Item : 4

DRAFT MINUTE OF
ARGYLL & BUTE HEALTH & SOCIAL CARE PARTNERSHIP (HSCP)
INTEGRATION JOINT BOARD
WEDNESDAY 29 MARCH 2017, COUNCIL CHAMBERS, KILMORY

Present :

Councillor Kieron Green	Argyll & Bute Council (Chair)
Robin Creelman	NHS Highland Non-Executive Board Member (Vice Chair)
Christina West	Chief Officer, Argyll & Bute HSCP
David Alston	NHS Highland Chair
Elaine Wilkinson	NHS Highland Non-Executive Board Member
Dr Michael Hall	Associate Medical Director, Argyll & Bute HSCP
Caroline Whyte	Chief Financial Officer, Argyll & Bute HSCP
Louise Long	Chief Social Work Officer
Dr Richard Wilson	GP Representative
Dr Peter Thorpe	Secondary Care Adviser, Argyll & Bute HSCP
Liz Higgins	Lead Nurse, Argyll & Bute HSCP
Elaine Garman	Public Health Specialist, Argyll & Bute HSCP
Anne Gent	Director of Human Resources, NHS Highland (VC)
Linda Currie	AHP Lead
Fiona Thomson	Lead Pharmacist
Denis McGlennon	Independent Sector Representative
Glenn Heritage	Argyll & Bute Third Sector Interface
Elizabeth Rhodick	Public Representative
Catriona Spink	Unpaid Carer Representative
Heather Grier	Unpaid Carer Representative
Councillor Mary-Jean Devon	Argyll & Bute Council
Councillor Anne Horn	Argyll & Bute Council
Councillor Elaine Robertson	Argyll & Bute Council
Kevin McIntosh	Staff Representative (Council)
Dawn MacDonald	Staff Representative (NHS)
Stephen Whiston	Head of Strategic Planning & Performance
Lorraine Paterson	Head of Adult Services (West
Allen Stevenson	Head of Adult Services (East)
David Ritchie	Communications Manager (Health)

Attending :

Douglas Hendry	Standards Officer
Annie MacLeod	Locality Manager, Oban, Lorn & Isles
Caroline Champion	Public Involvement Manager
Alex Taylor	Interim Head of Children & Families
Sheena Clark	PA to Chief Officer (Minutes)

Apologies : Maggie McCowan, Public Representative

ITEM	DETAIL	ACTION
1	**WELCOME**	
	The Chair welcomed everyone to the meeting.	
2	**APOLOGIES**	
	Apologies were as noted.	
3	**DECLARATIONS OF INTEREST**	
	Agenda item 5.3 - Councillor Devon advised that she is an ordained Elder of the Church of Scotland.	
4	**DRAFT MINUTE OF INTEGRATION JOINT BOARD 25-01-17 & ACTION LOG**	
	Heidi May, Director of Nursing and Fiona Thompson, Lead Pharmacist were in attendance at the meeting on 25 January 2017. The Minutes were approved. There were no matters arising.	
5	**BUSINESS**	
5.1	**Engagement & Consultation Feedback** Struan Lodge & Cowal Community Redesign – the Head of Adult Services (East) presented the report, outlining the planning and delivery of a number of public engagement events which gave the community, stakeholders and staff the opportunity to participate in discussions regarding the future redesign of Struan Lodge. The completed Feedback Report captured the key themes noted from the engagement events, Survey Monkey and completed questionnaires. The Struan Lodge Development Group (SLDG) launched their Strategy for Integrated Adult Care on 6 March 2017 and will be considered within the context of the Health & Social Care Partnership Strategic Plan. A further report will be brought to the IJB meeting in May 2017 which will address the points raised by IJB members today regarding availability of appropriate care and assistance, and will set out key recommendations and milestones which fit with the aims and objectives of the Strategic Plan. *The IJB noted the completion of the communication & engagement events; the key themes identified within the feedback report; the contribution by the Cowal Communication & Engagement Group; the content of the report by the SLDG; a further report will be presented to the IJB in May 2017.* Thomson Court Day Centre & Bute Community Redesign - the Head of Adult Services (East) presented the report, outlining the planning and	

	delivery of a number of public engagement events which gave the community, stakeholders and staff the opportunity to participate in discussions regarding the future redesign of services at Thomson Court Day Care Service. The IJB considered the recommendation that a new enhanced model of day service is developed to meet the needs of a growing frail/elderly population, retaining the existing day service and enhancing the support available to elderly people with dementia and frailty. In progressing this work the following areas of home care will be reviewed and monitored in developing the enhanced model. • Assessment of risks • Carer training as a unit • Time slots • 24 hour care availability • Capacity of volunteers and process for monitoring The Public Health Specialist stated that IJB's decision should be based on the knowledge of clear assessments of risk and a clear communication regarding risk of all models and services. *The IJB noted the completion of the communication & engagement events; the key themes identified within the feedback report; the contribution by the Bute Communication Group; agreed a new enhanced model of day service is delivered as detailed; noted a new service specification will be developed as detailed; noted the savings target of £20k will be met as detailed.*	**AS**
5.2	**Finance** **Budget Monitoring** – the Chief Financial Officer reported a projected year-end overspend of £0.7m at end January 2017. This is primarily in relation to the deliverability of the Quality & Finance Plan, the cost of medical locums and an increased demand for social care services. *The IJB noted the overall integrated budget monitoring report; noted the projected year-end overspend of £0.7m; noted the progress on delivering the Quality & Finance Plan and the shortfall in delivering savings; agreed the previously approved financial recovery plan requires to continue to be implemented.* **IJB Reserves Policy** – the Chief Financial Officer summarised the paper and advised that a reserves policy requires to be in place when the IJB are asked to set out the budget for 2017-18 and 2018-19. The policy sets out the framework under which reserves will be held and will be linked to the budget setting process of the IJB. *The IJB noted the contents of the report and approved the Reserves*	

Policy for the Argyll & Bute IJB

Integrated Budget Report 2017-18 to 2018-19 – the Chief Financial Officer informed the IJB of the budget gap of £11m for 2017-18 and £9m for 2018-19, a cumulative total of £20m. The IJB was asked to approve the proposed Quality & Finance Plan for 2017-18 to 2018-19 and to approve the Investment Plan to facilitate delivery of the service change to deliver financial savings of £11.6m across the two years. Further proposals to address the remaining budget gap of £8.4m are being developed and these will be presented to the IJB for approval at the end of May 2017.

The detail of the report and the proposals were extensively discussed by the IJB. Councillor Devon, Councillor Robertson and Councillor Horn voiced their concerns in relation to the deliverability of the Quality & Finance Plan in relation to service provision.

Members of the Strategic Management Team (SMT) emphasised that the outlined service changes are in line with the delivery of the Strategic Plan objectives which were agreed by the IJB. The impact of any further required savings would be further assessed by the SMT.

The Chief Financial Officer referred to section 3.8 of the report, Monitoring and Implementation, which provided information on the monitoring process in both operational and financial terms and detailed the process to provide the IJB with assurance that safeguarding issues in relation to service changes will be brought back to the IJB for approval if they are not in line with the principles set out in the report.

The IJB noted the overall budget position and resulting budget gap as detailed; approved the proposed Quality & Finance Plan as detailed; approved the principles for monitoring and implementation of the plan; approved the investment plan; noted the remaining budget gap as detailed; noted the requirement to engage with the Council and Health Board partners as detailed; noted the financial offers from the partners cannot be accepted at this stage as detailed.

Councillor Horn dissented on approving the proposed Quality & Finance Plan; approving the principles for monitoring and implementing the plan as detailed and approving the investment plan as detailed.

Proposed Quality & Finance Plan 2017-19 Communication Feedback – following engagement events during February and March, the report outlined the outcome of the initial community and staff engagement feedback. This work was carried out to provide the IJB with assurance that the HSCP's approach to communication and engagement activities is in line with Statutory Guidance CEL 4 (2010) and specifically the "informing" stage. As the deadline for responses is 31 March 2017 the report will be updated to reflect all feedback received. The full report will thereafter be published and available

	online. There was recognition by members of the IJB that it is important to clarify the public's understanding of the detailed information being presented to them at the engagement events. A demographic breakdown of who attended the events would inform the HSCP's arrangements of future communication and engagement activities to ensure the inclusion of those not being represented, i.e. young people and those who are vulnerable and hard to reach. *The IJB noted the content of the report and the plans for future events.*	
5.3	**Auchinlee Care Home Update** – the Head of Adult Services (West) updated the IJB on the expected closure of Auchinlee Care Home by end March 2018. Following a meeting of all parties it was acknowledged that the current care model was not safe or sustainable in the short term. It was agreed in principle that none of the current residents, subject to their individual needs and client choice, should be placed outwith Kintyre. A transitional period was agreed to develop a local alternative for the residents and a plan for an intermediate model of care is in place. The additional financial cost of £291k for the transitional arrangement is not currently included within the delegated budget for social care services. The IJB directed the Chief Officer to engage with the Council to request ring-fenced funding and an assurance of funding for any additional cost pressures which may occur as a result of this transitional period. The Vice-Chair also requested that the Council is approached to consider funding being available from the financial reserves. *The IJB noted the update; considered the outcome of the work to extend the operation of the home for a maximum of 12 months; considered the implications regarding risk; noted the estimated cost pressure of £291k; agreed the partnership arrangements; agreed the funding mechanism to progress the transition process, including an approach to Argyll & Bute Council.*	
5.4	**Performance Report** The Head of Strategic Planning & Performance summarised the detailed reporting on the HSCP's performance against National Health & Wellbeing Outcomes 5, 6, 7 and 8 for quarter 3. He highlighted Outcome 7, service users are safe from harm – there are 12 indicators being measured against this outcome, 9 are on track and 3 are off track and Outcome 8 – health & social care workers are supported – there are 4 indicators measured against this outcome – all 4 are off track. Ms Wilkinson queried the reported position for Outcome 5 in relation to the	

	reported rate of emergency admissions. Mr Whiston will discuss with Ms Wilkinson outwith the meeting. *The IJB noted the HSCP's performance against the reported outcomes; noted and discussed the actions identified to address deficiencies; noted the new performance indicators across 6 domains in 2017/18.*	**SW**
5.5	**Public Health Report – Obesity/Healthy Weight** The report presented by the Public Health Specialist advised that obesity is the biggest preventable burden on our economy, affecting people at all ages and stages in their lives. Child & adult healthy weight should not be thought of in isolation but in a collaborative way, creating healthy communities, developing and implementing local initiatives and linking to national campaigns to support the overall aim of reducing obesity. *The IJB noted the work that is being undertaken in partnership to promote healthy weight in Argyll & Bute.*	
5.6	**Clinical Care & Governance and Infection Prevention & Control** The Lead Nurse presented the report. Significant Adverse Events (SAER) – there are 13 SAERs at various stages of review. Details of reviewing, monitoring of actions and learning from events will be included in next report to the IJB. Significant Case Reviews (SCR) – there are currently 2 initial SCRs being undertaken in Argyll & Bute. Oban Laboratory – following the recent inspections a number of recommendations have been progressed as detailed in the report. Infection Control – during the reporting period 1 April 2016 to end February 2017, there were 8 cases of Staphylococcus aureus (SAB) and 13 cases of Clostridium difficile (CDI). Information on the context of the cases will be included in the next report to the IJB *The IJB noted the content of the report, the risks identified and the risk management plans.*	**EH** **EH**
5.7	**Staff Governance** The report provided updates on : • Employee Survey (Council) and iMatter (NHS)	

	• Organisation Change and Service Redesign • Employee Redundancy and Redeployment Position • Roll out of NHS Electronic Employment Support System (eESS) • Workforce Planninng • Terms & Conditions • Workforce Performance – Sickness Absence - *The IJB noted the content of the quarterly report on staff governance performance in the Health & Social Care Partnership.*	
5.8	**Chief Officer Report** The Chief Officer provided the IJB with a summary of her report. The Chief Officer formally congratulated Louise Long on her appointment as Chief Officer/Corporate Director of Inverclyde Health & Social Care Partnership and thanked her for her contribution to the IJB. Alex Taylor has been appointed as interim Head of Children & Families. Allen Stevenson will take over as Chief Social Work Advisor to the Council and IJB, commencing in May. Robin Creelman has been formally appointed as Chair of the IJB by NHS Highland Board, taking over at the conclusion of Councillor Green's term of office. *The IJB noted the Chief Officer Report*	
	Date of Next Meeting : Wednesday 31 May 2017 at 1.30pm in Army Cadet Drill Hall, Manse Brae, Lochgilphead (behind St Margaret's Church)	

ACTION LOG

– INTEGRATION JOINT BOARD 29-03-17

	ACTION	LEAD	TIMESCALE	STATUS
1	IT support to be looked at regarding Webex use for IJB meetings.	Christina West		Ongoing
2	Progress service redesign proposals as detailed in the templates.	Heads of Service		Ongoing
3	Equality Impact Assessments as noted.	Heads of Service		Ongoing
4	Review and monitor operational areas of homecare when developing Thomson Court Service Specification	Allen Stevenson		Ongoing
5	Significant Adverse Events – information to be included in next Clinical & Care Governance Report	Liz Higgins	May 17	
6	Infection Control – context of cases - information to be included in next Clinical & Care Governance Report	Liz Higgins	May 17	

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.1a

Date of Meeting: **31 May 2017**

Title of Report: **Freedom of Information Compliance - Publication Scheme for Approval**

Presented by: **Iain Jackson**
Governance & Risk Manager, Argyll & Bute Council

The Integration Joint Board is asked to:

Note the contents of this report.

1. EXECUTIVE SUMMARY

Argyll and Bute Integration Joint Board became subject to the Freedom of Information (Scotland) Act 2002 (FOISA) and the Environmental Information (Scotland) Regulations (the EIRs) 2004 (collectively known as "FOI law") on 27 June 2015.

It therefore has a duty under Section 23(1) of FOISA, to adopt and maintain a publication scheme which sets out the information that it publishes proactively and how to access it.

The publication scheme attached at appendix 1 has been approved by the Office of the Scottish Information Commissioner (OSIC) and the Board are requested to note the position.

2. INTRODUCTION

Argyll and Bute Integration Joint Board became subject to the Freedom of Information (Scotland) Act 2002 (FOISA) and the Environmental Information (Scotland) Regulations (the EIRs) 2004 (collectively known as "FOI law") on 27 June 2015.

3. DETAIL OF REPORT

The IJB has a duty under Section 23(1) of FOISA, to adopt and maintain a publication scheme which sets out the information that it publishes proactively and how to access it. The publication scheme is a model developed by the Office of the Scottish Information Commissioner (OSIC).

The scheme attached at appendix 1 was approved by the Office of the Scottish Information Commissioner (OSIC) on 13 April and it has been published on both the Council's and the NHS's websites at https://www.argyll-bute.gov.uk/health-and-social-care-partnership and http://www.nhshighland.scot.nhs.uk/Meetings/ArgyllBute/Pages/Welcome.aspx respectively.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact - Nil

5.2 Staff Governance - Nil

5.3 Clinical Governance - Nil

6. EQUALITY & DIVERSITY IMPLICATIONS

Nil

7. RISK ASSESSMENT

Nil

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Nil

9. CONCLUSIONS

This requirement for the IJB to have a publication scheme is a statutory obligation.

