcome is aimed at ensuring resources are used effectively and efficiently in the provision of health and social care services. We continued to invest in community-based support to help more people get treatment at home and avoid a hospital admission. During the lockdown staff across the partnership were supported to take on new roles to help support the delivery of critical services and emergency response during COVID.

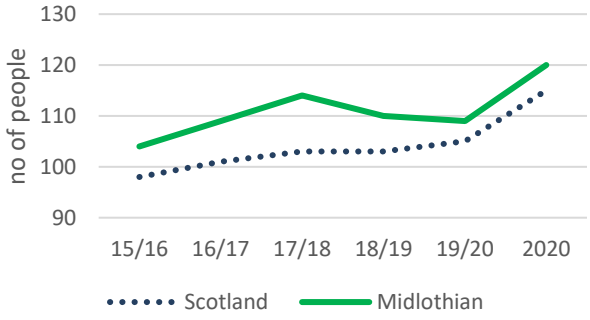
How we measure this outcome – yearly trends:

These are the national indicators used by Scottish Government to measure our progress towards this outcome.

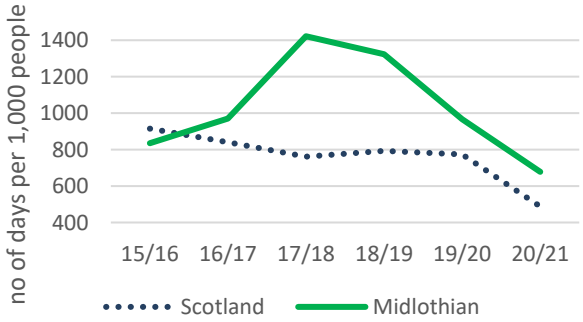
Adults thought services were coordinated**

* Due to changes in the 2019/20 survey wording, this indicator is no longer comparable to previous years.

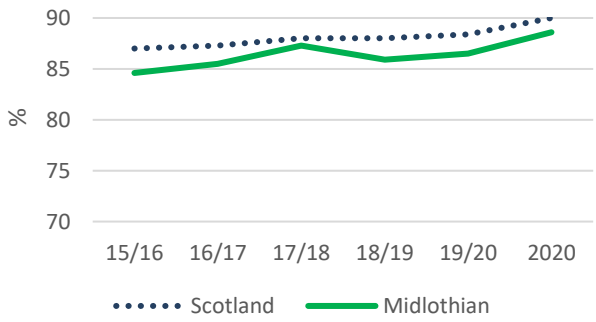
Readmission into hospital in 28 days

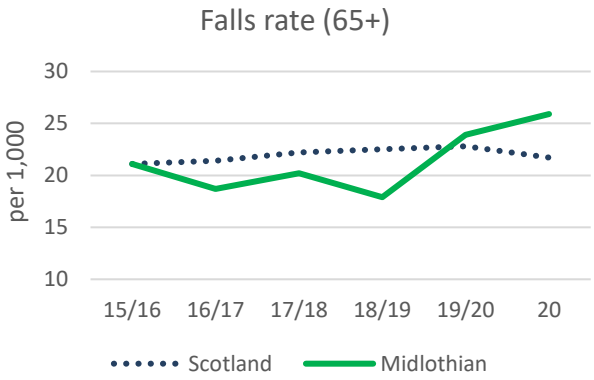


Delayed discharge (75+)

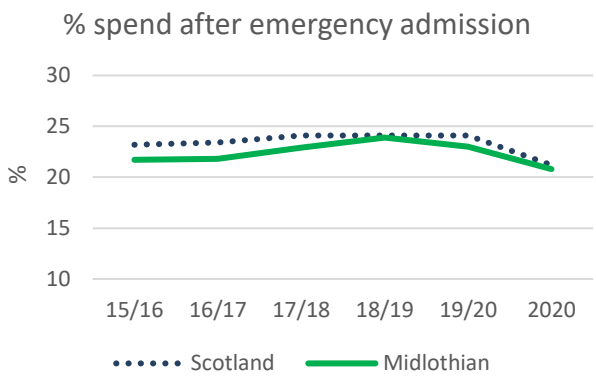


Last 6 months of life spent at home




Falls rate (65+)
per 1,000
30
25
20
15
10
15/16
16/17
17/18
18/19
19/20
20
Scotland
Midlothian

£


% spend after emergency admission
%
30
25
20
15
10
15/16
16/17
17/18
18/19
19/20
2020
Scotland
Midlothian

Getting home from hospital

We developed a new way of working that included the “Single Point of Access”.

This has reduced the number of people waiting in hospital to get home once they are well enough to leave, helped more people to avoid an unnecessary hospital admission and has increased the number of people who can get treatment at home.

Support during COVID

Alzheimer Scotland adapted its supports by moving many of its physical groups and activities online from Tea & Blether to Football Memories.

They also developed outdoor walking groups for people living with dementia, and provided ongoing wellbeing support, as an alternative for people who used its day services.

Taking on new roles

Staff from all over the organization took on new roles to support critical services during COVID.

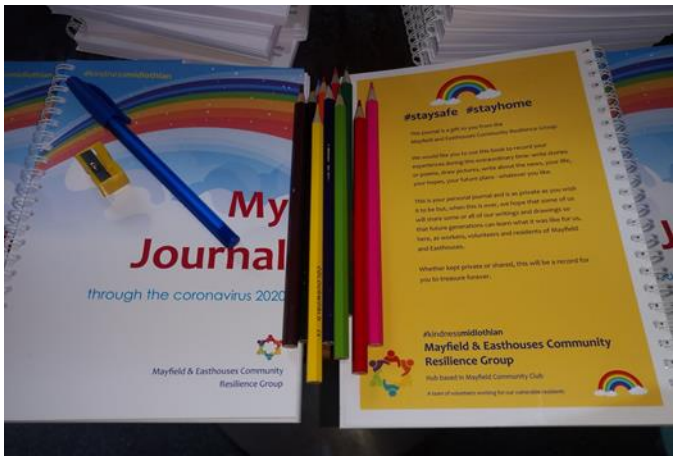
Many Sport and Leisure staff supported care work, vaccination centres and GP practices, they delivered medication and PPE delivery. Physiotherapy staff changed roles to assist respiratory teams. Staff also helped with wider Midlothian Council services including, education, waste, roads, IT and the contact centre.

LOCALITY PLANNING

A locality is ‘a smaller area within the borders of an Integration Authority’. In Midlothian we have two lcalities – East and West and this helps us plan services that suit local communities. We also use “Area Targeting” to support communities. Areas of Dalkeith/Woodburn, Mayfield/Easthouses and Gorebridge (in the East) and parts of Bonnyrigg, Loanhead and Penicuik (in the West) are areas of deprivation. There is more evidence of deprivation in the East locality as the data below indicates.

Each community council area has a neighbourhood plan that allows residents and Community Planning Partners to identify areas to work on together - using assets, activities and resources, from the public, voluntary and private sectors and local communities. These plans are based on local data, lived experience and community engagement and are at various stages of maturity . Some local priorities include Type 2 Diabetes prevention in Mayfield and Easthouses and Community Connections and the Food Bank in Gorebridge.

Tailored support for local communities



Community Treatment & Care

3 Community Treatment and Care centres were piloted in Penicuik, Eastfield and Roslin Practices through the roll-out of the Midlothian Primary Care Improvement Plan.

Community Treatment and Care Centres are a new approach which bring more staff into the practice team to assist with different clinical tasks (such as chronic disease monitoring, phlebotomy) which will increase capacity in General Practice. They have a range of benefits for patients including increased choice, increased capacity of GPs and more care delivered in the local community by a range of skilled professionals. Staff use the Midway Approach to help people prepare for their appointments to focus on what matters to them.

Care for People

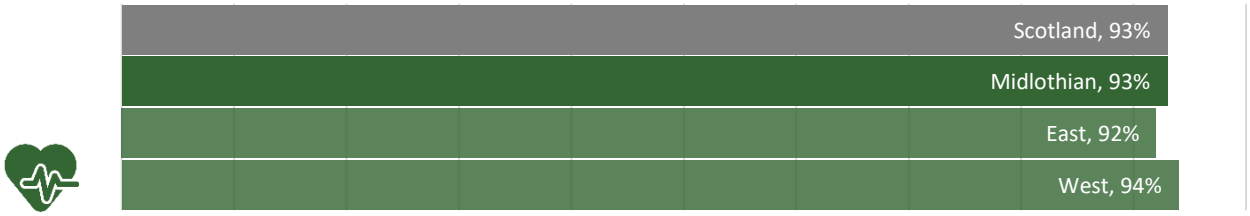
We were involved in the planning and delivery of activities to support people and communities affected by the lockdown through the Care for People Group, led by Midlothian Council Community Planning Partnership. The group ensures partnership working reduces the harmful effects of an emergency on individuals.

We worked alongside many local organisations such as Mayfield and Easthouses Community Resilience Group, Rosewell Resilience Group, and new groups, such as BERT in Bonnyrigg.

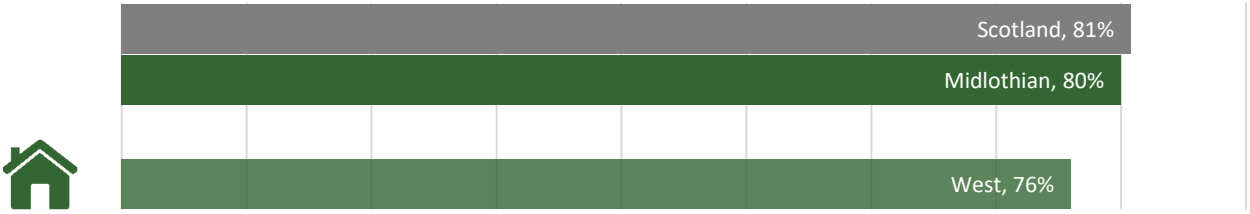
We supported the #KindnessMidlothian campaign to promote and coordinate the help on offer to people during the pandemic including the wide range support offered by local community groups

Indicator data by Locality

1 - Adults can look after their health well or very well

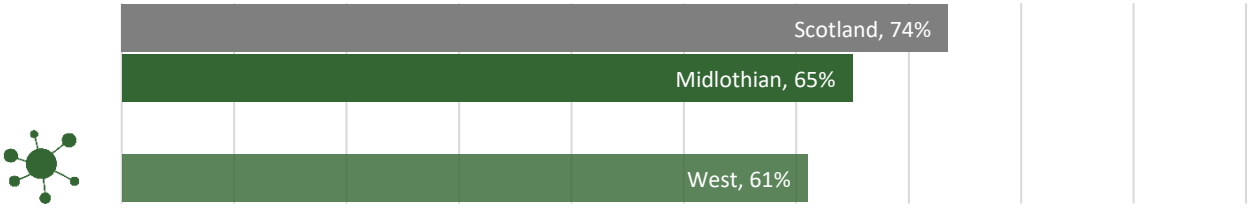


2 - Adults live as independently as possible*

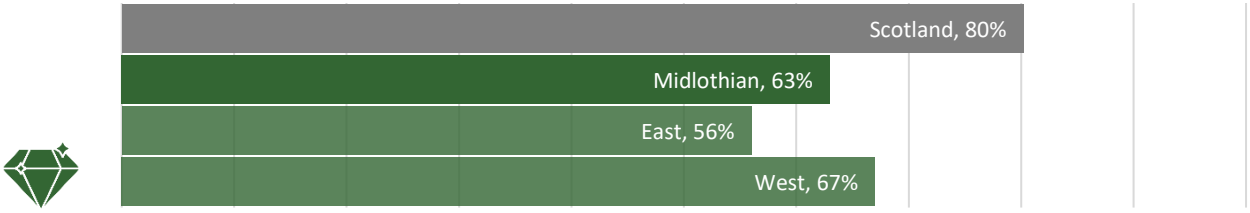


3 - Adults had a say in their help, care or support

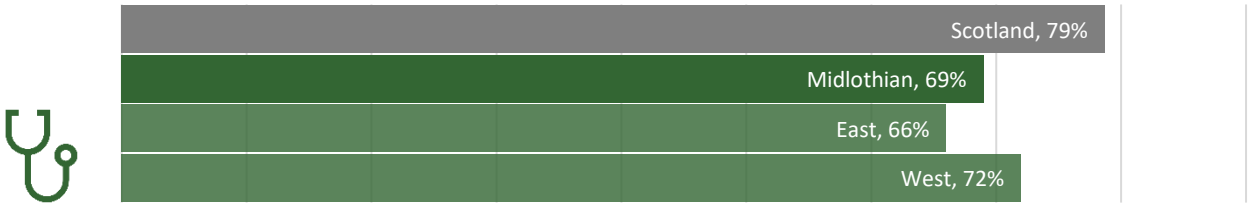
4 - Adults thought services were coordinated*



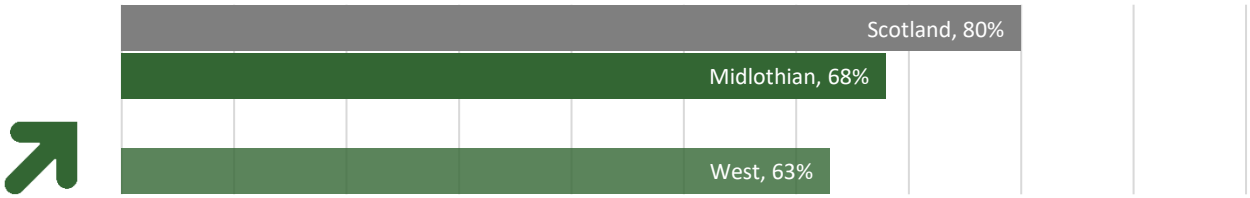
5 - Adults rated services as good or very good



6 - Adults had positive experiences at the GP

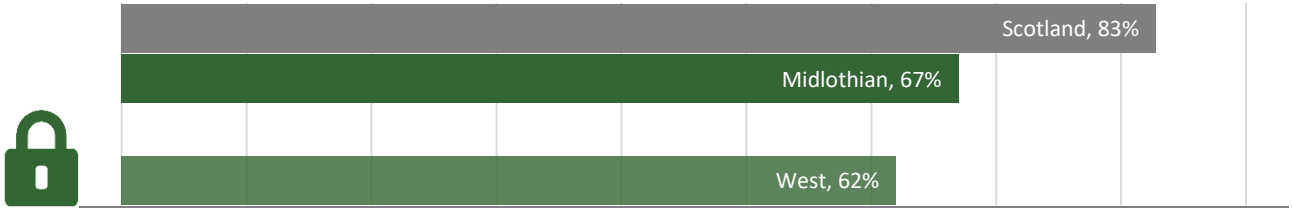


7 - Services maintained/improved their quality of life*



8 - Carers felt supported in their role

9 - Adults felt safe*



*Locality data for “East” for indicators 2,4,7,9 is currently unavailable due to the low response rate.

Discussion

Every two years, the Scottish Government asks 100,000 people across Scotland about their experience of health and social care services in the Scottish Health and Care Experience Survey. The most recent survey took place in 2019/20. In total 2,060 people from Midlothian contributed to this (a response rate of 30% 2.8% of the Midlothian population). The results of this survey were published by the Scottish Government on 15 October 2020 and used to give the results for national indicators 1 to 9. In addition to this survey data we have also included data related to quality of life and use of different services, these are listed in national indicators 10 to 20.

This report covers the period from 1st of April 2020 to 31st of March 2021. As a result of the COVID pandemic and the UK moving to lockdown on 23rd March 2020, this has been a year like no other. The pandemic and lockdown brought many challenges to the planning and delivery of health and social care services, but also supported the partnership to accelerate the delivery of certain plans.

We are committed to supporting people to stay well, to look after and maintain their health, and are pleased our figure for adults able to **look after their health very well or quite well** is now above the national average. We have a key focus on prevention and early intervention across all areas, and a range of programmes which aim to increase people's support and opportunities to stay well.

Our care services are good; but the percentage of **care services graded 'good' (4) or better** in inspections is lower than the Scottish average. Our care services continue to receive support to improve – for example the HSCP Care Home Support Team work with all independent and HSCP run care homes for older people.

While our figure for the percentage of **adults who spent the last 6 months of life at home or in a community setting** increased to 88.9% this was slightly lower than the Scottish average. However, this figure does not include time spent in our community hospital; thereby missing this group of people cared for in their local community.

Our **emergency admission rate and emergency bed rate** are higher than the national average, along with our figure for **days in hospital when ready to be discharged** and our **readmission to hospital rate**. We are committed to addressing this and increasing the number of people in Midlothian who receive the right support, in the right place, at the right time, including in their own home and local community. Work is underway to achieve this through the development of our "Home First" approach that includes a range of services that can help to prevent people being admitted to hospital in an emergency, and help people to keep well and in their own homes. This includes the Community Respiratory Team – supporting people to manage their COPD exacerbations at home.

Our figure for adults supported at home who agreed that they had a **say in how their help, care, or support was provided** was lower than the Scottish average. In response we are rolling out our "Midway" training programme to all health and social care staff. This helps staff to develop their approach to focus on what matters to someone, and support them to be directly involved in their care and decisions that affect their health and wellbeing.

Our figure for adults receiving any **care or support who rate it as excellent or good** was lower than the Scottish average as was our figure for adults supported at home who agree that their services and support had an **impact on improving or maintaining their quality of life**. We are committed to providing high quality care and support and will listen to people who use our services and identify areas for improvement. To address this we developed new guidelines for services that were bidding to deliver Care

at Home services through the Care at Home commissioning process. These guidelines included a human rights framework and key activities that aim to support the full range of rights for people who receive these services. Organisations that deliver these services will be evaluated to monitor how well they support people who receive their service and activities which support their human rights.

The percentage of adults **supported at home who agreed they felt safe** was lower than the Scottish average. This measure only relates to the very small number of people who responded to the survey who were in receipt of a health or social care service. We will listen to service users to understand this better and believe that the actions above around the Midway and human rights approaches being embedded in service delivery will make a difference.

The percentage of people with **positive experience of care at their GP practice** remains lower than the Scottish average. A range of work is underway to help address this. Medical practices are leading on improvements to make sure the patients with the highest need to get to the right clinician in the primary care team as soon as possible. The Health and Social Care Partnership is investing in new roles in practice teams such as Primary Care Mental Health Nurses and Advanced Physiotherapists, and investing in primary care buildings to improve physical capacity. Community Treatment and Care Centres (CTAC) are a new approach which the Health and Social Care Partnership has piloted over the past year bringing more staff into the practice team to assist with different clinical functions (e.g chronic disease monitoring, phlebotomy) which will increase capacity in General Practice and free up time available to GPs and their teams.

In the most recent Citizens Panel survey people reported more positively on their experience of care, with 92 % agreeing or strongly agreeing that they were was listened to, and 83% that they were treated with compassion and understanding.

The response for **unpaid carers feeling supported in their role** continues to be lower than the national average. Unpaid carers have a valuable and irreplaceable role. The partnership recognises more work must be done to make sure unpaid carers are identified and receive the support they need. To support this a wide range of unpaid carers and groups that support them were consulted in 2020 to understand their aims and priorities around carer support and services. Additional services to support carers were commissioned in March 2021. This included services to support carer health and wellbeing and financial situation. The pandemic reduced carer access to respite and other support although local services did adapt quickly to provide other, albeit more limited, options. In the most recent Citizens panel survey respondents who provided care to someone 61 % stated they were aware of local services that offer support to carers in Midlothian.

Our **falls rate** is now slightly higher than the Scottish average. To address this we have developed a new Falls and Fracture Prevention Action Plan which will be implemented over the next year.

Finally we are pleased our **premature Mortality Rate** has improved again this year and is now well below the Scottish average, showing fewer people in Midlothian are now dying before the age of 75.

FINANCE

How we spent our money

The Integration Joint Board had a total budget of **£165m** and ended the financial year with an **underspend of £8.3m**. This was due to an underspend on the IJBs operations of £1.7m and earmarked funding, predominantly for COVID not spent of £6.6m. For more information see our Annual Accounts.

	Budget	Spend	Variance
Direct Midlothian Services			
Community AHPS	£2,539,000	£2,187,000	£352,000
Community Hospitals	£5,045,000	£5,876,000	-£831,000
District Nursing	£3,878,000	£3,894,000	-£16,000
General Medical Services	£17,136,000	£17,136,000	£0
Health Visiting	£2,074,000	£1,957,000	£117,000
Mental Health	£2,739,000	£2,714,000	£25,000
Other	£17,093,000	£9,952,000	£7,141,000
Prescribing	£18,338,000	£18,257,000	£81,000
Resource Transfer	£7,158,000	£7,158,000	£0
Older People	£19,013,000	£17,074,000	£1,939,000
Learning Disabilities	£15,102,000	£15,812,000	-£710,000
Mental Health	£931,000	£891,000	£40,000
Physical Disabilities	£3,468,000	£4,168,000	-£700,000
Assessment and Care Management	£3,242,000	£2,847,000	£395,000
Other	£3,230,000	£2,944,000	£286,000
Midlothian Share of pan-Lothian			
Set Aside	£19,000,000	£19,029,000	-£29,000
Mental Health	£2,378,000	£2,454,000	-£76,000
Learning Disabilities	£1,360,000	£1,352,000	£8,000
GP Out of Hours	£1,160,000	£1,264,000	-£104,000
Rehabilitation	£1,062,000	£915,000	£147,000
Sexual Health	£668,000	£624,000	£44,000
Psychology	£836,000	£804,000	£32,000
Substance Misuse	£368,000	£363,000	£5,000
Allied Health Professions	£1,421,000	£1,304,000	£117,000
Oral Health	£1,748,000	£1,716,000	£32,000
Other	£3,359,000	£3,282,000	£77,000
Dental	£5,686,000	£5,686,000	£0
Ophthalmology	£1,705,000	£1,705,000	£0
Pharmacy	£3,636,000	£3,636,000	£0
TOTAL	**£165,373,000**	**£157,001,000**	**£8,372,000**

Challenges – this year

COVID-19 Financial Impact

The Health and Social Care Partnership via NHS Lothian submitted regular information to Scottish Government through the Local Mobilisation Plan (LMP) financial returns process and this remains the main route for confirming the additional cost and funding required in supporting the COVID-19 response. These returns covered costs for the entirety of the Health and Social Care Partnership. There were also additional Health costs within Hosted and Set Aside services. All financial positions are after a significant amount of additional COVID related expenditure has been supported either through redeployment of existing resources in year or through additional COVID-19 funding.

Additional funding allocations have been received to meet the additional costs and the financial impact of COVID-19 in 2020/21 is covered in full and where possible staff and resources were redeployed. The Scottish Government confirmed that COVID-19 funding allocations that have not been fully used in 2020/21 should be carried forward by IJB's to support COVID-19 plans in 2021/22. For Midlothian, this can be seen in the reserves statement within their Annual Accounts.

Social Care

There was a significant overspend within adult services, specifically for clients with complex needs with learning and physical disabilities. This pressure was offset by an underspend in services for older people.

Health

Although there were operational overspends within Community Hospitals, as a result in the changing environment and nature of patients these were offset by vacancies across the system and slippage of Programmes

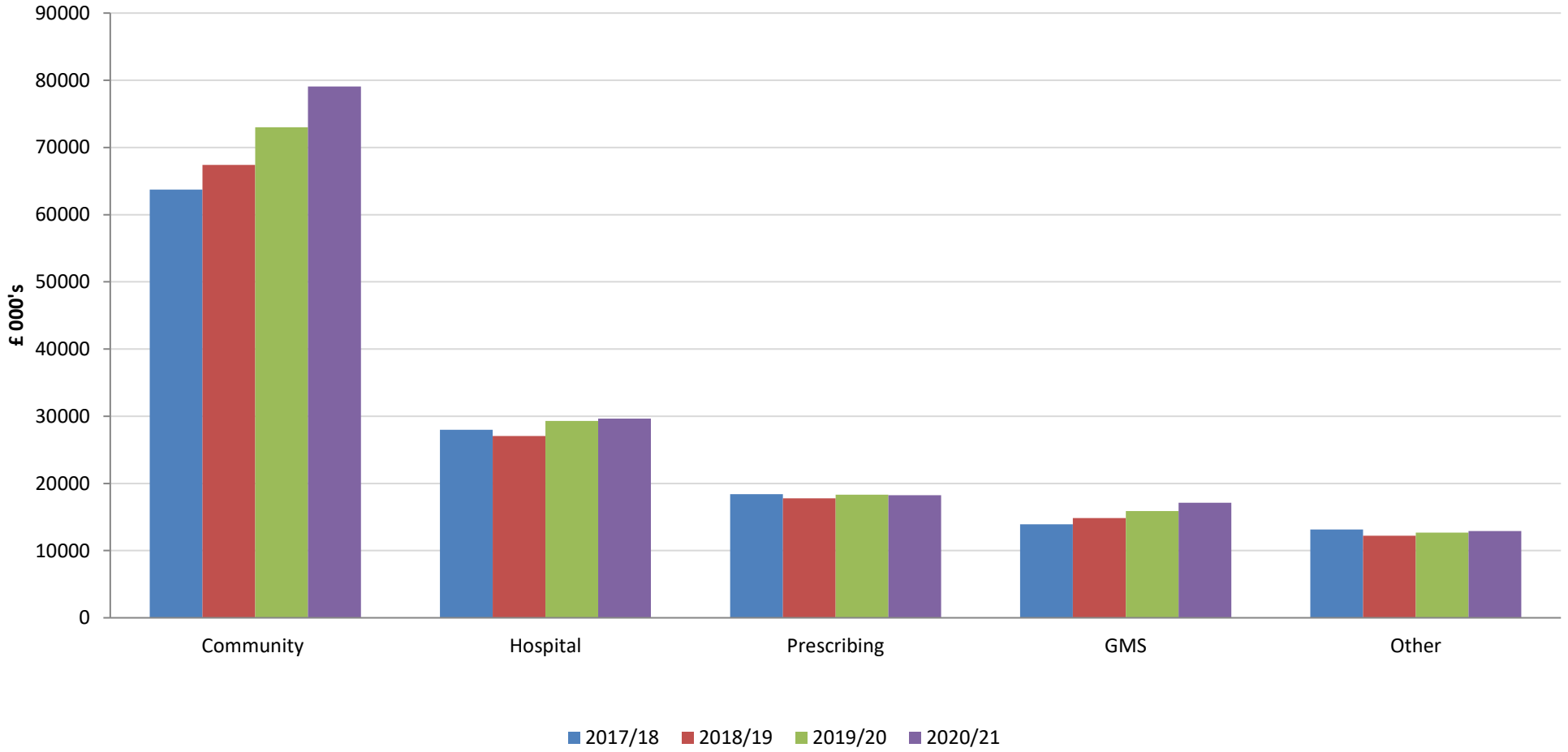
For our Hosted and Set Aside services the areas with continued pressures being experienced are Adult Psychology Services and Mental Health Inpatient services with additional capacity being required in year to cope with high demand. The main pressure for Set Aside services in this financial year lies within Gastroenterology Services and the ongoing pressure with drug costs for the treatment of long-term gastroenterology conditions. Junior Medical pay pressure also continued during this year, where additional staffing was required to fill gaps in rotas and where there were service pressures. The Junior Medical position has improved significantly from previous years but still remains a pressure.

The Scottish Government released funding to cover the impact of COVID costs on NHS Lothian's position and that funding has been allocated to delegated and set aside services to offset additional expenditure incurred. With COVID funding being allocated across the IJBs set aside specialities to cover additional costs incurred around extra staffing to cope with COVID, the overall position on set aside is much improved compared to previous years.

The IJB also has a duty under the Local Government Act 2003 to make arrangements to secure Best Value and does this through continuous improvement in the way in which its functions are exercised. Best Value includes aspects of economy, efficiency, effectiveness, equal opportunity requirements, and sustainable development.

Main areas of spend (2017/18-2020/21)

The graph below compares our spend trends for the past 4 years. We are unable to report on 2016/17 or previous data the same way. We are also unable to report on spend by locality as we do not hold data in this form.



Challenges – next year

Midlothian is the second smallest Local Authority in mainland Scotland but the fastest growing. This will continue to pose challenges for health and social care services whilst also changing some local communities. As people live for longer many more people will be living at home with frailty and/or dementia and/or multiple health conditions. An increasing number of people live on their own, and for some this will bring a risk of isolation.

Finance

In March and April 2021 the IJB undertook of its annual financial assurance process to review the budget offer for 2021/22 from Midlothian Council and NHS Lothian. This identified financial challenges but the IJB has accepted this budget as it passed the two tests of 'fair' and 'adequacy'..
As part of the budget setting process for 2021/22, NHS Lothian uplifted the baseline budget by 1.5% and Midlothian Council provided an uplift for pay awards and additional £1.0m to support demographic pressures .The challenge is to continue the transformation of the services that deliver the IJB's delegated functions whilst continuing to deliver high quality health and social care to the population the IJB supports. The IJB has developed a financial strategy and a medium term financial plan that were presented to the IJB at its meeting in December 2020. This plan will be refined once the impact of COVID is fully understood on the service delivery of the IJBs delegated functions. The IJB continues to develop this multi-year financial plan which will show how the resources available to the IJB will be used to deliver the ambitions of the Strategic Plan.

Reshape Services

The impact of the COVID-19 pandemic brought increased anxiety and pressure on many service users, unpaid carers and staff. While challenges changed over 2020/21, many will continue into 2021/22.
As well as presenting a tremendous challenge, the crisis also created an opportunity to build on existing and newly forming community connections. We will continue to work with the people in our communities to explore what opportunities for community resilience can be developed to ensure strong, sustainable, supportive communities. In December 2021 a Volunteer Lead was appointed to embed volunteering opportunities in HSCP services.

We look forward to building a stronger Midlothian, whatever the 'new normal' is.

We will continue to work with colleagues in acute services and other Lothian IJBs to reshape unscheduled care, maximising opportunities to reduce admissions to acute care, to increase rehabilitation opportunities and to offer local services by reshaping Midlothian Community Hospital. Some digital developments were accelerated during the pandemic and continue to be progressed.

Managing long-term conditions is one of the biggest challenges facing health and social care services worldwide, with 60% of all deaths attributable to them. Older people are more susceptible to developing long-term conditions; most over 65s have two or more conditions and most over 75s have three or more conditions. People living in areas of multiple deprivation are at particular risk. Work is underway to improve pathways for people with long term conditions, including work to improve outcomes for people with a neurological condition.

Many mental health problems are preventable, and almost all are treatable, so people can either fully recover or manage their conditions successfully and live fulfilling healthy lives as far as possible. The incidence of mental health issues in Midlothian is similar to the rest of Scotland.

Acute hospitals are under huge pressure due to unsustainable demand. We will continue to invest in community based support to minimise avoidable and inappropriate admissions and facilitate earlier

discharge home. By treating people closer to home, or in their own home we can support admission avoidance and improve people's outcomes.

Workforce

There is reduced availability of staff with appropriate qualifications or skills, including General Practitioners, Social Care Workers and Staff Nurses. This impacts on service delivery and development. In addition, the Covid-19 pandemic continues to influence the demand for, and deployment of, the health and care workforce. Mass vaccination programmes and other COVID related measures have increased pressure on already stretched resource. How the workforce interacts with people has also changed with an increased use of digital or telephone appointments

Review of Adult Social Care

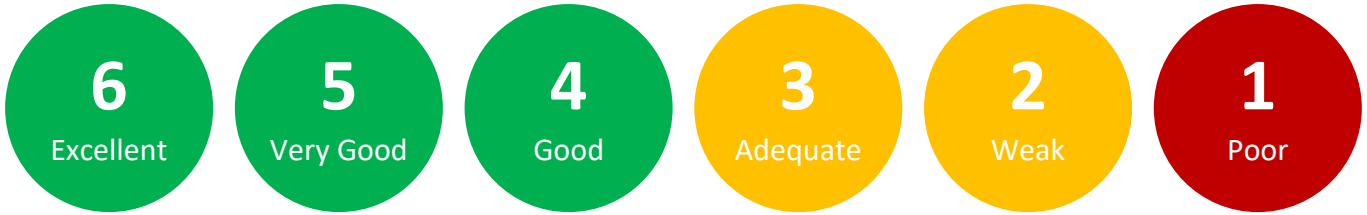
Following the Independent Review of Adult Social Care (published in February 2021), the IJB will closely scrutinise the Review, its recommendations and the implications for Midlothian and for partnership working. The Review was set up to recommend improvements to adult social care in Scotland. It looked at these in terms of the outcomes for people who use services, their carers and families and the experience of those working in the sector.