ARGYLL AND BUTE INTEGRATION JOINT BOARD

Publication Scheme: Guide to Information

1. PURPOSE

1.1 Argyll and Bute Integration Joint Board (IJB) is responsible for the strategic planning and reporting of a range of health and social care services delegated to it by NHS Highland Health Board and Argyll and Bute Council (described in full within its approved Integration Scheme). The Council and the IJB discharge the operational delivery of those delegated services through the partnership arrangement referred to as Argyll and Bute Health & Social Care Partnership. The IJB is responsible for the operational oversight of Argyll and Bute Health & Social Care Partnership (HSCP).

1.2 The Integration Joint Board's:

- Vision is to deliver services that help people in Argyll and Bute to live longer, healthier, happier and independent lives.
- Mission is to work with communities to improve health, support social care, tackle health inequalities and improve community wellbeing.
- The Core values are person centered care, integrity, engaged, caring, compassionate and respectful.

1.3 The IJB is a legal entity in its own right created by Parliamentary Order, following ministerial approval of its Integration Scheme (as per the Public Bodies [Joint Working] Act 2014). The IJB regards its publications and records as major assets, with its records an essential resource for the efficient and effective fulfilment of its governance, business and legal responsibilities.

1.4 The IJB became subject to the Freedom of Information (Scotland) Act 2002 when it was established on the 1 April 2016. Freedom of Information (Scotland) Act 2002 (the Act) requires Scottish public authorities to adopt and maintain a publication scheme as part of their legal obligation to:

- Publish the classes of information that they make routinely available.
- Tell the public how to access the information they publish and whether information is available free of charge or on payment.

1.5 We have adopted the Model Publication scheme produced by the Scottish Information Commissioner: www.itspublicknowledge.info/PublicationSchemeGuidance.
Our aim in adopting the Commissioner's Model Publication Scheme and in maintaining this Guide to Information is to be as open as possible.

1.6 The Model Publication Scheme is underpinned by six principles:

1.6.1 Principle One: Availability and formats

- Information published through this model scheme should, wherever possible, be made available on the authority's website.
- There must be an alternative arrangement for people who do not wish to, or who cannot, access the information either online or by inspection at the authority's premises. An authority may e.g., arrange to send out information in paper copy on request (although there may be a charge for doing so).

1.6.2 Principle Two: Exempt Information

- If information described by the classes cannot be published and is exempt under Scotland's freedom of information laws e.g., sensitive personal data or a trade secret, the authority may withhold the information or provide a redacted version for publication, but it must explain why it has done so.

1.6.3 Principle Three: Copyright and Re-use

- The authority's Guide to Information must include a copyright statement which is consistent with the fair dealing provisions of the Copyright, Designs and Patents Act 1988. Where the authority does not hold the copyright in information it publishes, this should be made clear.
- Any conditions applied to the re-use of published information must be consistent with the Re-Use of Public Sector Information Regulations 2015.
- The Commissioner recommends that authorities adopt the Open Government Licence and/or the non-commercial Government Licence, produced by The National Archives for their published information.

1.6.4 Principle Four: Charges

- The Guide to Information must contain a charging schedule, explaining any charges and how they will be calculated.
- No charge may be made to view information on the authority's website or at its premises, except where there is a fee set by other legislation e.g., for access to some registers.
- The authority may charge for computer discs, photocopying, postage and packing and other costs associated with supplying information. The charge must be no more than these elements actually cost the authority e.g. cost per photocopy or postage. There may be no further charges for information in Classes 1 – 7. An exception is made for commercial publications (Class 8) where pricing may be based on market value.

1.6.5 Principle Five: Contact details

- The authority must provide contact details for enquiries about any aspect of the adoption of the model scheme, the authority's Guide to Information and to ask for copies of the authority's published information.
- The Act requires authorities to provide reasonable advice and assistance to anyone who wants to request information which is not published. The authority's Guide to Information must provide contact details to access this help.

1.6.6 Principle Six: Duration

- Once published through the Guide to Information, the information should be available for the current and previous two financial years. Where information has been updated or superseded, only the current version need be available (previous versions may be requested from the authority).

1.7 Our aim is to make our Guide to Information as user-friendly as possible, and we hope that you can access all the information we publish with ease.

Contact Details

1.8 All enquiries, feedback and complaints relating to this Guide to Information, or any other aspect of Freedom of Information or Data Protection should be sent to:

Argyll and Bute Health & Social Care Partnership, Kilmory, Lochgilphead, Argyll, PA31 8RT Tel: 01546 604188; E-mail: iain.jackson@argyll-bute.gov.uk

1.10 You have legal rights to access information under the Model Publication Scheme (as described in this Guide to Information) and a right of appeal to the Scottish Information Commissioner if you are dissatisfied with our response. These rights apply only to information requests made in writing or another recordable format. If you are unhappy with our responses to your request you can ask us to review it and if you are still unhappy, you can make an appeal to:

Scottish Information Commissioner
Kinburn Castle, Doubledykes Road, St Andrews, Fife, KY16 9DS Tel: 01334 464610;
Email: enquiries@itspublicknowledge.info Website:
www.itspublicknowledge.info/YourRights

The Commissioner's website has a guide to this three step process, and operates an enquiry service on Monday to Friday from 9:00am to 5:00pm.

2. ACCESSING INFORMATION UNDER THIS SCHEME

Availability and Formats

2.1 The information published through this Guide to Information is, wherever possible, available on our website: https://www.argyll-bute.gov.uk/health-and-social-care-partnership. If the information you seek is listed in our Guide to Information but is not published on our webpage, we can send it to you by email, wherever possible. If you have any difficulty identifying the information you want to access, then please contact us to help you as above.

2.2 All information in the guide can be made available in hard copy form (i.e. paper copies). Hard copies of information can be requested from us over the telephone or in writing. When writing to us to request information, please include your name and address; full details of the information or documents you would like to receive; and ideally a telephone number so we can telephone you to clarify any details if necessary. If you prefer to visit us to inspect the information, please contact us to make an appointment to view the information.

Copyright and Re-use

2.3 Where the Partnership Board holds the copyright to published information, the information may be copied or reproduced without formal permission, provided that it is copied or reproduced accurately; it is not used in a misleading context; and the source of the material is identified.

2.4 Where the Partnership Board does not hold copyright in information it publishes, we will cite the source/copyright holder appropriately within those publications.

Exempt Information

2.5 Our aim in adopting the Commissioner's Model Publication Scheme and in maintaining this Guide to Information is to be as open as possible. However, there may be limited circumstances where information will be withheld from one of the classes of information listed in Section 3: Classes of Information. Information will only be withheld, however, where the Act expressly permits it. For example, information may be withheld where its disclosure would breach the law of confidentiality; harm an organisation's commercial interests; or if it is another person's personal information, and its release would breach the Data Protection Act.

2.6 Whenever information is withheld we will inform you of this, and will set out why that information cannot be released. Even where information is withheld it will, in many cases, be possible to provide copies with the withheld information edited out. You can complain to us, if you so wish, about any information which has been withheld from you.

Charges

2.7 Unless otherwise stated in Section 3: Classes of Information, all information contained within our scheme is available from us free of charge where it can be viewed online or where it can be sent to you electronically by email. There is no charge to view information online or at our offices.

2.8 However, we reserve the right to impose charges for providing information in paper copy or on computer disc. In the event that a charge is to be levied, you will be advised of the charge and how it has been calculated. Information will not be provided to you until payment has been received. Charges reflect the actual costs of supplying the information (e.g. photocopying and postage), as set out below.

Black & White Photocopying	
A4	10p
A3	20p
Colour Photocopying	
A4	20p
A3	40p
Alternative Formats	
CD-ROM / DVD	£1.00 per copy

Duration

2.9 Once information is published under a class as a minimum we will continue to make it available for the current and previous two financial years.

2.10 Where information has been updated or superseded, only the current version will be available. If you would like to see previous versions, you are welcome to make a request to do so.

3. CLASSES OF INFORMATION

3.1 We publish information that we hold within the following classes as specified by the Scottish Information Commissioner:

Class	Publication Descriptor
1	About Argyll and Bute Integration Joint Board.
2	How Argyll and Bute Integration Joint Board delivers its functions and services.
3	How Argyll and Bute Integration Joint Board takes decisions and what has decided.
4	What Argyll and Bute Integration Joint Board spends and how it spends it.
5	How Argyll and Bute Integration Joint Board manages human, physical and information resources.
6	How Argyll and Bute Integration Joint Board procures goods and services from external providers.
7	How Argyll and Bute Integration Joint Board is performing.
8	Commercial publications.
9	Open data

Class 1: About Argyll and Bute Integration Board.

Class Description: Information about Argyll and Bute Integration Joint Board, who we are and where to find us, how to contact us, how we are managed and our external relations.

The information we publish - How to access it/details of any changes under this class

As per the Public Bodies (Joint Working) Act 2014, Argyll and Bute Integration Joint Board was established on 1 July 2015 as the "body corporate" arrangement to which NHS Highland Health Board and Argyll and Bute Council had agreed to formally delegate health and social care services for adults and children to (i.e. as the Integration Joint Board for Argyll and Bute).

Further background information about the Integration Joint Board is available at: https://www.argyll-bute.gov.uk/health-and-social-care-partnership

General enquiries should be sent to: healthandsocialcare@argyll-bute.gov.uk

Class 2: How Argyll and Bute Integration Joint Board delivers its functions and services.
Class Description: Information about our work, our strategy and policies for delivering functions and services and information for our service users.
The information we publish - How to access it/details of any changes under this class
Argyll and Bute Integration Joint Board is responsible for the strategic planning and reporting of a range of health and social care services delegated to it by NHS Highland Health Board and Argyll and Bute Council. The Council and the Health Board discharge the operational delivery of those delegated services through the partnership arrangement referred to as Argyll and Bute Health & Social Care Partnership. The Integration Joint Board is responsible for the operational oversight of Argyll and Bute Health & Social Care Partnership (HSCP). Integration Scheme for Argyll and Bute is available at: https://www.argyll-bute.gov.uk/health-and-social-care-partnership Argyll and Bute Health & Social Partnership Board's Strategic Plan is available at: https://www.argyll-bute.gov.uk/health-and-social-care-partnership

Class 3: How Argyll and Bute Integration Joint Board takes decisions and what it has decided.	
Class description: Information about the decisions we take, and how we make decisions and how we involve others.	
The information we publish under this class	**How to access it/details of any changes**
Information about those decisions made by the Argyll and Bute Integration Joint and its supportive arrangements are detailed at: https://www.argyll-bute.gov.uk/integration-joint-board-meeting-minutes The procedure and business of the IJB require to be compliant with its Standing Orders: https://www.argyll-bute.gov.uk/health-and-social-care-partnership The Integration Joint Board's approach to involving others is set out within its Participation & Engagement Strategy: https://www.argyll-bute.gov.uk/health-and-social-care-partnership	

Class 4: How Argyll and Bute Integration Joint Board takes decisions and what it has decided.	
Class Description: Information about our strategy for, and management of, financial resources.	
The information we publish under this class	**How to access it/details of any changes**
Details of arrangements for the governance and management of financial resources by Argyll and Bute Integration Joint Board are provided at: https://www.argyll-bute.gov.uk/health-and-social-care-partnership The Integration Joint Board's strategy for the use of financial resources is Integration within its Strategic Plan: http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/SP%202016-2019%20%20Final.pdf Regular financial reports are considered at meetings of the Integration Joint Board: https://www.argyll-bute.gov.uk/integration-joint-board-meeting-minutes The arrangements for and minutes of the Partnership Board's Audit Committee are available at: https://www.argyll-bute.gov.uk/integration-joint-board-meeting-minutes	

Class 5: How Argyll and Bute Integration Joint Board manages human, physical and information resources.	
Class Description: Information about how we manage the human, physical and information resources.	
The information we publish under this class	**How to access it/details of any changes**
Argyll and Bute Integration Joint Board does not directly employ staff, with the exception of an element of the contracted time of the Chief Officer and the Chief Financial Officer – see the Annual Accounts for details: https://www.argyll-bute.gov.uk/health-and-social-care-partnership Staff who work within the management of the HSCP continue to be employed by either the Health Board or the Council (retaining their respective terms and conditions) as described within the HSCP's Workforce & Organisational Development Strategy: https://www.argyll-bute.gov.uk/health-and-social-care-partnership The Partnership Board does not own physical assets – the capital and assets (with their associated running costs) used by the HSCP belong to and are the responsibility of either the Health Board or the Council as per the Integration Scheme: https://www.argyll-bute.gov.uk/health-and-social-care-partnership The Council, the Health Board and the other local authorities within the Health Board area develop, review and maintain an Information Sharing Protocol, which has been extended to include the Partnership Board.	

Class 6: How Argyll and Bute Integration Joint Board procures goods and services from external providers.	
Class Description**:** Information about how we procure goods and services, and our contracts with external providers.	
The information we publish under this class	**How to access it/details of any changes**
It is not the practice of Argyll and Bute Integration Joint to directly procure goods or services, and so it does not hold information in this area. Any procurement related to the operations of the HSCP is undertaken through either the Council or the Health Board (and so those organisations hold that information).	
Class 7: How Argyll and Bute Integration Joint Board is performing.	
Class Description: Information about how we perform as an organisation, and how well we deliver our functions and services	
The information we publish under this class	**How to access it/details of any changes**
Performance information is routinely published: https://www.argyll-bute.gov.uk/health-and-social-care-partnership This includes the Partnership Board's Annual Performance Report: https://www.argyll-bute.gov.uk/health-and-social-care-partnership Regular reports on performance are considered at meetings of the Partnership Board: https://www.argyll-bute.gov.uk/health-and-social-care-partnership	
Class 8: Commercial publications.	
Class Description: Information packaged and made available for sale on a commercial basis and sold at market value through a retail outlet (e.g. bookshop, museum or research journal).	
The information we publish under this class	**How to access it/details of any changes**
Argyll and Bute Integration Joint Board does not publish any material that is packaged and made available for sale on a commercial basis; and so we do not hold any such information.	

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While Argyll and Bute Integration Joint Board does not itself hold open data sets and their metadata (as these are held by the Council and the Health Board) performance information is routinely published: https://www.argyll-bute.gov.uk/health-and-social-care-partnership This includes the Integration Joint Board's Annual Performance Report: https://www.argyll-bute.gov.uk/health-and-social-care-partnership Regular reports on performance and finance are also considered at meetings of the Partnership Board: https://www.argyll-bute.gov.uk/health-and-social-care-partnership	

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.1b

Date of Meeting: **31 May 2017**

Title of Report: **Review of Information Sharing Protocol**

Presented by: **Iain Jackson**
Governance & Risk Manager, Argyll & Bute Council

The Integration Joint Board is asked to:

Note the terms of the report.

1. EXECUTIVE SUMMARY

Argyll and Bute Council and NHS (Highland) entered into an Information Sharing Protocol (ISP) in April 2016, in order to regulate the sharing of information between both organisations as part of the integration of Health and Social Care.

The scheme of integration required a review of the ISP after one year and that review has now been completed.

A slightly amended ISP (appendix 1) has been signed off by all parties and this report is for noting by the IJB

2. INTRODUCTION

The scheme of integration required a review of the ISP after one year and that review has now been completed.

3. DETAIL OF REPORT

A slightly amended ISP (appendix 1) has been signed off by all parties and this report is for noting by the IJB

4. CONTRIBUTION TO STRATEGIC PRIORITIES

Nil

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact - Nil

5.2 Staff Governance - Nil

5.3 Clinical Governance - Nil

6. EQUALITY & DIVERSITY IMPLICATIONS

Nil

7. RISK ASSESSMENT

Nil

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Nil

9. CONCLUSIONS

Argyll and Bute Health and Social Care Partnership

Protocol

for

Sharing Information

between

Argyll and Bute Council

and

NHS Highland

Document Location

The source of the document will be found on Integration Sharepoint Site https://sharepoint.argyll-bute.gov.uk/sites/IntegrationofHealthandSocialCare/Shared%20Documents/Forms/AllItems.aspx

Revision History

Date of this revision: April 2016
Date of Next revision: April 2017

Revision Date	Version	Previous Revision Date	Summary of Changes	Changes Marked
April 2016	1.0		Incorporate feedback/comments from Information Commissioners Office and Integration Programme Board, Nov 2015	
April 2017	1.0	April 2016	Minor changes following input from Legal Services	

Distribution

This document has been distributed to

Name	Title	Date of Issue	Version
Cleland Sneddon	Chief Executive, Argyll and Bute Council	18.04.2017	1.0
Elaine Mead	Chief Executive, NHS Highland	18.04.2017	1.0
Christina West	Chief Officer, Argyll and Bute Health and Social Care Partnership	18.04.2017	1.0
Stephen Whiston	Head of Strategic Planning and Performance, NHS Highland	18.04.2017	1.0
Iain Jackson	Governance and Risk Manager, Argyll and Bute Council	18.04.2017	1.0

1. EXECUTIVE SUMMARY

1.1 Introduction

1.1.1 This document is a binding agreement between Argyll and Bute Council (a Local Authority established in terms of the Local Government etc (Scotland) Act 1994 and having their headquarters as noted at the end of this document Appendix 3) and NHS Highland (an NHS Board established in terms of National Health Service (Scotland) Act 1978 (as amended) (and having their headquarters as noted at the end of this document Appendix 3). This document will refer to them as "Local Authority" and "the Board" throughout or, when referring to them both, to "the Parties".

1.1.2 The Parties positively encourage their staff to share information appropriately about their service users when it benefits their care and when it is necessary to protect vulnerable adults or children. This document describes how the Parties will exchange information with each other - particularly information relating to identifiable living people, known legally as "personal data". The purpose of this document is to explain why the partner organisations want to exchange information with each other and to put in place a framework which will allow this information to be exchanged in ways which respect the rights of the people the information is about, while recognising the circumstances in which staff must share personal data to protect others, without the consent of the individual. This protocol complies with the laws regulating this, particularly the Data Protection Act 1998. This Protocol explains how and when it is permissible to share personal data, either with or without the consent of the individual. This Protocol is intended to provide a high level statement of principles on data sharing and associated issues, and to provide general guidance to staff on sharing or disclosing information. The intention is to enable the appropriate flow of information to enable services to be delivered and to give clear guidance to staff on their responsibility to share information where they have concerns about a third party. Staff must therefore familiarise themselves with the relevant summarised guidance and any local procedures before releasing information to the other Party. This Protocol is also intended to be made available to service users and others whose information may be exchanged, in order to be as open and transparent with those individuals as possible regarding what may happen with their personal information. A template for local guidance, where this is required, is included as Appendix 1.

1.1.3 This Protocol is based upon the Information Commissioners Office code of practice. This Protocol describes, in general terms, the main ways in which information will be exchanged and addresses all the areas mentioned in the Commissioner's Code of Practice. Each area is described in more detail in the corresponding section of the Protocol.

1.1.4 An increasing number of health and social care services are delivered through integrated health teams. For purposes of this Protocol, information handled within an integrated team is generally treated as being processed by both the Parties, rather than to attempt to ascribe it to one or other body.

1.2 Deciding to Share Personal Information

1.2.1 The Board and the Local Authority encourage their staff to share information about their service users for the purposes of better and more effective care and where information sharing is necessary to protect vulnerable adults or children who may not be service users. Information has been shared between the Parties for a number of years for the benefit of clients. Sharing relevant

information leads to benefits for service users in improved and more joined-up services. However, it is important to recognise that legal safeguards are in place to ensure that only relevant information is exchanged in the appropriate way and that it can only be seen by staff that require to see it for the purposes of their job. All staff of the Parties who have access to personal information are contractually obliged to treat it as strictly confidential, and all information exchanged is kept secure by both parties. There will be occasions when information will be shared without consent and these are described later in this Protocol. More detail on this can be found in section 2 below.

1.2.2 This Protocol is concerned with the exchange of information between the Parties. However, both staff and service users should be alerted to the fact that the Parties may exchange information with, or disclose information to, other organisations and agencies who are not a party to this Protocol. This will be governed by the appropriate legislation; the data protection policies and notifications of each Party should be referred to for more information on such exchanges and disclosures.

1.3 Fairness and Transparency

1.3.1 The Parties to this agreement explain the general nature of their data sharing arrangements in a number of ways – leaflets, posters, forms, and through their respective websites – and will continue to do so (and indeed, will continually develop and improve their approach to publicising these arrangements). The minimum content of such explanations is described later in this Protocol. The websites of the respective Parties also include more detailed information for those who wish to find out more. The Parties also have systems in place for dealing with inquiries, including inquiries about these arrangements, and are committed to being as open and transparent as possible about what information is exchanged and why. More detail on this can be found in section 3 below.

Security of Shared Information

1.3.2 The Parties recognise that the sort of information they exchange with each other requires the highest levels of information security. The Parties have strict information security policies which must be applied to information exchanged under this Protocol. All staff having access to shared information have professional and contractual confidentiality obligations which the Parties agree to enforce if necessary. This is reinforced through staff induction procedures and training.

1.4 Information Governance

1.4.1 Information sharing can best achieve improvements in service delivery if the information conforms to certain standards to ensure that it is accurate, up-to-date, and correctly applied to the right person. The Parties have their own systems to monitor and check the quality of the information they hold, including information exchanged with the other Parties. Sharing only takes place where there is no doubt that the information relates to the right person. The Parties have mechanisms for informing the others in the event that information is found to be incorrect, out of date etc.

1.4.2 By law, neither the Board nor the Local Authority are entitled to hold personal information for longer than is necessary. It is, however, not always easy to define how long it will be necessary to hold particular information, as circumstances may change and events may only come to light many years after they originally happened. The Parties will have their own policies on how long to keep different types of records (policies such as this are known as "retention schedules" as they describe how long to retain the different types of document or record). Shared information is covered by the retention schedule of the Party holding it subject to arrangements to ensure consistency of approach between the Parties on this.

Before introducing new methods of processing or sharing personal data it is good practice to consider the benefits as well as the risks and potential negative effects for the individuals to whom the data relates. A Privacy Impact Assessment (PIA) is one method of doing this. This protocol commits each party to conducting such assessments in certain circumstances.

1.5 Individual's rights

1.5.1 Everyone has the right to ask to see what information an organisation holds on them, to object to information about them being processed and to complain about the use of their information or denial of access to it. This Protocol spells out how these rights will be given effect to in a joint working environment. In essence, a request by someone to see the information held which relates to them (known as a "subject access request") addressed to either organisation will be taken to include any information relating to them which has been provided by the other Party, including information on any jointly held databases or held in a joint working environment such as the Argyll and Bute Health and Social Care Partnership.

1.5.2 Both Parties have a policy of being as open with people as possible, but there are circumstances (described in general terms later in this Protocol) where someone will not be given full access to their file. The procedures for subject access operated by the Parties also ensure that the rights of third parties who may be mentioned in someone else's files are adequately respected and, where appropriate, protected.

1.6 Freedom of Information

Both Parties are Scottish public authorities for purposes of the Freedom of Information (Scotland) Act 2002 and must respond to any request for recorded information made to them in a permanent form (such as letter or email). This would include an obligation to respond to requests about information sharing practices and procedures such as the arrangements under this Protocol. It should be noted that the actual personal information exchanged between the Parties will, in almost every case, itself be exempt from disclosure under the freedom of information legislation. All Parties will include this Protocol and its supporting documentation into their respective Publication Schemes.

1.7 Review

1.7.1 Information sharing initiatives will be reviewed regularly to ensure that they continue to meet their objectives in a way which is consistent with the rights of the individuals concerned. This Protocol builds on work previously undertaken between the Parties under previous Protocols. This Protocol will itself be subject to annual review.

2. DECIDING TO SHARE PERSONAL INFORMATION

2.1 The Board has the statutory responsibility to provide or arrange for the provision of a comprehensive range of healthcare, health improvement and health protection services. The Local Authority has the statutory responsibility to provide or arrange for the provision of social care services, education services and a number of other local authority functions which impact on the health and welfare of service users or those they are responsible for. In each case, many of the services the organisations provide can be provided better or more efficiently if there is a joined-up approach to these services – and this can only be done if the organisations are able to exchange relevant information with each other. Specifically, information is shared for the following purposes:

- to improve the quality of services for service users
- to protect vulnerable adults and children, who may or may not be service users themselves
- to provide staff with the information they need to deliver joined-up and integrated services
- to enable each Party to discharge its statutory duties within the joint working environment
- to produce consistent services and information
- to support joint care planning and commissioning.
- to support a single point of access and out of hours services for the community
- to support national initiatives on multi-agency working and information exchange
- to support statutory reporting functions and effective use of resources

- to assist the management teams of the Parties with planning and management information; and
- to enhance the robustness and effectiveness of systems to protect service users and others from harm
- other purposes which may emerge from time to time. Provided the Parties agree that such further uses are necessary and proportionate and that the information exchange underpinning such purposes is consistent with the over-arching principles of this Protocol, then this Protocol shall also apply to such other purposes. Any such additional functions which are identified will be added to this list on the next review of this Protocol and reflected as quickly as possible in the fair processing information made available to clients which is described in Section 3 below. The Parties will exercise a high degree of scrutiny to ensure that any additional purposes identified meet all the necessary requirements of this Protocol.

2.2 Where service planning or other objectives can be achieved equally well using statistical or anonymised data, then this is done in preference to exchanging details about identifiable people. The Parties only exchange information which can identify someone or be related to a specific person where using statistical or anonymised data will not achieve the objective. This approach is in line with the Caldicott Principles which govern the use and dissemination of health service information. The procedures (and this Protocol) are designed to ensure that data sharing between the Parties complies with all applicable law and professional guidance, including the requirements of the Data Protection Act 1998. As the Parties are also public authorities for purposes of the Human Rights Act 1998, this Protocol is also intended to ensure that the right to respect for private and family life laid out in Article 8 of the European Convention on Human Rights is observed and complied with at all times, and that any infringement of that right is a necessary, lawful and proportionate response to a particular situation.

2.3 In order to achieve the improvements in service delivery and the other purposes mentioned in paragraph 2.1, the following sorts of information are exchanged:

- non-personal statistical and financial information derived from personal data
- research data and findings derived from personal data
- standard demographic information about service users and those involved in their care (names, addresses, dates of birth, contact details etc)
- unique personal identifiers (including Community Health Index (CHI) numbers and internal reference numbers)
- the following information in respect of service users or those involved in their care only where relevant to the provision of joint services to those individuals or the protection of the service user and/or others from harm:
    - information concerning physical and mental health and condition
    - medication, aids, adaptations, social supports, therapeutic interventions
    - family history/circumstances and other significant relationships (eg marital status, dependants)
    - social circumstances and environmental factors
    - history of past involvement with any of the Parties
    - financial information
    - detail of enquiries or complaints received from and about service users and those involved in their care
    - history of violent or abusive behaviour
    - criminal record
    - assessment of risk or threat posed to or by an individual

2.4 The law in Scotland makes very few explicit references to sharing information in the way envisaged by this Protocol. Most of the information exchanged is carried out to better achieve the general duties and obligations which the Parties have. Where specific statutory "gateways" exist which authorise particular data exchanges between the Parties, these are utilised where appropriate and with appropriate publicity for those concerned.

2.5 In relation to Health and Social Care, information regarding individuals will be considered sensitive. All sharing of personal information requires to be carried out in light of the legitimate rights and expectations of service users and others, and an awareness of the risk to those individuals. For example will any individual be damaged by data sharing? Are they likely to object to data sharing? Will it damage their trust in either party?

2.6 In all cases, staff will be expected to maintain awareness of such risks and to only exchange information which is relevant to and required for the purposes of data sharing. Information will be accessed only by the staff with a need to see it, and will be kept secure at all times no matter which of the Parties holds it at any given time, in accordance with the data security policies of the Local Authority and/or the Board, as appropriate. All staff of both the Board and the Local Authority who have access to personal information are contractually obliged to treat it as strictly confidential.

2.7 There are also however risks of harm associated with not sharing information in some circumstances. There will be occasions when information about an individual will be shared without their consent, particularly to protect vulnerable adults and children, who may not themselves be service users. If any member of the Parties' staff believes there are risks to a vulnerable person which may be mitigated by sharing personal information, they are obliged to share that information, if necessary without consent. Staff will be expected to exercise good professional judgement in balancing these risks and to always operate within the context of sharing information in a secure, proportionate manner only when necessary to achieve the objectives set out above.

2.8 Otherwise this Protocol proceeds on the basis that information will be shared with the consent of the individual service user (or, if a person cannot consent by reason of age, mental condition etc, with the consent of the person who is legally able to take decisions on their behalf). Such consent must be informed and freely given, and the fact that consent has been given (or withheld, or withdrawn) must be clearly recorded in the appropriate service user file(s). Service users should also be advised as to the consequences which withholding consent may have in terms of affecting the services they can be offered. The status of this consent must be checked before information is released to the other Party. Everyone has the right to decline to give this consent, withdraw it once it has been given, or give consent only to a limited type of information sharing.

2.9 Information may be exchanged without the consent of the individual on the basis of lack of capacity of the individual to consent, or because of concerns or perceived risks regarding the welfare of the individual or others. More specifically, it may be shared without consent in the following circumstances:

2.9.1 if the individual cannot consent due to their age (noting that children aged 12 or above are presumed to have the required capacity to consent or not; if aged less than 12, it is necessary to assess the child's capacity to do so) where it is felt that the child aged less than 12 does not have capacity

then the person having parental rights should be asked to consent on their behalf, in accordance with local guidance procedures;

2.9.2 if the individual has lost the required mental capacity due to a long-term condition, then a person lawfully appointed and able to take welfare decisions on behalf of that person should be asked to consent on their behalf;

2.9.3 if the individual has lost the required mental capacity due to a long-term condition, and there is no person lawfully appointed and able to take welfare decisions on behalf of that person, then the relevant professionals will decide on behalf of that person in accordance with the tests laid down in incapacity legislation, on the basis of the person's known/ascertainable wishes, those of nearest relatives and primary carers etc. In all cases, the paramount consideration will be the welfare of the individual consistent with their expressed wishes;

2.9.4 if a person has lost capacity due to a short-term event (such as unconsciousness), information will only be exchanged where necessary to protect their immediate interests, and then only to the minimum extent necessary;

2.9.5 if one of the Parties' staff has concerns that there are risks to a vulnerable adult or child, information on a service user may be shared without consent

2.9.6 information will be exchanged in terms of the MAPPA arrangements (Multi-Agency Public Protection Arrangements) which the Local Authority, the Board and a range of other public bodies are party to under the laws governing management and supervision of offenders; and

2.9.7 information may be exchanged in relation to suspected serious criminal acts or other seriously improper conduct where no reasonable local authority or health board could fail to act on the information in its possession.