Although the financial implications of the recommendations cannot be assessed at this stage, the changes proposed do not come without costs. There are key areas with greater costs implications and but there is also opportunities to spend money better. The report describes that some costs arise in our current system because social care supports are often too focused on crisis management and late intervention, and not enough on prevention and empowering people to live fulfilling lives. Suggesting that with more effective care planning and delivery it could in some instances be put to better use to support people more effectively. The focus with all partners is to invest in preventative care rather than crisis responses, to avoid expenditure on poor outcomes

INSPECTIONS

The Care Inspectorate inspects our care homes and care at home services to check the quality of care. Read the full reports here.

The directors of Public Health in Scotland advised that inspection visits would present a risk of introducing and spreading COVID-19 in care homes. To limit the spread, and with agreement from Scottish Government the Care Inspectorate restricted their presence in services unless necessary. This resulted in the majority of services not being graded as normal and retaining the grades they had last received. Instead the Care Inspectorate intensified oversight using a range of remote and virtual approaches They award the following grades to services:



Name	Service Type	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning	Care & support during COVID
Highbank	Intermediate Care Home	10/11/2020	-	-	-	-	-	4 Good
Nazareth House	Care home for older people	22/01/2021	-	-	-	2 Weak	-	2 Weak
Nazareth House	Care home for older people	03/03/2021	-	-	-	-	-	3 Adequate
Newbyres Village	Care home for older people	21/01/2021	-	-	-	-	-	4 Good
Pine Villa	Care home for older people	27/07/2020	-	-	-	-	-	3 Adequate
Pine Villa	Care home for older people	31/08/2020	-	3 Adequate	-	3 Adequate	-	-
MLC - Domiciliary Care	Support - Care at Home	26/11/2020	-	4 Good	-	-	4 Good	4 Good
Springfield Bank	Care home for older people	11/02/2021	-	-	-	-	-	4 Good
Archview Lodge	Care home for older people	01/02/2021	-	-	-	-	-	3 Adequate
Archview Lodge	Care home for older people	26/02/2021	4 Good	-	-	-	3 Adequate	-

Name	Service Type	Date	Care & support	Environment	Staffing	Management & Leadership	Care & support during COVID
SCRT East	Support - Care at Home	02/12/2020	-	-	-	-	3 - Adequate
SCRT East	Support - Care at Home	08/12/2020	3 Adequate	-	3 Adequate	3 Adequate	-

Recommendations

Name	Date	Recommended Improvement	How we will change
Highbank	10/11/2020	1. People experiencing care who are at risk of falling should be cared for in ways that promote their safety and independence. The manager should ensure that appropriate falls prevention guidelines, risk assessments and support plans are in place for people, based on recognised falls prevention frameworks. Staff should be provided with training and support they need to understand this and apply it to their practice.	Mandatory Falls prevention training arranged. New Falls champion in post.
Nazareth House	22/01/2021	1. In order to ensure good outcomes for people experiencing care, the provider must ensure the care home environment is clean and infection prevention and control measures are improved. 2. In order to ensure good outcomes for people experiencing care the provider must have an effective and comprehensive quality assurance system in place.	1. New flooring ordered and new Radiator covers fitted. Lower corridor is currently being decorated and bathrooms are near completion. Social Distancing in lounge areas to be promoted by management. 2. Deputy to liaise with care staff and housekeeping to ensure paperwork is being completed when cleaning takes place.
Newbyres Village	21/01/2021	1. In order to ensure good outcomes for people experiencing care, the manager should ensure that people's meals and snacks meet their dietary needs and preferences when developing their outcome care planning. 2. In order to ensure good outcomes for people experiencing care, the manager should develop communication agreements with relatives. This would detail how communication would be established and in what circumstances. Also, to cover levels of expectations balanced with what is realistically achievable for all given restrictions at that time. This should be reviewed as restrictions change.	1. Care plans are being worked on to be more person centred. Residents are constantly being asked about their likes and dislikes and this is recorded in the plan. 2. Families were asked which method of communication they would prefer and how often they would like to be contacted and when they would like to be contacted. Quarterly News Letter sent out with updates eg Vaccinations, New staff, visiting. This is being constantly reviewed to help meet the family & resident's needs.
Pine Villa	27/07/2020	The provider should ensure that each resident has sufficient opportunity to participate in meaningful activity. This could be demonstrated by setting weekly and monthly recreational goals for residents.	
Pine Villa	31/08/2020	This was a focused follow up inspection.	n/a

Name	Date	Recommended Improvement	How we will change
Midlothian Council - Domiciliary Care	26/11/2020	1. People's care and support plans should be outcome focused, detailing the agreed goals they would like to achieve to support their independence as much as possible. 2. People's care and support plans should be reviewed on a more regular basis (six-monthly or as and when required) to ensure the service continues to meet their agreed outcomes. 3. People should be made aware of who is coming to care for them on a day to day basis. They should also be clearly communicated and consulted with about their agreed times and any changes to how and when the care is provided to them.	
Archview Lodge Care Home	26/02/2021	1. Demonstrate that all personal plans record all risk, health, welfare and safety needs, in a person-centred manner, which identifies how needs and choices are met. In order to do this, the provider must ensure that documentation and records are accurate, up-to-date, sufficiently detailed and reflect the care planned, or provided for people. 2. Ensure that personal plans record all risk, health, welfare and safety needs, in a coherent manner, which identifies how service user needs are to be met. In order to do this, the provider must: (1) ensure that documentation and records are accurate, sufficiently detailed and reflect the care planned or provided. (2) provide training so that staff are aware of their responsibility in maintaining accurate records and demonstrate that managers are involved in monitoring and the audit of records.	The provider will ensure all care plans are reviewed and updated to reflect the current needs of the current residents. The General Manager will prioritise the higher risk care plans where residents have complex needs and through to the other plans. The Clinical Development Nurse will provide document and care plan training to all registered nurses and Care Practitioners in the home so that they have a better understanding of the information required in the care plans. The General Manager will identify clinical training required through supervision with the staff. The General Manager and Deputy Home Manager will review care plans through the resident of the Day process. The Regional Director and Clinical Development Nurse will support the home and the staff and will review the progress made by the home.

Name	Date	Recommended Improvement	How we will change
SCRT East	02/12/2020	1. Communication should be improved to ensure that people supported are informed who is coming to the house and if carers are running late over the agreed time frames. 2. The service should provide all service users and their relatives with accurate information on what can be provided as part of the agreed support. This would include reference to travel time. Where travel time is not part of the allocated time then this must be effectively monitored to ensure that people get the correct support as agreed. 3. The statistics in place for the lengths of visits against what has been agreed should be individually evaluated to look at the reasons for the differences in these. This should be recorded and discussed with the person support and the commissioning authority.	
SCRT East	08/12/2020	No report on Care Inspectorate website.	

Communication & Engagement

Participation and engagement are key to achieving our aims and vision.

We are committed to developing our engagement with people, including our ongoing engagement with people and partner organisations through representatives from the third sector, carers and people with lived experience on all our formal planning groups including the IJB, the Strategic Planning group and Service Area planning groups.

Over the past year we have been developing a new public engagement statement to share this commitment and explain the range of ways people and organsiations can be involved in shaping the work of the Partnership and Integration Joint Board. www.midlothian.gov.uk/mid-hscp/info/4/data-1

The Public Bodies (Joint Working) (Scotland) Act 2014 highlights the importance and requirements of involvement and consult with relevant stakeholders, including patients and service users, in the planning and delivery of our work.

During the past year in addition to our ongoing engagement activities, we carried out a range of consultations to inform our services and plans. This included consultations on community mental health services, carers support services and care at home services to help us better understand needs, aims and priorities. We used this information when we carried out a recommissioning process for these services, where organisations could bid to offer services and support for these areas.

The Third sector summit did not take place in 2020 due to the impact of Covid-19. An online summit has been arranged for later in 2021.

Consultations undertaken during 2020/21

- Community Support for People with Mental Health Issues
- Community Support for Unpaid Adult Carers
- Care at Home
- Support for People with Frailty
- Equalities Outcomes
- Consultation with staff on Midlothian Local Housing Strategy
- Consultation with staff on Digital Projects
- Citizen's Panel

Integration Functions & Governance Decisions

Scheme of Integration
The plan to review the Scheme of Integration in 2020 was delayed due to COVID. The review will be resumed in summer 2021 by NHS Lothian and Midlothian Council in discussion with the IJB. The updated Scheme will be published in 2021.

Strategic Commissioning Plan
Work to develop the Strategic Commissioning Plan 2022-25 began with the IJB agreeing the vision and values for the new plan in December 2020 and agreeing strategic aims to support the plan in March 2021.

Midlothian Integration Joint Board Voting Members
Alex Joyce was a voting NHSL Member who stepped down from the IJB during the year. The Board agreed to appoint Mike Ash as a voting member of Midlothian IJB for the period 12 August 2020 to 30 April 2021

Directions
A review of the Directions took place during the year due the implications from Covid. Following this the Directions were revised and re-issued to NHS Lothian and Midlothian Council in October 2020

Key decisions taken by the Integration Joint Board in 2019/20.

- Approved Midlothian Health and Social Care Partnership IJB Budget for 19-20 - 11th June 2020
- Approved Annual Governance Statement for 19-20 - 11th June 2020
- Approved Midlothian Health and Social Care Partnership Annual Performance Report 19-20 - 27th Aug 2020
- Approved Midlothian Health and Social Care Partnership Audited Annual Accounts 19-20 - 10th Sep 2020
- Approved revised Directions for 20-21 - 8th Oct 2020
- Noted the Community Justice Annual Report - 8th Oct 2020
- Noted the Midlothian IJB 5 year rolling financial plan 2020/21 to 2024/25 - 10th Dec 2020

Copies of the relevant reports can be found in the committee reports at
https://midlothian.cmis.uk.com/Live/MidlothianIntegrationJointBoard/tabid/134/ctl/ViewCMIS_CommitteeDetails/mid/503/id/11/Default.aspx

COMMUNICATING CLEARLY

We are happy to translate on request and provide information and publications in other formats, including Braille, tape or large print.

如有需要我們樂意提供翻譯本，和其他版本的資訊與刊物，包括盲人點字、錄音帶或大字體。

Zapewnimy tłumaczenie na żądanie oraz dostarczymy informacje i publikacje w innych formatach, w tym Braillem, na kasecie magnetofonowej lub dużym drukiem.

ਅਸੀਂ ਮੰਗ ਕਰਨ ਤੇ ਖੁਸ਼ੀ ਨਾਲ ਅਨੁਵਾਦ ਅਤੇ ਜਾਣਕਾਰੀ ਤੇ ਹੋਰ ਰੂਪਾਂ ਵਿੱਚ ਪ੍ਰਕਾਸ਼ਨ ਪ੍ਰਦਾਨ ਕਰਾਂਗੇ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਬਰੇਲ, ਟੇਪ ਜਾਂ ਵੱਡੀ ਛਪਾਈ ਸ਼ਾਮਲ ਹਨ।

Körler icin kabartma yazilar, kaset ve büyük nüshalar da dahil olmak üzere, istenilen bilgileri saglamak ve tercüme etmekten memnuniyet duyariz.

اگر آپ چاہیں تو ہم خوشی سے آپ کو ترجمہ فراہم کر سکتے ہیں اور معلومات اور دستاویزات دیگر شکلوں میں مثلاً بریل (نابینا افراد کے لیے اُبھرے ہوئے حروف کی لکھائی) میں، ٹیپ پر یا بڑے حروف کی لکھائی میں فراہم کر سکتے ہیں۔

Contact 0131 270 7500 or email: enquiries@midlothian.gov.uk

Thursday 14th October, 2.00pm

Clinical and Care Governance Group (CCGG) report

Item number:	**5.6**

Executive summary

This report to Midlothian Integrated Joint Board aims to provide assurance regarding the Care and Clinical Governance arrangements within Midlothian Health and Social Care Partnership.

Board members are asked to note and approve the contents of this report

Clinical and Care Governance Group (CCGG) report

1 Purpose

1.1 This is the Clinical and Care Governance Group (CCGG) report for Midlothian IJB

2 Recommendations

2.1 Board members are asked to note and approve the content of this report

3 Background and main report

3.1 This report will update the IJB on the activity undertaken to provide assurance around the delivery of safe, effective and person-centred care in Midlothian.

The Clinical and Care Governance Group is the overarching group within Midlothian and is the means by which the IJB receives assurance from the Partnership around the safety, effectiveness and person centredness of MHSCP Services. Quality Improvement Teams are established and cover the services across the partnership, bringing together representatives of the multidisciplinary teams to report on and address clinical and care governance and delivery quality improvement as a result of learning and innovation.

The Quality Improvement Teams provide at least 4 reports per year utilising a reporting template which enables the Quality Improvement Teams to provide assurance on actions in place relating to safety alerts, adverse events and complaints, improvement work, implementation of specific standards and guidance, action plans arising from audit and inspection activity and any other service-specific issues which could have impact on the quality and safety of care the service provides. These issues may relate to areas covered in other groups (Health and Safety, Staff Governance, Finance and Performance) but which are assessed as creating a risk to the service's ability to deliver safe, effective or person-centred care.

Three groups are established to provide oversight of all significant adverse events reported within Midlothian. Specific groups are established to address patient/client falls and pressure ulcers. Another group, the Midlothian Safety and Experience Action Group has oversight of all other significant adverse events, including those which are drug related death or suicide by patients engaged with mental health and substance misuse services.

3.2 **Annual Report to NHS Lothian Healthcare Governance Committee**
Midlothian Health and Social Care Partnership is required to present an annual report to NHS Lothian's Healthcare Governance Committee. This report was

received at the September meeting of the committee and is included as an appendix to this report.

3.3 The Clinical and Care Governance Group

The Clinical and Care Governance Group meetings are now taking place on a quarterly basis. The group has not met since the last report to the Board.

3.4 Investigating and Learning from Adverse Events and Complaints

The HSCP Senior Management Team (SMT) receives a fortnightly formal verbal report from the Chief Nurse regarding the reporting and management of adverse events on the Datix system, and performance around the management of complaints.

Focussed work continues to address and progress the reviews of all adverse events which have fallen outwith targets for completion. This has resulted in a continued reduction in the number of significant adverse events which remain open beyond 6 months and the target timescales for investigation. The is illustrated in Chart 1.Work has continued to ensure that all outstanding learning and actions from previously investigated Significant Adverse Events are updated and progressed on the Datix reporting system. Chart 2 illustrates that between October 2019 and September 2021, the mean number of significant adverse events reported remains stable.

Chart 1 Significant adverse events open beyond 6 months

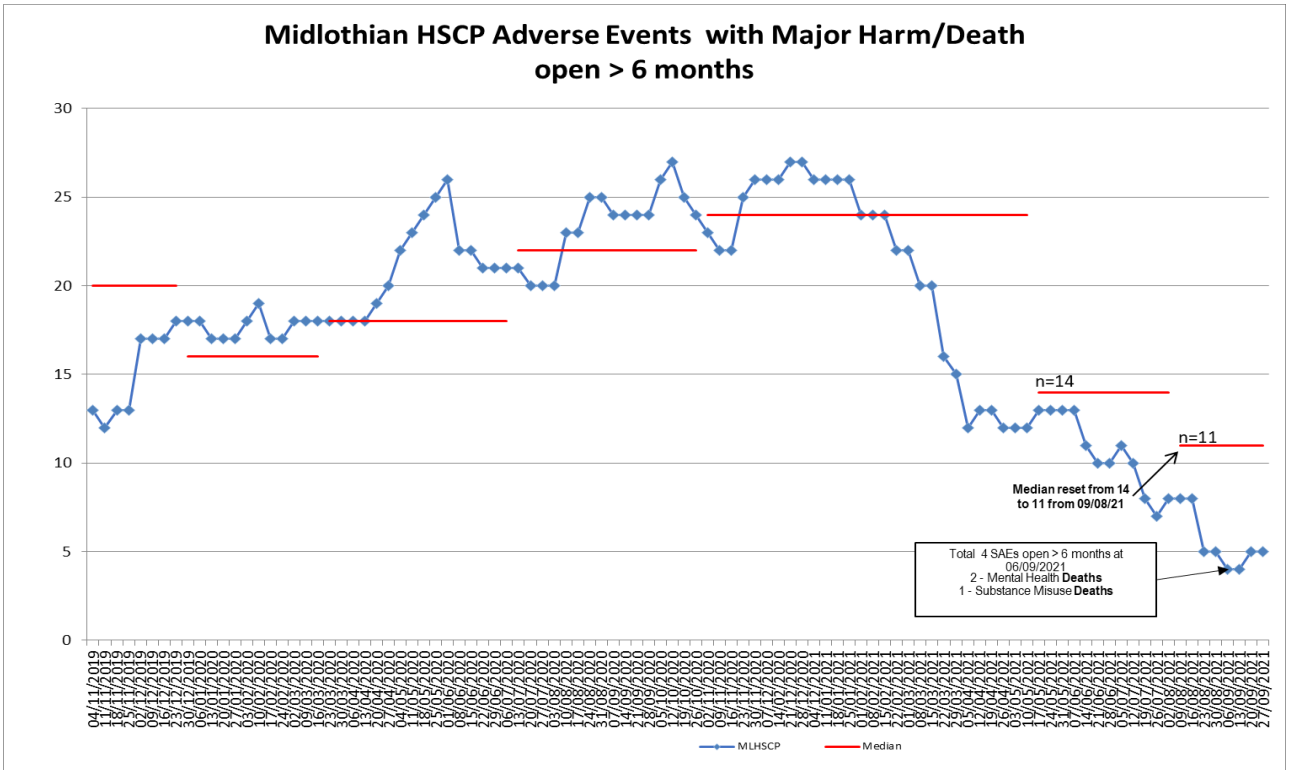
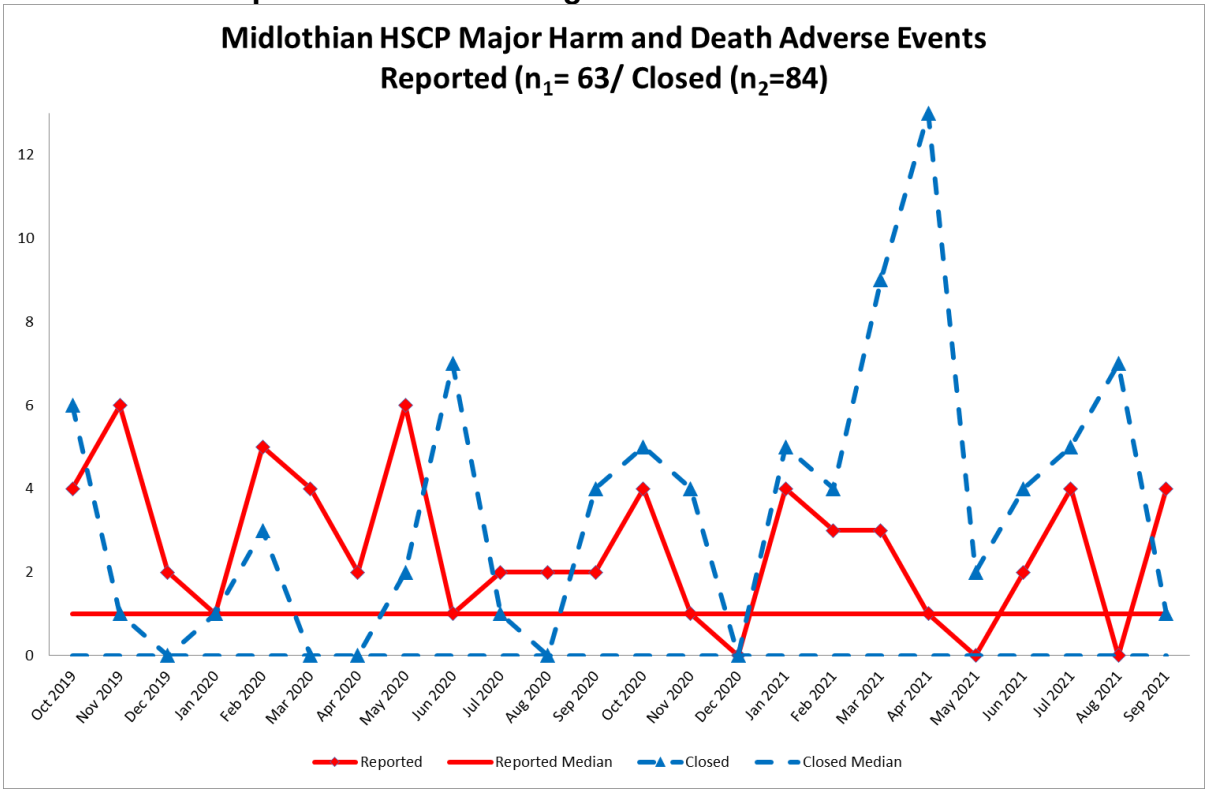


Chart 2: Reported and closed significant adverse events



The NHS Lothian Quality Improvement Support Team continue to support to the Midlothian Safety and Experience Action Group with improvement work around investigation of suicides and drug related deaths of people who were engaged with mental health and substance misuse services at the time of their death. process in place aims to enable early, proportionate investigation to take place to capture local learning, whilst ensuring that independent review is undertaken where appropriate. A Pan Lothian Groups has been established to share insights and learning and to provide confidence that thresholds for external review being commissioned are consistent and appropriate.

The Midlothian Safety and Experience Action Group reports directly to the NHS Lothian Patient Safety and Experience Action Group. Decisions and reviews approved by the Midlothian Safety and Experience Action Group are subject to the scrutiny of the NHS Lothian Medical Director and Executive Nurse Director. Decisions made at the Midlothian Safety and Experience Action are taken forward by the relevant teams where SAEs have occurred, with the relevant Quality Improvement Teams having responsibility to implement learning from adverse events and complaints in their areas. Learning and actions are shared with all Quality Improvement Teams leads at the Clinical and Care Governance Group to support shared learning and improvement across the partnership.

3.5 Clinical and Professional Oversight of Care Homes

Health Boards and local Health and Social Care Partnerships continue to carry responsibilities for the clinical and professional oversight of the care provided to people resident in care homes. Midlothian HSCP has local mechanisms in place to deliver its responsibilities and to link its work with pan-Lothian and national mechanisms.

Midlothian's Care Home Support Team has developed positive relationships with the managers and staff in the 10 care homes for older people in Midlothian. The team provides advice, support and education directly and maintain strong links with Lothian-wide specialist teams enabling the provision of additional specialist infection prevention and control, tissue viability, clinical education and quality improvement support. Partnership working with these teams, the Care Inspectorate and the social work teams within the Midlothian Health and Social Care Partnership delivers multidisciplinary perspectives on the care and support of older people within our local care homes. This enables proactive support of the delivery of person-centred care, and regular input to address issues and challenges being faced in the care homes as they arise using informal approaches and more formal procedures as required.

The Midlothian 'rapid rundown' takes place three times per week and delivers senior oversight of emerging issues and improvement work and the opportunity to discuss any concerns raised by care home managers and/ or identified by the Care Home Support Team. The data gathered by the Care Home Support Team and that which is entered directly into the national 'TURAS' safety huddle tool enables local assessment of risk and the provision of assurance around staffing, care standards and the actions in place to address the risks posed to care home residents by the COVID -19 virus.

Lothian wide Operational Oversight meetings are attended twice weekly and a Strategic Oversight Group meets fortnightly. These provide a forum for shared learning, discussion of general themes and opportunity to discuss any current issues with the Care Inspectorate, Public Health and Community Testing teams. Pan Lothian work is also progressing to address supplementary staffing solutions and training provision. A national network is in development which will offer further opportunities for the Midlothian Care Home Support Team to share and learn from their experience and that of colleagues across Scotland.

In recognition of the significant pressures in home care services, a Care at Home oversight group has being established to gather intelligence around the pressures and gaps in the delivery of care at home services with the aim of targeting support, developing solutions, assessing risk and providing mutual aid. This Midlothian group links with wider Lothian mechanisms to address the current concerns around capacity to deliver care at home services.

3.6 Inspections

The Clinical and Care Governance Group maintains oversight of the inspections undertaken by regulatory bodies, including the monitoring of action plans for improvements. The report following the unannounced inspection at Highbank Care Home on 5th July 2021 has been published. Gradings of 'good' were awarded in the relation to the domains of *'How well do we support people's wellbeing?* and *How good is our care and support during the COVID-19 pandemic?*

3.7 Midlothian Community Hospital

The Board was previously advised that 12 beds at Midlothian Community Hospital additional to the 2020 baseline were open. Following the successful recruitment

and induction of newly qualified registered nurses, a further 2 beds have been opened.

Workforce challenges persist and securing sufficient Nursing staff continues to be a factor limiting the bed capacity available in Midlothian Community Hospital. IJB members will be aware that this is a reflection of the national shortfall of registered nurses. The Partnership will continue its efforts to recruit staff to support further bed capacity to be available to enable people from Midlothian to receive their care locally.

3.8 Lothian Accreditation and Care Assurance Standards – LACAS

The Board have been advised of the implementation of the Lothian Accreditation and Care Assurance Standards across the inpatient areas in Midlothian Community Hospital.

Improvement work is progressing across these areas on specific areas of focus:

- Glenlee: pain assessment
- Edenview: Treatment Escalation Plans and pain assessment
- Loanesk: pain assessment and discharge planning
- Rossbank Unit: pain assessment and discharge planning

3.9 Workforce and clinical and care assurance

Board members have been aware of the significant pressures being experienced across a range of services due to increasing demand and complexity, seasonal pressures and sickness absence attributed to Covid and non-Covid causes.

Midlothian HSCP has developed a framework to enable managers to utilise clear criteria to identify and escalate demand and capacity pressures. This approach ensures that front line staff are involved in identifying the staffing levels they need to provide their usual level of service. The framework identifies the circumstances where decisions would be made about prioritisation of service delivery and ensures that staff at all levels have the support of senior managers in addressing the unprecedented pressures faced at this time. This approach is linked to reporting on Datix *(and other systems)* of any situations where the 'safe to start' position is not achieved. This structured approach ensures robust risk assessment and mitigations are enacted to ensure the safety of people using services and supports staff in the discharge of their professional accountability.

4 Policy Implications

4.1 This report should provide assurance to the IJB that relevant clinical and care governance policies are appropriately implemented in Midlothian.

5 Directions

5.1 Clinical and care governance is implicit in various directions that relate to the delivery of care.

6 Equalities Implications

6.1 There are no equalities implications arising directly from this report.

7 Resource Implications

7.1 Resource implications are identified by managers as part of service development. and additional resource may at times be required to ensure required standards of clinical and care governance are met. The expectation is that clinical and care governance is embedded in service areas and teams and that staff have time built in to attend the CCGG and undertake the associated responsibilities.

8 Risk

8.1 This report is intended to keep the IJB informed of governance arrangements and any related risks and to provide assurance to members around improvement and monitoring activity.

All risks associated with the delivery of services are monitored by managers and where appropriate they are reflected in the risk register.

9 Involving people

9.1 Midlothian staff are involved in the development and ongoing monitoring of processes related to clinical and care governance.

Public representatives on the IJB will have an opportunity to provide feedback and ideas.

10 Background Papers

10.1 N/A

AUTHOR'S NAME	Fiona Stratton
DESIGNATION	Chief Nurse
CONTACT INFO	Fiona.stratton@nhslothian.scot.nhs.uk
DATE	30th September 2021

Appendices: HCG Report

NHS LOTHIAN

Healthcare Governance Committee
7th September 2021

Chief Officer

HEALTHCARE GOVERNANCE COMMITTEE ANNUAL REPORT
MIDLOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP

1 Purpose of the Report

1.1 The purpose of this report is to advise the Committee of the clinical and care governance processes in place within Midlothian Health and Social Care Partnership (MHSCP). The committee is asked to consider these and the actions taken to identify and manage risks, develop services to mitigate these risks and provide quality assurance and governance of services.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 Confirm that the health and care governance arrangements for MHSCP as described in this paper provide moderate assurance to the committee.

2.2 Recognise the developments implemented by the partnership which have been implemented to improve the quality of care experienced by Midlothian residents.

2.3 Note the key risks identified, particularly in relation to the delivery of person-centred, safe and effective care, and the actions taken to mitigate these risks.

2.4 Note the developments planned for the coming year.

3 Scope of services

Midlothian is the second smallest but fastest growing Local Authority in mainland Scotland. 12,000 new houses will be built in the next 3 years. The Midlothian 2016 projection predicts a population of 100,000 by 2026, a 20% increase on the 2011 census population of 83,400. The largest percentage increase will be in those aged 75 and over. This will pose challenges for all our health and social care services whilst also changing the face of some of the local communities.

Services are led and managed by the Midlothian HSCP Core Management Team. This comprises the HSCP Director, Head of Adult Services, Head of Older People and Primary Care Services, Head of Integration and Transformation, Chief Nurse and Clinical Director, with support from the Chief Financial Officer and strategic planning and commissioning colleagues. The Partnership has recently advertised for a Chief Allied Health Professional. The Partnership has the vision that people

will be enabled to lead longer, healthier lives and that they will receive the right support at the right time and in the right place.

The range of services covered by the HSCP includes:

- Care homes and Care Home support
- District Nursing
- Intermediate care, Home First and Discharge to Assess
- Community Treatment and Care Centres (CTACs)
- Midlothian Community Hospital
- Adult Exceptional and Complex Needs Service ACENS (hosted)
- Hospital at Home
- Adult Social Work
- Allied Health Professional (AHP) including hosted Lothian Dietetics
- Community Learning Disabilities
- Community Mental Health and Substance Misuse
- Older Peoples' Mental Health
- Primary Care (GP, community pharmacy, dentistry and optometry services)
- Public Health and Health Improvement
- Sport and leisure.

4 Management and oversight of quality

Clinical and Care Governance Group

The Clinical and Care Governance Group is the overarching group within Midlothian and is the means by which the Senior Management Team and the Midlothian Integrated Joint Board (MIJB) receives assurance from the Partnership around the safety, effectiveness and person centredness of MHSCP Services. Quality Improvement Teams are established covering the services across the partnership and bring together representatives of the multidisciplinary teams to report on and address clinical and care governance

The Quality Improvement Teams (QITs) provide at least 4 reports per year utilising a reporting template which enables the QIT Chairs to seek and to provide assurance on actions in place on key aspects of care and clinical governance (Appendix1). The templates provide an opportunity to identify any other service-specific issues which could have impact on the quality and safety of care the service provides. These issues may relate to areas covered in other groups (Health and Safety, Staff Governance, Finance and Performance) but which are assessed as creating a risk to the service's ability to deliver safe, effective or person-centred care.

The Integrated Joint Board receives regular reports from the Chief Nurse highlighting the risks, mitigations and service developments reported to the CCGG. Where appropriate, risks are added to risk registers at service or partnership level following discussion in the Senior Management Team.

The HSCP Senior Management Team (SMT) receives a fortnightly report from the Chief Nurse regarding the reporting and management of adverse events and complaints on the NHS Lothian Datix system and the Midlothian Council complaints

system. This invites scrutiny and discussion of performance and actions required. This is also the forum where issues requiring escalation from the CCGG are discussed. Appendix 2 summarises the key challenges faced by the partnership and the actions taken to address these in the past year. Appendix 3 provides updates from service areas over the period covered by this report which are not addressed in the main body of the report.

The Chief Nurse and Clinical Director will work with the newly appointed Head of Adult Services, The Head of Older People and Primary Care Services, the Chief Social Work Officer and the Chief Allied Health Professional to continually review and seek to improve the structures and processes in place to deliver effective Clinical and Care Governance in Midlothian HSCP.

5 Service quality outcomes and actions

Inspections

The Clinical and Care Governance Group maintains oversight of the inspections undertaken by regulatory bodies, including the monitoring of action plans for improvements associated with Healthcare Improvement Scotland inspections and Care Inspectorate Inspections of internally provided regulated services.

Mechanisms are in place to ensure discussion takes place of the inspection findings of external organisations, including regular meetings between local teams and service inspectors as part of routine oversight of care homes which informs decisions about the provision of support and any escalation of concerns as required. The collated grades and reports from registered services in Midlothian for 2020-21 are shown in Appendix 4.

Healthcare Improvement Scotland undertook an unannounced inspection of the Medicine of the Elderly wards at Midlothian Community Hospital between the 22nd and 24th September 2020.

The inspection focussed on ensuring the older people in hospital receive care that:

- meets their care needs in relation to food, fluid and nutrition, falls and the prevention and management of pressure ulcers
- manages risks specifically for standard infection prevention and control precautions, falls, and the prevention and management of pressure ulcers, and
- is safe and effective, and in line with current standards, best practice and delivered with local systems and policies in place to effectively manage the care provided.

The inspection noted that patients were treated with dignity and respect and that there was good verbal communication between the ward teams to ensure safe delivery of care. An action plan was developed to address observed areas for improvement which included assessment and monitoring of oral health and nutrition, management of mealtimes, and falls alarms. A monitoring programme is in place to provide continuing oversight and assurance of the key areas within the action plan.

Nurses and Allied Health Professionals from Midlothian have been nominated to participate in working groups to deliver an updated Lothian Falls Strategy. Colleagues from acute and community settings across Lothian will be involved in work which aims to improve the prevention and management of falls. Midlothian HSCP's Falls lead chairs a local group to ensure this work results in improved experience and outcomes from people in Midlothian when living in their own home, a care home or as an inpatient at Midlothian Community Hospital.

Lothian Accreditation and Care Assurance Standards – LACAS

Midlothian Community Hospital's Edenview and Loanesk wards participated in the inaugural Lothian Accreditation and Care Assurance Standards benchmarking exercise in May of this year. Edenview gained a Bronze award and Loanesk Silver.

The most recent round of assurance assessments were published at the end of July. Loanesk achieved a Gold award and Edenview Silver. Participating for the first time in a LACAS review, Glenlee ward and the Rossbank unit both received Bronze awards.

This approach provides the multidisciplinary team with knowledge and skills to develop and deliver quality improvement work to address key components of patient care and has the support of a senior nurse with additional training in Quality Improvement. The approach is now rolled out across all adult inpatient services in Midlothian and plans will be developed to take forward benchmarked accreditation and assurance activity across community teams in time.

Where concerns about standards of care are raised a number of mechanisms support the Partnership to addressing these and the underlying causes. Examples include the fortnightly Senior Management Team meeting, the Core Management Team huddle, Public Protection mechanisms e.g. initial referral discussion, multi-agency meeting, large scale investigation, and the development of ad hoc working groups to address a specific area of concern. The majority of care concerns would sit within an existing group and have the continued oversight of the CCGG.

Electronic Care Planning and Risk assessment

Electronic care planning and risk assessment was successfully implemented in Midlothian Community Hospital on 7th July 2021. This Lothian -wide initiative supports a more person-centred approach to care planning and improved information sharing. Staff embraced this initiative with enthusiasm, including highlighting their preparations on social media. The approach enables the development of care plans which reflect what is important to the person; staff value the opportunity to spend time talking to their patients to properly get to know them. Compliance has consistently been recorded at 100%.

Care Homes for Older people

Health Boards and local Health and Social Care Partnerships continue to carry responsibilities for the clinical and professional oversight of the care provided to people resident in care homes in line with the Scottish Government guidelines (May 2020).Midlothian HSCP has local mechanisms in place to deliver its responsibilities and to link its work with pan-Lothian and national mechanisms.

Midlothian has 10 care homes for older people, 2 of which are HSCP run with one being an intermediate care facility. The remaining 8 are privately run either by private companies, charitable organisations or independent family care homes.

Midlothian Care Home Support Team identified significant concerns about the quality of care being delivered to residents in Thornlea Care Home in November 2020. Following an inspection by the Care Inspectorate in December, the Care Inspectorate applied to the Sheriff Court to suspend its registration, and the Care Home was closed on 18th January 2021. Appropriate alternative accommodation was arranged for the remaining residents and significant HSCP resources were deployed to support the safe care of residents over the transition period. This incident represents a very difficult period for the residents and their families, and the staff involved.

Midlothian's Care Home Support Team has been funded to have increased capacity and provides a proactive and preventative support approach as well as a reactive response where care homes need additional support/advice/training. They provide advice, support and education directly and maintain strong links with Lothian-wide specialist teams, enabling the provision of additional specialist infection prevention and control, tissue viability, clinical education and quality improvement support. Partnership working with these teams, the Care Inspectorate and the social work teams within the Midlothian Health and Social Care Partnership delivers multidisciplinary perspectives on the care and support of older people within our local care homes. This enables proactive support of the delivery of person-centred care, and regular input to address issues and challenges being faced in the care homes as they arise using risk assessment skills to drive informal approaches and more formal procedures as required.

Substantial support has been provided to care homes for older people to address the challenges faced throughout the Covid-19 pandemic. Examples include the provision of direct support to meet staffing challenges, input to meet the complex care needs of individual residents, vaccination, testing of staff and residents, support with the reintroduction of visiting and providing practical and emotional support to staff affected by the impacts of the loss of residents in unprecedented numbers. Quality improvement approaches have been utilised to develop checklists to build on the learning the team has acquired and to ensure a thorough and consistent approach.

The Midlothian 'rapid rundown' takes place three times per week and provides regular senior oversight of emerging issues and improvement work and the opportunity to discuss any concerns raised by care home managers and/ or identified by the Care Home Support Team. The data gathered by the Care Home

Support Team and that which is entered directly into the national 'TURAS' safety huddle tool enables local assessment of risk and the provision of assurance around staffing, care standards and the actions in place to address the risks posed to care home residents by the COVID -19 virus.

Lothian wide Operational Oversight meetings are attended twice weekly and a Strategic Oversight Group meets fortnightly. These provide a forum for shared learning, discussion of general themes and opportunity to discuss any current issues with the Care Inspectorate, Public Health and Community Testing teams. Pan Lothian work is also progressing to address supplementary staffing solutions and training provision. A national network is in development which will offer further opportunities for the Midlothian Care Home Support Team to share and learn from their experience and that of colleagues across Scotland.

Midlothian HSCP continues to work closely with partners including Midlothian Council, NHS Lothian, the Care Inspectorate and Scottish Care. The care home workforce is an area of ongoing development and this will continue to be a focus for 2021. Midlothian is one of the partners involved in the plans to develop a Lothian Care Academy to provide a route into health and social care work.

6 Impact on People Experiencing Care

Feedback

QIT templates require each service area to report on its approaches to gathering feedback from people who use our services. This promotes the discussion of feedback within QITs and for this to inform service delivery. Approaches are shared at the CCGG to support the sharing of best practice. Recent discussion of the use of Care Opinion website by the Hospital at Home team has led to a number of other teams exploring the potential to utilise this approach, and others to reinvigorate their paper-based efforts.

Outcomes

The Partnership took a report to the IJB in February of this year which addressed the Outcomes Approach to Performance Management. This report highlighted this need to develop ways of measuring and reporting more effectively the outcomes achieved through the delivery of health and social work services. The Partnership is progressing work to develop Outcome Maps at each level of the organisation. A new software programme, *OutNav*, makes it possible to capture and link a wide range of evidence for evaluating progress with each of the stepping-stones in these maps.

Good progress has been made over the past few months in developing outcome maps for the frailty system of care and the service delivered at Number 11 (joint mental health, drugs and alcohol, and criminal justice services). The third area of activity has been the development of an outcome map for the Partnership at a strategic level.

The process of outcome mapping at a strategic level will become increasingly robust as the mapping work on individual services expands across the Partnership thereby providing evidence of progress at a strategic level. The intention is to complete the three initial areas of mapping work by mid-September and then move on to the development of outcome maps for pathways in and out of acute services, and for unpaid carers.

Identifying and measuring contributions of individual services is complex and cannot rely on one or two key performance indicators. Our third-party partner, *Matter of Focus*, has developed software, referred to as OutNav, that enables a wide range of relevant information to be captured and linked, including service user and staff feedback, individual patient stories as well as hard performance data such as numbers of people delayed in hospital. A major benefit of this system is that it provides real-time reports across all the organisation's activities using a wide range of evidence. The system offers the facility to pull in data gathered routinely by the third and independent sectors, relevant to measuring improvement in outcomes, crucial given how much social care is outsourced but, as yet, is not fully utilised in measuring our performance as a Partnership.

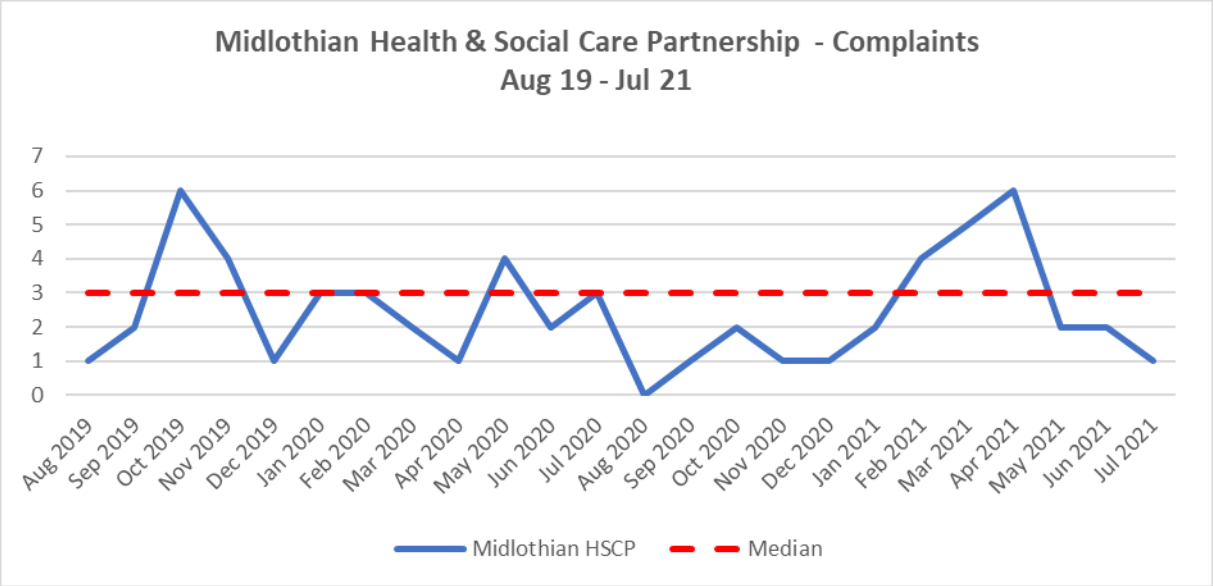
The approach will not only provide an accessible yet comprehensive approach to measuring performance, it will also enable the Partnership to maintain a real-time approach to self-assessment. The Care Inspectorate link inspector is working with us to capitalise upon this added benefit of the approach. An enhanced capacity to measure outcomes is consistent with the priority now being given to outcomes by the inspection agencies. The implementation of this new approach will enable the Partnership to provide, more effectively, the evidence that the Care Inspectorate and Health Care Improvement Scotland will seek during any future inspections.

As with any new approach, it will be critical that mechanisms are put in place to ensure it is maintained on an ongoing basis. This will require clear allocation of responsibilities and a quality assurance system, such as regular reporting on service outcome maps to the Finance and Performance Group. The system will also require increased analytical support and the recent approval given to the creation of a new Strategic Programme Manager for Performance Management will help provide such support and leadership.

Complaints

Midlothian HSCP receives a small number of complaints and the systems for oversight and scrutiny aim to deliver responses to stage 1 and Stage 2 complaints within the Scottish Complaints Ombudsman's targets of 5 days and 20 working days respectively. Chart 1 show 59 complaints received over the 2-year period August 2019 – July 2020, with a stable median of 3 complaints received per month. The fortnightly SMT has oversight of response times for complaints, ensuring proactive and real time actions are agreed to respond to the concerns people raise about the care provided.

Chart 1: Complaints reported August 2019 – July 2021



The QIT template requires service areas to report on their learning from complaints and to share their learning and the actions they have undertaken to make changes in response to learning from complaints. Heads of Service scrutinise and and sign off individual complaint responses and action plans.

Plans have been developed to deliver learning opportunities in autumn 2021 for managers responsible for the investigation and response to complaints. This aims to improve their confidence, quality of response and performance against target response times in this important aspect of addressing the concerns of people who have expressed concerns about the care they or their relative have received.

7 Impact on staff

Midlothian HSCP responded to the Scottish Government's request to strengthen existing local arrangements for staff wellbeing and to provide support and practical advice specific to the pandemic. A lead person was identified to develop a framework for the physical and psychological wellbeing of staff to ensure a coordinated and committed approach and a working group was convened with representation from a range of staff groups. A dedicated team was established to respond to concerns, queries and information requests and to provide regular information and updates. A Wellbeing post has now been established to provide dedicated leadership on staff wellbeing.

The HSCP conducted a staff survey in early January 2021 to establish an understanding of what matters to the staff within the partnership in relation to their health and wellbeing and determine whether the resources for support were effective or not. The findings have been analysed and will inform the ongoing work of the staff wellbeing group and the workstreams to be taken froward by the wellbeing lead.

The partnership's plan is that all service managers and team leaders will be trained in 'Good conversations' and some staff are undertaking training to become NHS Lothian Peer Supporters. It is the intention of Midlothian HSCP that all staff will be trained in 'Good conversations' within the next two years which should impact on staff wellbeing as well as operational practice.

Preparations for the annual iMatter survey are underway at the time of writing. In addition, Midlothian HSCP is exploring the potential of an opt in mobile app or web based tool, which is has been reported to be effective in enhancing employee engagement, improving reported wellbeing, and to provide the opportunity for recognition by supporting real time discussions. Trickle had already been trialled in some Musculoskeletal services prior to being rolled out across both the Home First and No.11 teams within Midlothian in May 2021. Over the past few months, the platform has been used to gauge how staff are feeling and what was contributing to both 'good days and bad days' using a 'how was your day' function. The responses are anonymous but asks staff to fill in the contributing factors, so it allows the HSCP to understand how staff are feeling and identify any areas for improvement. The platform has also been used to share important information with teams regarding drop-in vaccine clinics and there have been examples of Trickle being used to share good practice. There are now over 100 users signed up and the project team are working closely with the Trickle team to try and increase uptake and improve utilisation.

8 Delivery of Safe, Effective and Person -centred care

Adverse events

Chart 2 illustrates the 1638 adverse events reported in Midlothian HSCP between August 2019 and July 2021.The median number for all adverse events (85 per month) has increased reflecting a higher level of incident reporting in 2020 (median 53 per month) compared to 2019 (median 73 per month), which has continued over 2021. Adverse events resulting in no known adverse effect or minor harm are addressed locally by Charge Nurses/ Team Managers and reviews and action plans approved by Service Managers. The top 3 categories of **all** adverse events are Falls (723), violence/ aggression/abuse/ harrassment (535) and medication (140).

Chart 2: Adverse Events Reported August 2019 – July 2021

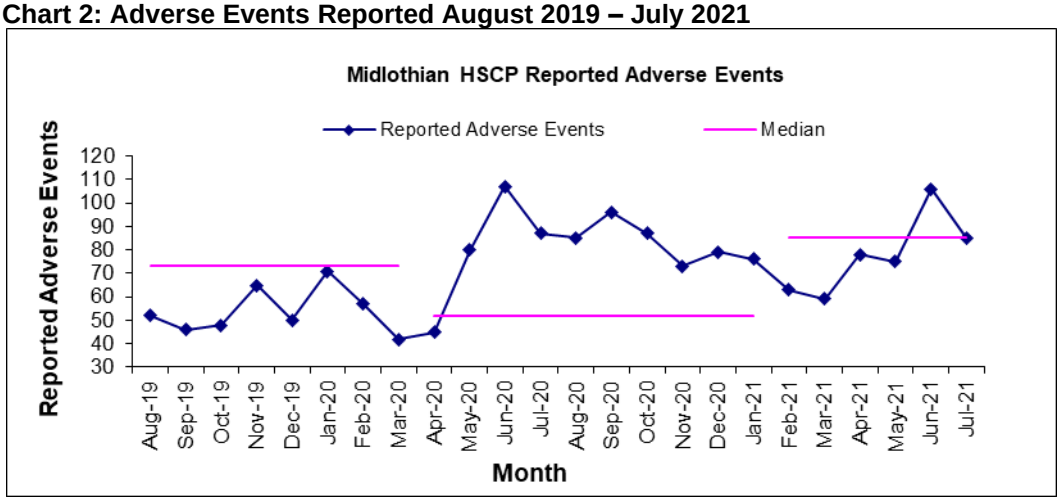
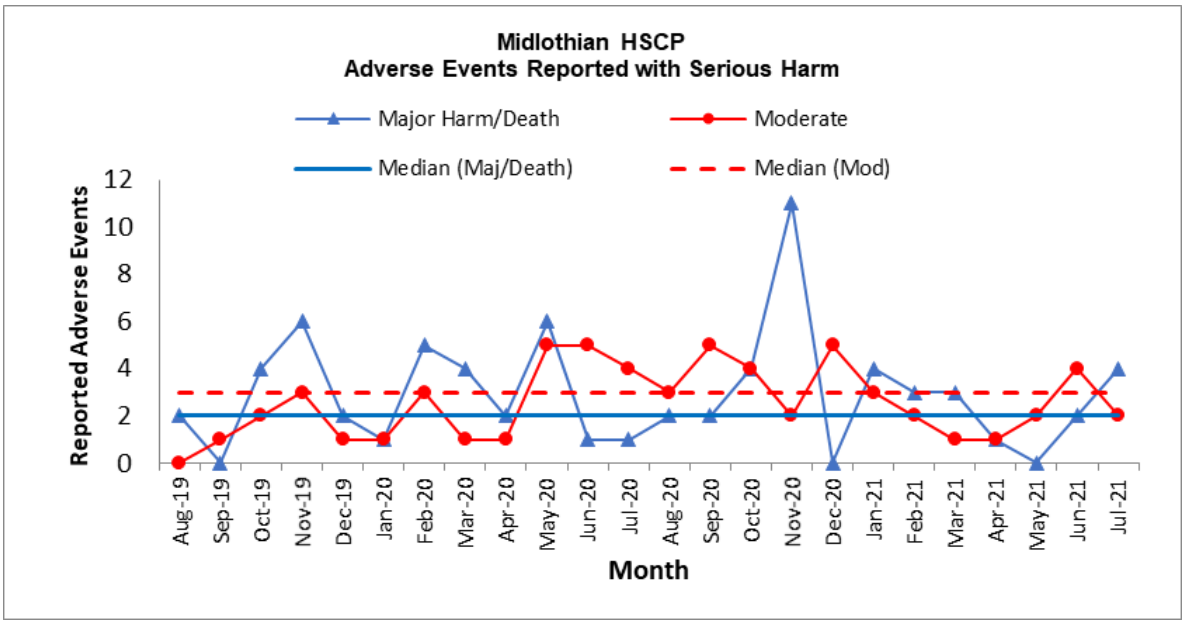


Chart 3 illustrates 131 serious adverse events resulting in moderate (61 incidents) or major harm/death (70 incidents) over the 2-year period August 2019 to July 2021. The median number of adverse events resulting in major harm (2 per month) or moderate harm (3 per month) has remained stable. The peak in events reported in November 2020 relates to an outbreak of COVID 19 in Midlothian Community Hospital that affected a number of staff.

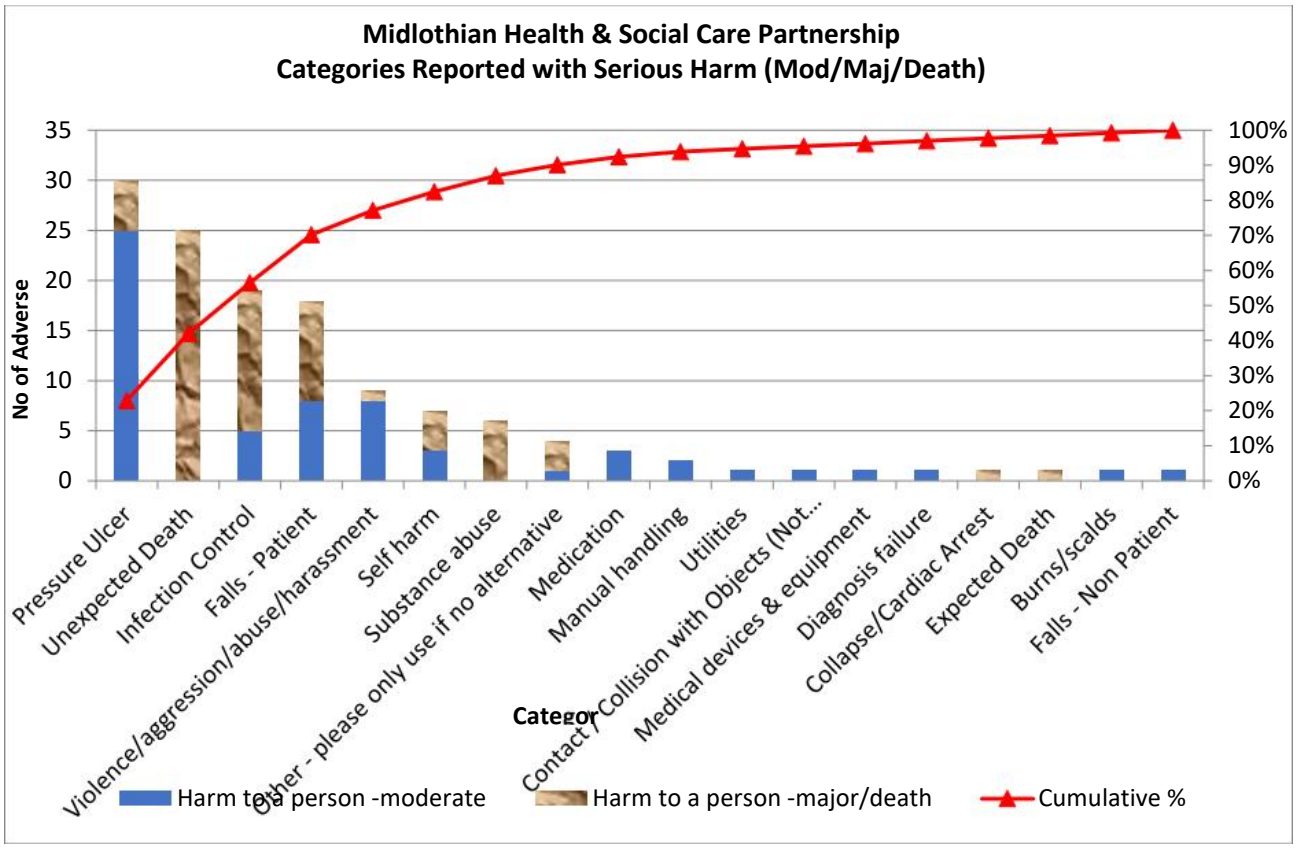
Chart 3: Categories of adverse events reported August 2019 – July 2021



Three groups are established to provide oversight of all significant adverse events reported within Midlothian. Specific Lothian pathways are delivered by groups address patient/client falls and pressure ulcers. Another group, the Midlothian Safety and Experience Action Group has oversight of all other significant adverse events, including those which are drug related deaths or suicide by patients engaged with mental health and substance misuse services.

Chart 4 illustrates the categories of adverse events reported between August 2019 and July 2020. The top 3 categories of adverse events with serious harm are pressure ulcers (n = 30), unexpected death (n=25) and infection control (n=19). The infection control figures have been significantly impacted by outbreaks of Covid -19.

Chart 4: Categories of adverse events reported August 2019 – July 2021



A group which previously met as the commissioning group for suicides and drug related deaths has been working with the NHS Lothian Quality Improvement Support Team to develop its approach to provide oversight of harm. The renamed Midlothian Safety and Experience Action Group has prioritised actions to adopt changes to the investigation of suicides and drug related deaths of people who were engaged with or recently discharged from mental health and substance misuse services at the time of their death. These changes are being adopted Lothian-wide to enable early, proportionate investigation to take place to enable local learning, whilst ensuring that independent review is undertaken where appropriate. MSEAG now meets fortnightly (previously monthly) with aligned administrative support, a revised agenda and processes to support effective administration of this work.

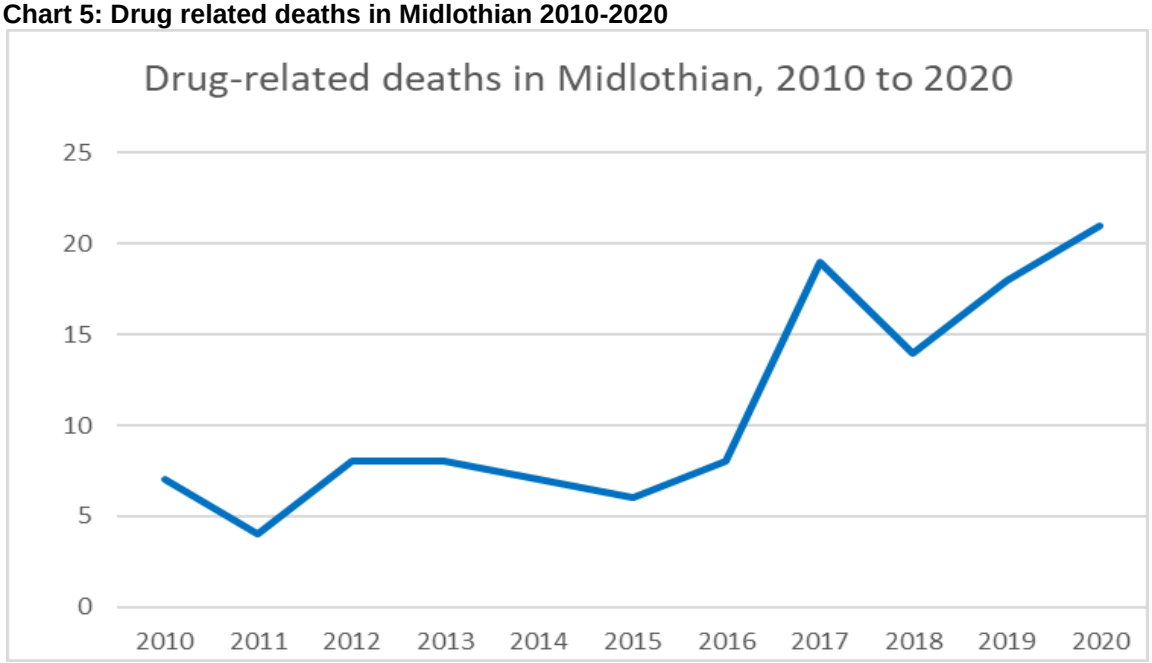
The Midlothian Safety and Experience Action Group submits its minutes to the NHS Lothian Patient Safety and Experience Action Group. Decisions and reviews approved by the Midlothian Safety and Experience Action Group are subject to the scrutiny, including final approval from the NHS Lothian Medical Director and Executive Nurse Director.

Decisions made at the Midlothian Safety and Experience Action Group are taken forward by the relevant teams where SAEs have occurred, with the relevant Quality Improvement Teams having responsibility to implement learning from adverse events and complaints in their areas. Learning and actions are shared with all Quality Improvement Team leads at the Clinical and Care Governance Group to support shared learning and improvement across the partnership. MSEAG will develop its work to have an overview of harms in service areas and will continue to link with the CCGG to progress actions to deliver improvement.

Drug related deaths
Addressing the high incidence of drug related deaths is a national priority and work being undertaken in Midlothian to address this public health issue warrants discussion in this report.

Midlothian's average rate of Drug-related deaths between 2016 and 2020 was 17.5 per 100,000 of population against a Scottish figure of 20.6. Chart 5 illustrates the annual incidence of drug related deaths in Midlothian since 2010.

Chart 5: Drug related deaths in Midlothian 2010-2020



The local substance misuse team has robust links with the fortnightly Lothian wide drug related death meeting where trends, data, and up to date intelligence around street drugs are discussed. Standard harm reduction and Take-Home Naloxone training are part of one to one work in the service. Pathways are established to support people being released from prison and a new initiative to provide medication assisted treatment to people in police custody is in development.

Midlothian is the pilot site for 2 of the 10 new Medication Assisted Treatment (MAT) standards. The MAT standard 3 pilot offers assertive outreach to individuals identified at a weekly multi-agency huddle as having experienced a near fatal overdose. MAT standard 9 aims to provide an integrated, person centred mental health and substance misuse service to people who present to Substance Misuse Services with a concurrent mental health problem.

Drop-in services were suspended during COVID restrictions but have now recommenced in Dalkeith and the potential to run a similar service in Penicuik is being explored. Patients who are on the waiting list can attend the drop-in service and benefit from a same day service provided by a nurse prescriber. Work is underway with MELD, our partner agency, with the aim of improving access and meeting the 21-day HEAT target for those who do not access the drop-in clinic.

The DAISy (Drug and Alcohol Information System) was launched in April this year by Public Health Scotland. The system holds data on all patients referred to the service Depending on the length of time someone remains in treatment, DAISy prompts reviews at 12, 26 week and 52 weeks, on top of routine appointments.

Future include proposals to improve the use of TRAK to support communication with the mental health team and the development of recovery-based approaches individual and group approaches.

Monitoring Harm

This annual report has allowed the Partnership to highlight the potential for it to maintain more cohesive overview of the monitoring of harm and the actions being progressed to deliver improvement and address preventable causes. Midlothian Community Hospital undertakes a daily safety huddle to review staffing, patient needs and known risks. The Medicines Management, Food Fluid and Nutrition groups, and Falls Improvement groups will support the delivery of a continuous quality improvement approach based on data and appropriate engagement of staff. Plans are at an advanced stage to appoint a Performance manager whose responsibilities will support the collation and reporting of data. This will support continuing efforts to deliver improved care and clinical governance.

Equitable care – support for difficult to reach groups

Midlothian HSCP has a well-established Health Inclusion Team staffed by Specialist Nurse Practitioners. These nurses work with people most vulnerable to poor health and health inequalities; this includes people with challenges related to mental health, substance misuse, homelessness and offending/criminal justice. It also includes gypsy/travellers, unpaid carers, people attending food banks and frequent attenders at the Emergency Department.

They support people to improve and manage their health and to access local services, such as drug treatment or welfare rights. Nurses provide an outreach service and offer time-limited self-management support. The Health Inclusion Team nurses are skilled in using health behaviour change, person centred approaches and deliver health needs assessments in community-based venues often linked to local services to improve reach and engagement. The Health Needs Assessment offers the opportunity and time to discuss both health and social issues that have an impact on lives. HIT staff also deliver Healthy Living Skills Groups when appropriate.

The nurses visit each of Midlothian's homeless hostels every one or two weeks. They knock on each resident's room door, offering the opportunity to speak to a nurse about their health and wellbeing. Every conversation is different and guided by what matters to the person. It can take a while for people to build up trust with the nurses. The nurses also provide support and advice to hostel staff when working with people with complex needs and can support people to access a wide range of local services. They also offer naloxone training, blood borne virus testing, sexual health assessments, contraception and STI testing.