2.10 In any case where mental capacity is an issue, staff will follow procedures laid down in relevant local guidance documentation on how capacity is to be assessed, and will not make unsubstantiated assumptions regarding capacity or otherwise without a proper assessment being carried out.

2.11 In line with legislation and the Information Commissioner's advice, the Parties agree that it is not appropriate to ask for someone's consent in circumstances where the relevant professional staff acting in good faith have taken the view that the information in question will be released whether that consent has been given or not.

2.12 It is anticipated that most data sharing between the parties will be on the basis of routine joint working and pre-planned activities. However there may be instances, particularly urgent or emergency situations, where staff of either party may be asked to share information with staff from the other on an unplanned ad-hoc basis. This could be for a number of reasons, for example, to protect either staff or service users or to ensure emergency provision of services. In these circumstances the person requesting information may not be the person that the other party's member of staff normally deals with. In such situations, the following process should be observed:

2.12.1 The person receiving the request should satisfy themselves as to the identity of the person making the request and their reasons for making the request.

2.12.2 The person receiving the request should ascertain whether the person making the request has obtained the consent of the data subject to data sharing and, if not, should make a decision as to whether the circumstances require that consent should be sought before the data is shared or whether it is reasonable in all circumstances to share the data without seeking consent.

2.12.3 In determining what is reasonable, the staff member should have regard to the balance of risk as outlined at 2.6 – 2.8 above.

2.12.4 If deciding to share information then the data shared should be the minimum necessary to meet the requirements of the situation and data should be shared by the most secure means available.

2.12.5 Both the person making the request and the person providing the information should make a reasonable detailed record that data sharing took place and the reasons for it and include a description of the data shared.

3. FAIRNESS AND TRANSPARENCY

3.1 It is a basic requirement of data protection law that individuals should be told (or easily be able to find out) who is holding information relating to them, what that organisation will do with that information, and who they will pass it on to. In terms of this Protocol, both Parties are "data controllers" of the personal information which they hold, including information which they have received from each other. For joint/integrated team settings, such as those within the Argyll and Bute Health and Social Care Partnership, both Parties are jointly data controllers of information held in the joint team or integrated Partnership. This position should be made clear to any service user who approaches either Party and whose information may be shared under this Protocol.

3.2 The position regarding the identity of the data controller and the arrangements for sharing information between the Parties will be publicised by both Parties in a range of ways: through leaflets, poster, wording added to forms, and on the websites of the Parties. The minimum content of such a privacy notice is described in Appendix 2. The Parties will, through ongoing contact with service users and engagement with them, continue to raise awareness of the content of the privacy notice.

3.3 The content described in Appendix 2 is regarded as the minimum required to comply with the general legal obligation to provide a privacy notice. It is recognised that some service users and others will be interested in receiving much more information than this basic minimum. The Parties agree to respect such wishes by developing more detailed supplemental fair processing information to be provided to interested persons on request and published on their respective websites.

3.4 As described in section 2 above, most information will be exchanged on the basis of the express consent of the individual concerned. Such consent requires to be informed consent and will only be valid if the individual has been given an appropriate privacy notice prior to consenting to what is described. However, as described in paragraphs 2.7, 2.9 and 2.10 there are circumstances where consent is not required. The Parties will, so far as possible, continue to provide appropriate fair processing information to the affected individuals even when their consent is not required (and not asked for) prior to the information being released. However, in some cases this is not appropriate, for example where telling someone about the proposed release of information might actually endanger a child or vulnerable adult. This will only happen in the circumstances described in paragraphs 2.9.5, 2.9.6 or 2.9.7 and even then only where the relevant professionals involved have formed a view that notifying the individual would have undesirable consequences for themselves or someone else.

3.5 The more detailed supplemental fair processing information described in paragraph 3.3 will, in particular, advise people as to when information will be shared without their express consent, and will also advise as to the sorts of activity where the Parties would release information without revealing the fact that they have done so to the individuals concerned.

4. SECURITY OF SHARED INFORMATION

4.1 The information passed between the Board and the Local Authority under this Protocol can include sensitive personal data. The Parties have evaluated the appropriate level of security and have concluded that the highest available levels of both organisational and technical security measures will be applied to this information.

4.2 Both the Board and the Local Authority have information security policies which are designed to protect the information (particularly, but not exclusively, personal information) which they hold. These policies are binding on all staff of the employing Party and disciplinary action could be taken against staff who violate them. The policies apply to information held by that Party, whether it has originated with that Party or been passed to it by the other. Where there is a joint or integrated team, each member of staff continues to be bound by their own organisation's security policy. The governance arrangements for such joint working will address any particular security issues which require to be addressed beyond the scope of the general information security policies. Where the Board and a Local Authority establish any joint databases, the agreements regulating the creation and use of such databases will explicitly assign responsibility for information security to one or the other Party to ensure that this is not overlooked.

4.3 The Parties will review their respective information security policies and associated procedures in the light of this Protocol to ensure that they are compatible with each other. Any identified areas where they are not will be the subject of local guidance designed as a minimum to bring the less secure Party up to the level of the most secure one, and ultimately to bring both Parties up to

the highest available levels of both organisational and technical security measures as indicated in Section 6.1. In addition, the professional staff of both organisations have shared professional values and obligations of confidentiality to service users and may be subject to professional disciplinary action (as well as, or instead of, disciplinary action by their employer) if they breach those obligations. This is emphasised in staff training.

In extreme cases of knowingly and recklessly disclosing personal information without the consent of the data controller, a criminal offence may have been committed and in appropriate circumstances any Party may refer a member of staff (or other individual) to the Police in connection with such an event. Staff disclosing personal data in line with this Protocol and any relevant local procedural guidance will be deemed to be acting with the permission of the data controller and so not be liable to criminal prosecution.

4.4 The Parties will each ensure that the other Party is promptly notified of any security breaches, or significant security risks, affecting shared information. In addition, should the breach be considered significant, the ICO will also be notified. The Parties will, where appropriate, work together to rectify any such breach or mitigate any such risk to information security. If personal data is lost as a result of a security breach, the Parties will consider on a case by case basis whether to notify the affected individuals of the breach.

5. INFORMATION GOVERNANCE

5.1 Information Standards

5.1.1 Shared information only has value if it is accurate and up-to-date. The Local Authority and the Board each have a range of initiatives underway to check the quality and accuracy of the data which they hold, and particular emphasis is placed on checking the accuracy and quality of information to be shared externally. These include case recording audit and revision exercises, supervision of case management procedures and similar data quality exercises.

5.1.2 Similarly, information exchange can only work properly in practice if it is provided in a format which the Party receiving it can utilise.

5.1.3 In all cases of data exchange, local guidance documentation will examine the precise data sets and fields which require to be exchanged in order to achieve a particular objective. These will be subject to periodic review at a local level to ensure the continued relevance of all the information exchanged.

5.1.4 The quality of data is important whether in shared records or in records held by one Party only. The Parties will make arrangements for periodic sampling of records held to evaluate the accuracy and general quality of data held.

5.1.5 The Parties undertake to notify the other as soon as practicable if an error is discovered in information which has been provided to the other Party, to ensure that the Parties are then able to correct their respective records. This will happen whether the error is discovered through existing data quality initiatives or is flagged up through some other route (such as the existence of errors being directly notified to one or other Parties by the data subject's themselves).

5.1.6 The Parties undertake to have in place risk management and disaster recovery processes which protect the integrity of personal data held for the purposes of data sharing or held in any joint databases or held in a joint working environment.

5.1.7 Relevant managers within each organisation will have the responsibility to notify through their own organisation's reporting procedures any significant failing in the systems that hold these data. The Parties undertake to notify each other as soon as practicable if any such failing is identified and is likely to remain unresolved for significant period of time.

5.2 Retention

5.2.1 The Parties have their own policies on how long to keep different types of records (policies such as this are generally known as "retention schedules" as they describe how long to retain the different types of document or record). For some records, the retention period is laid down by law; for others, the Parties determine themselves how long they need to keep the records for. Shared information will be covered by the relevant provision of the holding Party's retention schedule, although it should be noted that it is still also covered by the retention schedule of the originating Party. In terms of operational requirements, the other Parties may not need to keep the information for as long a period as the originating Party, particularly for files with an extremely long statutory retention period. This is covered within the Parties' existing retention schedules

5.2.2 The Parties will ensure that their retention schedules (particularly relating to shared information) will be subject to periodic review to ensure that information is being kept only for as long as it is required.

5.2.3 The respective retention schedules of the Parties describe, where applicable, the relevant statutory or professional regulatory or other guidance which has informed or set the retention period for the information in question.

5.2.4 The Parties have established mechanisms for archiving information which they require to retain for a period but which is not required for normal operational use. Such archiving helps comply with respect for the privacy of those involved by significantly reducing the number of people with potential or actual access to that information.

5.2.5 In general, information exchanged under this Protocol will be shared with the other Party, and the originating Party will have retained a copy of the information for its own continuing use. Against this position, the Parties therefore agree that when information has reached the point where it is no longer required by one Party, that that Party will securely delete or destroy the information (in accordance with good information security practice) rather than returning it to the other Party. In some limited situations the

Parties may be acting as "data processors" for each other. In these instances the originating Party remains the data controller of the information and the other Party is merely acting as their agent, processing the data under instruction. In these circumstances the Party acting as data processor will either delete/destroy the information or return it to the originating Party, as determined by the instructions of the originating Party under the relevant data processing agreement.

5.2.6 Data quality initiatives undertaken by the Parties will include within their scope a review of adherence to the agreed retention periods to ensure these are being applied correctly.

5.3 Privacy Impact assessments (PIA)

5.3.1 A Privacy Impact Assessment is a tool for assessing, prior to implementation, the benefits, risks and potential negative effects of any new or substantive change in the manner of processing or sharing personal data.

5.3.2 Each party agrees to carry out a PIA before implementing any new process involving the use of personal data where either party considers likely to have a substantive or significant impact upon the sharing of data under this protocol or on the use or sharing with third parties of any data that is held on any jointly held databases or held in a joint working environment

5.3.3 Such a PIA will include formal consultation with the other party as to the risks, benefits, privacy implications and potential reputational damage to the parties in introducing the new process and will be in line with guidance produced by the Information Commissioner's Office.

6. INDIVIDUAL'S RIGHTS

6.1 <u>Access to Personal Information</u>

6.1.1 Everyone has the right to ask to see what information an organisation holds which relates to them. The Parties have existing routes to give individuals access to the information held, which are encouraged and should continue to operate even in a joint working environment. However, the routes may not always provide access to complete files, which the formal right covers. This Protocol accordingly spells out how this right will be given effect to in a joint working environment.

6.1.2 The basic principle applied is that a subject access request addressed to either organisation will be taken to include any information relating to them which has been provided by the other Party, including information on any jointly held databases or held in a joint working environment such as a Community Health and Care Partnership. However, if there is any such shared information then a joint team meeting will be held to consider whether specific rules relating to health, social work or education files apply to any of the information concerned (and which might mean the individual is not given access to that information). This joint team meeting will also consider whether it would be appropriate to charge for the access request. The Parties have a policy of being as open with people as possible, but there are circumstances (described in paragraph 7.5 and 7.6 below) where someone will not be given full access to their file.

6.1.3 The Parties have existing procedures for processing subject access requests. It is recognised that not everyone will wish to see all the information held on them but may instead be interested in one particular issue. To facilitate this, and in addition to assisting those who might have difficulty in reading or understanding a copy of their file, the Parties permit individuals to attend their offices and inspect/be talked through their file, with appropriate explanations (and where appropriate, the offer of counselling) from professional staff. The Parties have existing accessibility strategies and access to translating and interpreting services should these be required to facilitate access by those with disabilities or for whom English is not their first language.

6.1.4 Any request to either of the Parties will be taken to include shared information which that Party has access to. The subject access procedures followed by both Parties therefore include searching any joint databases where appropriate, to ensure that all relevant information is located and, unless exempt (on which see paragraph 7.5) provided to the applicant. A request made to a joint team will be processed by whichever of the Parties appears most directly involved with the subject matter of the request.

6.1.5 A service user who wishes to request a copy of all the information on them held by each of the Parties must be advised that this can only be done by making separate requests, one addressed to each Party, from whom they want information.

6.1.6 A subject access request also includes the obligation on the data controller to advise the data subject as to the purpose the information is held and any potential recipients of that information. In terms of this Protocol, the Parties agree that they may refer to the fair processing material described in paragraph 3.3 above, and to this Protocol. Where information has been received by one Party from another, this will be clearly explained to the data subject (and the Parties will ensure that their records management procedures relating to joint working are able to capture this information).

6.2 Withholding data from subject access

6.2.1 The Parties agree that, consistent with their respective obligations under the Data Protection Act 1998 (and regulations made under the Act), not all information exchanged in terms of this Protocol should be released in response to a subject access request. In particular, care needs to be taken in respect of requests relating to Schedule 1 offenders, adults with mental incapacity, children, and deceased persons. The Parties agree to issue local guidance to their staff on how to respond to requests relating to these groups.

6.2.2 Information may be withheld in responding to a subject access for a number of reasons listed in the Data Protection Act 1998. In terms of the information shared in terms of this Protocol, information may be withheld on various grounds. The following are the most obvious examples but this list is not exhaustive and where appropriate (and if necessary following the joint team meeting referred to in paragraph 7.1) information may be withheld on other grounds permitted by the Act or regulations.

6.2.3 Schedule 1 offenders: information may be withheld which would prejudice any ongoing investigations or prosecutions, or would permit confidential witnesses or complainers to be identified, or would increase the risk posed by the offender to third parties; in the case of investigations, the fact that information is being withheld may itself be withheld to avoid tipping someone off about the fact that the investigation is taking place;

6.2.4 Children and adults with incapacity: since by definition the request must be being made by someone acting on the data subject's behalf, information may be withheld if the data subject has made it clear that they did not expect or wish the person acting on their behalf to see the information;

6.2.5 In the case of children, a request may be declined if the Parties feel that the person making the request is exercising their parental rights by making the request other than in the best interests of the child;

6.2.6 Deceased persons: while information relating to deceased persons is not covered by the provisions of the Data Protection Act, the Parties agree that this information remains sensitive and confidential in nature and should be protected by appropriate measures. In general, requests for information relating to the deceased will only be complied with where the law confers such a right (under the Access to Medical Records Act 1987 as amended) or where it can be seen to be compatible with ongoing professional obligations of confidentiality to the deceased person and their right to privacy;

6.2.7 In all cases, information relating to someone other than the immediate data subject may be withheld, other than information about health, social work or education staff (and even this may be withheld if there are concerns over e.g., staff safety);

6.2.8 Where clearly medically indicated, health information may be withheld from a person because providing it to them may cause serious mental or physical harm to the applicant or others;

6.2.9 Information may also be withheld where it would be likely to prejudice the carrying out of social work or health services by causing harm to the physical or mental health of any person;

6.2.10 Information exchanged under the MAPPA arrangements (see paragraph 2.9.7), will almost always be exempt from data protection requests.