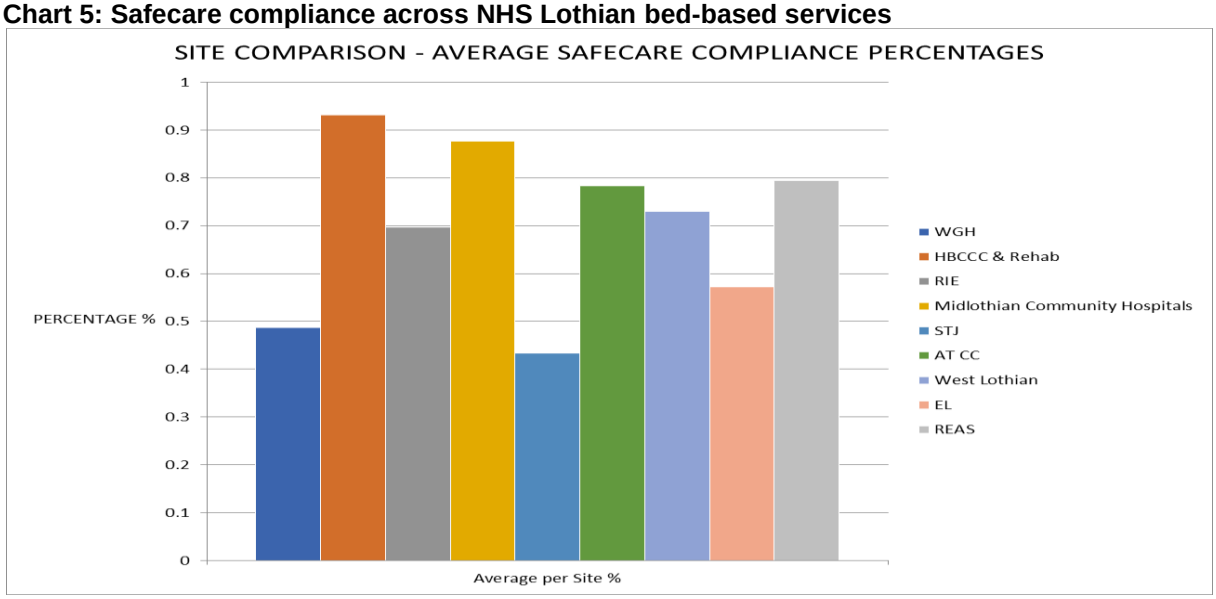
9 Workforce management and support

A suitably trained workforce in sufficient numbers underpins the delivery of safe, effective and person-centred services. Challenges in recruiting sufficient staff with the appropriate skills and experience to our services are a key risk for the partnership and have been highlighted throughout this report.

Midlothian HSCP has developed and submitted an interim Workforce Plan to the Scottish Government and a 3-year workforce plan is in development. Analysis of the current workforce, service demand and capacity, recruitment and retention challenges and current approaches is being undertaken involving relevant stakeholders within the partnership.

Nursing teams are engaging in the rollout of the programme of preparation to run the workforce and workload tools as part of the programme to deliver in the requirements of safe staffing legislation. Chart 5 compares the level of compliance with the Safecare tool across all bed-based facilities. Performance in Midlothian Community Hospital is recognised as being exemplary and is an important element of evidencing appropriate staffing on our hospital wards. Work is underway to provide Senior Charge Nurses with the skills to further improve their utilisation of the tool

Chart 5: Safecare compliance across NHS Lothian bed-based services



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Training and development plans

Midlothian HSCP is committed to developing a workforce with the capacity and capability to provide appropriate, evidence based, safe, effective and person-centred services.

Annual appraisal conversations are being resumed as service pressures associated with COVID ease, enabling staff to have conversations with managers about the knowledge, skills and supports they need to undertake their roles.

Training opportunities continued to be provided virtually throughout the pandemic to address mandatory training needs. There is awareness that a number of face to face programmes, including the management of violence and aggression, continue to be paused, and managers continue to highlight the risks associated with the continued absence of this provision.

Midlothian HSCP recognises the need for staff to work differently to understand and empower the people they work with and have adopted 'The Midway' as an approach – where staff are facilitators, not fixers, shift power to the person, understand trauma and recognise inequality. Good Conversations training and bitesize programmes resumed after a pause in the early part of the pandemic. We have trained staff so that anytime someone contacts our services, the focus is on their needs and what matters to them and what their personal circumstances are. We have now trained 435 people in the approach, including third sector partners.

Training opportunities are made available across the Community Planning Partnership (CPP), for example training on health inequalities, health literacy, suicide prevention, and weight stigma. Midlothian continues to implement the Trauma Awareness Framework. Training was paused until September 2020, but courses are now being delivered with good representation from many areas of the CPP.

10 Quality improvement based leadership

Processes for staff development, training and learning for improvement
This is an area for the Partnership to develop improved focus and data to support future planning. Senior managers report that staff in Midlothian HSCP have accessed a range of quality improvement learning opportunities based on learning needs identified in personal development plans and through opportunities arising from service development. Data on uptake, completion and impact is not readily available.

There is widespread awareness of the opportunities available through online learning, the NHS Lothian Quality Academy and webinars and other online opportunities available through professional organisations and NES. The acquisition of quality improvement knowledge and skills is promoted through the Professional Nursing Forum and the Care and Clinical Governance Group. The LACAS programme is providing opportunities for staff in Midlothian Community hospital to participate in care assurance and to learn skills in tandem with the delivery of quality improvement projects. The Feeley Report recognises the opportunities that the wider application of quality improvement methodology within social care can offer.

Staff empowered to test ideas and improve and share lessons to deliver high quality care
QIT reports evidence service and quality improvement work is underway in all areas, with ideas generated from staff directly involved in care. There is a significant amount of development work undertaken in the partnership that bear the hallmarks of quality improvement without being framed or presented using QI methodology.

11 Key Risks

11.1 Capacity of services to meet increased demand due to increasing population, age, and frailty. Primary Care sustainability linked to this.

11.2 Lack of availability of staff with appropriate qualifications or skills, including General Practitioners, Staff Nurses, Advanced Nurse Practitioners, Advanced Physiotherapy Practitioners, District Nurses, Health Visitors and Social Care Workers. Impacts on Midlothian HSCP timescales to implement some of the solutions planned.

11.3 Quantified through vacancy levels, project delays, waiting lists and amount of support to services as detailed in the previous sections. Monitored by Chief Officer and Joint Management Team Midlothian HSCP.

12 Risk Register

12.1 The Midlothian HSCP risk register identifies and manages a number of risks and the key risks are noted below, which are all supported by agreed measures in which to mitigate and manage the risks effectively:

- Capacity of service to meet increased demand due to increasing population, age, and frailty – this is being addressed through the Primary Care Plan
- Lack of availability of staff with appropriate qualifications or skills, including General Practitioners, Staff Nurses, Advanced Nurse Practitioners, Advanced Physiotherapy Practitioners, District Nurses, Health Visitors and Social Care Workers this is being addressed through the HSCP Workforce Strategy
- Emergency admissions and Delayed Discharges, particularly in relation to lack of care at home – this is being addressed through Care at Home recommissioning, Delayed Discharge plans and Acute Services Planning

12.2 Risk management

External audit of NHS Lothian's Risk Management Policy and supporting Risk Management Operational Procedure was undertaken in Summer 2021.

As a division of NHSL, Midlothian HSCP was required to evidence compliance with the Risk Management Policy. The audit confirmed that the Risk Management processes within Midlothian provided high assurance and demonstrated best practice in several areas:

- Midlothian HSCP Senior Management Team meet every 2 weeks and risk is a standing agenda item.
- The Senior Management Team is supported by 4 committees (Business Management Governance Group, Finance and Performance, Staff Governance and Clinical Care and Governance) each of which have risk as a standing agenda item.

- Service level risks are considered monthly via the Business Management Governance Group.
- Monitoring of risks is through these forums.

12.2 **Resilience and Major Incident Planning**

Midlothian HSCP provides assurance to NHSL annually on resilience and major incident planning. Service Managers are required to review and update their service specific resilience plans which then feed into the overarching Midlothian Resilience Plan. This is currently being progressed with updates due in September 2021.

A new digital control room was developed to mirror NHSL GOLD Command which allows our SMT Incident Management Team to quickly mobilise virtually when required. An exercise was carried out in July 2021 to test the practicality and functionality of this tool and further exercises will be completed with a partnership wide approach later in the year.

13 Impact on Inequality, Including Health Inequalities

13.1 There are no implications for health or other inequalities from the issues raised in this paper

14 Duty to Inform, Engage and Consult People who use our Services

14.1 This update provides factual information and accompanying commentary. It does not contain any proposals for action or change which might impact on services, patients or service user

14.2 Work is underway to develop and progress consultation on Midlothian's 2022-2025 Strategic Plan.

15 Resource Implications

15.1 There are no new resource implications arising from this report. All aspect of the monitoring and reporting mechanisms for the governance of Midlothian HSCP's services are included in the routine work of local services and in appropriate groups and committees

Fiona Stratton
Chief Nurse
26 August 2021
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Appendix 1

XXXXX Group QIT

Report for Period XXX to XXX 2020

Meeting XX pm, DATE, MONTH 2020

VENUE

Attendees at QIT:

Apologies for QIT:

1. Update on XXXXX Group Actions from Last C&CGG Meeting / Action Log

Action for this group	Update

2. **Standards**

The following relevant guidance / standards have been issued/created in period.

Guidance / Standards	Update	Actions to take forward
e.g. Duty of Candour		

3. Quality Improvement Project Updates

Provide brief update below and verbal update at meeting. Include details of any new projects.

Project	Update	Actions to take forward

4. Safety

Issue	Details	Actions to take forward
Relevant Safety Alerts/Action Notices		
NHS Incidents (DATIX)		

Issue	Details	Actions to take forward
NHS SAE		
Council (SPHERA)		
Internal Issue Follow Up		
External Issues Follow Up		
Provider Contract Monitoring		
Items added to Risk Register		

5. Internal / External Reviews and Inspections

Internal / External	Inspecting body / responsible Manager	Date of Inspection /Audit/Review	Comments / Update	Actions to take forward

(Care inspectorate grades: Quality of care and support / Quality of environment / Quality of staffing / Quality of management and leadership

6. Shared learning and Actions (from incidents / complaints / inspections)

Issue	Update	Actions

7. Responsiveness of services

Area/Issues	Update	Actions
Recruitment/Retention		
Mandatory Training		
Waiting Times		
Delayed Discharge		
Public Protection		
MAPPA / CJ		

8. Links to other groups / meetings

Meeting / Date	Update	Actions

9. Feedback

Issue	Update	Actions
Patient/Public feedback		
Staff experience		
NHS Complaints		
Council Complaints		
Disciplinary		
Induction		

10. Safe Staffing Implementation

Activity	Update	Actions
For discussion at meeting		

11. Reporting

Activity	Update	Actions

12. Date of Next Meeting

Appendix 2

Midlothian HSCP Key challenges & actions to address

COVID-19
The impact of the COVID-19 pandemic brought many challenges and much disruption to the Health and Social Pare Partnership, its partners and the communities it serves. There was increased anxiety and pressure on many service users, unpaid carers and staff. While challenges may have changed over 2020, they will continue into 2021. Covid will continue to influence how the HSCP delivers core services, works with partners and communities and develops the workforce. In addition the Partnership will adapt to deliver Covid related services, such as vaccination clinics.

A growing and ageing population
We are the second smallest Local Authority in mainland Scotland but the fastest growing. This will continue to pose challenges for health and social care services whilst also changing some local communities. As people live for longer many more people will be living at home with frailty and/or dementia and/or multiple health conditions. An increasing number of people live on their own, and for some this will bring a risk of isolation.

Higher rates of long-term conditions
Managing long-term conditions is one of the biggest challenges facing health care services worldwide, with 60% of all deaths attributable to them. Older people are more susceptible to developing long-term conditions; most over 65s have two or more conditions and most over 75s have three or more conditions. People living in areas of multiple deprivation are at particular risk with, for example, a much greater likelihood of early death from heart failure. They are also likely to develop 2 or more conditions 10-15 years earlier than people living in affluent areas.

Higher rates of mental health needs
Many mental health problems are preventable, and almost all are treatable, so people can either fully recover or manage their conditions successfully and live fulfilling healthy lives as far as possible. The incidence of mental health issues in Midlothian, while similar to the rest of Scotland, is a concern. Living in poverty increases the likelihood of mental health problems but also mental health problems can lead to greater social exclusion and higher levels of poverty. People who have life-long mental illness are likely to die 15-20 years prematurely because of physical ill-health.

Our services are under pressure
People place a high value on being able to access effective health services when they need them. People expect to receive high quality care services when these are needed whether as a result of age, disability, sex, gender or long term health conditions. Yet there are a number of pressures on our services.

Financial pressures
Financial pressures on public services are well documented. There is no doubt that we need to do things differently: the traditional approach to delivering health and care services is no longer financially sustainable.

Workforce pressures
The Covid-19 pandemic has and will continue to influence the demand for, and deployment of, the health and care workforce for the foreseeable future. Mass vaccination programmes and other large-scale recruitment programmes related to COVID 19 have increased pressure on already stretched resource. How the workforce interacts with people has also changed with an increased use of digital or telephone appointments. The Scottish Government has requested that IJBs develop a 3-year Workforce Plan no later than 31st March 2022.

Unpaid carers
Unpaid carers fulfil significant, valuable and wide-ranging roles within Midlothian communities, helping to keep people with care and support needs within our communities. During the pandemic many people have become carers for the first time, or seen changes to their caring role, resulting in them providing significantly more care for their elderly, sick or disabled family, friends and neighbours. Through this period Community services supporting carers have continued to offer a range of support, including digitally, and by telephone, though services supporting the person they provide support to may have been reduced, e.g. respite and day services, resulting in an impact on carers. It is essential that we work to reduce the significant pressure and impact of caring that carers report feeling, by continuing to explore innovative options to enable support to be given to both carers and the cared-for, and for there to be opportunities for breaks from caring leading to caring being more sustainable. We are constantly looking for ways to offer respite and support to reduce the stress and impact of caring.

Acute hospitals
Acute hospitals are under huge pressure due to unsustainable demand and financial restrictions. We need to invest in community based and work with carers alternatives that will minimise avoidable and inappropriate admissions and facilitate earlier discharge. By treating people closer to home, or in their own home we can support admission avoidance and improve patient outcomes.

Appendix 3

Midlothian HSCP Service Overview 2020-2021

COVID-19 Response

The impact of the COVID-19 pandemic brought many challenges and much disruption to the Health and Social Pare Partnership, our partners and the communities it serves. There was increased anxiety and pressure on many service users, unpaid carers and staff. While challenges may have changed over 2020, they will continue into 2021.

As a Partnership, the top priority was the safety of patients, clients, communities and staff. In response to the situation it was important to be innovative and support clients effectively and safely during this time. Staff continued to see people face-to-face where this was clinically essential, but in order to reduce face-to-face contact, where feasible, teams made a number of changes to how they delivered services throughout the pandemic.

As well as managing changes to existing services, the Partnership also provided care and treatment to people who had contracted COVID-19 and their families. It also provided support to partner agencies around changed provision, infection control and other requirements, including the provision of personal protective equipment (PPE) and staff testing. In addition, COVID-19 related services had to be established, often at short notice as the pandemic escalated, such as the COVID-19 Testing and Assessment Hub at Midlothian Community Hospital. Many staff across the Partnership were redeployed to other roles, assisting in care homes and PPE centres.

Midlothian's COVID Vaccination Programme links with the NHS Lothian Vaccination Programme Board. A dedicated clinical and administrative team manages and delivers the Midlothian programme, ensuring access and the delivery of a safe vaccination programme. With this support, vaccinations are being delivered in line with the Joint Committee of Vaccination and Immunisation (JVCI) 9 category age and clinical risk related prioritisation programme. The HSCP will run two mass-vaccination sites to deliver a service to the 51,204 residents in Midlothian who are eligible for a COVID Booster Vaccination and Seasonal Flu vaccination.

Unpaid (Family) Carers

Work continued to support carers in partnership with local organisations, in particular VOCAL Midlothian but also Alzheimer's Scotland and others. While traditional respite options have been limited due to the pandemic, especially for older people, alternative support to carers is being progressed and additional funds were provided for Wee Breaks. Work progressed to re-commission carer support services in 2021. This involved a comprehensive community engagement programme. Contracts were awarded in March 2021.

Multi-disciplinary approach to mental health, Substance Misuse and Justice Services

In 2019 staff from across mental health, substance misuse, Justice and Third Sector co-located in '**No.11**' in Dalkeith, allowing for a new trauma informed, collaborative way of working with and supporting individuals, particularly those with multiple complex needs.

The service is part of the Scottish Government's Trauma Informed Workforce Pilot. There have already been some excellent examples of joint working to support vulnerable clients. Service delivery had to change during the pandemic.

Improving Services for Older People
There is one internal and three externally contracted providers in Midlothian delivering Care at Home to older people. All care at home services have managed to continue their normal service delivery in recent months. COVID-19 has had an effect on the workforce as a number of staff were in the shielding group due to their own health conditions. A care at home recommissioning exercise has just been completed. Based on extensive research, analysis, knowledge and experience of staff within older peoples and procurement services and consultation and engagement with key stakeholders, the new model delivers block contracts for independent providers. This will enable them to offer terms and conditions of employment which should improve recruitment and retention. Delivery on a locality basis is designed to reduce travel time and increase direct contact and consistency of care provider enabling a more person centred, outcomes focused and relational service. This model is more costly but signals Midlothian's commitment to invest develop services to meet demand and address complexity of need.

Extra Care Housing:
As with many other areas, Midlothian faces many challenges in addressing the housing and care needs of an ageing population with increasingly complex requirements. Extra Care Housing is a model of accommodation and care that supports people to live in their own tenancy. Plans for the development of extra care housing complexes across three sites in Midlothian is ongoing with spring 2022 proposed for completion.

Frailty
The increasing prevalence of frailty, as a result of our rapidly ageing population, is contributing to a health and care system that will be unsustainable in its current form. People with severe and moderate frailty (3,500 people) account for 4% of Midlothian's population and 31% of unscheduled activity in the Royal Infirmary of Edinburgh in 2019. Midlothian HSCP and the Midlothian GP Cluster continue to use the electronic frailty index (eFI) to inform strategic direction and service developments.

During the COVID-19 response 2,719 people estimated to have moderate or severe frailty were contacted and supported by the Red Cross Welfare Call service (issues identified including hearing aid battery replacements, social isolation, shopping, and prescriptions). In 2020-21 the Red Cross supported older people to access £201,000 of Attendance Allowance through their income maximisation work.

People living with moderate or severe frailty who were part of a dedicated GP service saw in a reduction in subsequent admissions to hospital in 2020-21.

Learning Disability, Autism and Complex Needs Housing
No Midlothian citizen with complex care needs is currently delayed in hospital and nobody lives away from the area, other than through their own choice or where there is an assessed need for them to be supported outside Midlothian.

Supporting independent living is a key priority for the Learning Disability Services. Work is ongoing to develop a range of housing options based on individual needs and to ensure individuals can access appropriate housing as their needs change. The model of proactive behavioural support services continues to be developed within Midlothian.

Day Services for people with Learning Disabilities have been impacted by COVID-19. Many continued to operate although with reduced capacity as a result of physical distancing and infection control requirements.

Primary Care
In early weeks of the crisis demand on GP Practices was quadruple that in previous years. All practices managed to remain open during the COVID-19 response but some changes occurred. For example, there was a significant change with the move to total-telephone-triage. There was also an increase in the use of Near-Me.

There has been a considerable increase in the number of Anticipatory Care Plans written for vulnerable patients.

Work to implement the Primary Care Improvement Plan continues to be progressed including planning around CTACs (Community Treatment and Care Centres). A number of CTAC staff assisted in the Covid Vaccination programme during 2020-21.

The Thistle Foundation (Wellbeing Service) and VOCAL, third sector organisations, continue to work with the Primary Care Team in GP Practices to offer supported self-management and carer support. Primary Care Mental Health Nurses are now in all 12 GP Practices in Midlothian.

Physiotherapy: There is now a single point of access for community services, so long Covid rehabilitation will be managed through this. Based on scoping work, the decision was made not to have a separate team managing Long Covid, instead the patients will be directed to an existing team depending on the predominant symptoms the patient experiences. However, this will continue to be reviewed. Near-Me continues to be an option when appropriate. There are currently a number of services for Long Covid available depending on the needs of the person.

Technology Enabled Care
Midlothian HSCP has ambitions for digital transformation that will support integration. Work continues to progress with the third sector and digital organisations to collaboratively design the ideal service model for people living with frailty.

Work has progressed to consult and engage with people living with frailty to support ambitions to see how and where technology could support people. Work also continued on connecting health and social care data to help us understand the needs of the population and the effectiveness of services. There was also progress in the development of infrastructure to allow us share data between health and social care services.

Public Health
Midlothian HSCP remains committed to tackling inequalities and investing in preventative work. Work to progress the CPP sponsored whole-system Type 2 Diabetes Prevention

Strategy was progressed after a delay due to COVID-19. Health assessments and other support to people in homeless accommodation continued during the pandemic.

Some programmes such as Ageing Well and Midlothian Active Choices (MAC) could not operate as planned due to Covid restrictions, however some activity has restarted in line with infection control guidelines.

The Welfare Rights Service continued to provide effective support to people receiving a service from the HSCP. 239 people with cancer received support from the MacMillan Welfare Rights Advisor and the wider team during 2020-21 and generated £4,226,848 of income for Midlothian residents.

Physical Disability
Work continues to reshape services currently provided at the Astley Ainslie Hospital. In addition work restarted in September to review the pathway for people recovering from a stroke. Funding to improve our support for people living with a neurological condition was awarded to the HSCP in March 2021.

Developing a Local Approach to Acute Services
In Midlothian, despite considerable efforts to strengthen community services and prevention, progress in reducing hospital-based activity was inconsistent (with the exception of the pandemic period). The challenge is to design and implement more radical change at a faster pace to ensure that our hospital services are able to provide high quality, timeous treatment when community-based alternatives are neither appropriate nor viable. Midlothian HSCP is committed to working with partners to reduce both attendance at A&E and unplanned admissions whilst also facilitating earlier discharge.

This work is supported by community-based service change such as plans around rehabilitation, diabetes prevention and the reduction of crises through, for example, improved identification and support around Frailty (involving the third sector). In addition, the Partnership recognises that supporting people to stay out of hospital or to be discharged sooner will often be dependent on the ability of family carers to provide support. This means continually strengthening support systems to unpaid carers.

The development of a Home First Model in Midlothian is progressing where people are supported out of hospital early, with a greater emphasis on supporting people at home through investment in care at home, early intervention and prevention.

Cancer
Midlothian HSCP commenced work on Improving the Cancer Journey (ICJ) during 2021. ICJ is a partnership between Macmillan and the four Lothian Health and Social Care Partnerships (HSCPs). Midlothian Council hosts the Programme on behalf of the four HSCPs.

The ICJ Programme aims to meet the non-clinical needs of people living with cancer; it will promote self-management and person-centred solutions in line with the policy direction set out by HSCPs and NHS Lothian. Progress was delayed but recruitment to key local posts was successfully concluded.

Health and Homelessness
Midlothian HSCP and Housing Services continue to work together to support people affected by homelessness. The Housing First programme commenced in July 2020 aiming to provide secure council tenancies per annum targeted at hard to reach and vulnerable homeless households. Many of these households have previously spent lengthy periods living in emergency accommodation. A specialist support provider will offer intensive support to people in order to sustain their accommodation. The Health Inclusion Team continued to offer on-site support to people living in the homeless hostels following risk assessments

Appendix 4: Care Inspectorate Gradings for Services for Older People in Midlothian

The Care Inspectorate inspects our care homes and care at home services to check the quality of care.

The directors of Public Health in Scotland advised that inspection visits would present a risk of introducing and spreading COVID-19 in care homes. To limit the spread, and with agreement from Scottish Government the Care Inspectorate restricted their presence in services unless necessary. This resulted in themajority of services not being graded as normal and retaining the grades they had last received. Instead the Care Inspectorate intensified oversight using a range of remote and virtual approaches They award the following grades to services:

Name	Service Type	Date	People's wellbeing	Leadership	Staff team	Setting	Care & support planning	Care & support during COVID
Highbank	Intermediate Care Home	05/07/2021	4 Good	-	-	-	-	4 Good
Nazareth House	Care home for older people	06/07/2021	2 Weak	-	-	-	-	3 Adequate
Nazareth House	Care home for older people	18/05/2021	-	3 Adequate	3 Adequate	3 Adequate	-	-
Newbyres Village	Care home for older people	21/01/2021	-	-	-	-	-	4 Good
Pine Villa	Care home for older people	27/07/2020	-	-	-	-	-	3 Adequate
Pine Villa	Care home for older people	31/08/2020	-	3 Adequate	-	3 Adequate	-	-
MLC - Domiciliary Care	Support - Care at Home	26/11/2020	-	4 Good	-	-	4 Good	4 Good
Springfield Bank	Care home for older people	27/07/2021	2 Weak	-	-	-	-	2 Weak
Springfield Bank	Care Home for older people	27/05/2021	-	3 Adequate	-	-	-	-
Archview Lodge	Care home for older people	01/02/2021	-	-	-	-	-	3 Adequate
Archview Lodge	Care home for older people	26/02/2021	4 Good	-	-	-	3 Adequate	-
Aarron House	Care home for older people	10/03/2020	5 Very Good	4 Good	5 Very Good	4 Good	4 Good	-
Drummond Grange	Care home for older people	18/06/2021	4 Good	-	-	-	-	3 Adequate
Rosehill	Care home for older people	03/03/2020	5 Very Good				4 Good	-
Pittendreich	Care home for older people	11/04/2019	3 Adequate	4 Good	4 Good	3 Adequate	4 Good	-

Name	Service Type	Date	Care & support	Environment	Staffing	Management & Leadership	Care & support during COVID
SCRT East	Support - Care at Home	02/12/2020	-	-	-	-	3 - Adequate
SCRT East	**Support - Care at Home**	08/12/2020	3 Adequate	-	3 Adequate	3 Adequate	-

14th October 2021, 14.00

Midlothian Health & Social Care Partnership Winter Plan 2021/22

Item number:	**5.7**

Executive summary

The purpose of this report is to update the Integration Joint Board on Midlothian Health & Social Care Partnership's (HSCP) winter planning. Health and Social Care Services come under increased pressure over the winter months due to a greater incidence of ill-health and the impact of adverse weather conditions. Services will also be grappling with the ongoing COVID-19 pandemic this winter in addition to the usual increased pressures.

This report outlines the work being undertaken locally to prepare for winter pressures. The overarching Winter Plan is joined up to cover a wide range of areas – reducing delayed discharges, preventing admissions, increasing service capacity, gritting priority areas, implementing the flu and Covid booster programme, and resilience planning for severe weather, ongoing COVID-19 measures, and staff absences. There is also an ongoing focus on supporting staff wellbeing and a winter communications plan both for staff and the public.

A Winter Executive Management Group has been mobilised to meet weekly, in tandem with an operational manager group. Performance management is a key part of this process, with the use of a winter dashboard to track key performance indicators and progress against winter plans.

Board members are asked to:

1. Note this Winter 2021/22 report
2. Approve the approach to winter planning

Midlothian Health & Social Care Partnership Winter Plan 2021/22

1 Purpose

1.1 The purpose of this report is to provide Midlothian Health & Social Care Partnership's Winter Plan 2021/22 and outline plans in coping with increased pressure through effective forward planning and the provision of additional capacity in key services.

2 Recommendations

2.1 As a result of this report what are Members being asked to:-

- Take assurance that Winter Plan is in place
- Approve the approach to winter planning

3 Background and main report

3.1 Every year, NHS Boards are required to write plans to ensure resilience over winter in response to the well-documented additional pressures experienced in hospitals and community-based services during the winter due to increased ill-health and the impacts of adverse weather. This year, there is additional pressure from the ongoing COVID-19 pandemic on top of the usual winter pressures.

3.2 Although the winter period is specifically January-March, the Health & Social Care Partnership looks at winter as the 6-month period from October-March to account for planning, recruitment, and increased pressures before January.

3.3 In addition to the Partnership's contribution to NHS Lothian's Winter Plan, Midlothian Health & Social Care Partnership is creating a local Winter Plan for 2021/22 that covers a wide range of focus areas. This includes the following key areas:

- Resilience – We will ensure our services are prepared for increased winter pressures, both in increased demand and reduced capacity due to staff absences, severe weather, etc.

- Patient Flow – We will maximise patient flow by increasing capacity in and streamlining intermediate care services, to reduce delayed discharges and hospital length of stay, and provide care as close to home as possible.

- Infection Control – We will ensure services are delivered safely and encourage maximum vaccination uptake in staff and patients.

- Impact & Inequalities – We will recognise and mitigate the negative impacts of winter and ongoing Covid on more vulnerable groups

- Communications – We will put a robust communications plan in place for both the public and staff so important and urgent messaging is shared with the right people at the right time.

- Workforce Mental Health & Wellbeing – We will support the mental health and wellbeing of our workforce.

- Monitoring and Escalation – We will put robust monitoring and escalation systems in place to review progress against the winter plans.

3.4 To support these key priorities, Midlothian HSCP is undertaking several winter initiatives which are outlined in more detail in the full plan but summarised below:

- NHS Lothian winter funding was prioritised for the Community Respiratory Team to increase capacity to prevent admissions and facilitate earlier discharges for patients with respiratory conditions (excluding asthma)

- The Integration Joint Board and NHS Lothian Gold Command were supportive of funding an additional 20 Healthcare Support Workers to increase carer capacity in the Home First teams to reduce delayed discharges and length of stay in hospital for patients, providing more care to patients at home.

- Additional funding is available from the British Red Cross for a Local Area Coordinator who would work with the Home First team, and the Frailty Local Area Coordinator, to provide support for patients upon discharge from hospital to free up carer capacity and also provide crisis prevention in the form of aids and adaptations, falls alarm, transport, regular check-ins, and reducing social isolation.

- The HSCP is re-assigning internal resources by seconding an Occupational Therapist to work alongside the Frailty GP to undertake an intensive review of patients with moderate and severe frailty attending A&E, in order to reduce A&E attendances, and hospital admissions and readmissions.

- The HSCP is undertaking a review of the top five potentially preventable admissions to the Royal Infirmary of Edinburgh, working with clinical and operational staff to put plans in place to reduce these admissions where clinically appropriate and offer local alternatives to care.

- In addition to the above, all services have submitted winter resilience and capacity maximisation plans.

3.5 The Winter Plan in its entirety is attached in Appendix I. This includes:

- High level action log
- Proposed winter initiatives and service-level plans

- Winter EMT membership
- Key performance indicators
- Winter Readiness Self-Assessment submitted to NHS Lothian

3.6 The Winter Executive Management Group will meet weekly to track progress against the winter plans and performance against key indicators. This can be stepped up in frequency as required throughout the winter period and additional check-ins and/or rapid rundowns established as needed.

3.7 Performance management and data will be a key part of these meetings. Agreed key performance indicators will be shared and monitored to pre-empt issues and track progress against plans. It is expected that winter plans will impact Midlothian's hospital activity and therefore these KPIs are focused on patient flow. A winter dashboard is being developed to provide timely metrics against agreed targets.

4 Policy Implications

4.1 Winter planning takes account of national guidance on safely reintroducing services and preparing for winter. It also closely links with Midlothian Council and NHS Lothian planning to ensure a joined up and consistent approach is taken.