6.3 Objections to data processing

6.3.1 Individuals can object where the use of their personal data is causing them substantial, unwarranted damage or distress. This can be an objection to a specific use of information about them or to the fact that either or both Parties hold any information at all on that individual.

6.3.2 If this objection is put in writing by the individual (often referred to as a 'section 10 notice') then the party receiving it is obliged to reply in writing within 21 days. This reply should either confirm that the party intends to comply with the request to stop processing data in the manner specified and the timescale within which this will be done, or should confirm that they find the request unreasonable and do not intend to comply, in which case they must state reasons.

6.3.3 The Parties each agree to have in place procedures to deal with such requests. Where the request covers information on any jointly held databases or held in a joint working environment then the party who receives the request agrees to notify the other party and to jointly discuss the matter before responding.

6.3.4 A person who wishes each of the parties to cease processing information held on them must be advised that this can only be done by submitting separate written notifications, one addressed to each Party.

6.4 Complaints

6.4.1 Individuals may have complaints about how their information is being shared, the accuracy of data held by either party, the fairness of comment and opinion relating to them or the manner in which a request to access data or notice to cease processing has been dealt with.

6.4.2 Each party agrees to deal with such complaints under the complaints procedure in place within their respective organisations.

6.4.3 Each party agrees to analyse and report on complaints received and to communicate to the other party where it appears to them that a significant number of complaints, or one or more complaints of a serious or significant nature, have been received relating to data sharing activities between the two parties. There should then be a joint discussion at management level in order to identify and resolve any problems within the data sharing activity.

7. FREEDOM OF INFORMATION

7.1 As noted above at paragraph 1.8.1, both Parties are Scottish public authorities for purposes of the Freedom of Information (Scotland) Act 2002 (FOISA). In consequence, the Parties are obliged to respond, within twenty working days, to any request for information they receive. They are both additionally required to produce and maintain a Publication Scheme (describing the classes of information which they publish), requiring the approval of the Scottish Information Commissioner. The Publication Schemes of the Parties are available on their respective websites. The Parties will refer to this Protocol and its supporting documentation in their respective Publication Schemes and will include this Protocol and the supporting documentation on their websites for public perusal.

7.2 The Parties' obligations under FOISA include an obligation to respond to requests about information sharing practices and procedures such as the arrangements under this Protocol. Any request for information submitted to either Party will be processed under that Party's existing FOI handling procedures, and if necessary pass up through that Party's internal review procedure if the applicant is dissatisfied. The actual personal information exchanged between the Parties will, in almost every case, itself be exempt from disclosure under FOISA, because exemptions built into the legislation mean that you cannot use FOI to obtain personal information about yourself (the appropriate route for this is a subject access request under the Data Protection Act 1998); nor can it be used to obtain information about someone else except in unusual circumstances. Requests for information submitted to a joint team will be routed through the most appropriate procedure, based on the nature of the request and the information sought, unless the applicant has expressed a preference for the request to be

handled by one Party rather than the other. It should be noted that some information, such as that exchanged under the MAPPA arrangements (see paragraph 2.9.6), will almost always be exempt from both data protection and FOI requests.

7.3 A request for information may include a mixture of both personal information and non-personal information. Such requests require to be handled carefully and may require a joint team meeting to be convened to discuss the most appropriate way of dealing with this. The website of the Scottish Information Commissioner (www.itspublicknowledge.info) includes detailed guidance on this issue and should be referred to in appropriate cases.

8. REVIEW

8.1 Existing data sharing protocols cease to have effect on the day this Protocol is signed by the Chief Executives of the Parties. This Protocol itself will continue in force until it is superseded by another Protocol in due course, or if both Parties agree to terminate it. Either Party may withdraw on giving six months' notice in writing of its intention to do so.

8.2 The Parties will also review this Protocol and the operational arrangements which give effect to it, if any of the following events takes place:

8.2.1 One (or more) of the Parties is found to have breached the terms of this Protocol in any significant way, including any data security breach or data loss in respect of personal data which is subject to this Protocol;

8.2.2 Any Party indicates that it intends to withdraw from this Protocol; or

Any such unscheduled review may be either in respect of the entire Protocol, or only in respect of the elements of the Protocol directly relating to the event which triggered the review.

8.3 The local guidance procedures and other documentation to be issued under this Protocol will be subject to document control and approval procedures agreed jointly by the Parties affected by the procedures in question.

8.4 If there is a dispute between the Parties concerning this Protocol, the Parties shall attempt to settle matters amicably on the basis of their respective professional perspectives. If a dispute cannot be resolved by the officers immediately concerned, they shall both escalate matters to a higher management tier, and ultimately to their respective Chief Executives IN WITNESS WHEREOF this information sharing protocol consisting of this and the twelve preceding pages, together with the two appendices attached, are signed for and on behalf of the Parties as follows:

Executed for and on behalf of:	NHS Highland
Signature	
Name (Print)	Elaine Mead
Job Title (Print)	Chief Executive
Date of Signature (Print)	
Location	Assynt House, Inverness

Executed for and on behalf of:	Argyll and Bute Council
Signature	
Name (Print)	Cleland Sneddon
Job Title (Print)	Chief Executive
Date of Signature (Print)	
Location	Kilmory, Lochgilphead

Executed for and on behalf of:	Argyll and Bute Health and Social Care Partnership
Signature	
Name (Print)	Christina West
Job Title (Print)	Chief Officer
Date of Signature (Print)	
Location	Aros, Lochgilphead

Appendix 1: Template for local guidance procedures

Introduction

This template exists to assist in identifying the key procedures that will be used to allow the legal sharing of information between partner agencies in providing effective joint services to their users.
Type in your response to each area and attach this document to the information sharing protocol. Together this then forms both a legal and procedural framework document for information sharing.

1. Aims and Responsibilities:

State the aims of your service here.

2. Information storage

How many formats will information be stored in. (i.e. Paper systems, electronic systems including spreadsheets etc.) Give brief descriptions of each one.

3. Information Sharing / Security

State when and how in the course of your work that information may get shared and any procedures that are followed in facilitating for this. Is data shared by written format, joint access to systems etc. Who has access to this data? How is this access monitored?

4. Consent Issues:

How are Service Users made aware of consent issues? How is consent obtained – by whom? How is this recorded? How are staff made aware of the client/patients consent? State any current procedures adhered to.

5. Care management

State briefly how a persons care is managed from assessment through to service provision and what methods are used for recording by various parties involved (ie paper file, electronic, CareFirst etc)

6. Retention of information

Give details of any relevant procedures for retention and archiving of data and include relevant link or contact to obtain access to this document

7. Subject access

The Local Authorities and NHS Greater Glasgow and Clyde have separate procedures to comply with the requirements of the Data Protection Act, and access to personal records (include relevant link or contact to obtain access to this document)

8. Complaints

The Local Authorities and NHS Highland have separate procedures to enable people to complain about any aspect of their services, including breaches of the data-sharing protocol (include relevant link or contact to obtain access to this document)

Appendix 2: Privacy Notice - Minimum Content

The Privacy Notice to be given or made readily available to Service Users whose personal data is or is likely to be shared in terms of the Protocol for sharing information shall as a minimum include the following:

- The identity of the Party whose notice it is;
- The fact that the Parties work jointly to provide improved services;
- The fact that such joint working requires information to be shared in order to work properly;
- The fact that such information will only be shared between the Parties in accordance with agreed policies and procedures with the result that
    - information will (except in exceptional circumstances) only be shared with the Service User's consent
    - information is only shared on a need to know basis where it is necessary for the better provision of Services
    - information shall be kept secure and confidential by all Parties and only accessed by the staff who need to access it for purposes of improved service delivery
- All parties may require to disclose information to other public bodies where this is necessary for the provision or detection of crime or the protection of children and vulnerable adults.

Appendix 3: Headquarters

Argyll and Bute Council
Kilmory, Lochgilphead, Argyll, PA31 8RT

NHS Highland
Aros, Blarbuie Road Lochgilphead PA31 8LB

Argyll and Bute Health and Social Care Partnership
Aros, Blarbuie Road Lochgilphead PA31 8LB

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.2

Date of Meeting : 31 May 2017

Title of Report : Elected Member Representation on IJB Audit Committee and Clinical & Care Governance Committee

Presented by : Caroline Whyte, Chief Financial Officer
Liz Higgins, Lead Nurse

The Integration Joint Board is asked to :

- **Note** the changes in membership of the Integration Joint Board and the impact on the representation on the Audit Committee and Clinical & Care Governance Committee
- **Appoint** two elected member representatives to the IJB Audit Committee
- **Appoint** one elected member representative to the Clinical and Care Governance Committee

1. EXECUTIVE SUMMARY

1.1 Following the Local Government Elections and the subsequent changes to elected member representation on the IJB there is a requirement for the IJB to appoint new members to the Audit Committee and Clinical & Care Governance Committee.

1.2 The IJB Audit Committee membership includes two elected members. There is a requirement to appoint two new elected member representatives, one of which will require to be appointed as Vice-Chair of the Audit Committee.

1.3 The Clinical and Care Governance Committee membership includes one elected member. There is a requirement to appoint one new elected member to the Committee.

2. INTRODUCTION

2.1 This report outlines the requirement for the IJB to make new appointments to the Audit Committee and Clinical & Care Governance Committee.

3. DETAIL OF REPORT

Audit Committee

3.1 The IJB Audit Committee Terms of Reference are included as Appendix 1. Membership of the Audit Committee includes six members of the IJB and professional advisors, the current IJB members are noted below:

Elaine Wilkinson (Chair)	NHS Highland Board
Vacancy (Vice-Chair)	Argyll and Bute Council
David Alston	NHS Highland Board
Vacancy	Argyll and Bute Council
Betty Rhodick	IJB Member
Heather Grier	IJB Member

3.2 There is a requirement to appoint two new elected member representatives, one of which will require to be appointed as Vice-Chair of the Audit Committee. The appointment to Vice-Chair cannot be the Chair of Vice-Chair of the IJB.

Clinical and Care Governance Committee

3.3 The draft Clinical and Care Governance Committee Terms of Reference are included as Appendix 2. Membership includes two members of the IJB and professional advisors, the current IJB members are noted below:

Robin Creelman (Chair)	NHS Highland Board
Vacancy	Argyll and Bute Council

3.4 There is a requirement to appoint one new elected member representative to the Clinical and Care Governance Committee.

3.5 Other than the changes to elected member representation on these Committees the membership is assumed to be unaffected and will be reviewed in line with the requirements set out in the Terms of Reference.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

4.1 The IJB require to ensure appropriate arrangements are in place for representation on the sub committees of the IJB.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

None

5.2 Staff Governance

None

5.3 Clinical Governance

5.3.1 Appointment of appropriate membership to the Clinical and Care Governance Committee to ensure oversight of the delivery of safe and effective person-

centred care and the delivery of professional standards of care and practice in Argyll and Bute.

6. EQUALITY & DIVERSITY IMPLICATIONS

None

7. RISK ASSESSMENT

7.1 Risk of non-compliance with the Terms of Reference and agreed representation on Committees if new elected member representatives are not nominated.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None

9. CONCLUSIONS

9.1 The IJB are required to nominate new elected member representatives to the IJB Audit Committee and Clinical and Care Governance Committee to replace the elected members no longer part of the Integration Joint Board. These arrangements would be effective immediately with the new members invited to the next meetings of the respective Committees.

APPENDICES:

Appendix 1 – IJB Audit Committee Terms of Reference
Appendix 2 – Clinical and Care Governance Committee Draft Terms of Reference

Argyll & Bute Health and Social Care Partnership
Integration Joint Board Audit Committee Terms of Reference

1. INTRODUCTION

1.1 The Integration Joint Board (IJB) is required to properly manage its financial affairs. A key component to fulfilling this obligation is to have an Audit Committee.

1.2 The IJB Audit Committee was established as a Standing Committee of the IJB on 29th February 2016.

2. PURPOSE OF THE IJB AUDIT COMMITTEE

The IJB Audit Committee will have a key role with regard to:

2.1 Ensuring sound governance arrangements are in place for the IJB; and

2.2 Ensuring the efficient and effective performance of Argyll & Bute's Health and Social Care Partnership in order to deliver the outcomes set out in the Integration Scheme.

3. CONSTITUTION OF THE IJB AUDIT COMMITTEE

Appointments

3.1 The IJB will make all appointments to the IJB Audit Committee including the appointment of the Chair and Vice-chair of the Committee.

Membership

3.2 The Committee will consist of six members of the IJB. The Committee will include four voting members, two from Health and two from the Council.

Chair and Vice-Chair

3.3 The Chair and Vice-Chair of the IJB Audit Committee will be voting members of the IJB appointed from those members appointed to the IJB Audit Committee; one will be from the Council and one will be from Health. Neither may be the Chair or Vice-Chair of the IJB.

3.4 The appointment of Chair and Vice-Chair will be for a two year term.

3.5 The initial appointments to the IJB Audit Committee, approved on 29th February 2016, were;

Name	Designation
Elaine Wilkinson (Chair)	Non Executive member, NHS Highland
Elaine Robertson (Vice-chair)	Councillor, Argyll & Bute Council
David Alston	Non Executive member, NHS Highland (Chair from 1st April 2016)
Anne Horn	Councillor, Argyll & Bute Council
Heather Grier	Service User Representative - Carer
Betty Rhodick	Service User Representative - Public

Quorum

3.6 Three members of the Committee will constitute a quorum, with at least one of the members being the Chair or Vice-Chair.

Frequency of Meetings

3.7 The Committee will meet at least quarterly.

In Attendance

3.8 The Chief Officer, Chief Finance Officer and Chief Internal Auditor and other professional advisers or their nominated representatives will attend meetings. Other persons may attend meetings by invitation of the Chair.

3.9 The external auditor will be invited to attend meetings of the IJB Audit Committee.

Sub-groups

3.10 The Committee may at its discretion set up working groups for specific tasks. Membership of working groups will be open to anyone whom the IJB Audit Committee considers will be able to assist in the task assigned. The working groups will report their findings and any recommendations to the IJB Audit Committee.

4. POLICY AND DELEGATED AUTHORITY

4.1 The IJB Audit Committee is authorised to request reports and to make recommendations to the IJB on any matter which falls within its Terms of Reference.

5. REMIT

5.1 The IJB Audit Committee will review the overall internal control arrangements of the IJB and make recommendations to the IJB regarding signing of the Governance Statement and any other matters within its Terms of Reference.

5.2 Specific areas of responsibility include:

Performance Monitoring

i. To ensure that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against agreed objectives, levels and standards of service.
ii. To consider reports on performance and to review progress against the national outcomes and the outcomes in the Strategic Plan.

Audit

i. To review and recommend the annual Internal Audit Plan to the IJB.
ii. To oversee and review progress on actions taken on audit recommendations and report to the IJB on these as appropriate.
iii. To consider monitoring reports on the activity of Internal Audit.
iv. To consider External Audit Plans and reports as appropriate; any matters arising from these and management actions identified in response.
v. To review risk management arrangements and receive regular risk management updates and reports.
vi. To ensure compliance with IJB governance arrangements and strategies e.g. Risk Management Strategy, Participation and Engagement Strategy.
vii. To be responsible for setting its own work programme including reviews in order to properly advise the IJB on matters covered by the IJB Audit Committee's Terms of Reference.
viii. To escalate matters of concern to NHS Highland and/or Argyll & Bute Council, as required, for resolution.

Final Accounts

i. To consider the annual financial accounts of the IJB and any related matters before submission to and approval by the IJB.

Standards

i. To promote the highest standards of conduct and professional behaviour by IJB members.
ii. To assist IJB Members in observing the relevant Codes of Conduct.

Appendix 3: Terms of Reference for Clinical and Care Governance Committee

1. PURPOSE OF THE COMMITTEE

- To ensure the delivery of safe and effective person-centred care and the delivery of professional standards of care and practice within Argyll and Bute

- To provide assurance to the Integrated Joint Board that systems, processes and procedures are in place and are delivering effective clinical and care governance throughout Argyll and Bute

This will include the following:

- To develop and monitor clinical and care assurance systems to regulate the quality and safety of health and care services
- To monitor implementation of Care Inspectorate and NHS Healthcare Improvement Scotland clinical standards and other external review body standards and guidelines – such as Mental Welfare Commission, SPSO etc
- To oversee self evaluation and preparation for joint inspections and to oversee local implementation of recommendations following review
- To oversee the review all incidents to identify trends, to take appropriate action and disseminate lessons learnt across Argyll and Bute (and NHS Highland where appropriate)
- To oversee the review of all feedback, including complaints and compliments, to ensure proper management, identify trends and disseminate lessons learnt across Argyll and Bute (and NHS Highland where appropriate)
- To review Significant Event Review findings and ensure completion of resulting action plans
- Overseeing the development, agreement and review of clinical and care procedures, guidelines and protocols for delegated functions of the HSCP. The NHSH Board governance structures should be utilised to ratify clinical policies, guidelines and protocols e.g. the Area Drugs and Therapeutics Committee for policies relating to medicines, similarly the Council structures should be utilised for care procedures, guidelines and protocols where necessary to met legal requirements.
- To oversee the Clinical and Care Governance Risk Register and to ensure that risk management procedures are followed across Argyll and Bute

- To oversee the development of local risk registers and action plans. To identify risks requiring attention and report to the IJB as required
- To ensure that professional standards are adhered to and that systems for governing regulatory requirements for professionals are in place as laid out in the professional Assurance Framework.
- To oversee implementation of framework for professional supervision of clinical and care professionals working in Argyll and Bute

2. REPORTING

The Clinical and Care Governance Committee is accountable to the Integration Joint Board and will provide assurance report for each of the IJB meetings. It will also provide assurance reports, via the IJB to the NHS Highland Clinical Governance Committee and to Argyll and Bute Council .

The CCG Committee will receive reports and advice from the following groups:

- Locality CCG groups
- Specific clinical and care groups e.g. maternity services, blood transfusion, infection control, child protection, adult protection, health and safety

3. HOW THE COMMITTEE WORKS

- The CCG Committee will meet on a regular basis (frequency to be determined by IJB schedule).
- Agendas will follow standard template which will cover all elements of the CCG framework.
- Assurance reports will be developed and delivered in advance of each meeting to ensure that all group members have time to scrutinise and analyse the information.
- CCG Committee will develop briefing for all staff after each meeting covering key points and actions agreed
- CCG Committee will provide assurance report to IJB for each of its meetings
- CCG Committee will provide assurance/exception reports as required by NHS Highland/Argyll and Bute Council

Appendix 4: MEMBERSHIP

NAME	ROLE
Mike Hall	Clinical Director
Liz Higgins	Lead Nurse
Louise Long **Lorraine Paterson** **Allen Stevenson**	Chief Social Work Officer and Head of Children and Families and Criminal Justice Head of Adult Service West Head of Adult Service East
Christina West	Chief Officer
Elaine Garman	Public Health Specialist
Fiona Thomson	Lead Pharmacist
Euan Thomson	Assistant Clinical Dental Director
Linda Currie	Lead AHP,
Fiona Campbell **Julian Gascoigne / Mark Middleton**	Clinical Governance Manager Risk / Health and Safety Managers
Anne Horn	1 Councillor
Robin Creelman	1 Board Non Executive Member
Mike Roberts **TBC**	Patient/Public Representative Patient/Public Representative
TBC	Staffside

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.3

Date of Meeting: 31 May 2017

Title of Report : CARE AT HOME – NEW MODEL OF CARE UPDATE

Presented by : Allen Stevenson

The Integration Joint Board is asked to :

Note the contents of this report with regards to the progress recorded with the implementation of the new model of care for care at home services.

1. EXECUTIVE SUMMARY

1.1. This report aims to update IJB on a report presented to the board in May 2016. The IJB noted Community Services Departmental Management Team in June 2015 agreed the trial of a new model of care. Two trials had been successfully completed and agreement was reached to roll out across all localities.

2. INTRODUCTION

2.1. The Council on behalf of the Argyll and Bute Health and Social Care Partnership (HSCP) have a requirement to commission care at home services, for adult services.

2.2. These services are delivered across all localities and are provided by the third and independent sectors.

2.3. Procurement and Commissioning Team facilitate this commissioning through a range of formal, contractual arrangements.

2.4. The regulator, for all services, is the Care Inspectorate which has statutory powers to carry out regular inspections against the requirements of the National Care Standards and statutory regulations.

2.5. The Council on behalf of the HSCP currently contracts with 15 providers of care at home services for older people, providing a total of 11,200

hours per week to 850 Service users. Spend in this area is significant, approx. £9.9m per year.

2.6. The market for these services in Argyll and Bute can be challenging, the most rural areas are particularly difficult to service and work is ongoing to make packages in these areas more efficient and more sustainable for providers. Work is underway in B&C, H&L and OLI to implement the new model of homecare. The new model is an outcome focused model and is not restricted by times and tasks. Services will be delivered in mapped areas, reducing travel time and freeing up capacity for the sector. This fits with the neighborhood model that the HSCP is currently looking to implement in some localities. Work will commence in MAKI once a decision is reached about the future of in house services. Due to the methodology of the redesign of these services there is no longer a requirement for providers to have a call monitoring system in place. The call monitoring system measures, in the main, when carers arrive and leave visits. In addition it also records continuity of care workers. A decision has been made that the time measuring element of the system is no longer required; however it would be useful for Quality Assurance purposes if providers retained the element around continuity of staff.

3. PROGRESS BY LOCALITY

3.1. HELENSBURGH & LOMOND

Discussions with the providers, staff and Scottish Care commenced in February 2017. These meetings highlighted the need for implementation of the new model to be split in to two phases due to the level of change to current services and the uncertainty surrounding alternate SDS options.

3.1.1. Phase 1 – Remove times and visit durations from Care Plan times for all services. Geographically map and commission care for the outlying areas.

Phase 2 –Geographical map central Helensburgh for the commissioning of care at home services.

3.1.2. The progress so far in Helensburgh has been excellent with all partners recognising the benefit of the proposal and being keen to implement. Providers and Care managers have worked actively with service users and their families/carers to relay the key messages and positives of the proposed changes in order to make the transition as smooth as possible.

3.1.3. Phase 1 was implemented on 1st May 2017. The mapping within this phase affected 30 service users. Early indications from Adult Services staff about this phase are positive. Positive feedback has also been received from Providers advising the changes have allowed staff to prioritise visits on their rotas and a noticeable difference in travel time

that will in turn free up capacity. The Procurement and Commissioning Team intend to carry out a Quality Assurance exercise with all the service users affected by this change later this month; the aim of this is to obtain a balanced view on the implementation of phase 1 and instruct us on how/when to implement phase 2. We have also accessed a small amount of locality ICF slippage to have some contingency in place for a 10 day period, to support the change.

3.1.4. Phase 2 – Map and arrange changes to provision in East and West of Helensburgh. Phase 2 will be planned once the Quality Assurance exercise is complete; we are planning to proceed with this immediately after Phase 1 has been implemented and evaluated. The plan is to implement Phase 2 on 1st July 2017.

3.2. COWAL

3.2.1. Discussions with the providers, staff and Scottish Care commenced in July 2016. These meetings highlighted the need for implementation of the new model to be split in to two phases due to the level of change to current services and the uncertainty surrounding alternate SDS options.

3.2.2. Phase 1 – Remove times and visit durations from Care Plan times. Phase 2 –Geographical map the locality for the commissioning of Care at Home services.

3.2.3. Providers and Case Managers have worked actively with service users and their families/carers where appropriate to relay the key messages and positives of the proposed changes in order to make the transition as smooth as possible, admin support was accessed to ensure all service users and their families had information of any changes that would affect them and were given the opportunity to contact their case manager if they wished to discuss the model further or were unhappy with any of the proposed changes.

3.2.4. Phase 1 was implemented in October 2016, with providers reporting positive changes to the way in which carers can now prioritise/order visits on their rotas and the subsequent reduction in travelling time. This has led to increased availability from providers to timeously facilitate requests for packages of care.

3.2.5. Phase 2 – Phase 2 will be planned following the implementation of Phase 1 on Bute and the evaluation of the implementation for Phase 1 on both Cowal and Bute. HCPOs are pro-actively commissioning as per agreed mapped areas to ensure the impact of change to service users and providers is minimal.

3.2.6. The learning from Helensburgh has been that the small investment from ICF to allow a staff contingency to support this change has been extremely beneficial and should be considered for this locality.

3.3. BUTE

3.3.1. Discussions commenced with the providers and staff in March 2017. It was agreed that Phase 1 would be implemented on Bute alongside a pilot whereby providers would complete the detail on the Care Plan and share with the Case Manager.

3.3.2. Phase 1 and Pilot – Service User letter has been drafted and admin support secured to send to all service users and their families/informal carers where appropriate. Meeting held with care assessment staff. The planned date for implementation has been delayed by three weeks due to resources; planned implementation date is now the 8th of May 2017. Phase 2 –will be planned following the implementation of Phase 1 on Bute and the evaluation of the implementation for Phase 1 on both Cowal and Bute.

3.4. OBAN, LORN & ISLES

3.4.1. Discussions with the providers, staff and Scottish Care commenced in October 2016. These meetings highlighted the need for implementation of the new model to be split in to two phases due to the level of change to current services and the uncertainty surrounding alternate SDS options. Within the Oban locality, the outlying areas were already mapped so the mapping exercise took place for Oban town centre. As with other localities, it was decided to implement the model in 2 phases.

3.4.2. Phase 1 - Removal of Care Plan times and durations of visits was implemented on 1st December. This was met with very little concern by the service users although is taking a bit of time to bed in with HSCP staff and Providers.
Phase 2 – Geographical mapping was due to be implemented from 1st March.

3.4.3. Phase 1 – This is now normal practice for the assessment process. The Providers are working to this model as far as possible although there are still a small amount of service users who are having difficulty in accepting appropriate times. For future commissioned services this will be the norm so eventually, it should not be an issue.

3.4.4. Oban has been experiencing an issue with staffing and recruitment over the last few weeks due to several members of staff leaving. One provider in particular lost a Co-Ordinator and six members of care staff within a four week period. The reasons for staff leaving were variable and the start of the tourist season has had an impact. Three of the six members of staff who resigned are known to be working as personal assistants within Direct Payment services.

3.4.5. Phase 2 - Mapping the town area has been postponed to allow the Providers time to stabilise due to the circumstances noted in 3.4.4. HCPOs are seeking to pro-actively commission services as per agreed

mapped areas to ensure the impact of change to service users and providers is minimal, however, due to the resource difficulties faced by providers in Oban, this is not always possible. Work has to take place to begin to transfer services within the mapped areas to allow the Provider to work within one town area in order to create capacity; this is also proving problematic due to lack of staff resources. Ideally, a floating staff member for a short time would be able to assist with this process; the learning from Helensburgh has been that the small investment from ICF to allow a staff contingency to support this change has been extremely beneficial and should be considered for this locality.

3.5. MID ARGYLL, KINTYRE & ISLAY

3.5.1. Implementation has not started in this locality due to the medication issue facing the in-house service. Once this issue is resolved, planning will commence.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

4.1 Our externally provided care at home service has a vital role to play in the redesign of the health and social care system across Argyll and Bute, as the HSCP develop its locality planning solutions for communities. It is recognised we need to apply more effective commissioning solutions for these services, within localities.

4.2 The plan to move to mapped areas, providing outcome focussed services, in blocks of hours' will assist the Council and Providers to free up capacity within localities in order to meet the HSCP's strategic priorities. In addition this proposal assists the Council to work with the providers to implement the Fair Work Practice agenda.

4.3 For information - Adult Services have been approached by SDS Scotland. They are fine with the methodology around the redesign of the services but raised concerns around service user choice. We have responded to their concerns and assured them that all assessments continue to be carried out using SDS principles and all options will be considered. A further update will be provided to SDS Scotland once the Quality Assurance exercise is completed in Helensburgh.

5. GOVERNANCE IMPLICATIONS

5.1	FINANCIAL IMPACT	None
5.2	STAFF GOVERNANCE	Public Bodies (Joint Working) (Scotland) Act establishing HSCP. National Minimum Wage
5.3	CLINICAL GOVERNANCE	None
5.4	EQUALITY & DIVERSITY	None

	IMPLICATIONS	
5.5	RISK ASSESSMENT	None
5.6	PUBLIC & USER INVOLVEMENT & ENGAGEMENT	Service User consultation to be carries out

6. CONCLUSIONS

This report is an example of intelligent commissioning and will assist the IJB to make small financial efficiencies. More importantly, it releases resource capacity to provide services to people waiting.

It will lead to improved conditions of service for care staff, increased skills in the staff group and to additional flexibility and resources when required.
This model brings Argyll & Bute's Care at Home service into line with partners in Health, where the quality and outcome of the service visit is more important that the time and task associated with it.

APPENDICES

Appendix 1 – Tighnabruich Consultation
Appendix 2 – M&J Consultation

Appendix 1.

Tighnabruaich Consultation

Between Tuesday 15th and Friday 18th March 2016, a consultation was undertaken to seek feedback from stakeholders following a change to the way in which services are delivered in Tighnabruaich, Cowal.

For several months, Allied Healthcare have been successfully delivering care under a blocked hour's model, as opposed to the historic rotas, allocated visiting times and set durations.

Argyll & Bute Council's Procurement and Commissioning Team consulted five supported individuals, two family members, two Allied Carers and one Senior Community Nurse. The consultation was conducted by way of a questionnaire, to allow comparison in answers. All supported individuals were visited at home whilst NHS and Social Care staff participated via telephone and email.

The results of the consultation highlighted that there was a general unawareness of the change in model due to the minimum disruption caused to the delivery of care, except a slight variation in arrival times for visits. Flexibility and responsiveness were reported as being much improved in comparison, particularly by staff members. *"Supported people are not rushed, we have time to adapt to emergencies without worrying we're going to be late for the rest of the day."*

- Mrs M explained she had a fall 6 days prior to my visit, the carer was able to stay with her until the ambulance arrived to provide her with comfort and support in the absence of any family members living locally.