5 Directions

5.1 This plan will support the work of a number of the Directions, including Directions related to Inpatients and Accident & Emergency, Older People, Midlothian Community Hospital, Community Health Services, Care at Home, Unpaid Carers and Public Health.

6 Equalities Implications

6.1 Although there are no direct implications for equality groups arising from this report, some people may have been particularly affected indirectly by the pandemic and will be affected by winter.

6.2 Work will continue through the Care for People group to support people in the Midlothian community throughout the winter period. A focused short life working group has also been mobilised to address isolation and loneliness for older people during the winter period.

6.3 Integrated Impact Assessments will be carried out where necessary for any service changes.

7 Resource Implications

7.1 The winter funding process changed for the 21/22 financial year. In previous years bids were submitted to the unscheduled care group for consideration, however the new process was to allocate funding to areas, on a recurring basis, based on previous successful bids. The result of this was that Midlothian were allocated

£74,000 to prioritise winter plans locally. This resource was prioritised for the Community Respiratory Team to increase capacity to prevent admissions and facilitate earlier discharges for patients with respiratory conditions (excluding asthma).

7.2 Further support was sought from the Integration Joint Board, with support from NHS Lothian Gold Command, to fund an additional 20 Healthcare Support Workers with appropriate administrative support. The cost of this proposal was £756,000 per annum (these costs will be spread over two financial years). The rationale of the investment was to increase carer capacity in the Home First teams to reduce delayed discharges and length of stay in hospital for patients.

7.3 Additional funding of £40,000 from British Red Cross was agreed to fund a Local Area Coordinator to work alongside the Discharge to Assess team, to provide support for patients upon discharge from hospital.

7.4 Additional winter initiatives are funded from existing HSCP resources. Key winter initiatives are the intensive review of people with moderate and severe frailty attending A&E (this will be undertaken by the frailty GP and an OT seconded through reassignment of internal resources to support this test of change) and reviewing the top 5 Potentially Preventable Admissions.

7.5 There is work ongoing at a corporate level within NHS Lothian to identify appropriate funding streams for the vaccination programme. It is anticipated that the additional costs driven by the enhanced flu programme will be funded from the Covid allocation and the core base vaccination programme will need to be funded by the HSCP, as it has been in previous years.

8 Risk

8.1 There is a potential risk of another wave of COVID-19 happening concurrently with flu and other increased winter pressures.

8.2 The risk of not preparing as well as possible for winter is that the hospital system is unable to cope with the volume of attendances and unplanned admissions. It is important that resilience plans are in place for local services and staff to continue to function at full capacity. This includes maximising flu vaccinations, preparing for adverse weather, anticipating local lockdowns, and ensuring contingency plans are in place for staffing shortages that occur despite forward planning.

8.3 Midlothian Health & Social Care Partnership must ensure that it is able to protect staff and service users from COVID-19 as far as is possible. However, it must also ensure that it is able to return to providing the full range of services to address the broader health and care needs of the population. Crucially, this must include the resumption of prevention and early intervention activities.

9 Involving people

9.1 Planning has taken place across services with a range of key Health & Social Care Partnership managers. Staff-side representatives will be involved throughout the winter planning process. It is key that the Winter Plan continues to be monitored and adapted with input from key stakeholders to ensure it encompasses many perspectives and takes a joined-up approach.

10 Background Papers

10.1 nil

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Appendices:
Appendix I: Midlothian Health & Social Care Partnership Winter Plan 2020/21

Midlothian Health & Social Care Partnership Winter Plan 2021/22

INTRODUCTION

This document forms the Midlothian Health & Social Care Partnership's (HSCP) overarching Winter Plan for 2021/22. The overall aim of winter planning is to ensure that the partnership is prepared for winter pressures, alongside ongoing pressures due to COVID-19, so that we can continue to deliver high quality care. It is recognised that demand for services is likely to be at its highest level during the winter period. This plan builds on lessons learned from Winter 2020/21.

The required outcomes of winter planning are to ensure:

- That comprehensive, joined-up plans are in place in Midlothian Health and Social Care Partnership with established monitoring and escalation processes.
- The provision of high-quality services is maintained through periods of pressure.
- The impact of pressures on the levels of service, national targets and finance are effectively managed.

The Winter Plan will be a standing agenda item on the Senior Management Team (SMT) Business meeting. Levels of pressure in the system, progress against plans, and other issues will be monitored and escalated as necessary by a Winter Oversight Group, with a tactical Winter SMT group convening where necessary for any emergencies or when risk has been escalated.

REVIEW OF PREVIOUS WINTERS

Managers noted several key lessons from reviewing previous winters. Key themes are summarised below:

- Recruiting to vacancies as early as possible to account for delays in recruitment
- Planning for severe weather – arranging 4x4 access, preparing staff to work remotely, and changing work bases where possible
- Planning service cover/annual leave as early as possible
- Ensuring services are maintained throughout the festive period
- Recognition that additional workforce from last winter may not be available this winter – specifically, those staff who were redeployed during lockdown and were able to help other areas. Community/volunteer responses may be reduced also due to easing of Scottish Government Covid restrictions, but also workforce fatigue.

These lessons, paired with lessons from the pandemic, highlight the need to plan ahead and prepare for the worst to ensure that staff are safe and service delivery is maintained.

A review of progress against the winter 2020/21 plan showed positive performance during the winter period. Extra capacity was agreed in intermediate care teams as part of the winter funding allocation process; this provided extra Allied Health Professional (AHP) and Clinical Support Worker (CSW) staff, and the teams were able to facilitate more discharges and prevent more admissions than their averages before the winter period.

Staff sickness absence levels were lower in Midlothian HSCP compared to the overall rate for NHS Lothian for winter 2020/21, and to Midlothian's absence levels in the previous winter (2019/20). Informal staff feedback at the winter workshop felt that this could be a benefit of the increased flexibility in working patterns that have developed from the pandemic and could partially be due to staff feeling a 'need to be there' due to the importance of their work. This also raised the necessity to focus on staff wellbeing and the longer-term impacts on working throughout the pandemic on staff.

KEY PRIORITIES FOR ACTION IN 2021/2

Our key priorities for Winter 2021/22 are summarised below:

- Resilience – We will ensure our services are prepared for increased winter pressures, both in increased demand and reduced capacity due to staff absences, severe weather, etc.

- Patient Flow – We will maximise patient flow by increasing capacity in and streamlining intermediate care services, to reduce delayed discharges and hospital length of stay, and provide care as close to home as possible.

- Infection Control – We will ensure services are delivered safely and encourage maximum vaccination uptake in staff and patients.

- Impact & Inequalities – We will recognise and mitigate the negative impacts of winter and ongoing Covid on more vulnerable groups

- Communications – We will put a robust communications plan in place for both the public and staff so important and urgent messaging is shared with the right people at the right time.

- Workforce Mental Health & Wellbeing – We will support the mental health and wellbeing of our workforce.

- Monitoring and Escalation – We will put robust monitoring and escalation systems in place to review progress against the winter plans.

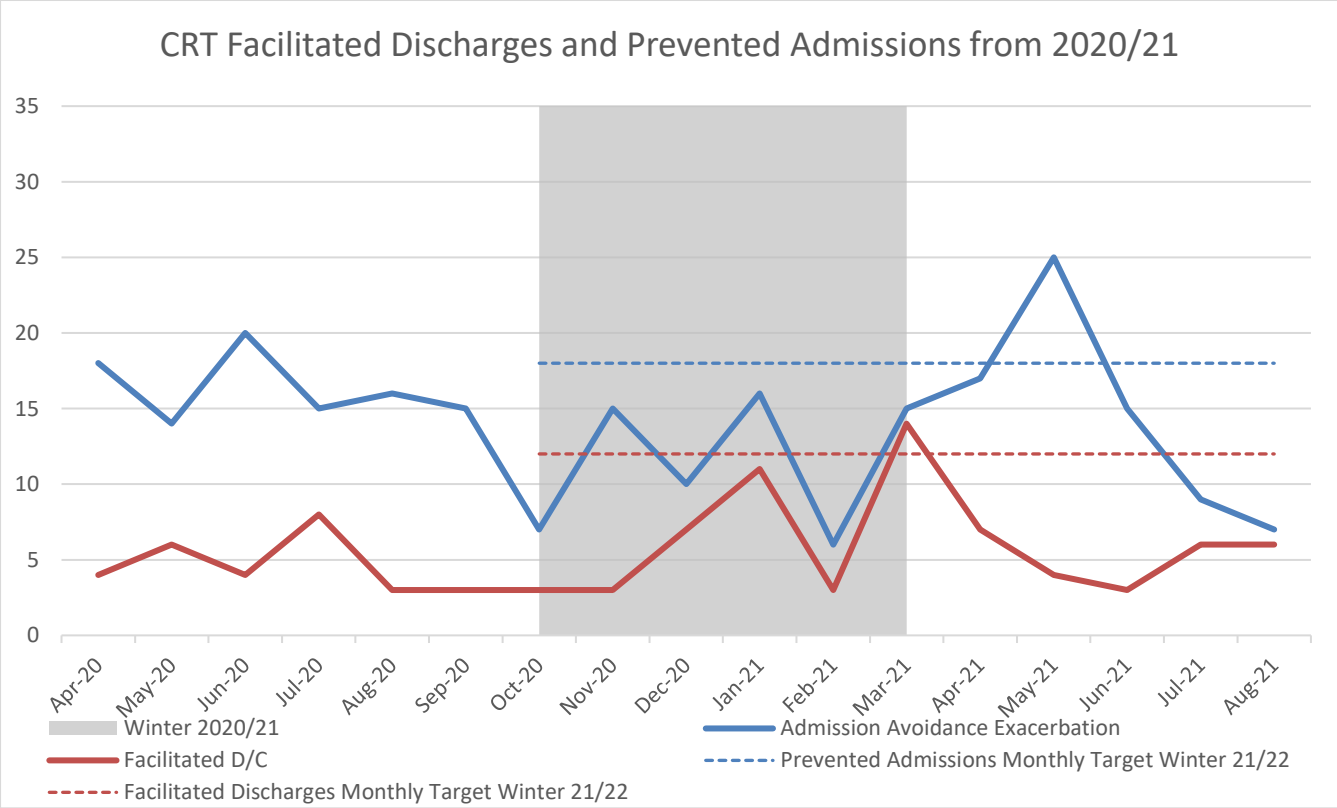
The table in **Appendix I** shows our high-level against these priorities. A detailed action plan will sit behind this with timescales and key performance indicators. This will be used to monitor progress against the winter plan and will be a live document. The below is only an indication of actions to prepare for winter.

For the purposes of this plan, the entire winter period is considered October 2021 – March 2022, to account for planning and preparation timescales and an increase in winter pressures before January.

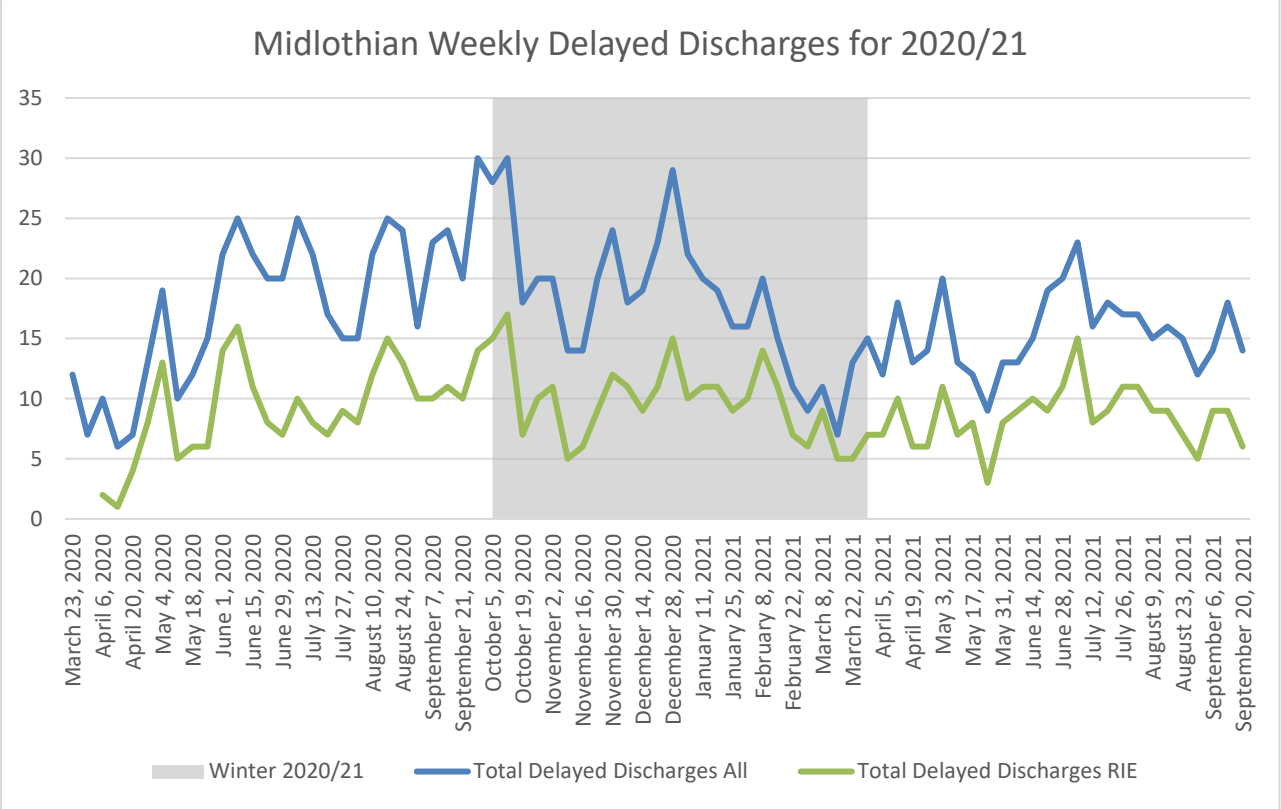
RESOURCED WINTER INITIATIVES

To support these key priorities, Midlothian HSCP is undertaking several winter initiatives, as outlined in **Appendix II** and summarised below:

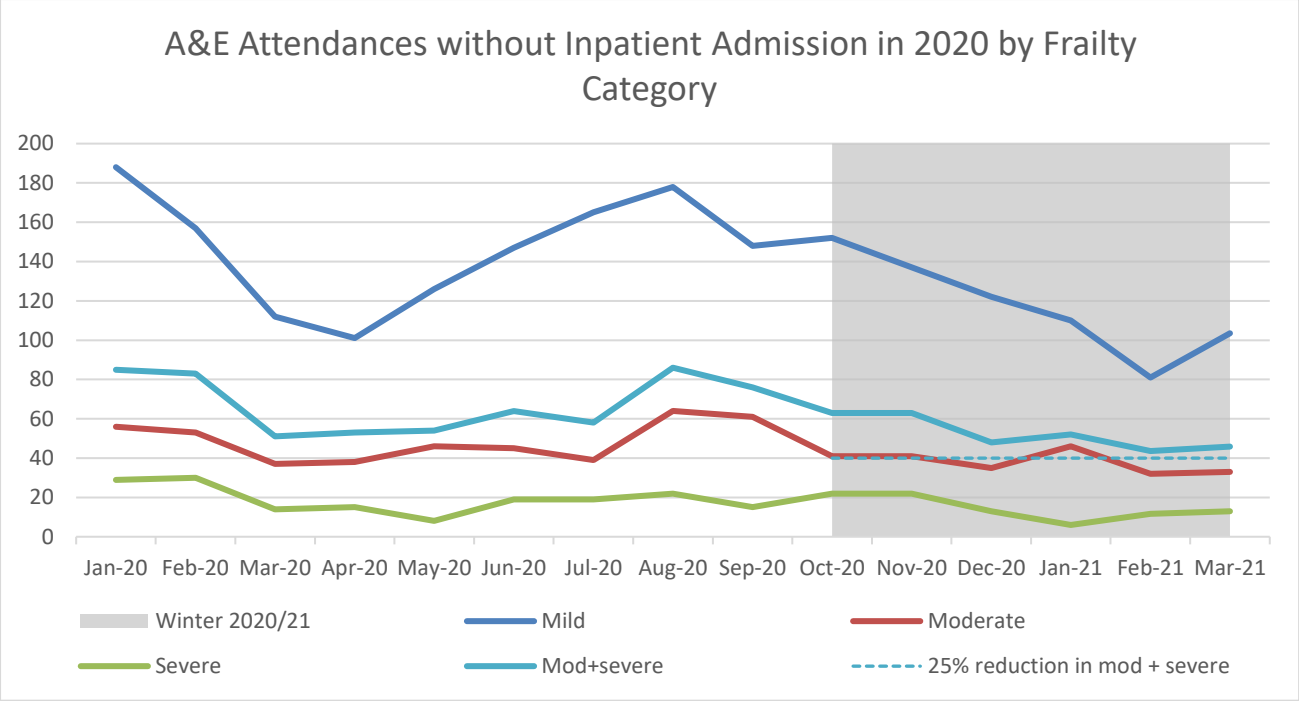
- NHS Lothian's winter funding process changed to provide a proportionate 12-month recurring funding award as opposed to the previous bidding process in place. Midlothian's allocation was £74,000, based on historical winter funding. This resource was prioritised for the Community Respiratory Team (CRT) to increase capacity to prevent admissions and facilitate earlier discharges for patients with respiratory conditions (excluding asthma). The chart below shows recorded facilitated discharges and prevented admissions by CRT from 2020/21.More information on this initiative and intended impact is in **Appendix II.**



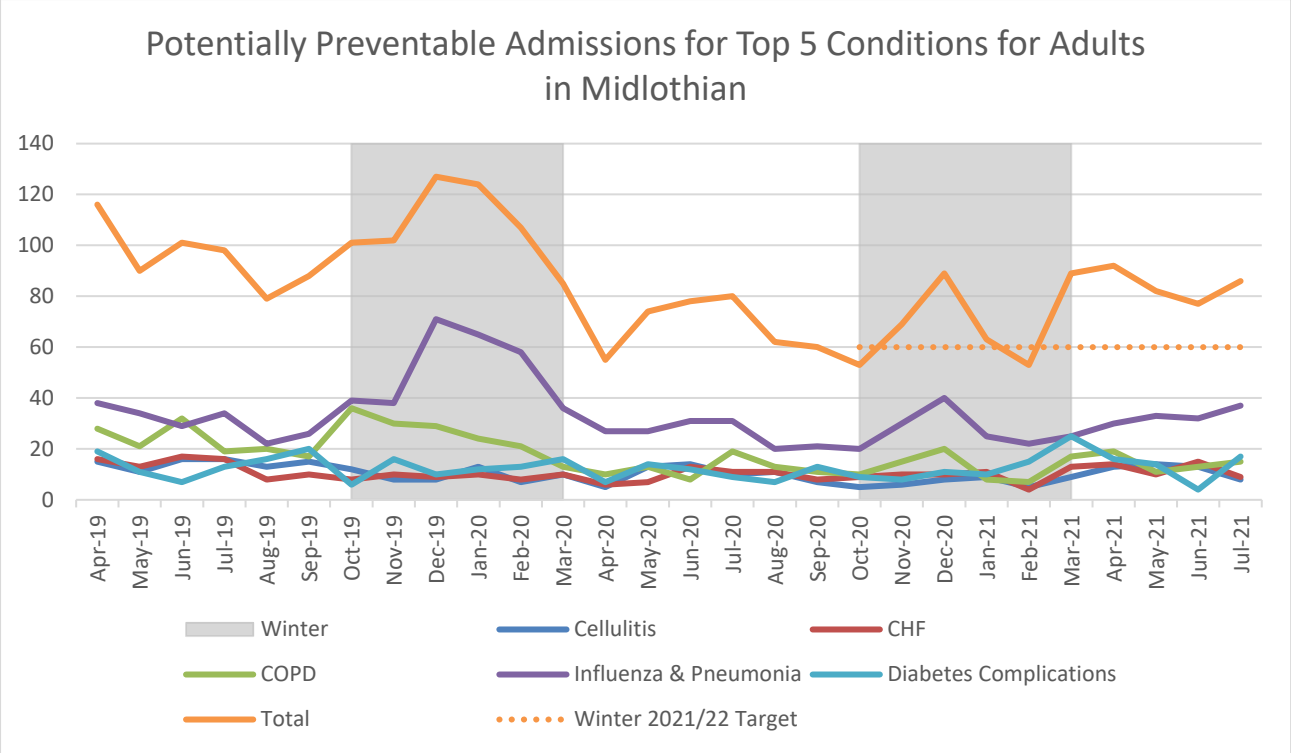
- The Integration Joint Board (IJB) and NHS Lothian Gold Command were supportive of funding an additional 20 Healthcare Support Workers (£756,000) to increase carer capacity in the Home First teams to reduce delayed discharges and length of stay in hospital for patients, providing more care to patients at home.
    - Additional funding (£40,000) is available from the British Red Cross for a Local Area Coordinator (LAC) who would work with the Home First team, and the Frailty LAC, to provide support for patients upon discharge from hospital to free up carer capacity and also provide crisis prevention in the form of aids and adaptations, falls alarm, transport, regular check-ins, and reducing social isolation.
- The graph below shows weekly Midlothian from 2020/21. The lighter green line represents delays from the Royal Infirmary of Edinburgh. More information on the intended impact of this initiative is in **Appendix II**.



- Plans are in place to re-assign internal resources to second an Occupational Therapist (OT) to work alongside the Frailty GP with a Winter Frailty Team approach in one practice population, extending the review to all patients with severe or moderate frailty attending A&E or discharged from an unplanned admission of under 24 hours. This will reduce A&E attendances and hospital admissions and readmissions. The chart below shows A&E attendance by frailty cohort for the 2020 calendar year where there was no inpatient admission. More information on the intended impact of this initiative is in **Appendix II**.

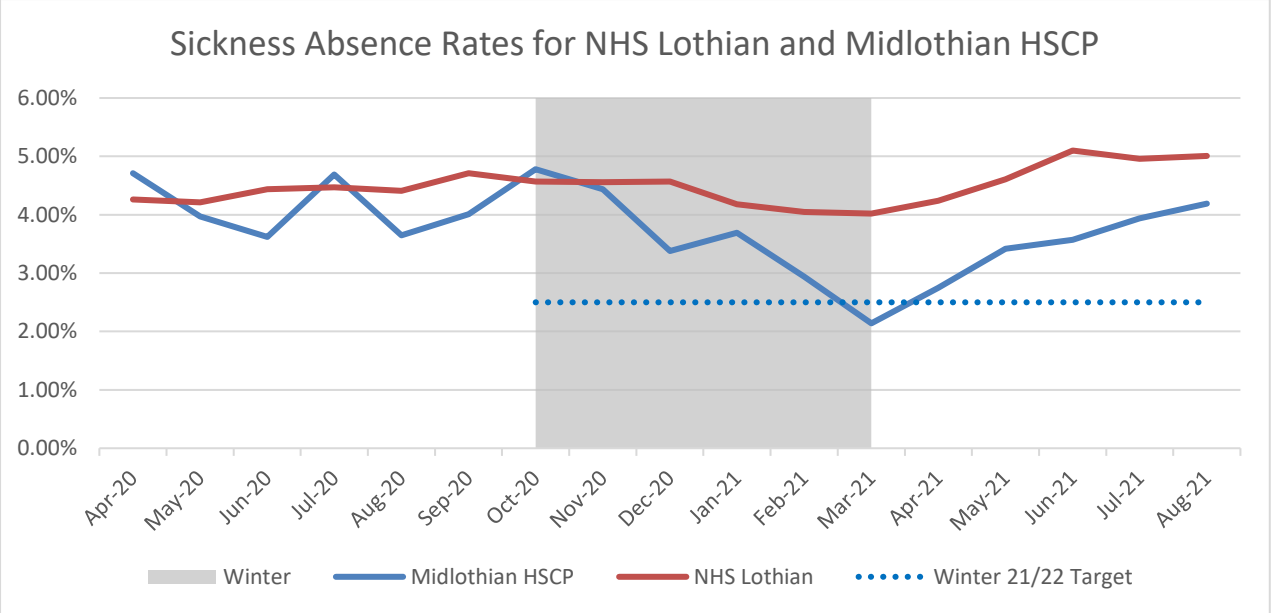


- The HSCP is undertaking a review of the top five potentially preventable admissions to the Royal Infirmary of Edinburgh, working with clinical and operational staff to put plans in place to reduce these admissions where clinically appropriate and offer local alternatives to care. The top 5 potentially preventable admission conditions for Midlothian are Cellulitis, Diabetes Complications, Influenza & Pneumonia, Congestive Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD). The graph below shows the number of potentially preventable admissions for adults in Midlothian for these conditions. More information on this initiative and its intended impact are in **Appendix II.**



- In addition to the above, the HSCP will deliver a comprehensive flu and Covid booster vaccination programme; this year, all vaccinations will be administered by the HSCP, with none will be delivered by General Practice. This was a requirement from the 2018 GP Contract and associated Memorandums of Understanding (MOU) that vaccination activity will transfer from General Practice from October 2021 (this has been revised in the recently published MOU which delays this transfer until April 2022). A synergistic approach to the delivery of Covid-19 and Flu vaccination will be pursued where appropriate to maximise uptake of both vaccines. Data will be used to determine any pockets of lower uptake in vaccination rates for targeted communication and pop-up clinics to encourage uptake. The programme aims to meet vaccination rate targets set by Scottish Government and reduce the number of potentially preventable flu and Covid-related hospital admissions, as well as community infection spread

- Finally, all services have submitted winter resilience and capacity maximisation plans. These are also summarised in **Appendix II.** Sickness absence rates for Midlothian HSCP were consistently lower than NHS Lothian's overall rates last winter. This lower level of sickness absence should be maintained due to service resilience planning in tandem with the focus on staff wellbeing. The graph below shows these figures in more detail.



MONITORING AND REVIEWING WINTER PLANS

Senior managers will hold a weekly winter meeting to monitor and assess progress against the winter plans. This will be used to escalate issues that arise during the peak winter period. This will feed into the fortnightly Senior Management Team meetings as a standing agenda item. The priority will be to monitor the levels of pressure in the system and the effectiveness of the winter plan, and identify further action as required.

Performance management and data will be a key part of these meetings. Agreed key performance indicators (KPIs) will be shared and monitored to pre-empt issues and track progress against service winter plans. It is expected that winter plans will impact Midlothian's hospital activity and therefore KPIs are focused on patient flow through hospitals. The aim is to reduce time spent in hospital or attending A&E by improving access to community services, providing care in the community where possible, and ensuring out community services are resilient through winter to provide the necessary capacity. These KPIs are summarised in **Appendix III** with previous figures for comparison against this winter.

Winter EMT membership is detailed in **Appendix IV**.

A winter readiness self-assessment checklist was completed for NHS Lothian and this is attached in **Appendix V**.

Appendix I: High-Level Action Plan

	Action Plan	Lead
1.0	***Resilience:*** *We will ensure our services are prepared for winter by:*	
1.1	Business continuity plans for all services will be reviewed and updated by 15/09/2021, which detail escalation processes and essential service provision in response to critical incidents such as another lockdown, major staff absence, or severe weather. This includes assurance on resilience planning from GP Practices.	L Friedman R King
1.2	Services will have resilience plans in place for their workforce by providing robust plans to account for staff absence and/or staff inability to travel due to severe weather	L Friedman R King
1.3	All services will have contingency plans for severe weather by providing robust plans for issues such as transporting staff, traveling to patients in the community, and delivering care to vulnerable patients. These will also link to Midlothian Council plans for accessing 4x4 vehicles when required to transport staff in severe weather.	L Friedman R King
1.4	Resilience plans for travelling in severe weather will also link with Midlothian Council for gritting roads and footways and clearing car parks for our identified priority areas through close working between council and health & social care colleagues. This includes prioritising the two mass vaccination sites at the Community Hospital and Gorebridge Leisure Centre.	L Friedman R King
1.5	All services will ensure sufficient capacity is in place over the festive period and to cover 7-day working where appropriate by agreeing staff cover and rotas and ensuring resilience plans are in place to deal with lockdown, severe weather, and/or unexpected staff absence during this period.	G Cowan N Clater
1.6	Clear communication and escalation channels will be put in place by instating a Winter Executive Management Group, with the ability to step this up in frequency and mobilise other channels of communication where required.	L Friedman R King
1.7	Individual services will prepare for major incidents by Red-Amber-Green (RAG) rating caseloads and prioritising per their resilience plans and updating this regularly	G Cowan N Clater
1.8	All staff will ensure individual resilience plans are in place that take into consideration risks such as car preparation, school closures, travel plans in severe weather, health & wellbeing, and general winter safety. These will be promoted by managers and team leads and through normal staff communication channels such as the Council website, social media, and all-staff emails.	G Cowan N Clater
1.9	Building upon the contribution of the third sector during the pandemic and working through the Care for People group to build resilience for service delivery, such as access to 4x4 vehicles and assistance with medicine and food delivery	N Clater
1.10	Developing HSCP workforce planning for redeployment and rapid induction training for carers to mitigate risks to staffing levels	A Fraser
2.0	***Patient Flow:*** *We will prevent admissions, reduce hospital length of stay, avoid delayed discharges, support patient flow, and build on the Home First approach as far as possible by:*	
2.1	Strengthening our intermediate care model and reducing delayed discharges, with continued rollout of Home First and proactive flow hub arrangements	G Cowan
2.2	Recruiting additional Healthcare Support Workers into the Discharge to Assess team	G Cowan
2.3	Continue to progress with increasing the bed capacity of Glenlee Ward in Midlothian Community Hospital	K Jack
2.4	Expanding the capacity of the Community Respiratory Team to account for increased respiratory-related hospital activity during winter	D Crerar
2.5	Implementing a Falls Prevention Plan through the Strategic Falls Group	G Chapman

2.6	Linking in with Royal Infirmary of Edinburgh winter plans and discharge planning	G Cowan
2.7	Strengthening the Hospital at Home service and bringing paramedics into the model to support clinical decision-making	G Cowan
2.8	Working alongside the national redesign of urgent care to redirect patients from acute hospital settings where appropriate to deliver care at home or in a community setting, including mental health pathways	G Cowan N Clater
2.9	Providing robust support to care homes through our Care Home Support Team	F Stratton M Reid
2.10	Undertaking intensive review and case management of patients over 75 years who frequently attend A&E	J Megaw
2.11	Continued investment in the frailty GP Mid-Med model for proactively supporting patients with frailty	J Megaw
3.0	***Infection Prevention and Control:*** *We will ensure our services are delivered safely by:*	
3.1	Standard infection control measures will be taken to address the requirements of the most common infections, for example, Norovirus, Clostridium difficile, Influenza, MRSA	F Stratton
3.2	Contingency plans are in place to minimise the impact of outbreaks of infection by complying with infection control audits and completing associated infection control action plans	F Stratton
3.3	PPE stock and supplies are managed with contingency plans in place should demand greatly increase to ensure supplies are available to safely deliver services	L Swadel
3.4	COVID-19 Health Protection Scotland and Scottish Government guidance is followed ensuring defined patient pathways	F Stratton
3.5	Accessible and timely COVID-19 testing pathways should be available to all who require a test in line with the national Testing Strategy	R King
3.6	Implement an effective immunisation programme against seasonal influenza and follow Scottish Government guidance for the continued rollout of the Covid-19 vaccination programme. This includes encouragement of high staff uptake across the HSCP.	J Megaw
4.0	***Impact & Inequalities:*** *We will mitigate the impact of winter on vulnerable groups by:*	
4.1	Recognising that COVID-19 and winter has and will continue to detrimentally impact certain groups of people – not only older people and those with underlying health conditions but also those who are vulnerable simply because they do not have the resources and opportunities to stay well	All
4.2	Services will carry out integrated impact assessments where necessary	G Cowan N Clater
4.3	Investigate options to support older people through winter to regain confidence, combat social isolation, and increase activity.	G Cowan C Evans
4.4	Midlothian's Public Health team will contribute to the winter plan, focusing on the things that keep people well during winter. For example, reducing fuel poverty and financial and food insecurity, increasing good physical and mental health, reducing loneliness, increasing community resilience, and increasing the number of people vaccinated for Covid-19 from population groups who face unjust, unfair, and avoidable differences.	R Hilton
4.5	Piloting green prescribing to promote physical and mental health as forms of prevention and alternatives to care in acute and primary care settings	T McLeod
4.6	Promote community resources and services available to support staff and the people they care for regularly via communication channels	W Fleming
4.7	Working through the Care for People group to mobilise support for people in the community through volunteers, the third sector, and other partners	N Clater