- Other benefits of increased flexibility and responsiveness were; the ability to work around appointments, the reduction in anxiety of both carers and supported people as there is no more 'clock watching'. Increase of availability was quoted as 'peace of mind,' as often, the most complex of care packages are in the most rural areas. Several supported individuals stated that they now have an increased confidence in the service.

- Mrs W suffers from recurring cellulitis. During a good spell she is able to manage the majority of her own personal care with carers providing minimal assistance, however, when her legs are infected she requires

increased supported. Previous to the implementation of the blocked hour's model, carers would be expected to seek authorisation for this increased time in order to assist Mrs W, or they would be running late for the rest of their visits. The new model allows the responsiveness to provide care as it is required without being late for the next planned visit.

- When asked about outcomes, participants of the consultation referred to the personalisation that the new flexibility allows for, providing care that is as changeable as the individuals needs and not to fit in with invoicing and rota computer systems.
  "The model is not one size fits all, it is tailored to the changing needs of the supported person"
  "There are no longer any '15 minute visits. Under this new model the durations of visits are flexible to meet the person's needs on any given day"
  "I do not like my once per week bath carried out by a male carer so the female carers ensure that if he is on duty on the due day, they carry it out on another day"

Participants felt the new model empowers Carers and those supported. The model provides better continuity of care to those who use the service; further promoting privacy, dignity and choice.

"Continuity of care is better than it used to be, I am used to the faces that come in. I can get to know them and they can get to know my wicked sense of humour"

Other comments included;-

"This model displays a better work ethic"
"Having two carers at all times is also a good idea for winter planning and lone working"
"There should be open communication between the care provider and Health & Social Care colleagues surrounding availability to ensure joined up thinking and working"
"Better conditions of working seem to be attracting new carers to the area which is a breath of fresh air"
"Carers are able to help people when they need it without having to call their office for permission"
"I would not be able to remain in my own home without the service".
"In both models the carers value my dignity"
"Could not give a higher recommendation" (to the carers)

Procurement & Commissioning Team
Blocked Hours Consultation Report
Submitted 23/3/2016

Appendix 2

M&J Care – New Model of Care Consultation

Between Friday 29th July and Thursday 18th August, a full consultation was undertaken to seek feedback from service users, staff members and stakeholders following a change to the way in which services are delivered by M&J Care in the Helensburgh & Lomond locality.

For several months, M&J Care have been successfully delivering care under a blocked hour's model, as opposed to the historic rotas, allocated visiting times and set durations.

Argyll & Bute Council's Procurement and Commissioning consulted with 9 service users, 8 M&J carers, 3 Homecare Procurement Officers and 1 Team Leader from the Health and Social Care Partnership. The consultation was conducted by way of a questionnaire, to allow comparison in answers. All service users and M&J staff members were consulted in person by either a member of the PCT or supported by Team Leaders from M&J Care. Health and Social Care Partnership staff participated via email.

The results of the consultation highlighted a mixed view around the awareness of change to the new model of care. Those who were not aware of the change explained this was due to minimal disruption caused to the delivery of care, except from a slight change in times of visits. Those who had an awareness explained that this had been a positive change to services, with more flexibility of carers. Continuity of carers was reported as being much improved in comparison, by both staff members and service users.

Feedback from Service Users:

"I feel that the service is excellent, I am very happy with the regular carers that come in to me"

"I cannot provide anything in particular with regards to improvements as I am very happy with everything".

"I receive the same regular girls to support me and I feel confident that should any extra care need arise they are competent to deal with this".

"It can be a long lonely day and staff that come to see me spend time with me and more when needed".

"Happy with the care M&J provider. No problems with times or flexibility of carers visits'.

"Staff are all kind and caring, they make me feel comfortable. Sometimes they are not always the regular carers but all the girls are nice".

Feedback from M&J Care staff:

"All tasks are being completed and we have that extra time to talk to the clients without feeling rushed".

"Clients have that extra bit of reassurance, and have felt comforted if they are not feeling well that day and we are able to stay that bit longer".

"The new blocks are working really well. I was quite apprehensive when they were first introduced and felt clients would have reduced time with carers and staff would be rushing from service to service. The new model has worked brilliantly for both staff and clients".

"Rota's are now more organised and are running more smoothly. Staff sickness levels have reduced and all staff are enjoying the new model".

"Staff stress levels have decreased with more flexibility in the new blocks".

"New model has improved services. 2 carers has been great in comparison to lone working".

Health and Social Care Partnership staff advised that they had not seen much of a change since the New Model of Care had been introduced. They did note that the number of complaints/service improvements had decreased since the implementation.

On occasions where the need has arose for carers to stay longer, all staff reported that clients were very appreciative that they were able to stay with them. Service User's advised that they felt comforted knowing that carers were there if needed.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.4

Date of Meeting : **31 May 2017**

Title of Report : **Living Wage Update – 2017-18 Uplifts**

Presented by : **Caroline Whyte, Chief Financial Officer**

The Integration Joint Board is asked to :

- **Note** the requirement to offer commissioned care providers an appropriate inflationary uplift to support them to meet the increase in the Scottish Living Wage from £8.25 to £8.45 per hour from 1 May 2017
- **Note** the 2.8% increase in care home placement fees agreed by COSLA following the conclusion of the 2017-18 National Care Home Contract negotiations which is to be implemented from 10 April 2017
- **Agree** to delegate authority to the Chief Officer to negotiate and agree an inflationary uplift for non-residential care providers from 1 May 2017, provided that the total cost does not exceed the total of £2.391m currently provided for in the 2017-18 budget.

1. EXECUTIVE SUMMARY

1.1 In 2016-17 the Scottish Government allocated additional funding to Health and Social Care Partnerships to allow them to support Adult Care Providers who employ care workers to pay the Scottish Living Wage from 1 October 2016, along with meeting various requirements of Fair Work Practices. A detailed financial assessment process was carried out with providers in 2016-17 to ensure they were provided with an uplift that allowed them to fulfil the requirement to pay care workers a minimum of £8.25 per hour. The Scottish Living Wage rate increased to £8.45 from 1 May 2017 and there is a requirement to carry out further negotiations with providers around an appropriate rate uplift that will allow them to meet the requirements of paying their care staff the increased rate.

1.2 The Scottish Government earmarked funding of £100m to HSCPs in 2017-18 to fund Scottish Living Wage costs, this funding is earmarked from the Health baseline funding uplift. For Argyll and Bute the share of £100m is £1.820m and the estimated cost of the implementation of the Living Wage for 2017-18 is £2.391m, a shortfall of £0.571m. An amount totalling £2.391m has been provided for in the 2017-18 budget. The IJB are asked to delegate authority to

the Chief Officer to proceed with negotiations with care providers on the basis that the total agreed uplifts cannot exceed this budget allocation, if this is not possible a further update will be brought back to the IJB.

1.3 Fees for residential care for older people have already been settled nationally for 2017-18 with an inflationary uplift agreed at the conclusion of the annual National Care Home Contract negotiations. It should be noted that the 2017-18 negotiations were extremely difficult as care home providers were looking for increases significantly higher than those offered and the process of negotiations for 2018-19 may be even more difficult.

1.4 The other care services impacted by the Living Wage are commissioned care at home and supported living services, direct payments, commissioned learning disability day services, commissioned care home placements for younger adults, commissioned day services for older people and commissioned overnight response services. All of these, apart from direct payments, will require negotiations with providers to agree appropriate uplift rates. Some providers have already approached the HSCP with proposed uplift rates and in some cases these are significantly higher than expected. The detailed open book approach which was undertaken in 2016-17 will not be required, as there is confidence that providers are starting from a baseline position of paying their staff the rate of £8.25, but there is a still a requirement as part of the process to ensure the ongoing financial sustainability of providers.

2. INTRODUCTION

2.1 The report outlines the proposed approach for negotiations with care providers to agree the inflationary uplifts to care fees for 2017-18. Following the detailed work undertaken in 2016-17, it is expected that all providers will currently have sufficient funding to pay the 2016-17 SLW rate of £8.25 and that the process for 2017-18 should less complex and may comprise an inflationary increase to applied consistently across all providers, whilst ensuring the ongoing financial sustainability of individual providers.

3. DETAIL OF REPORT

2016-17 Living Wage Costs

3.1 Appendix 1 summarises the final Living Wage costs for 2016-17 for each of the service areas. The total cost of the implementation from 1 October 2016 was £1.410m.

2017-18 Estimated Living Wage Costs

3.2 There are four main elements to the Living Wage cost in 2017-18 which were recognised separately in the £100m of funding, these are:

- Full year impact of implementation - recognising that in 2016-17 the implementation started on 1 October 2016
- Uplift rates to new SLW rate of £8.45 from 1 May 2017
- Additional funding for sustainability, recognising that providers may not be in a position to fund a 25% contribution to the rate increase
- Additionality for sleepovers, to uplift the rate to the new National Living Wage rate of £7.50 from 1 April 2017

The estimated costs for each of these elements is included in the table below:

Living Wage Element	Share £m	Estimated Cost £m	(Shortfall) /Excess £m
£50m full year impact of implementation	0.910	1.410	(0.500)
£20m to uplift rates to new living wage rate of £8.45	0.728	0.577	0.151
£20m sustainability			
£10m sleepovers	0.182	0.404	(0.222)
TOTAL	**1.820**	**2.391**	**(0.571)**

3.3 The table above highlights that the estimated costs are £0.571m in excess of the expected share of £100m and that the costs exceed the allocation for the elements in relation to the full year impact of implementation and for sleepovers. This is reflective of the detailed open book approach undertaken in 2016-17 to ensure we were clear around the starting position for providers, this enabled us to offer providers tailored rates to ensure affordability and sustainability of services, the agreed uplifts for homecare services ranged from an uplift of 0% to 17.6% based on individual circumstances. This approach, instead of an alternative of a flat rate uplift for all providers ensured that we funded individual providers to fulfil the obligation to pay the Living Wage for all hours worked, including travel time. The rurality of Argyll and Bute results in a significant element of travel, there is also limited competition from providers which requires us to ensure providers are supported to provide sustainable services. In addition for some providers there had been no inflationary increase to services for a number of years, there were a range of rates and some tenders were from a number of years ago. We are now in a level position moving into negotiations for 2017-18.

3.4 In relation to sleepovers the starting position in terms of the hourly rate was low, we never provided for the full rate increase for sleepovers in 2016-17 to bring them up to the NLW as there was an expectation that savings in the Quality and Finance Plan would significantly reduce the number of sleepovers, which would in effect reduce the cost pressure. There is a significant cost in 2017-18 due to the further six month increase in rate which will not be able to be accommodated from the expected reduction in the overall number of sleepovers and the requirement to increase the rate to £7.50 per hour from 1 April 2017.

3.5 An estimate has been made of the costs for 2017-18 based on the increase in the Scottish Living Wage and National Living Wage rates for each of the service areas, a summary of the estimated cost by service area is in the table below:

Service Area	Full Year Impact of £8.25 uplift from 1 Oct 2016 £'000	Estimated Increase to £8.45 rate from 1 May 2017 £'000	Estimated Cost 2017-18 £'000
Care Home Placements for Older People	305	151	456
Care at Home and Supported Living	774	299	1,074
Direct Payments	88	37	125
Older People Day Services	6	4	10
Overnight Response	2	11	13
Care Home Placements for Younger Adults	201	66	267
Learning Disability Day Services	33	10	43
Totals	**1,410**	**578**	**1,987**
Sleepovers	343	61	403
Grand Total	**1,752**	**638**	**2,391**

3.6 The total estimated costs are based on assumed flat rate increases for all providers based on the expected impact of the increase in the Scottish Living Wage rate from £8.25 to £8.45 and the increase in the National Living Wage rate for sleepovers increasing from £7.20 to £7.50. These estimated increases in rates will be the basis of negotiations with providers to ensure that the delivery of the Living Wage commitment can be contained within the total resource of £2.391m set aside in 2017-18 for implementation.

3.7 Care fees for residential care for older people have already been settled nationally for 2017-18 with an inflationary uplift of 2.8% agreed at the conclusion of the National Care Home Contract negotiations. It should be noted that the 2017-18 round of negotiations were extremely difficult as care home providers were looking for a significantly higher increase. The negotiations for 2018-19 may be even more difficult, if national negotiations are not successful the alternative is local negotiation and agreement of rates. Following standard practice, the new rates associated with the NCHC will be implemented retrospectively from 10 April 2017 as part of the annual care home placement financial reassessment process which is underway.

3.8 So far one provider for Care at Home Services has contacted the Commissioning Team to request an uplift in their fees, requesting an uplift of 8%. This request has been turned down on the basis of affordability and a review of the provider's current work is being undertaken to identify any opportunities to reduce their overhead costs as an alternative to increasing their rates. An assumed inflationary uplift of 1.8% is currently included in estimates for care at home and supported living services.

3.9 The care fees for providers looking after younger adults, typically those affected by learning disabilities, physical disabilities and mental health difficulties are excluded from the National Care Home Contract. None of the providers delivering these services are located within Argyll and Bute and typical practice is for the Partnership to match the rates agreed by host Partnerships unless the service commissioned by the Argyll and Bute Partnership is significantly

different from those commissioned by the host Partnership. So far 10 care homes (from a total of 38) have contacted the Commissioning Team requesting uplifts ranging from 2.8% to 11%, excluding the highest requests the average request received is 3.81%.

Next Steps

3.10 It is clear that there are expectations from commissioned providers in relation to the rate uplifts for 2017-18, it is important that we communicate with them at the earliest opportunity to manage expectations around the expected rate increases, both to ensure we can get agreement over uplifts and can allow prompt payment to providers and also in order that we can assess if the overall implementation can be delivered within the set aside budget.

3.11 The IJB are asked to delegate authority to the Chief Officer to co-ordinate formal negotiations with care providers and agree rate uplifts for 2017-18, provided that the overall impact in terms of cost does not exceed the £2.391m set aside in the budget for implementation. If this not possible a further update will be brought back to the IJB.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

In order to deliver on strategic priorities, commissioned care providers delivering services on behalf of the HSCP need to be adequately funded in order to ensure they can continue to be sustainable partners in the delivery of care in Argyll and Bute.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

Where the financial impact cannot be contained within the approved budget for the Living Wage in 2017-18 a further report will be brought to the IJB.

5.2 Staff Governance

None

5.3 Clinical Governance

None

6. EQUALITY & DIVERSITY IMPLICATIONS

None

7. RISK ASSESSMENT

A financial risk may arise if the providers reject the offer put forward by the partnership and request a higher uplift.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None

9. CONCLUSIONS

9.1 The engagement with Adult Care Providers in 2016-17 resulted in an open and transparent discussion as part of the negotiations, this resulted in a positive outcome for both providers and the HSCP. This approach needs to continue and will be used to inform negotiations for 2017-18.

9.2 With the Integration Joint Board's approval, arrangements will be put in place to conduct the 2017-18 fee uplift exercise with care providers. The overall aim being that the financial impact will be contained within the resources set aside for implementation. Where this is not possible, a further report will be presented to the Board before the negotiations are concluded.