5.0	***Communications:*** *We will ensure a robust staff and public communications plan by:*	
5.1	A clear communications plan with the public will be established by sharing timely and relevant information through channels such as social media, the Council website, general practice websites, and a winter Older People's newsletter. This will require close working between and contributions from the communications team, planning groups, the Strategic Falls Lead, and all other services.	W Fleming
5.2	A clear communications plan with staff will also be established by utilising various staff communication channels to share important updates, good news stories, promotion of staff wellbeing activities and initiatives, and other winter-specific information around falls, travel, car safety, etc.	W Fleming
5.3	The all-staff distribution list for the HSCP will be kept up to date to ensure people receive communications.	L Friedman
5.4	Publishing the Midlothian HSCP public website	C Shilton
5.5	A major vaccination campaign and communications plan will be undertaken to promote vaccination uptake	W Fleming J Megaw
6.0	***Wellbeing:*** *We will support the mental health and wellbeing of our workforce by:*	
6.1	Appointing a staff wellbeing lead (due to commence in September 2021) who will engage and consult with front line services to ensure a range of options and opportunities are available for staff to access support and development to enable them to continue with their role	A Fraser W Armitage
6.2	Ensuring the staff wellbeing group meets the actions and directions from the evaluation of the staff wellbeing survey	A Fraser W Armitage
7.0	***Monitoring & Escalation:*** *We will monitor progress against the winter plan by:*	
7.1	Risks will be escalated, and progress monitored through reporting by exception via an established Winter Executive Management Group.	L Friedman R King
7.2	Progress against the plan will be monitored and reported via the Senior Management Team fortnightly meetings	L Friedman R King
7.3	Develop a winter dashboard with agreed key performance indicators, metrics, and targets for tracking progress against plans	J Megaw

APPENDIX II: RESOURCED WINTER INITIATIVES & SERVICE-LEVEL PLANS

Service	**1. COMMUNITY RESPIRATORY TEAM (CRT)**		
The Midlothian Community Respiratory Team was initially funded to provide respiratory support to patients with a diagnosis of COPD only. The aim of the team being to prevent unnecessary hospital admission, facilitate earlier appropriate discharge from hospital where an admission was unavoidable and provide community respiratory support to reduce the burden of COPD on Primary and Secondary care. Throughout Covid 19, with additional funding, the team have expanded where possible to include a CRT+ service and take on patients with additional respiratory diagnoses where capacity allows. There is still a cohort of patients not known to CRT in the community, so referrals continue to increase and in turn this increases the number of patients who can self-refer back into the service over time. There is a concern that without additional funding, the team will not be in a position to meet the anticipated respiratory demand beyond COPD over the winter period. This is a particular priority over a period where the prevalence of respiratory conditions increases and the likelihood of another Covid 19 winter remains high. Confidence in the vaccine will allow for more socialisation and a return to more normal activities, which may result in increased exacerbation rates.			
Additional Capacity	Cost	Funding Source	Risk
1 WTE B7 APP 0.2 WTE B5 Dietitian	*£63468* *£8656* *Total £72,124*	*NHS Lothian Winter Funding*	**MED** Risk of delay in recruitment which will reduce the ability to meet projected impact. Risk of internal recruitment may further delay intended impact.
Intended Impact			
Reduction in Midlothian Scottish Ambulance Service call outs, A&E attendances, hospital admissions and length of stay for respiratory conditions (excluding asthma). Increase in patient confidence and self-efficacy with managing respiratory symptoms in the patients' own home. This additional capacity increases the existing capacity by 50%. Therefore we expect a 50% increase in facilitated discharges and prevented admissions over the 6-month winter period compared to last winter's baseline capacity. During Winter 2020/21, between October-March, the CRT team facilitated 49 discharges and prevented 71 admissions to hospital. A 50% increase for Winter 2021/22 equates to 73 facilitated discharges/294 bed days saved, and 106 admissions prevented/639 bed days saved over the 6-month period. We will continue to monitor caseload numbers and bed days saved for both admission prevention and facilitated discharge work. We will also monitor the impact on primary care, by measuring GP hours saved.			
Key Performance Indicators for monitoring			
Prevented Admissions Facilitated Discharges Bed Days Saved CRT Contacts Respiratory-related admissions and A&E attendances GP Hours Saved			

Service	2. OLDER PEOPLE'S SERVICES		
Frailty drives unscheduled hospital activity. ED attendance by the severely frail cohort is a predicter for future ED attendance and/or admission (50% of ED attendance from cohort will have a further ED attendance in following 6/12). The health and care system does not reliably assess an ED attendance or short admission associated with frailty with intention of preventing future hospital activity. The focus of this investment would be prevention of frailty presentations and unscheduled frailty admissions along with reducing the length of stay by having a Mid Care Model to address unmet clinical and social needs			
Additional Capacity	Cost	Funding Source	Risk
1 Frailty GP 1 B7 OT	None – Existing Resource	*Existing HSCP resource*	**LOW** Capacity already resourced and agreed
Intended Impact			
We plan to use the Mid Med Model for intensive assessment and support within the community for one practice population. Further investment of an additional Band 7 Occupational Therapist will allow multidisciplinary proactive review of all ED attendance in cohort prioritised using SPARRA (Scottish Patients at Risk of Readmission and Admission) The value this post will add is proactively following-up all moderately and severely frail patients who either attended ED but were not admitted or were discharge with an unplanned admission of under 24 hours. These patients are likely to be known to practice GPs, who the team will work closely with to identify those patients who would most benefit from review. This model can also be extended to the severe cohort with high SPARRA. A combination of clinical-note review and patient assessment using the Winter Frailty Team approach will identify and address unmet clinical and social needs. This will be used to inform pathway development and relationships between services. Reduction in A&E attendances by frequent attenders Reducing in hospital admissions and A&E attendances by those with severe frailty. 50% of ED attendance from frailty cohort will have a further ED attendance in following 6 months. Aim to reduce this to 25%. Currently weekly average of: 22 severely frail unscheduled admissions, 5 severely frail 28-day readmissions, 7 A&E attendances. Aim to reduce these by 25%.			
Key Performance Indicators for monitoring			
A&E attendances, including for frequent attender cohort and those with frailty Hospital admissions, including those with frailty Readmission rate for those with frailty Anticipatory Care Plan Quality			

Service	3. HOME FIRST		
Despite the significant amount of development work under Home First, care capacity issues remain the main reason for blockage in flow for Midlothian patients delayed in hospital beds. Delays for packages of care from our Internal service and External providers, over the summer period, have prevented the improvements expected. Whilst the delays performance in Midlothian remains improved on previous years, the additional demand anticipated on the system over winter, remains a concern. Recruiting additional Healthcare Support Workers (HCSWs) will increase carer capacity in the Home First team. Additional funding is available from the British Red Cross for a Local Area Coordinator (LAC) who could be embedded within the Home First team, and provide support to patients upon discharge from hospital in the form of aids and adaptations, falls alarms, transport, and reducing social isolation – all forms of crisis prevention. They would work closely with the frailty local area coordinator to support those living with frailty who may already be known to the service.			
Additional Capacity	Cost	Funding Source	Risk
20 WTE HCSWs 1 Local Area Coordinator	£756,000 £40,000	*MIJB and NHS Lothian Gold Command* *British Red Cross*	**MED** Risk of delay in recruitment which will reduce the ability to meet projected impact. Risk of bottlenecks in system waiting on longer packages of care in the community.
Intended Impact			
Reduction in delayed discharges Currently Discharge to Assess team consistently bridging in 14-22 packages of care per week. 13 census delayed discharges in August 2021. Intent to move all hospital discharges through Discharge to Assess. This increased carer capacity will allow for more throughput out of hospital. The additional HCSWs should be able to provide care for 32 more patients per week at home, reducing social delays The local area coordinator would have capacity for a caseload of 30 patients. This should lead to a reduction in waiting times for aids and adaptations (driven by local area coordinator), and a reduction in social admissions and re-admissions (crisis prevention from support local area coordinator)			
Key Performance Indicators for monitoring			
Delayed Discharges Hospital Length of Stay Packages of care Waiting times Hospital admissions and re-admissions			

Service	4. POTENTIALL PREVENTABLE ADMISSIONS		
Public Health Scotland publishes data on Potentially Preventable Admissions (PPAs) which are 19 identified conditions which result from medical problems that may be avoidable with the application of public health measures and/or timely and effective treatment, usually delivered in the community. A working group was established in Midlothian HSCP to undertake an intensive review of these admissions and progress a targeted action plan. The identified top 5 PPAs for Midlothian residents in 2020/21 were Cellulitis, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Diabetes Complications, and Influenza & Pneumonia.			
Additional Capacity	Cost	Funding Source	Risk
None	None	*Existing HSCP Resource*	**MED** Risk of delays in making any service changes or improvements Interdependencies with acute teams who may be under other pressures
Intended Impact			
Reduction in potentially preventable admissions for top 5 identified conditions. Monthly average of 69 PPAs for top 5 conditions in winter 2020/21; aim to reduce this by 10% for average of 60 PPAs per month. Reduction in occupied bed days for conditions. These are wide ranging as monthly bed days for Influenza/Pneumonia are close to 500 while closer to 75 for Cellulitis. A 25% reduction in overall averages would take bed days down from 200 monthly to 125 monthly. Increased local options for care and chronic disease management.			
Key Performance Indicators for monitoring			
Admissions for top 5 conditions A&E attendances and other related episodes of care Length of stay for top 5 conditions Access to community treatment and support			

Service	5. ALL HSCP SERVICES		
All HSCP services are considering their resilience planning and looking at different ways of working for winter to maximise capacity and maintain service delivery. This includes: - Workforce resilience for staff absence - Festive Period and 7-day cover - Severe weather resilience planning - Staff transport, getting to patients, travel time, staff and patient safety, Red-Amber-Green rating patients, changing work bases, etc. - Flu and Covid vaccination staff uptake - Reduced face-to-face/use of telephone and Near Me - Recruiting to establishment/vacancies - Remobilisation of services previously closed or reduced during lockdown			
Additional Capacity	Cost	Funding Source	Risk
See details below	None – Existing Resource	*Existing HSCP resource*	**MED** All services will complete their resilience plans Risk of significantly severe weather or significantly high sickness absence levels Risk with recruitment delays for recruiting to vacancies
Intended Impact			
All services to have resilience plans in place to maximise capacity and maintain service delivery throughout winter and festive period where required Services will be prepared to deliver services remotely where possible Services will move staff bases around where possible in severe weather Reduction in staff sickness absence levels. Maintain 2.5% levels of sickness absence (lowest levels in Winter 2020/21).			
Key Performance Indicators for monitoring			
Staff sickness absences Establishment/vacancy gaps Activity over weekends and festive periods Hospital activity impacted by capacity in community			
Service-specific plans (in addition to the above resilience planning which applies to ALL)			
Service	***Initiatives (additional to resilience planning)***		
Community Respiratory Team	- Upskilling Band 3 and 4s for managing anxious patients and encouraging self-management - Increased capacity (see appendix I) will increase prevented admissions and facilitated discharges - Optimisation work to reduce GP time - Improving quality of anticipatory care planning - Take on patients with other respiratory conditions beyond COPD		
Home First and Single Point of Access	- Additional HCSWs to support Discharge to Assess Team (D2A) (see appendix I) - All hospital discharges to go to D2A - Reablement OTs to move to Home First - British Red Cross local area coordinator supporting people after discharge - aids and adaptations, etc.		

	- Upskilling Band 3, Band 4s, and Community Care Assistants to see more routine return patients - Daily huddles to discuss capacity; second huddle if required - Work with MCPRT (Midlothian Community Physical Rehabilitation Team) to maximise capacity, reduce waits for slow stream rehab, and prevent deterioration - Increased focus on discharging direct from ED and AMU and strengthening these links - Admission prevention work with Rapid Response team having access to packages of care - SPOA return to 7/7 working when staffing in place
Older People and Frailty	- Intensive review of those with frailty attending A&E or discharged from hospital within 24 hours (see appendix I) - Review and management of top 10 frequent attenders to A&E over 75 years - Local Area Coordinator from British Red Cross supporting people in the community with frailty
Care at Home	- Streamlining of roles and responsibilities to free up capacity - Dedicated schedulers to focus on efficiency of service - Use of CM2000 for accurate and live data - Review of referral process into the service to reduce delays
Hospital at Home	- Looking at adding paramedics to model for clinical decision-making and 7-day working - Move to dependency-level capacity - Change of TRAK structure to increase maximum bed capacity - Working with pan-Lothian review of Hospital at Home model
MCH	- Daily monitoring of staffing levels - Review of admission criteria to support flow hub - SOP for escalation of shifts to Agency - Increasing capacity to manage increased demand and complexity
District Nursing	- Increasing capacity to manage increased demand and complexity - Agreement to add Advanced Nurse Practitioners into District Nursing service to facilitate faster access to treatment and release workload from GPs
Care Home Support Team	- Daily calls to all care homes and minimum weekly support visits - Increased capacity since team was established from 5 WTE to 10 WTE and to include Occupational Therapist for referrals - Quality Improvement Projects - Restore2, Anticipatory Care Planning - to increase timely assessment and care - Nurse Practitioner secondment to review and support post-hospital discharged residents and those with soft signs of deterioration
Mental Health & Substance Misuse	- Redesign of Urgent Care pathways - Midlothian Intensive Home Treatment Team redesign for same day access for crisis/distress - Delivering Distress Brief Intervention - Substance Misuse has recommenced drop-in clinic - Outreach nurse to Homeless accommodation for high-risk, hard to reach cohorts
Primary Care & Vaccinations	- CTAC (Community Treatment and Care) model still in pathfinder stage and looking at models of service delivery to be established by April 2022

	- Vaccination programme following Scottish Government guidelines for both flu and Covid boosters. Expanded flu cohorts this year. Synergistic approach where applicable to deliver both vaccines at once. Two mass vaccination sites plus Penicuik clinics to account for geographical challenges. - Monitoring weekly vaccination uptake to identify pockets of lower uptake for targeted communications and pop-ups - GP practices updating business continuity and resilience plans
Pharmacy	- Band 5 Pharmacy Hub Technicians - Flexible workload planning in spring/summer in preparation for winter pressures - Recruiting additional 7.2 WTE Pharmacists
Falls	- Integrated Falls Pathway Development - Improved onward referrals from Scottish Ambulance Service callouts - Joint working with Midlothian Council Roads Team for gritting/clearing of key HSCP facilities - Winter falls prevention communication campaign
Community Justice	- Route Map phased plan - New Unpaid Work Supervisor to assist with backlog in Unpaid Work Hours - Considering 0 hours contracts for unpaid work to increase flexibility - Spring and Stride groups restarted in space with extra capacity - 3 temporary contract social workers to assist with workload
Sport & Leisure	- In-house qualification courses and casual staff recruitment to deliver operations - Remobilisation of leisure centres closed previously - Flexible staff working e.g., when Snowsports Centre closes due to adverse weather
Disabilities	- Working with commissioned services for continuity planning - Working from home protocols for fieldwork staff - Flexible redeployment of staff when services are cancelled/reduced
MSK	- Upskilling Band 4 staff to support routine orthopaedic patients, freeing up capacity in the team - Improving patient journey/process from booking to first appointment
Dietetics	- Digitalised group services now in place - Over establish within budget for acute inpatient priority - Create ‘Lothian Flexible Crew’ by orientating and upskilling staff - Working with home Enteral nutrition supplier for resilience planning
PPE Hub	- Buffer stock to be ordered
Workforce Planning	- Wellbeing Lead appointed - Progressing actions from staff wellbeing survey - Directions for services with identified 'hard to fill' posts - Additional SVQ assessor posts to meet demand - Additional Learning & Development Asst. to improve access to training - Rapid induction training for care at home staff to mitigate risks of winter pressures

APPENDIX III: KEY PERFORMANCE INDICATORS

Key Performance Indicator	Previous figures (Winter Oct 2020-Mar 2021)
A&E Attendances (Incl. falls and frailty)	8443 A&E arrivals to RIE (1407 monthly, 351 weekly) 395 A&E attendances for falls (66 monthly, 16 weekly) 28 severely frail people attending A&E monthly 20 severely frail people discharged following unplanned admission within 24 hours 50% of frailty cohort attending A&E will have a further A&E attendance in following 6 months
Hospital admissions	22742 Unplanned TRAK Admissions (3790 monthly, 947 weekly) 129,026 OBDs (21504 monthly, 5376 weekly) 354 falls-related admissions (59 monthly, 15 weekly)
Delayed discharges	Average Daily Census Delays from RIE: Dec 2020: 12 Jan 2021: 13 Feb 2021: 8 Mar 2021: 8
MCH Ward and Hospital at Home - admissions, discharges, length of stay	MCH Average 25 admissions per month Hospital at Home average 39.5 admissions per month
Care at Home requested hours*	**Ongoing work within the service to streamline performance reporting. These figures may change.* 1075.8 total hours requested as of 23/08/21. Average 13 referrals per week in previous winter
CRT activity - prevented admissions, facilitated discharges, exacerbation management	71 prevented admissions 49 discharges 139 self-managed exacerbations
Staff sickness absence rates	3.56% average

APPENDIX IV: Winter EMT Membership

Name	Role
Morag Barrow	*Director*
Grace Cowan	*Head of Older People's Services & Primary Care*
Nick Clater	*Head of Adult Services*
Fiona Stratton	*Chief Nurse*
Hamish Reid	*Clinical Director*
Mairi Simpson	*Integration Manager*
Jamie Megaw	*Strategic Programme Manager*
Roxanne King	*Business Manager*
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APPENDIX V: WINTER READINESS SELF-ASSESSMENT FOR NHS LOTHIAN

Preparing for Winter 2021/22: Supplementary Checklist of Winter Preparedness: Self-Assessment

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **COVID -19, RSV, Seasonal Flu, Staff Protection & Outbreak Resourcing**
6. **Respiratory Pathway**
7. **Integration of Key Partners / Services**

These checklists supplement the narrative and deliverables identified in your RMP4 and support the strategic priorities for improvement identified by local systems from their review of last winter's pressures and performance and experiences of managing Covid -19.

Your winter preparedness assessment should cover systems, processes and plans which take into account the potential impacts of COVID-19, Respiratory Syncytial Virus (RSV), seasonal flu, other respiratory conditions and severe weather impacts. Plans should recognise that some of these events may occur concurrently and should take into account system wide impacts. Plans should also reflect a strategic as well as operational approach to maintain service resilience and business continuity.

The checklists also include other areas of relevance but are not exhaustive. Local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery.

NHS National Boards should support local health and social care systems to develop their winter plans as appropriate.

Winter Preparedness: Self-Assessment Guidance

- Local governance groups can use these checklists to self-assess the quality of overall winter preparations and to identify where further action may be required. This should link to the guidance available for continual provision of service available on the associated web links highlighted on the accompanying paper.

- The following RAG status definitions are offered as a guide to help you evaluate the status of your overall winter preparedness.

RAG Status	Definition	Action Required
■ **Green**	Systems / Processes fully in place & tested where appropriate.	Routine Monitoring
■ **Amber**	Systems / Processes are in development and will be fully in place by the end of October.	Active Monitoring & Review
■ **Red**	Systems/Processes are not in place and there is no development plan.	Urgent Action Required

1	Resilience Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action /Comments
1	NHS Board and Health and Social Care Partnerships (HSCPs) have clearly identified all potential disruptive risks to service delivery and have developed robust Business Continuity (BC) plans to mitigate these risks. Specific risks include the impact of Respiratory Infections (e.g. Covid, RSV, Seasonal Flu) on service capacity, severe weather and staff absence. Business continuity arrangements have built on lessons identified from previous events, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter preparedness to ensure that business continuity management principles are embedded in Remobilisation / Annual Operating Plans as part of all-year-round capacity and service continuity planning *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details.* This guidance Preparing for Emergencies Guidance*sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☒ ☒		All services updating service resilience plans and additional winter-specific resilience planning by 13/09. Winter operational briefing with services was held on 30/08 to review previous winter experiences and go over resilience planning requirements. Baseline capacity will be monitored to evaluate services' resilience planning.
2	BC plans take into account all critical activities across the NHS Board / HSCPs spectrum of activity and include analysis of the risks of disruption and their actual effects and demonstrate that planning has been based upon the likelihood and impact of worst case scenarios. Risk assessments take into account staff absences including those likely to be caused by a range of scenarios and are linked to a business impact analysis to ensure that essential staff are in place to maintain key services. All critical activities and actions required to maintain them are included on the corporate risk register and are actively monitored by the risk owner. The Health Board and HSC partnership have robust arrangements in place to support mutual aid between local / regional partners in respect of the risks and impacts identified	☒ ☒ ☒		As above All services completing resilience plans to maintain baseline capacity, taking into account staff sickness absence. Planning for annual leave to ensure service deliver is maintained over winter period.
3	The NHS Board and HSCPs have appropriate policies in place to cover issues such as : • what staff should do in the event of severe weather or other issues hindering access to work, and • arrangements to effectively communicate information on appropriate travel and other advice to staff and patients	☒		Working with Midlothian Council teams and local voluntary groups for access to transport in severe weather. Service level agreement

	• how to access local resources (including voluntary groups) that can support a) the transport of staff to and from their places of work during periods of severe weather and b) augment staffing to directly or indirectly maintain key services. Policies should be communicated to all staff and partners on a regular basis. *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*			has been updated and SOP for accessing 4x4s is being produced. Individual services are maintaining lists of staff who can drive other staff. Services also prepared for staff to work from home or change work base as required.
4	NHS Board/HSCPs websites will be used to advise patients on any changes to service access arrangements or cancellations of clinics / outpatient services due to severe weather, reduced staffing levels etc,	☒	■	Communications via social media and website. All staff communication mechanisms for the HSCP are in place. Process for any emergency/urgent comms in place and draft scheduled comms plan including holiday closures being developed.
6	The NHS Board, HSCPs and relevant local authorities have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.	☒	■	Midlothian Council have developed plans for this

2	Unscheduled / Elective Care Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	**Clinically Focussed and Empowered Management**			
1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity and visibility of other key performance indicators *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☒		Winter EMT established and meeting weekly w/c 13/09 as avenue for escalation and dissemination of information; performance monitoring is a key part of this Daily huddles for intermediate care services and delayed discharges All staff communication channels established Monthly IJB Brief commencing 07/10 to include winter information
1.2	Effective communication protocols are in place between clinical departments and senior managers across the whole system, to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked with key actions and timescales assigned to individuals.	☒		As above Involved with NHS Lothian Gold Command and local authority Gold when initiatied
1.3	A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU.	☐		N/A

	This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact. *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care, with PDDs (planned dates of discharge) visible and worked towards, to ensure patients are discharged withouth delay.*			
1.4	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☒		Full HSCP strategic winter plan by 18/09 to cover capacity and workforce, substantiated by robust action plan. Going to IJB in October.
2	**Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID-19 activity (both short and medium-term) based on forecast emergency and elective demand and trends in infection rates, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**			
2.1	Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated, including identification of winter surge beds for emergency admissions *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *Weekly projections for COVID demand and the capacity required to meet this demand including an ICU surge plan with the ability to double capacity in one week and treble in two weeks and confirm plans to quadruple ICU beds as a maximum surge capacity.* *Plans in place for the delivery of safe and segregated COVID-19 care at all times.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This*	☒		Building performance monitoring and KPIs to be regularly reported to weekly winter EMT, looking for risks/bottlenecks in delays, beds, capacity, demand, etc. relating to HSCP community performance

	requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period. *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID-19 surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*			
2.2	Pre-planning created pathways which provide an alternative to admission, and optimised the use of inpatient capacity for the delivery of emergency and elective treatment, including identification of winter / COVID-19 surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work. *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring. Where electives are cancelled consideration should be given on whether the Scottish Government Access Support team should be informed in order to seek support and facilitate a solution.* *Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.* *Management plans should be in place for the backlog of patients waiting for planned care in particular diagnostic endoscopy or radiology set in the context of clinical prioritisation and planning assumptions*	☐		N/A
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge. To note this year the festive period public holidays will span the weekends.**			

3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☒	■	Winter operational briefing with service managers on 30/08 as reminder for holiday cover. Resilience planning templates to be completed by 13/09. All services to have holiday cover plans by 01/10.
3.2	Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services.	☒	■	As above Services planning/approving annual leave currently for winter period.
3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations*	☐		Working with NHS Lothian within their Cat. 1 responder responsibilities
3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.*	☒	■	Communications plan in place to disseminate information and emergency comms process in place.
	Develop whole-system pathways which deliver a planned approach to urgent care ensuring patients are seen in the most appropriate clinical environment, minimising the risk of hospital associated infection and crowded Emergency Departments.	☒	■	Representation on NHS Lothian Unscheduled Care Programme Board Local planning in place to support key pathways

	Please note regular readiness assessments should be provided to the SG Unscheduled Care team including updates on progress and challenges.			Continued development of Home First models and pathways
	To ensure controlled attendance to A&E services a 24/7 Health Board Flow Navigation Centre will offer rapid access to a senior clinical decision maker and be staffed by a multi-disciplinary team, optimising digital health when possible in the clinical consultation and should have the ability to signpost to available local services, such as MIU, AEC, GP (in and out of hours), pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate. Referrals to the flow centre will come from: • NHS 24 • GPs and Primary and community care • SAS • A range of other community healthcare professionals. If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide viable appointments / timeslots at A&E services. The impact on health-inequalities and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments.	☒	■	As above Representation on RUC Project Board Working with acute, primary care, and flow centre colleagues to build professional to professional pathways to Midlothian's Single Point of Access
	Professional to professional advice and onward referral services should be optimised where required Development of pathways across whole system for all unscheduled care working with Scottish Ambulance Service to access pathways and avoid admission.	☒	■	As above. Single Point of Access now in place CRT/SAS pathway established to avoid admissions

				Funding secured to develop pathway with paramedics within Hospital at Home
4	**Optimise patient flow by proactively managing Discharge Process utilising PDD (Planned Date of Discharge) and associated discharge planning tools such as – Daily Dynamic Discharge, to shift the discharge curve to the left and optimise in day capacity,and ensure same rates of discharge over the weekend and public holiday as weekday.**			
4.1	Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*	☒	■	Daily delayed discharge calls to discuss plans Enhancement of Home First Model 7-day operation of Single Point of Access and Flow Hub Recruitment of additional HCSWs into D2A to move delays out of RIE Investment in Frailty GP project from HSCP Additional OT working with frailty GP to review A&E attendances of those with severe/moderate frailty Intensive assessment of top 10 frequent attenders to A&E over 75

				Enhanced services from British Red Cross to support discharge Improving anticipatory care planning Plans in development for top 5 potentially preventable admissions Delays part of performance monitoring system built into weekly EMT tracking
4.2	To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate. *Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.*	☒	■	Home First, Flow Hub, and SPOA now covering 7 days per week.
4.3	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.* *Extended opening hours during festive period over public Holiday and weekend*	☐		N/A
4.4	Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services	☒	■	As above

	should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre-Christmas discharge *There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes*			HSCP Pharmacy recruiting to vacancies to increase capacity for winter surge Recruitment for additional D2A capacity commencing (risk in any recruitment delays)
5	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**			
5.1	Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels. *This will be particularly important over the festive holiday periods.* *Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions.* *Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*	☒	🟨	Workforce issues relating to Covid currently impacting significantly on availability of packages of care across the system. Plans in place to review current processes and systems to free up additional capacity. Use of RAG risk assessment for all clients when required. Recruitment of additional 20 HCSWs to support care for our Home First team. Working within Scottish Government guidance. Regular status communication to local authority and NHS Lothian Gold Command in line with other partnerships.
5.2	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible. *Partnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.*	☒	🟩	These processes are in place

	All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible			
5.3	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.*	☒		Process in place for SAS/acute services to view this information if developed by the practices
5.4	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. *KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.*	☒		ACPs in place for care homes. Specific focus on frail patients who have them as part of innovation models currently in place.
5.5	COVID-19 Regional Hubs fully operational by end November. Additional lab capacity in place through partner nodes and commercial partners by November. Turnaround times for processing tests results within 24/48 hours.			**N/A**
6.0	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
6.1	Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector and into the Scottish Government. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.*	☒		Work with communications teams in NHS Lothian and Midlothian Council around key messaging

	Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.			
6.2	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around direction to the appropriate service are effectively communicated to the public.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.* *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*	☒		Working with NHS Lothian and Midlothian Council communications team that uses all available media to communicate with staff and public HSCP Public website will be launched 09/09/21 Winter communication plan in place to disseminate information

3	**Out of Hours Preparedness** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	The OOH plan covers the full winter period and pays particular attention to the festive period and public holidays. *This should include an agreed escalation process.* *Have you considered local processes with NHS 24 on providing pre-prioritised calls during OOH periods?*	☐		Assumption that this section relates to Lothian Unscheduled Care Services, not Midlothian HSCP. Midlothian HSCP will ensure key services are working over the festive period and will work with LUCS for OOH pathways.

2	The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.	☐		N/A
3	There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.	☐		N/A
4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?*	☐		N/A
5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☐		N/A
6	There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa	☐		N/A
7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.	☐		N/A
8	Ensure there is reference to provision of dental services, that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*	☐		N/A
9	The plan displays a confidence that staff will be available to work the planned rotas.	☐		N/A

	While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.			
10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☐		N/A
11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.	☐		N/A
12	There is evidence of joint working between the Board and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☐		N/A
13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☐		N/A
14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☐		N/A
15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic flu and other emergency plans, including provision for an escalation plan.	☐		N/A

	The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.			

4	Prepare for & Implement Norovirus Outbreak Control Measures *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*	☒		In place
2	IPCTs and HPTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their IPCTs and Health Protection Teams (HPTs) are supported to undertake the advance planning to ensure that Norovirus outbreaks in hospitals and care homes are identified and acted upon swiftly. Boards should ensure that there are sufficient resources to provide advice and guidance to ensure that norovirus patients are well looked after in these settings.*	☐		N/A
3	PHS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff	☒		In place
4	How are NHS Board communications regarding bed pressures, ward closures, kept up to date in real time. *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☒		Communication in real time via flow hubs regarding bed capacity.

5	Debriefs will be provided following significant outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☒	■	Business as usual within clinical areas
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation via the PHS Norovirus Activity Tracker.	☐		N/A
7	Are there systems in place that would ensure appropriate patient placement, patient admission and environmental decontamination post discharge in ED and assessment areas	☐		N/A
8	NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.*	☐		N/A
9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple bays / wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☐		N/A
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation.	☐		N/A

11	Are there systems in place to deploy norovirus publicity materials information internally and locally as appropriate,	☒	■	In Place
12	Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of COVID-19.	☒	■	Will communicate any NHS Lothian communications from the Directorate through all available channels to our community

5	COVID -19, RSV, Seasonal Flu, Staff Protection & Outbreak Resourcing *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	Staff, particularly those working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients and other staff, as recommended in the CMOs seasonal flu vaccination letter published on Adult flu immunisation programme 2021/22 (scot.nhs.uk) and Scottish childhood and school flu immunisation programme 2021/22 . Further CMO letters will be issued before the flu season begins to provide further details on aspects of the programme, including the marketing campaign and details of education resources for staff administering vaccinations.	☒		Planning assumptions in place but awaiting final guidance form Scottish Government to finalise plans for flu and Covid-19 vaccination programmes for staff and patient cohorts.
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; that staff fully understand the role flu vaccination plays in preventing transmission of the flu virus and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake. Vaccine uptake will be monitored weekly by performance & delivery division*	☒		Planning assumptions to tun two mass vaccination sites operating 6 days a week with extended hours for staff to attend, but awaiting final Scottish Government guidance Care home staff will be vaccinated in care homes

3	The winter plan takes into account the predicted surge of seasonal flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. SG procures additional stocks of flu vaccine which is added to the stocks that Health Boards receive throughout the season, which they can draw down, if required. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals co-ordinated and issued by the Vaccinations Strategy Division.)*	☒		Midlothian HSCP Winter Plan to be finalised and agreed by Senior Management Team 15/09
4	PHS weekly updates, showing the current epidemiological picture on COVID-19, RSV and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Public Health Scotland and the Vaccinations Strategy Division within the Scottish Government monitor influenza rates during the season and take action where necessary, The Outbreak Management and Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. PHS produce a weekly influenza bulletin and a distillate of this is included in the PHS Winter Pressures Bulletin.*	☒		Weekly Winter EMT will monitor PHS updates Midlothian Public Health Team involvement
5	Adequate resources are in place to manage potential outbreaks of COVID-19, RSV and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☒		Outbreaks managed under Public Health processes

6	Ensure that sufficient numbers of staff from high risk areas where aerosol generating procedures are likely to be undertaken such as Emergency Department, Assessment Units, ID units, Intensive Care Units and respiratory wards (as a minimum) are fully aware of all IPC policies and guidance, FFP3 fit-tested and trained in the use of PPE for the safe management of suspected COVID-19, RSV and flu cases and that this training is up-to-date. ***Colleagues are reminded of the legal responsibility to control substances hazardous to health in the workplace, and to prevent and adequately control employees' exposure to those substances under all the Regulations listed in the HSE's 'Respiratory protective equipment at work' of HSG53 (Fourth edition, published 2013). https://www.hse.gov.uk/pUbns/priced/hsg53.pdf***	☒	■	HPS guidance in place at all times Local PPE Hub established with processes in place Staff communications of guidance continue to be in place
7	Staff in specialist cancer & treatment wards, long stay care of the elderly and mental health (long stay) will also will be required to continue to undertake asymptomatic weekly testing for COVID-19 throughout this period. We are actively reviewing the current asymptomatic Healthcare Worker testing Operational Definitions to ensure they are still fit for purpose.	☒	■	Staff testing in place at Midlothian Community Hospital and monitored

8	Ensure continued support for care home staff asymptomatic LFD and PCR testing and wider social services staff testing. This also involves the transition of routine weekly care home staff testing from NHS Lighthouse Lab to NHS Labs. Support will be required for transfer to NHS by end of November, including maintaining current turnaround time targets for providing staff results. *Enhanced care home staff testing introduced from 23 December 2020 . This involves twice weekly LFD in addition to weekly PCR testing review of enhanced staff testing underway. PCR testing - transition to NHS lab complete. Good level of staff participation in PCR testing.* *Testing has been rolled out to a wide range of other social care services including care at home, sheltered housing services.*	☒	■	Staff testing in line with national guidance with support for asymptomatic care home testing
9	NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2020/2021) which will allow for monitoring of take up against targets and performance reporting on a weekly basis. The eligible cohorts are as follows: • Adults aged over 65 • Those under 65 at risk • Healthcare workers • Unpaid and young carers • Pregnant women (no additional risk factors) • Pregnant women (additional risk factors) • Children aged 2-5 • Primary School aged children • Frontline social care workers • 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household • Eligible shielding households The vaccinations are expected to start this week (week commencing 28th September), and we will be working with Boards to monitor vaccine uptake. This	☒	■	Performance monitoring in place and will be tracked via winter EMT

	will include regular reporting that will commence from day 1 of the programme utilising automated data collection methods for performance monitoring. Public Health Scotland will report weekly.			
10	**Low risk** – Any care facility where: a) triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact who have isolated/shielded AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the test date OR b) Individuals who have recovered from COVID-19 and have had at least 3 consecutive days without fever or respiratory symptoms and a negative COVID-19 test OR c) patients or individuals are regularly tested (remain negative) **Medium risk** Any care facility where: a) triaged/clinically assessed individuals are asymptomatic and are waiting a SARSCoV-2 (COVID-19) test result with no known recent COVID-19 contact OR b) testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR c) asymptomatic individuals decline testing **High risk** Any care facility where: a) untriaged individuals present for assessment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 (COVID-19) positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who	☐		

	have been triaged/clinically assessed and are waiting test results OR d) symptomatic individuals who decline testing So all emergency admissions where COVID-19 status is unknown/awaited will fall into the medium risk pathways until testing can be undertaken to allow them to transition into green.			
11	All NHS Scotland Health Boards have provided assurance that all emergency and all elective patients are offered testing prior to admission. *Testing after admission should continue to be provided where clinically appropriate for example where the person becomes symptomatic or is part of a COVID-19 cluster.*	☐		N/A
12	Staff should be offered testing when asymptomatic as part of a COVID-19 incident or outbreak investigation at ward level when unexpected cases are identified. This will be carried out in line with existing staff screening policy for healthcare associated infection: https://www.sehd.scot.nhs.uk/dl/DL(2020)01.pdf *In mid-February 2021, the scope of the LFD testing pathway was expanded further to include patient facing primary care staff (general practice, pharmacy, dentistry, optometry), hospice staff, and NHS24 and SAS call handlers. Some hospice staff had been included in the original scope where staff worked between hospitals and hospices, so this addition brought all patient facing hospice staff into the testing programme.* *On the 17 March Scottish Government announced that the scope of the HCW testing pathway would be further expanded to include all NHS workers. The roll out is currently underway and we expect that all Boards across Scotland will have fully implemented the roll-out of twice weekly lateral flow testing to eligible staff by the end of June 2021. This will include staff who may have been shielding or working from home and is in line with national guidance.*	☒		In Place

	Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-COVID-19-healthcare-worker-testing/			

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*		RAG	**Further Action/Comments**
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☒		Community Respiratory Team remain operational within Midlothian
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☒		Additional investment in Community Respiratory Team which may support 7-day working, dependent on recruitment
1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*	☒		In place
1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*	☒		Fact-sheet for patients specific to winter time Working with NHS Lothian and Council communications team around key messaging
2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**			
2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation.	☒		In place

	Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).			
2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.	☒	■	Pathway in place from hospital to home. Expanded Community Respiratory Team in place (MCRT+) for discharge planning for any respiratory patient.
3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**			
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data,* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☒	■	In place
4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			

4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☒ ☒ ☒ ☒		This is managed by our Hospital at Home team. CRT have developed COVID oxygen weaning pathway. Staff have access to community respiratory team and the team is available over the festive period.
5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**			
5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.*	☒		In Place

7	Key Roles / Services		RAG	Further Action/Comments
	Heads of Service	☒		
	Nursing / Medical Consultants	☒		Inability to recruit to some trained nursing roles within HSCP has and will continue to impact on ability to safely maintain and maximise bed numbers. Mitigation plans in place but recruitment challenges remain a risk.
	Consultants in Dental Public Health	☐		
	AHP Leads	☒		
	Infection Control Managers	☒		
	Managers Responsible for Capacity & Flow	☒		
	Pharmacy Leads	☒		
	Mental Health Leads	☒		
	Business Continuity / Resilience Leads, Emergency Planning Managers	☒		
	OOH Service Managers	☒		
	GP's	☒		
	NHS 24	☐		
	SAS	☐		
	Other Territorial NHS Boards, eg mutual aid	☐		

	Independent Sector	☒	■	
	Local Authorities, incLRPs & RRPs	☒	■	
	Integration Joint Boards	☒	■	
	Strategic Co-ordination Group	☒	■	
	Third Sector	☒	■	
	SG Health & Social Care Directorate	☐		

COVID-19 Surge Bed Capacity Template **Annex A**

		Baseline ICU Capacity	Double Capacity and Commitment to deliver in one week	'Triple plus' Capacity Commitment to deliver in two weeks	ICU Max Surge Beds	Y - Correct / N Incorrect with comment	Please list assumptions & consequences to other service provision to meeting these requirements
PART A: ICU	Please confirm that your NHS Board can deliver the stated level of ICU Capacity in the time periods set out						

PART B: CPAP	Please set out the maximum number of COVID-19 patients (at any one time) that could be provided CPAP in your NHS Board, should it be required		
PART C: Acute	Please set out the maximum number of acute beds that your NHS Board would re-provision for COVID-19 patients (share of 3,000 nationally), should it be required		

Annex B

Infection Prevention and Control COVID-19 Outbreak Checklist

(Refer to the National Infection Prevention and Control Manual (NIPCM) for further information http://www.nipcm.hps.scot.nhs.uk/)

This COVID-19 tool is designed for the control of incidents and outbreak in healthcare settings.

Definitions: 2 or more confirmed or suspected cases of COVID-19 within the same area within 14 days where cross transmission has been identified.
Confirmed case: anyone testing positive for COVID-19
Suspected case: anyone experiencing symptoms indicative of COVID (not yet confirmed by virology)

This tool can be used within a COVID-19 ward or when there is an individual case or multiple cases.

Standard Infection Control Precautions;
Apply to all staff, in all care settings, at all times, for all patients when blood, body fluids or recognised/unrecognised source of infection are present.

Patient Placement/Assessment of risk/Cohort area	**Date**				
Patient placement is prioritised in a suitable area pending investigation such as for a single case i.e. single room with clinical wash hand basin and en-suite facilities					
Cohort areas are established for multiple cases of **confirmed** COVID-19 (if single rooms are unavailable). Suspected cases should be cohorted separately until confirmed. Patients should be separated by at least 2 metres if cohorted.					
Doors to isolation/cohort rooms/areas are closed and signage is clear (undertake a patient safety risk assessment for door closure).					
If failure to isolate, inform IPCT. **Ensure all patient placement decisions and assessment of infection risk (including isolation requirements) is clearly documented in the patient notes and reviewed throughout patient stay.**					
Patient placement is reviewed as the care pathway changes. NB: Patients may be moved into suspected or confirmed COVID-19 cohorts or wards to support bed management.					
Personal Protective Clothing (PPE)					

1. PPE requirements: PPE should be worn in accordance with the **COVID 19 IPC addendum** for the relevant sector: • **Acute settings** • **Care home** • **Community health and care settings** 2. All staff should wear a FRSM in accordance with the updated guidance on face coverings, which can be found **here**.					
Safe Management of Care Equipment					
Single-use items are in use where possible.					
Dedicated reusable non-invasive care equipment is in use and decontaminated between uses. Where it cannot be dedicated ensure equipment is decontaminated following removal from the COVID-19 room/cohort area and prior to use on another patient.					
Safe Management of the Care Environment					
All areas are free from non-essential items and equipment.					
At least twice daily decontamination of the patient isolation room/cohort rooms/areas is in place using a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) available chlorine (av.cl.).					
Increased frequency of decontamination (at least twice daily)is incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g. "frequently touched" surfaces such as door/toilet handles and locker tops, over bed tables and bed rails.					
Terminal decontamination is undertaken following patient transfer, discharge, or once the patient is no longer considered infectious.					
Hand Hygiene					
Staff undertake hand hygiene as per WHO 5 moments: using either ABHR or soap and water					
Movement Restrictions/Transfer/Discharge					
Patients with suspected/confirmed COVID should not be moved to other wards or departments unless this is for essential care such as escalation to critical care or essential investigations. Discharge home/care facility: Follow the latest advice in COVID-19 - guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.					
Respiratory Hygiene					
Patients are supported with hand hygiene and provided with disposable tissues and a waste bag					
Information and Treatment					
Patient/Carer informed of all screening/investigation result(s).					
Patient Information Leaflet if available or advice provided?					

Education given at ward level by a member of the IPCT on the IPC COVID guidance?					
Staff are provided with information on testing if required					

14th October 2021, 2.00pm

Workforce Plan

Item number:	**5.8**

Executive summary

The purpose of this report is to highlight the workforce planning currently underway to support the development of the new Workforce Strategic Plan 2022-2025.

The report also aims to raise awareness of the new initiatives and actions being undertaken to reduce the challenges that specific service teams are having in relation to their workforce.

Board members are asked to:

. Note the current strategic workforce planning.

Acknowledge and provide any comment/feedback on the actions and initiatives that are being implemented.to address the challenges that specific workforce teams are experiencing.

Workforce Plan

1 Purpose

1.1 The purpose of this report is to highlight the workforce planning currently underway to support the development of the new Workforce Strategic Plan 2022-2025

1.2 The report also aims to raise awareness of the new initiatives and actions being undertaken to reduce the challenges that specific service teams are having in relation to their workforce, to improve service delivery, and mitigate risks of this re-occurring in the future.
.

2 Recommendations

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

Note the current strategic workforce planning.

Acknowledge and provide any comment/feedback on the actions and initiatives that are being implemented.to address the challenges that specific workforce teams are experiencing.

3 Background and main report

3.1 The Midlothian Interim Workforce and Development Plan 2021/22 was submitted to Scottish Government on 30th April 2021 and the IJB agreed to implement this plan at the IJB Meeting on 16th June 2021.

3.2 In line with the priorities outlined in the Interim Workforce and Development Plan 2021/22 further workforce planning is currently underway to support the development of the Workforce Strategic Plan 2022-2025. This will ensure the right people, are in the right roles, with the right skills at the right time and to maximise the potential of individual members of the workforce. This will enable the partnership to continue to achieve its strategic and operational priorities and support the partnership in successfully delivering the new Strategic Plan 2022-2025.

3.3 A Workforce Strategic Planning Group has been established which will support the development of the Workforce Strategic Plan 2022-2025. The membership includes a wide range of stakeholders including community partners, local employers and union representatives.

3.4 Key strategic priorities in terms of staff wellbeing have been identified from the recent staff survey. Plans to address these will be included in the new Strategic Workforce Plan.

3.5 Currently there are a number of workforce challenges that are impacting on specific service teams across Midlothian HSCP. These can primarily be attributed to:

- The impact of Covid-19;
- lack of available workforce for social care locally;
- type of role where vacancies are highest.

The workforce teams that are impacted the greatest are care at home, care homes and nursing staff where there are high absence levels.

3.2 Managers in Midlothian HSCP have a robust approach to absence management and are supported in this by both Midlothian Council and NHS Lothian policies and procedures. Absence management is being managed and monitored through the team managers, service managers and through the staff governance meetings. The service mangers are working closely with HR colleagues to seek support and solutions to manage the absences effectively and efficiently. This has included dedicated training sessions on the absence management policies to all team supervisors in the service and more accurate data on absence to identify trends and themes. Managers also engage with Partnership and Staff Side representatives in a pro-active manner to resolve issues in a timely manner.

3.6 To increase recruitment and support the existing staff, there are a number of positive actions and initiatives currently underway:

- The new staff wellbeing lead for the HSCP commenced in post at the beginning of September. They are holding focus groups with care staff and managers to seek feedback and develop solutions on how staff can be supported to be well at work. They are prioritising the teams with high absence rates.

- A communication was sent to all council staff (via email) on the option of a move to working in Care at Home permanently, temporarily or as a casual staff member. There has been a good response with over 20 enquires and a number of interviews taking place.

- Rapid induction training has been successfully set up and delivered by the HSCP learning and development team to ensure staff can quickly receive the mandatory training and support required.

- There is ongoing recruitment to vacant posts through external adverts to the wider population. Additionally there is potential for the HSCP to be part of wider recruitment campaigns both within Midlothian and for health and social care staff as part of Scottish Government plans. Feedback from existing staff in these teams to provide support in these vital roles.

- A new initiative is being explored with Midlothian Council Communications Department to increase the local workforce over winter. This would involve a communication to ascertain if appropriate people might be willing to provide short term support to a neighbour.

4 Policy Implications

4.1 There is an Interim Workforce Plan 2021-22 in place and work is currently underway to develop a 3-year Workforce Plan for 2022-2025.

4.2 The Health and Care (Staffing) (Scotland) Act 2019 introduced into legislation guiding principles for those who commission and deliver health and care services, which explicitly state that staffing is to provide safe and high quality services and to ensure the best health care or care outcomes for service users.

4.3 A range of local and national polices support the direction of the IJB to support people to live at home independently for as long as possible, and to receive high quality safe person-centred care. Having well-staffed services such as Care at Home and Care Homes impacts positively on reducing delayed discharges and ensuring that people can live independently in their own homes for as long as possible.

5 Directions

5.1 This report is relevant to Direction 15 Care at Home "Implement a multifaceted workforce plan that includes council and external providers by July 2021" However workforce has relevance to a number of directions to ensure services have appropriately trained staff.

6 Equalities Implications

6.1 People with protected characteristics, including older people and people with disabilities, who rely on care and support to enable them to live safely and well in their own homes may be disproportionately affected is workforce planning is not undertaken effectively.

7 Resource Implications

7.1 The current resource implications are around managing the budgets and high absence rates where cover needs to be provided and therefore incurring over time and additional hours to the service budget. These are being closely managed and monitored through the service's team managers, accountants, service managers and the finance governance group.

8 Risk

8.1 There are 2 key risks to consider should the mitigating actions not have sufficient impact:

- Risk to service delivery with high absence and vacant posts
- Risk of increasing financial costs of covering absence across the services with locum, bank and agency staff

9 Involving people

9.1 There is ongoing involvement with staff who work in the key service areas.

9.2 Carer focus groups will be established by the Wellbeing Lead to provide support, and forums for discussion.

10 Background Papers

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Appendices:

14th October 2021, 2.00pm

Vaccination Programme Update

Item number:	**5.9**

Executive summary

The purpose of this report is to provide an update to the IJB on the Seasonal Influenza and COVID vaccination programme

Board members are asked to:

- Note progress with the programme

Report

Vaccination Programme Update

1 Purpose

1.1 The purpose of this report is to provide an update to the IJB on the Seasonal Influenza and COVID vaccination programme

2 Recommendations

2.1 As a result of this report what are Members being asked to:-

- Note progress of the programme

3 Background and main report

3.1 Midlothian HSCP is responsible for the Seasonal Influenza and COVID Vaccination programme for Midlothian residents. All vaccinations will be provided by HSCP services with the exception of the schools-based flu vaccine programme (teachers and young people) which is organised by NHS Lothian's Community Vaccination Team. The HSCP is supported by NHS Lothian and is using a national appointment booking system.

3.2 The programme has commenced and at 5th October there were 12,649 Midlothian residents who had received a Seasonal Influenza vaccination and 3,983 people had received a COVID Booster. The HSCP is prioritising residents by following JCVI and Scottish Government guidance. People in Stage 1 are being invited forward in the first instance along with people aged 12-15 for an initial COVID vaccination and people who are severely immunosuppressed for a third dose.

Stage 1 (offered a third dose COVID-19 booster vaccine and the annual Flu vaccine, as soon as possible from September 2021):

- Immunosuppressed
- All Adults > 70
- All Adults >16 who are Clinically Extremely Vulnerable
- Front Line Health and Social Care Workers

Stage 2 (offered a third dose COVID-19 booster vaccine as soon as practicable after Stage 1, with equal emphasis on deployment of the Flu vaccine where eligible):

- All adults aged 50 years and over
- All adults aged 16-49 who are in an influenza or COVID-19 at-risk group
- Adult household contacts of immunosuppressed individuals.

The extended 2021/22 Flu programme also includes:

- Unpaid and young carers
- Teaching staff including support staff
- Secondary school pupils and

3.3 The HSCP is running three main vaccination clinics for adults: Gorebridge Leisure Centre, Eastfield Medical Practice (weekends only in October) and Midlothian Community Hospital. These sites combined have a capacity of over 90,000 appointments by December 6th. In addition, there is a domiciliary service for people who are housebound. Care Home residents, along with staff there will receive their vaccinations at the care home. The 0-5 year old immunisation programme is running from many small community venues. General Practices are not providing vaccinations this year and the HSCP will undertake these as part of the agreement from the 2018 General Medical Services (Scotland) Contract.

3.4 The vaccination programme formally commenced on 20th September, initially focusing on Health and Care staff and people who are 70 years of age or older, whilst also providing vaccinations for Evergreen (1st/2nd dose COVID vaccinations) and 12-15 COVID vaccinations.

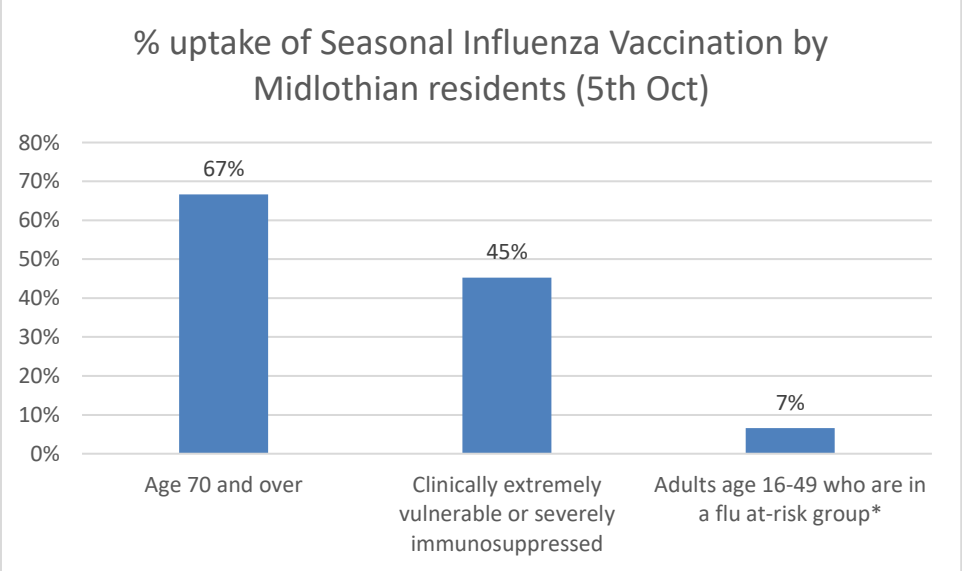
4 Performance

4.1 There are now 66,442 residents in Midlothian who are fully vaccinated for COVID (1st and 2nd dose). This is 85% of the eligible cohort.

4.2 3,983 people in Stage 1 have received their Booster vaccination. This is 18.5% of this cohort. The Booster programme started on 27th September.

4.3 12,649 people in Midlothian have received a Seasonal Influenza vaccination. In this there are 8,893 people aged 70 or over which is 67% of this cohort. The Scottish Government target for this cohort is 90%.

4.4 The following chart shows the cumulative uptake for seasonal influenza vaccination:



5 Policy Implications

5.1 There are no policy implications

6 Directions

6.1 No impact on a Direction.

7 Equalities Implications

7.1 The vaccination programme will be delivered from three main venues in Midlothian. This is different from previous years when vaccinations were mainly provided from General Practice buildings. This will increase the distance most residents will need to travel. The HSCP is using this approach due to combination of factors including clinical safety, vaccine logistics (cold storage) and limited suitable buildings in Midlothian.

The HSCP has already configured its service model to improve access for people living in the Penicuik are (EH26 postcode) by opening up weekend clinics in Eastfield Practice. The service model is under regular review by the HSCP focussing specifically on DNAs and information provided from the national and NHS Lothian contact centres. This information will inform the service model later in the Autumn.

8 Resource Implications

8.1 The vaccination programme is fully funded from a combination of HSCP and COVID budgets

9 Risk

9.1 The main risk for the IJB to recognise is the challenge to deliver the vaccine targets set by Scottish Government. These are higher for the Seasonal Influenza programme than has previously been achieve (e.g. the goal for 75+ is 90% and last year Midlothian achieved 86%).

10 Involving people

10.1 The HSCP is using public feedback during the programme to review and refine the programme.

11 Background Papers

11.1 No further papers

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DATE	7th October 2021

14th October 2021, 14.00

Chief Social Work Officer – Annual Report 2020 - 2021

Item number:	**5.10**

Executive summary

To provide Council and IJB with the annual report of the Chief Social Work Officer (CSWO). The shortened report provides Council and IJB with a high level overview of key issues and challenges as a result of Covid-19.

Board members are asked to:

- **Note the Chief Social Work Officer's Annual Report for 2020-21;**

Chief Social Work Officer – Annual Report 2020 - 2021

1 Purpose

1.1 To provide Council and IJB with the annual report of the Chief Social Work Officer (CSWO). The shortened report provides Council and IJB with a high level overview of key issues and challenges as a result of Covid-19.

2 Recommendations

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

Note the Chief Social Work Officer's Annual Report for 2020-21

3 Background and main report

3.1 The requirement that every local authority should have a professionally qualified Chief Social Work Officer is contained within Section 45 of the Local Government (Scotland) Act 1994. The particular qualifications are set down in regulations. This is one of a number of officers, roles or duties with which local authorities have to comply. The role replaced the requirement in Section 3 of the Social Work (Scotland) Act 1968 for each Local Authority to appoint a Director of Social Work.

The attached report uses the reduced template developed for the 2019-20 report, taking cognizance of the ongoing pressures being experienced across the sector as a result of Covid-19.

4 Policy Implications

4.1 None

5 Directions

5.1 There are no implications on Directions arising from any decisions made in this report.

6 Equalities Implications

6.1 None

7 Resource Implications

7.1 This report does not make recommendations which entail the allocation of resources.

8 Risk

8.1 CSWO's have well-developed arrangements in place to assess and manage risk both within social work services and in inter-agency contexts. This has been particularly prevalent during the ongoing Covid-19 pandemic where as CSWO with a children and families background I have had to liaise with colleagues in health and social care to support the roll out of robust governance and oversight around high risk areas such as care at home and residential care homes settings. Having positive professional working relationships with a clear understanding of each other's roles has reduced any potential risk.

9 Involving people

9.1 The report highlights the involvement of users of services in the development of services

10 Background Papers

10.1

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DATE	7th October 2021

Appendices: Chief Social Work Officer Annual Report (Attached).

Chief Social Work Officer's Annual Report 20/21

Midlothian – A Great Place to Grow

Executive Summary

The CSWO is required to produce an annual report. The format changed some years ago, when local authorities were asked to use a template devised by the Chief Social Work Adviser to the Scottish Government to ensure consistency across Scotland in annual report submissions. As a result of the pandemic, this format has once more been altered to reflect the challenges that the pandemic has brought to social work services across Scotland.

Background:

Every local authority must have a professionally qualified CSWO as per Section 45 of the Local Government (Scotland) Act 1994. The role is to ensure that provision of appropriate professional advice in the of a local authority's statutory function as described in Section 5 (1B) of the Social Work A(Scotland) Act 1968. The role covers the full range of a local authority's social work functions to provide a focus for professional leadership and governance. The role also provides strategic and professional leadership in the delivery of social work services.

This is the first report written by the Chief Social Work Officer, Joan Tranent, following the departure of Alison White in July 2021.

Main Report:

Give the workload implications of the pandemic, the government's chief social work advisor set out a requirement for this year's report to focus on the following areas:

- → Governance and accountability arrangements
- → Service quality and performance
- → Resources
- → Workforce
- → COVID-19

The report acts as the required annual report to elected members on the operation of the statutory social work complaints process. The report highlights the impact that Covid-19 has had upon Midlothian's communities and its social work and public protection services, as well as indicating how these continue to affect and contribute to even greater levels of need and vulnerability for local people living in Midlothian.

Next Steps

A draft of this report will be shared with the Chief Social Work Advisor to the Scottish Government by the end of September 2021. The report shall go to both the Council Meeting and the IJB for sign off in October 2021.

Financial impact

The report is an overview of strategic and operations social work matters covering the areas of Children's services, Adult's and Justice based social work. There is no financial impact from this report, which will not have already been considered through existing Council Committees or the Integrated Joint Board.

Stakeholder/Community Impact:

All social work services have the expectation to engage the participation of those citizens who require the support and assistance of those services. Each departmental area has existing mechanisms in place to address stakeholder and community impact.

Policy Implications

There are no direct policy implications of this report. However, the report highlights the areas of practice, service delivery and policy that will require further review as the full impact of the pandemic on services becomes clearer.

Introduction

I am pleased to present the Chief Social Work Officer's annual report for 2020/21, having just taken over the role in July 2021. The report provides a summary of social work and key social care activity, including key developments and information on statutory decisions made by the Chief Social Work Officer on behalf of the Council and Council services. The report is not intended to be exhaustive but gives an indication of trends, priorities, challenges and opportunities over the past year. In recognition of the arrival and impact of the COVID 19 pandemic, the report includes a summary of how our services have responded and adapted during this time.

Staff have worked incredibly hard to meet the challenges of fulfilling the social work task within the context of COVID, and I want to express my sincere thanks and appreciation to them for their commitment and dedication to protecting and improving the lives of the most vulnerable people in our Midlothian communities.

Joan Tranent
CSWO & Chief Officer Children's Services, Partnerships & Communities

92,460 people living in Midlothian

18% of people are **over 65**

20% are under 16

3% of children looked after are on the CP register (as of 31/03/2021)

It is projected that the **over 75 age group** is to see the largest percentage increase **+40.9%** over the next 10 years

Section 1.

Overview of Governance Arrangements

The strategic direction for the role and contribution of social work and social care services in protecting and improving the wellbeing and outcomes of Midlothian residents sits within the context of community planning, and the integration of health and social care. The Midlothian Community Planning Partnership jointly deliver the Single Midlothian Plan which sets out its 4 priorities:

Reducing the gap in learning outcomes
Reducing the gap in heal outcomes
Reducing the gap in economic circumstances
Reducing carbon emissions in Midlothian to net zero by 2030

Social work services in Midlothian are delivered between Midlothian Council and Midlothian Integration Joint Board. Adult social work and social care services, including health visiting and school nursing services and justice social work are delegated to the IJB and delivered and managed by the Midlothian Health and Social Care Partnership services. Children's social work services are managed and governed by the council and part of the People and Partnership Directorate.

The role of the **Chief Social Work Officer** has just transferred to the Chief Officer for Children's Services, Partnerships and Communities in July 2021 following the departure of the previous Head of Adult Services who also held the CSWO role. Social work and social care services play a vital role in championing and addressing the impact of poverty and inequality in the lives of vulnerable people and are well placed to inform the prevention and early intervention agenda that is embedded in the key strategic plans for Midlothian. Most social work functions take place within the context of joint operational working with colleagues within the H&SCP and council services and across key partner agencies including the third sector. The principle strategic partnerships that lead and direct the work to protect and improve the lives of vulnerable people are:

- East and Midlothian Public Protection Committee (EMPPC)
- Getting it Right for every Child - Midlothian Children's Strategic Partnership (CSP)
- Midlothian Health and Social Care Partnership (MH&SCP)
- Midlothian Community Justice Partnership (CJP)
- MELDAP (Mid and East Lothian Drug and Alcohol Partnership)

Section 2.

Service Quality and Performance –

Justice Social Work:

Unpaid work team delivered **3568** **hot meals**

8924 hours remain outstanding for unpaid work group

35 clients gained **SCQF recognised qualifications**

15 active **Spring service users**

The Covid-19 pandemic has challenged all services including Justice Social Work and Community Justice. Adapting service delivery within the context of limited face-to-face contact has impacted on both service users and staff. The use of technology has been at the forefront of service delivery to provide consistency of contact giving some predictability in the pandemic. In line with 'Connecting Scotland', funding was sourced to ensure that digital poverty was addressed via the use of tablets and smart phones as well as data. Of which 400 top ups were provided. Continuation of the No.11 Allocations Service has been hugely beneficial to those individuals who were liberated from Scottish Prison Service establishments as part of the early release programme. Data gathered since the inception in 2019 of the No 11 Allocations Service shows that every individual liberated from HMP to Midlothian has an offer of suitable accommodation, voluntary support through Change Grow Live and if necessary substance misuse support.

Addressing employability during the pandemic became a greater need particularly for those within Midlothian communities who were involved with the justice system. Training sessions were delivered to staff in conjunction with Recruit with Conviction, a project that promotes safe, suitable and sustainable employment for people with convictions. This was to ensure frontline workers understood the legislative changes within the Management of Offenders Act (Scotland) Act 2019, which came into force on 30 November 2020.

The partnership continues to monitor actions within Community Justice Outcome Improvement Plan 2020-2023. Relaying the importance of Community Justice and increasing awareness is embedded throughout the actions within the plan. To aid this, Midlothian's Community Justice Toolkit has been developed. This is now a compulsory learning module for all Midlothian Council Staff and will be available for partnership agencies and for young people in Midlothian's High schools.

Multi Agency Public Protection Arrangements (MAPPA)

Due to Covid-19, 20/21 was a challenging one in many respects, not least for the ongoing management of those who are assessed at risk of serious harm. At the end of 20/21 there were a total of 13 such offenders being managed by Justice Services within Midlothian. Throughout the last year agencies have continued to work effectively together to share information and to ensure that appropriate risk management strategies are in place.

The overall total number of individuals convicted of sexual offences and managed within our MAPPA processes was 54, the vast majority of whom are managed at MAPPA level 1. The numbers managed under MAPPA within Midlothian has remained fairly static over the last 2 years. The Justice Social

Work Service are the Responsible Authority for 21 individuals who have committed a sexual offence and are managed under MAPPA arrangements. The ability of all agencies to adapt to new ways of working, as a result of the pandemic, has been monitored and reviewed. The most recent quarterly audit of cases managed by both Justice Social Work Services and the Sex Offending Police Unit highlighted good practice and positive examples of multi-agency working.

The Team continue to work closely with colleagues on the Sex Offender Policing Unit and are aware of the potential for the lockdowns, which were part of managing Covid-19, to have increased the incidents of sexually harmful behaviour online.

Unpaid Work

The 2020/21 reporting year proved to be a challenging time for the Unpaid Work Team due to the impact of the Covid 19 pandemic and the associated lockdowns. Despite restrictions in place for much of the year the unpaid work team found new and creative ways to support both our clients and the communities that we serve. Our staff assisted with making telephone calls to those who had received shielding letters from the government to ensure that they had received and understood their advice letter and to promote the services available to them. The team also assisted local foodbanks and community larders by collecting groceries that were being donated from shops and supermarkets and transporting these to their distributions hubs.
In addition to supporting our communities the Unpaid Work Team maintained regular telephone contact with our service users to support and manage the risks of the client group during a time of unprecedented stress. The team were trained in using, and training service users in the use of Naloxone to assist colleagues from the Substance Misuse Service minimise risks of overdose at a time when clients were having less face to face appointments with support services. The Team also delivered interventions including an individual offending behaviour pack to help promote client's desistance from further offending and to promote their engagement with the virtual recovery community.

Despite the reduction in work placements and face to face contact the Unpaid Work Team developed and implemented a training pathway for clients. This new pathway starts with all clients undertaking a Scottish Credit and Qualifications Framework (SCQF) award at Level 4 in Health and Safety. Working with the Community Lifelong Learning Team (CLL) a further pathway has been developed to allow clients to undertake a variety of training courses including: an adult achievement award, CSCS card (needed to work on building sites), digital skills, an introduction to wellbeing or to work to improve their literacy and numeracy skills.

The Covid 19 pandemic resulted in the reduction in cases being dealt with by our local Court (Edinburgh Sheriff Court) and in the last year the team received 42 new Orders with conditions of unpaid work. This was significantly down on previous years, although as placements were unable to go ahead for much of the reporting year a backlog of hours started to build. The Scottish Government in recognition of the growing backlog brought in legislation to allow a 35% reduction in outstanding Orders. Due to social distancing, the size of unpaid work groups remain smaller than in the past and to support the Team getting through this backlog of hours a further unpaid work supervisor is being employed to increase the capacity of our team. This will also assist the Team prepare for any increase in work from Edinburgh Sheriff Court who will be employing expanded opening hours from September 2021 to get through their own backlog work.

Men's Group Work Service

The Midlothian Community Justice Outcome Improvement Plan 2020-2023 was published in April 2020 and sets out 40 actions that Midlothian Community Justice Partnership will take forward over the coming three years to deliver better outcomes for those affected by the justice system.

The Men's Group will be facilitated by social workers (from Justice and the Substance Misuse Service) and peer support workers with lived experience. The expectation is that all men placed on a CPO will be considered for the Men's Service. It is hopeful that as the group develops, other external services that aim to promote better outcomes for men will become involved. The Men's Group is set to start in mid-June 2021.

Women's Group Work Service – Midlothian Spring Service

The Spring service has continued to develop as an example of a trauma informed and gendered specific service, supporting women who are affected by histories of complex trauma and have issues with substance use, mental health and/or offending behaviour. Spring is a collaborative service, involving staff from Women's Aid East and Midlothian (women's support worker), Access to Industry (Shine worker), Health in Mind (Peer support worker), NHS (Spring Occupational Therapist and Health Inequalities Team nurse) and Justice Social Work (Spring Social Worker, Caledonian Women's Worker and Justice Social Worker). Research indicates that there are significant benefits to creating a 'one stop shop', where women can access support for all of their needs under one roof.

There are currently 15 active service users and 22 women on the waiting list. Developments in the service have included revising the 'Stepping Stones' programme, which is renamed 'Stepping Forward'. The key focus of these

changes has been on integrating the theme of emotional regulation and distress management throughout all 11 sessions. The Spring Occupational Therapist has focused her time on refining the Stepping Forward programme and updating the afternoon sessions, focused on 'steps to wellbeing'.

Despite the challenges of Covid-19 women still reported improvements; 83% of women reporting improvements in 'identity and self-esteem' and 83% of women indicating an improvement in 'trust and 'hope' (these findings are based on the domains within the outcomes star for recovery). Both of these domains are often scored very low for women who have experienced trauma and are identified as being significant barriers to recovery. Therefore, achieving improvements in these domains is a key outcome measure for the service.

765 children attended a hub or early years setting over the summer of April 20-21

Midlothian has **2 children's houses** run by Council which care for young people aged 12-18

4% rise in **Children Protection** referrals

25% rise in **Domestic abuse** referrals

34% rise in **financial assistance** claims

Over **100** children discussed in Team around the Child meetings

COVID 19 brought unprecedented times and associated challenges across the whole of Children's Services. At the commencement of Covid-19 the People and Partnership Directorate agreed the need to work together and share resources during school closures to make sure that all vulnerable families were supported. A directorate wide guidance document which included a gatekeeping process was introduced to review referrals for families in need and provide appropriate supports including 1:1 youth work and places at early years and school hubs.

The Care Inspectorate managed to complete their : **Joint Inspection of services for children and young people in need of care and protection in Midlothian before Covid-19 lock down happened at the end of March 2020.** The following grades were awarded;

- Leadership and Direction – GOOD
- Impact on Families – GOOD
- Impact on Children and Young People – GOOD
- Improvement in the safety, wellbeing and life chances of vulnerable children and young people – GOOD

Following the inspection we are working collaboratively with partners in health, police, education, SCRA and the third sector, to implement the areas identified for improvement. The plan will be monitored via the GIRFEC Board.

The joint inspection highlighted the positive impact of our Early Intervention approach across the partnership which supports the identification and management of risk at an early stage of intervention. Relationships with colleagues in partner agencies have continued to strengthen and this is supported by the work of our two Early Intervention and Prevention Development Officers.

Despite the impact of COVID, Team around the Child (TATC) meetings continued to take place between April 2020 and March 2021 with referrals received from 9 different referral sources. The annual evaluation of TATC acknowledges a lack of available family supports for 5-12 age group. This is something the group will look into in 2021. An audit was undertaken in relation to secondary school wellbeing meetings with positive results.

The LAC attainment fund, jointly shared between education and children's services, agreed to employ 3 x children and families practitioners in an effort to drive down poor attendance and to support improved attainment. A positive evaluation of the intervention of these practitioners has been completed evidencing improved outcomes for the children and young people. In partnership with one of our commissioned services Artlink, we supported the development of the project, which now offers therapeutic

intervention for young people who are offending, LAC young people and those experiencing mental health issues.

The Youth Justice Strategy was completed and signed off by the GIRFEC board in September 2020.

Safe and Together

Over the past year we have delivered nine 'Domestic Abuse: Revised Approaches in Midlothian' briefings to 125 people across the council and are training a further 19 workers in the Safe and Together core principles. Nine managers are also completing the supervisory training. Our second annual audit is due for completion which shall evidence how the training is impacting on practice.

We are continuing to develop the Families First Perpetrator programme and are now rolling out referrals into this programme to partner agencies. We acknowledge that we need to continue to develop work with perpetrators of Domestic Abuse and are in the process of introducing a Developing Dads Group that will create informal steps to engage with Safe and Together principles to support preparatory work to reflect on the impact of their behaviour on family functioning.

Income maximisation

In September 2020 an income maximisation worker was commissioned via Penicuik CAB with a remit to work with families where children were either on the child protection register or subject to a CSO at home. Between October and the end of December 2020 this worker received 21 referrals which led to 10 direct contacts with parents. Outcomes of these referrals have evidenced an encouraging start with an evidenced service user financial gain of £5,757.50. A number of parents were also signposted onto other services for additional support i.e. fuel poverty, employment etc. We have commissioned this service for a further year.

Children Services – Looked after population

At the time of writing this report, we have 235 who are looked out with their parents care and 32 who are looked after at home with a compulsory supervision order in place via the children's hearing system. The numbers change on a daily basis. Within Midlothian, the numbers of children being looked after has reduced year on year as our commitment and focus is towards keeping families together where safe to do so, in line with the recommendations from The Promise.

Much of the change can be attributed towards building local capacity and capability within our services. In particular, our move towards earlier intervention, increased outreach and strengthening families. The development of the Family Group Decision Making project has enabled a shift in the balance of care towards family care.

Family Group Decision Making

Following the success of the pilot exercise we have now embedded FGDM into our mainstream work. Since October 2020 – January 2021, the service received 25 referrals with only two families choosing not to engage. This decrease in non-engagement demonstrates that with the appropriate resources local families will engage. This is an area of work that will continue to grow as we divert resources to earlier intervention and preventative work.

Midlothian Council – Young People's Houses

To strengthen the skills and capability of our staff working in our care homes we provided a range of learning and development opportunities. This included safe and together, confident staff-confident children, trauma informed and relationship based practice. We also introduced a nurturing approach throughout our care homes. An overarching document called 'Building Positive Relationships' was introduced after consultation with staff and carers from across the Local Authority.

While the impact of COVID cannot be underestimated in terms of how it has affected our most vulnerable young people, it is a testament to our staff that our young people have coped remarkably well during the pandemic. Our care staff continued to provide a high level of care and support throughout the pandemic through changing shift patterns and working in bubbles, despite dealing with a number of COVID related matters on a personal level.

External Residential Provision

Children's Services have seen a marked reduction in children and young people being placed externally. However, our recent data suggests that there is a real change in the age and profile of the few children who have been placed externally, mainly due to the level of distress and trauma these children aged between 5-12 years present. Some young children are unable to cope with the intimacy, which is part of family living, and can only cope with a residential provision at that point in their lives. In February 2021 Children's Services were fortunate that the Elected Members agreed funding to purchase a house which will deliver a local therapeutic environment for a maximum of 3 children to help them heal and recover from their previous experiences and in doing so be able to be reintroduced into family living. A project board has

been established to begin planning with the aim of being fully functioning in April 2022.

Foster Care – Midlothian

We currently have 52 fostering households in Midlothian and the team who support the carers have the responsibility for recruiting and assessing all potential foster carers. The recruitment of foster carers remains an ongoing challenge. This can be due to resignations or because some elect to permanently care or adopt the child/ren for whom they care for. While this is a good outcome for children it has an impact on our ability to provide resources for children and young people.

Adoption Service

In the last year the team have undertaken 4 adoption assessments and are currently involved in 4 step parent adoptions, this is an increase of assessments compared with previous years.
As well as the recruitment and assessment the team are heavily involved in working with other children's services workers in relation to preparing children for living with alternative families, whether this be a permanent carers or adopter. The team 'track and family find' for individual children.

Continuing Care Service

We currently have 38 young people in Midlothian who are supported and cared for under a continuing care arrangement and 12 carers who have been formally approved as adult carers for those young people. When the young person moves on the carers will revert to being foster carers.

Kinship Care

Historically, Midlothian have had high numbers of kinship carers though we have noted an increase in the number of kinship placements during Covid-19 and believe this is in part due to the success of the Family Group Decision Making Project . Whilst this growth area is to be welcomed, we do acknowledge that our current kinship resources are directed towards the assessment and care planning demands of kinship care. As a consequence, there is little time to provide early interventions and supports within the wider community. Our proposal is that we align early intervention and engagement with kinship care alongside the Family Group Decision Making Service.

Independent Reviewing Team (IRO)

Despite the Covid-19 challenges and a slight delay while workers and families adapted to using virtual technology, Child Protection Case Conferences and Looked after Child Reviews continued to take place. Again this is testament to the commitment of social workers, partner agencies and families who have worked together to address the many challenges these changes have brought.

Type of Review	Number of children reviewed between March 2020 – February 2021	
Child Protection Case Conference	243	
LAAC Review	321	
LAC Review	129	
	Total: 693	

National House Project (NHP)

The NHP was officially launched in Midlothian on 1 July 2020. Between 1 July 2020 and 30 September 2020, 10 young people were successful in gaining a place on the project. The young people are all care experienced and come from a range of placement/care backgrounds. A steering group was established with representation from: NHP; Children's Services; Residential Services; Police Scotland; Housing Services; NHS Lothian; Community and Lifelong Learning; Skills Development Scotland and the 3rd sector (Gorebridge Community Cares). As part of the initial stages of the project, an updated housing nomination document was developed and as such, Housing Services have committed 6 properties per cohort. Meetings have been organised with the 3 Housing Associations who have indicated an interest in supporting the project. In early 2021 a successful application was made to Connecting Scotland for 30 iPads/Chromebooks (including Wi-Fi) to support the young people involved in the NHP.
An official press release was issued on 28 October 2020 which received positive and significant press and social media interest.

Complex Needs and Challenging Behaviour (including Lothian Exceptional Needs Group (LENS)
Five young people with complex and challenging behaviours reside in long stay houses in Woodburn and Penicuik. Action for Children and Barnardos are commissioned by Midlothian Council to manage these houses. A third house (2 bedded) has more recently been established.

0-12 years Practice Team

Permanence planning remains the primary focus for the 0-12 Team. The 0-12 Team have operated throughout the pandemic and where possible have endeavoured to progress care planning for children in care. Nevertheless, for a variety of different reasons, COVID-19 has impacted on certain cases and as such, there are a few examples of timescales not being in line with the very high practice standard set via our PACE work. We shall endeavour to ensure we focus on this work over the coming year.

12+ Practice Team

This service user group can often be chaotic and unpredictable and this requires the team to be flexible, creative and realistic in their approach. The team are passionate about promoting the life chances of care experienced young people (CEYP) and will often go to extraordinary lengths to achieve a positive outcome for a young person. The team have established relationships with a number of stakeholders, including: NHS Lothian; local schools/colleges; Police Scotland; National House Project; Community Lifelong Learning and Justice. The partnership work with the Community Lifelong Learning team is a particular example where a collaborative approach is helping to keep young people in local schools and communities where ordinarily they would be at risk of accommodation and/or school exclusion. It is extremely rare for the 12+ Team to remove a child from their home/community setting – this practice and culture has developed over time and is aligned to the current national drivers mainly The Promise.

Corporate Parenting

Midlothian Council's revised Corporate Parenting Plan (2020-2023) is currently being reviewed and updated. Our Corporate Parenting Board meets 4 times a year to review the plan. In addition to the Corporate Parenting Board and in order to widen and encourage participation with CEYP, there are a range of groups held, including: a fortnightly core group for 12-26 year olds; monthly satellite groups at each of Midlothian's secondary schools and sessions for the mini-champs (under 12s). All of the groups focus on the positives and negatives of care in Midlothian, with a key focus on education; employment; health & safety; housing; care; communication and relationships.

Hawthorn Family Learning Centre

COVID-19 has had a profound impact on Hawthorn and the way the service has been run. Most significantly, restrictions have limited the ability to provide day care and family support in the usual fashion. And yet it provided opportunities to learn, to try new and creative solutions and continue to develop our service and support for families and the community.The team were an active part in providing whole family support via a Hub in March – August 2020 supporting existing children, their siblings and new families. Over 18 weeks of lockdown and school holidays, Hawthorn provided 89 days of support. This included support for 121 children from 63 vulnerable families. During this time, 2162 children crossed the door, were provided food and supported with learning and activities.

The community engagement during COVID-19 lockdown and the increase of referrals has evidenced the changing nature of the service and the change in the community perception of the support that Hawthorn can provide. Based on the learning from COVID-19 Hawthorn has made a range of changes to make referral and induction to the service easier, to reintroduce 3-5 placements, routinely provide home learning packs and extend our registration and support from birth to the end of primary school.

Going forward the national drivers around UNCRC, The Promise and Child Poverty are all large areas of work that will impact upon Children's Services. In the coming year we shall ensure we are able to contribute to these significant issues at a national and local level to support change and improve service provision.

Midlothian Health and Social Care Partnership

Midlothian Health and Social Care Partnership (HSCP) brings NHS Lothian and Midlothian Council together and is responsible for services that help Midlothian residents to live well and get support when they need it. This includes all community health and social care services for adults in Midlothian and some hospital-based services such as Accident and Emergency.

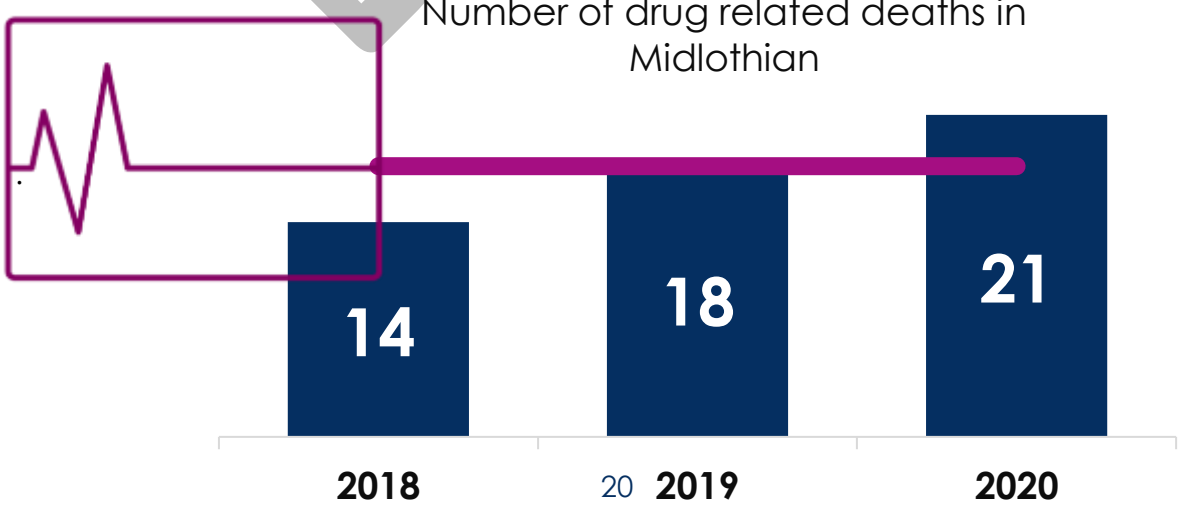
1,623 carers received an **adult support plan**

2,278 carers received 1o1 support by **VOCAL** during 2020-21

316 carers accessed short breaks

Midlothian has **10 care homes** for older people - 8 privately run and 2 run by H&SCP

Number of drug related deaths in Midlothian



Three year average (17.66)

The Midlothian Integrated Joint Board (IJB) has governance responsibility for the services that the Health and Social Care Partnership delivers and manages the allocation of the budget, approximately £131million a year. The IJB gives instructions to Midlothian Council, NHS Lothian, or both on the key actions they need to deliver for the

VISION

People in Midlothian are enabled to lead longer and healthier lives.

Values

Our services will provide the right support for you, at the right time and in the right place.

HSCP COVID-19 Response

The COVID-19 pandemic brought many challenges and much disruption to the Health and Social Pare Partnership, its partners and the communities it serves. There was increased anxiety and pressure on many service users, unpaid carers and staff. While challenges may have changed over 2020, they continued into 2021.

As a Partnership, the top priority was the safety of clients, communities and staff. In response to the situation it was important to be innovative and support clients effectively and safely during this time. Staff continued to see people face-to-face where this was clinically essential, but in order to reduce face-to-face contact, where feasible, teams made a number of changes to how they delivered services throughout the pandemic.

Care Homes for Older people

Health Boards and local Health and Social Care Partnerships continue to carry responsibilities for the clinical and professional oversight of the care provided to people resident in care homes in line with the Scottish Government guidelines (May 2020). Midlothian HSCP has local mechanisms in place to deliver its responsibilities and to link its work with pan-Lothian and national mechanisms.

Midlothian Care Home Support Team identified significant concerns about the quality of care being delivered to residents in Thornlea Care Home in November 2020. Following an inspection by the Care Inspectorate in December, the Care Inspectorate applied to the Sheriff Court to suspend its registration, and the Care Home was closed on 18th January 2021. Appropriate alternative accommodation was arranged for the remaining residents and

significant HSCP resources were deployed to support the safe care of residents over the transition period. This incident represents a very difficult period for the residents and their families, and the staff involved.

Midlothian's Care Home Support Team has been funded to have increased capacity and provides a proactive and preventative support approach as well as a reactive response where care homes need additional support/advice/training. They provide advice, support and education directly and maintain strong links with Lothian-wide specialist teams, enabling the provision of additional specialist infection prevention and control, tissue viability, clinical education and quality improvement support. Partnership working with these teams, the Care Inspectorate and the social work teams within the Midlothian Health and Social Care Partnership delivers multidisciplinary perspectives on the care and support of older people within our local care homes. This enables proactive support of the delivery of person-centred care, and regular input to address issues and challenges being faced in the care homes as they arise using risk assessment skills to drive informal approaches and more formal procedures as required.

Substantial support has been provided to care homes for older people to address the challenges faced throughout the Covid-19 pandemic. Examples include the provision of direct support to meet staffing challenges, input to meet the complex care needs of individual residents, vaccination, testing of staff and residents, support with the reintroduction of visiting and providing practical and emotional support to staff affected by the impacts of the loss of residents in unprecedented numbers. Quality improvement approaches have been utilised to develop checklists to build on the learning the team has acquired and to ensure a thorough and consistent approach.

The Midlothian 'Care home rapid rundown' takes place three times per week and provides regular senior oversight of emerging issues and improvement work and the opportunity to discuss any concerns raised by Care Home managers and/ or identified by the Care Home Support Team. The data gathered by the Care Home Support Team and that which is entered directly into the national 'TURAS' safety huddle tool enables local assessment of risk and the provision of assurance around staffing, care standards and the actions in place to address the risks posed to care home residents by the COVID -19 virus.

Midlothian HSCP continues to work closely with partners including Midlothian Council, NHS Lothian, the Care Inspectorate and Scottish Care. The Care Home workforce is an area of ongoing development and this will continue to be a focus for 2021. Midlothian is one of the partners involved in the plans to develop a Lothian Care Academy to provide a route into health and social care work.

Drug related deaths

The local substance misuse team has robust links with the fortnightly Lothian wide drug related death meeting where trends, data, and up to date intelligence around street drugs are discussed. Standard harm reduction and Take-Home Naloxone training are part of one to one work in the service. Pathways are established to support people being released from prison and a new initiative to provide medication assisted treatment to people in police custody is in development.

Midlothian is the pilot site for 2 of the 10 new Medication Assisted Treatment (MAT) standards. The MAT standard 3 pilot offers assertive outreach to individuals identified at a weekly multi-agency huddle as having experienced a near fatal overdose. MAT standard 9 aims to provide an integrated, person centred mental health and substance misuse service to people who present to Substance Misuse Services with a concurrent mental health problem.

Care at Home

There was one internal and three externally contracted providers in Midlothian delivering Care at Home to older people in 2020-21. Within the Care at Home service an enablement model was adopted and this enabled MERRIT carers to co-work with intermediate care to facilitate patient flow. This work continues.

Support to Unpaid Carers

In early 2021 services were re-commissioned in line with changes in Carer's Act legislation and the Midlothian carer support service review and comprehensive consultation undertaken in 2020 on this foundation.

Work continued to support carers in partnership with local organisations, in particular VOCAL Midlothian but also Alzheimer's Scotland and others. While traditional respite options were very limited due to the pandemic, especially for older people, alternative support to carers was progressed and additional funds were provided for Wee Breaks. Social Workers and others including VOCAL also discussed alternative ways to use SDS budgets.

Services to People under 18 Years

Health visiting recruitment continued on rolling basis across Lothian. Health Visitors continued to manage larger caseloads with support from Nursery Nurses, as maternity leave and sickness absence impacted on staffing levels.

Nursery Nursing is fully staffed and only a small vacancy gap remains in HV admin.

Work continues to achieve full implementation of the Universal Pathway; work will be undertaken to achieve full implementation once COVID restrictions ease and the effects on capacity that staffing issues have created are fully resolved and we expect this to be addressed by November 2021.

Learning & Development

Offered **9** placements to **social work students**

7 students completed and **graduated to become social workers** during last year

2 social workers completed Practice Educators

3 completed Link worker training

Developing the workforce continues to be a key priority for the Council and for the Midlothian Health & Social Care Partnership. Over the last 18 months it has proved particularly challenging to provide the essential training for the registered workforce to ensure they meet the requirements of the SSSC and the services are Care Inspectorate compliant. The Practice Learning and Development team have sought alternative models and forums to deliver training/assessment including the rapid induction for new care staff during the height of the Covid Pandemic in 2020.

NQSWs: We have continued to support our NQSWs by adapting support sessions to online delivery and have increased our support by working with Borders and East Lothian to offer a bi-monthly joint session for NQSWs across authorities- this has been well received and evaluated.

Children & Families: We were able to adapt some of our core training to an online format and have delivered regular sessions on Mental Health & Suicide Awareness; Child Protection level 1 and Domestic Abuse and Safe & Together (co-delivered with Safe & Together Champions).

In terms of postgraduate study staff members have access to: Leadership & Management, Adult Support & Protection, Child Welfare & Protection, Occupational Therapy, Dementia Studies, Practice Education and the Mental Health Officer Award.

It has been particularly challenging to keep up to date with Team Teach training to new staff and refresher training due to the nature of the training that needs to be face to face. This was ceased last year, however this was re-established this year with around 100 staff receiving Team Teach training to date.

The SVQ Assessment centre has managed to continue working and supporting staff with their qualifications despite the restrictions – all be it to a lesser extent. However a successful external verifier visit that was highly complementary about the SVQ Assessment centre is testimony to the team and their diligence to keep going and adapting approaches to support staff achieve their qualifications. We are recruiting an additional SVQ assessor to support the team to increase resource to ensure all new staff and existing staff have access to an SVQ assessor in a timely manner to complete their qualification for registration within the appropriate timescales.

Achievements with SVQ for 2020/21

- Early years Modern Apprenticeships Level 3 (CYP) 56 completed, plus 25 in process
- Foundation Apprenticeships - 10 from year one completed NPA CYP and 9 Year twos completed whole qualification **CYP** = 19 and **H & SC** – 9 completed
- Commenced another 10 year ones
- Level 2 in H&SC = 20
- Level 3 in H&SC = 3
- Level 4 in H&SC = 5
- Level 3 in CYP = 8

- Level 4 in CYP = 2
- Level 4 in Management = 8 = 5
- IV award = 1
- Assessor Award = 4

There are many programmes in place commencing August 2021 which will include Community Justice – supporting unpaid work people to complete SVQ's while undertaking the unpaid work. In addition Foster Carers in Midlothian as well as, Childminders in Midlothian and East Lothian.

The challenges facing the delivery of learning & development for the workforce continue to reflect the national picture. As the pressure on operational staff increases, the ability to release staff for essential learning & development is challenging for managers in frontline services. The Learning & Development staff continue to liaise closely with managers in order to design the delivery of learning and development as closely as possible to meet their needs/capacity for release of staff.

Public Protection

The East Lothian and Midlothian Public Protection Committee (EMPPC) is the local strategic partnership responsible for the overview of policy and practice in relation to Adult Protection, Child Protection, Offender Management and Violence Against Women and Girls. The primary aim of the Committee is to provide leadership and strategic oversight of Public Protection activity and performance across East Lothian and Midlothian. It discharges its functions through four sub groups.

Over the past year due to the impact of Covid-19,we established a senior managers' partnership meeting on a weekly, then fortnightly basis. This provided the opportunity for additional information sharing about the impact of the COVID pandemic restrictions on service delivery, staffing and the operational delivery of the work of the East and Midlothian Public Protection Office (EMPPO) in its support of the work of the EMPPC and associated sub-groups. This arrangement enabled us to have a dynamic and early response to emerging issues and risks and in line with phases of lockdown and restrictions and issuing of national Guidance.

Adult Support and Protection**:** Midlothian received 453 referrals, a 3.25% reduction over the previous year. Police, followed by Health, were the largest single referrer accounting for 29% of referrals. In Midlothian over the past year the most common type of harm investigate under ASP was financial and the most common category of client group with an ASP investigation was 'infirmity due to age accounting for 45% of referrals.

Child Protection: In light of Covid-19 we produced local interim guidance to supplement the national child protection guidance which reflected our own local procedures. Hubs were quickly established to children who required to be in school and for those whose parents were deemed to be part of the critical workforce. During the year we implemented the national child protection minimum dataset to review our performance data on an academic quarterly basis.

Violence against women and girls: The impact of Covid-19 upon the number of referrals relating to domestic abuse seen a slight reduction of referrals from police (1.1%). There was also a decrease of 3.4% of the number of sexual crimes report to police over the year. Given a second lockdown happened during this reporting period it was acknowledged that the ability to report these type of crimes was restricted due to lack of opportunity for the victim and not all services offering face-to-face contact.

Conclusion

This past year has continued to be a challenge for social work and social care staff with Covid-19 remaining the focus of much of our work. The competing demands of still having to manage, for some on a daily basis, the impact of Covid-19 and the impact this has on our workforce remain very much a live issue. Whilst the vaccination programme has been a success and invaluable in protecting us by reducing the numbers of people being admitted to hospital, we continue to face many challenges as we enter another winter. This coupled with the very busy landscape in social work services around new national policies and the National Care Service Consultation, which has just arrived in our inboxes means that the year ahead will require significant input from us as leaders.

The NCS and the proposed reforms around social care and social work represent one of the most significant pieces of public service reform to be proposed. The proposed inclusion of children's service and justice were not foreseen at the beginning of these discussions, and I hope when writing the next CSWO report in 2022 we have had the opportunity and time to fully consult and appreciate both the positives and the risks such proposals may bring.

Finally, my thanks once again to all staff during what has and continues to be a very challenging time.

APPENDIX 1

The Midlothian Community Justice Outcome Improvement Plan 2020-2023

APPENDIX 2

Report of a joint inspection of service for children and young people in need of care and protection in Midlothian - August 2020

APPENDIX 3

Integrated Children's Services Plan- September 2020

APPENDIX 4

East and Midlothian Public Protection Annual Report 2020

For access to these Reports, please contact Lorraine O'Malley, PA at Email – Lorraine.O'Malley@midlothian.gov.uk