APPENDICES:

Appendix 1 – 2016-17 Living Wage Financial Impact Summary

APPENDIX 1

2016-17 Living Wage Financial Impact Summary

Service Area	Detail	Estimated Cost
Commissioned Care at Home and Supported Living Services	Argyll and Bute based provider's uplifts are based on an individual assessment of each provider's funding requirement to ensure sufficient funds are in place to deliver the National Living Wage requirement from 1 April 2016 and the Scottish Living Wage requirement from 1 October 2016. The uplifts for providers based out-with Argyll and Bute will be set by each provider's host HSCP but an estimate is included based on the weighted average of the assessed uplifts identified for providers based within Argyll and Bute (10.22%). There a range of uplifts agreed for providers from 0% for some to a maximum of 17.6% for one provider, based on affordability.	£774,316
Commissioned Care Home Placements for Older People	The National Care Home Contract uplifts were agreed by the relevant stakeholders earlier this year on the basis of HSCPs funding 75% of the uplift required to meet the cost of the National Living Wage from April and the Scottish Living Wage from October. This was agreed at a 2.5% increase from April and a further 4% increase from October. There is no scope to apply a different uplift in this area.	£305,000
Direct Payment Recipients	This relates to funding provided to service users to enable them to purchase care from agencies of their choice in their area and/or to employee their own personal assistants. Standard rates are paid for personal assistants and a best rate for agencies in each area. The rate for personal assistants has been recalculated based on £8.25 per hour and 100% funding of the uplift. The rate for agencies has been uplifted based on the weighted average of the uplifts assessed for Argyll and Bute based providers.	£87,954
Commissioned Learning Disability Day Services	This relates to Day Services purchased from external providers in the Helenburgh and Lomond area. The uplifts are based on a mixture of specific provider proposed rates and equivalent uplifts to those assessed for Care at Home and Supported Living.	£32,925
Commissioned Care Home Placements for Younger Adults	This relates to care home places purchased for younger adults, not children. All of these places are out-with the Argyll and Bute area and will be agreed in discussion with host HSCPs. An estimate is included based on the weighted average of the assessed uplifts identified for Care at Home and Supported Living providers based within Argyll and Bute at 10.22%.	£201,362
Commissioned Day Services for Older People	This relates to day services purchased from external providers in the Helenburgh and Lomond area. The uplifts are based on a submission from the supplier involved.	£6,177
Commissioned Overnight Response Services	This relates to overnight responder services provided in 7 areas by a single provider and is based on an assessment of this specific service type.	£2,043
	Total Estimated Cost	**£1,409,777**

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.5

Date of Meeting: **31 May 2017**

Title of Report: **Struan Lodge Re-Design**

Presented by: **Allen Stevenson Head of Adult Service (East)**

The Integration Joint Board is asked to :

- Note additional time to consider a strategy report by Struan Lodge Development Group (SLDG) has allowed constructive discussions with the Chair of the group to take place relating to the strategy.
- Note further consideration within this report of the key themes that emerged from the engagement events as detailed within the Community and Staff feedback report.
- Note the operational issues that have emerged since the original proposal relating to the re-design of Struan Lodge in June 2016.
- Agree the original proposal to cease 24 hour care at Struan Lodge care home cannot proceed at this time due to operational issues that have emerged since June 2016.
- Note additional work relating to the whole system re-design of services across Cowal will be undertaken between June 2017 and February 2018. This will include further engagement events with communities to build on the work undertaken to date.
- Note a further report will be presented to the Integration Joint Board (IJB) in March 2018 detailing the re-design work completed and final recommendations.
- Note non achievement of savings relating to the re-design of Struan Lodge in 2017/18.

1. EXECUTIVE SUMMARY

1.1 The Integration Joint Board (IJB) agreed to a further pause in relation to the re-design of Struan Lodge for a period of two months in March 2017. This pause was put in place to allow time for consideration of the SLDG strategy relating to Adult Care Services in Cowal.

1.2 The Head of Adult Services (East) met with the Chair of the SLDG to discuss the content of the group's report and agreed the key issues to be taken forward from the report. The report compiled by the SLDG sets out a medium to long term vision for Adult services in Cowal which includes the future role of Struan Lodge.

1.3 A separate Community Feedback Report was completed by the HSCP Public Involvement Manager. This report captured all the feedback from conversation café/drop in events, survey monkey and hard copy questionnaires returned by members of the community. Submissions were received up to the last day of the engagement period. The report was presented to the Integration Joint Board at its meeting in March 2017.

1.4 The main finding from the Community and staff feedback report confirmed that no consensus of opinion was secured from those with an interest in health and social care services across Cowal. This was not unexpected given the wide range of people that attended events or returned questionnaires.

1.5 A number of significant operational issues have emerged since the original proposal was considered by the IJB in June 2016. These include, the diminishing availability of residential vacancies from the independent sector, the current instability of provision of care home placements across Argyll and Bute which is now impacting on provision in Cowal and the unexpected closure of Craigard residential care home on Bute.

1.6 There is not sufficient capacity or stability at this time within the independent sector in Cowal to move towards ceasing 24 hour residential care home placements at Struan Lodge.

1.7 The original proposal relating to the development of a community hub at Struan Lodge cannot be delivered in 2017 as per the original proposal. There is insufficient care home placement capacity to allow for the loss of the current 12 beds at Struan Lodge.

1.8 The current combination of operational factors should not stop work being taken forward to look at the whole system of health and social care services across Cowal which includes the development of a community hub. It is vitally important that work is taken forward to develop services that will meet the known challenges of delivering services to a growing number of older people who will require support to live at home for longer with complex care needs.

1.9 Shifting the balance of care remains at the centre of the transformational change needed to deliver improved outcomes for adults and older people across Argyll and Bute. Re-design work needs to be taken forward in Cowal to develop a range of services to meet future demands.

1.10 There will be no savings delivered in relation to the proposed re-design of Struan Lodge in 2017. This will have an adverse impact on the current Quality and Finance Plan of £175,000k for 2017/18. Alternative savings options need to be identified to cover this gap.

2. INTRODUCTION

2.1 Argyll and Bute Health and Social Care Partnership (HSCP) are actively working to deliver the transformational change required across Argyll and Bute to meet the future needs of an ageing population, as demand grows within an increasingly challenging financial climate across public services. The scale of the challenges ahead is unprecedented and will require everyone to work smarter in the future by using our resources more efficiently and effectively.

2.2 The current health and social care system needs to change. We need to shift the balance of care by supporting people to stay at home longer to live healthier happier and independent lives. To do this we need to develop our approach to preventative interventions delivered increasingly in peoples own home or more homely settings.

2.3 Our Strategic Plan (2016-2019) identified 6 key areas of focus and set out our locality priorities in response to the national policies of the Scottish Government. Feedback from communities during the consultation period on the strategic plan identified that our communities want the HSCP to reduce the need for emergency or urgent care by improving our approach to anticipatory care. Our communities also identified the need for us to prevent ill-health, increase levels of confidence and ensure our staff were able to help people to improve their skills and confidence to remain at home.

2.4 The Argyll and Bute Integration Joint Board (IJB) agreed to a pause in work relating to service re-design at Struan Lodge in November 2016 due to concerns raised by the community. A move to ceasing 24 hour care residential placements was rejected by various people and groups including the Struan Lodge Development Group. A pause between December 2016 and February 2017 has allowed the community to take part in a series of conversation café/drop in events about the future design of services for people living in Dunoon and Cowal.

2.5 An additional pause of two months was agreed by the IJB in March 2017 to allow Officers the opportunity to consider the detail of the report by the SLDG relating to a medium to long term strategy for Adult Services in Cowal.

3. DETAIL OF REPORT

3.1 During the pause period agreed by the IJB in November 2016, Officers supported work by the Communication and Engagement Group to develop a community redesign leaflet which set out the current service model in Cowal, the proposed changes and the process that would be followed during the pause. The leaflet was then distributed widely. A set of questions were also developed to ensure we asked the community the same questions which could then be collated at the end of the process.

3.2 The Communication and Engagement Group in Cowal was populated by a mixed group of people with varying degrees of experience in developing and delivering community events.

3.3 The Community Feedback report captured the key themes from the Cowal engagement events. It was a thorough report which sets out the detail of all the conversations that took place as well as the content of survey monkey and hard copies of the questionnaires submitted to the team.

3.4 The key themes/general points are captured on a table within the report and include the following:

	Key Themes / General Points
1	Promotion of good health and well being
2	Support to maintain independence at home for as long as possible
3	More services for people with mental ill health, including services for people with a diagnosis of dementia
4	More support for carers including respite care and overnight care
5	Strachur Hub – fabulous model, replicate in other outlying areas (spokes) with Struan Lodge as the hub
6	Day centre / day care – including activities
7	More should be done to tackle loneliness and isolation
8	Need convalescence type facility for everyone
9	Reliable and accessible transport
10	NHS Greater Glasgow & Clyde : more service provided locally, less in Inverclyde / Paisley / Glasgow; better communication; discharges from hospital better co-ordinated; better arrangements for appointments
11	Out of Hours services very limited
12	Concern this is just about cutting costs which will impact on quality of care
13	People want more choice
14	Crossroads & Befrienders – fantastic services, need more money to expand
15	Sheltered housing
16	Struan lodge should retain residential care – anxieties about capacity within the private sector; need to work with provide homes to support improvement in standards of care; future increased need for residential care; fear what will happen if residents are moved from Struan Lodge
17	Concern about reducing the number of beds at Cowal Community Hospital
18	Care at Home – more needed locally based on individual need

3.5 Community Feedback report

This report does not end with a consensus position in terms of public and community opinion re the proposal to develop a new community hub at Struan Lodge. The original proposal set out the plan to cease 24 hour care at the Struan Lodge site and develop a community hub to offer advice, help and support to a wider group of frail elderly people in Cowal. It was proposed that 24 hour residential care home beds would be commissioned from the existing independent sector in Cowal.

3.6 Community feedback

There was very clear anxiety and opposition to the loss of providing 24 hour care at Struan Lodge mainly by people who attended events in central Dunoon. This view was not shared with people who attended events outside Dunoon. The more rural communities were much more interested in how the HSCP could re-design services to increase the provision in outlying rural areas. Some people who attended the drop in sessions discussed the benefits of replicating the Strachur Hub as an example of providing services that are local and very effective at increasing older people's access to support that tackles isolation and loneliness. People in the rural communities of Cowal were more interested to know that there was enough capacity across Cowal if someone required 24 hour residential care in a care home.

3.7 Struan Lodge Staff Feedback

During the engagement phase a session was organised with Struan Lodge staff on 3rd February 2017 and their detailed feedback is recorded in full within the Community and Staff Feedback report. The staff at Struan Lodge remain very concerned about the long term future of the care home under the current proposals. The staff have been through similar re-design processes and many are still unhappy that the future of Struan Lodge is subject to on-going re-design which includes the loss of the 24 hour residential care beds at the site.

During this period of uncertainty the staff have continued to focus on delivering person centred care of the highest standard. They have also handled enquiries from residents and their families on a daily basis. The staff and management team deserve tremendous credit for having a business as usual approach to delivering care to the current residents

3.8 Families of Current Residents Feedback

During a session with the families of current residents there was universal disapproval and disbelief for the need for the current residents to be moved from their current placements at Struan Lodge. Families have a very positive relationship with staff and feel their family members are thriving in a very caring and supportive care home. Families confirmed their loved ones are settled, happy but fearful of what the future would hold if they had to leave their current placement. Families also articulated the view that Struan Lodge are providing the gold standard level of care which is not replicated across other care homes.

4.0 STRUAN LODGE DEVELOPMENT GROUP

4.1 During discussions with the Chair of the SLDG a number of key issues have been drawn out and agreed as significant. These are detailed on Page 4 and 5 of the SLDG document. They are detailed under number 2, 5 and 10.

Number 2 - *The phased development of the Struan Lodge site to create a new 50 bed unit to meet the demographic and operational needs of the community based on assumptions detailed in the report*.

Response - There are currently no plans to create additional care home beds by the statutory partners at this time. Capital plans are agreed many

years in advance and there is no commitment by either Argyll and Bute Council or NHS Highland to earmark significant funds to build new care homes. Additional work relating to the future requirements for care home beds needs to be linked to the planned review of care home capacity across localities in the East and West. The Partnership need to define requirements for care home beds as part of the model of care in relation to the medium to long term. These projections need to take account of shorter lengths of stay in care homes as a result of people being supported at home for longer periods.

Number 5 - *Use Struan Lodge to facilitate transitional care arrangements for Cowal residents awaiting hospital discharge from whatever location and thus eliminate bed blocking.*

Response The opportunity to use Struan Lodge as an alternative to people remaining in Cowal hospital when they are medically fit for discharge would eliminate delayed discharge and be a better interim solution for the patient/family and the organisation. This would ensure that beds at the Cowal hospital would only be occupied by people who require hospital based medical and nursing interventions. Expensive delays in occupying a bed when fit for discharge could be eliminated.

Work on a robust Intermediate Care (step up/down) policy needs to be developed further across Argyll and Bute as we develop our community team model across localities. The use of Struan Lodge needs to be considered further as part of this re-design work.

Number 10 *Provide tailored day care facilities and services for over 65's and create outreach links with villages of Cowal to ensure appropriate services for all*.

Response This is exactly what development of the community Hub would provide. A person centred enhanced day service that links in other sources of support all under one roof is one of the key objectives of developing the enhanced service with links to the rural communities across Cowal.

4.2 Feedback from Information Services Division (ISD)

Data tables in the SLDG report have also been shared with the partnerships link worker from the Scottish Government Information Services Division (ISD) for comments. The following comments have been received;

- Population projections become less reliable the further we look into the future. Caution should be taken the further we look into the future.
- The census shows that in Argyll & Bute as a whole there has been a reduction in number of care homes and registered places across the last decade of 31% and 24% respectively.
- The number of residents in care homes has also dropped over the same period by 22% which has meant that even though the number of places has decreased the occupancy has remained broadly similar.
- The average age of care home residents on admission is getting older (82 in 2016 compared to 78 in 2006). This would need to be factored into any model.

- Average length of stay (LOS) has experienced some fluctuations over the decade but has remained broadly similar. Additional work in relation to LOS needs to be considered moving forward.
- The occupancy figures quoted for Cowal in 2016 are higher than for A&B as a whole in the Census. The paper suggests demand increased between 2013 and 2016 which is at odds to decrease shown from the Census for the partnership. This data requires further consideration by operational and planning colleagues.

4.3 Financial Information

Many people who attended the events across Cowal were unaware of the difference between the costs of providing placements at Struan Lodge as opposed to the other care homes in Cowal. This issue was the subject of significant debate. Staff at the community engagement events were able to confirm the respective cost of Struan Lodge £1404.00 per week as opposed to £567.00 per week for placements at the other care homes. Some people who attended events expressed the view that this was not sustainable and in some ways wasteful given the pressure on public service budgets. The table below highlights and confirms the financial cost of placements per week.

Financial Placement Cost (per week)

Struan Lodge	£ 1404.00
Private Sector	£ 567.00

**Financial information above from Argyll and Bute Strategic Finance Team and verified by Chief Financial officer from ABHSCP*

4.4 Care Home Capacity and Occupancy (End April 2017)

The current availability of care home beds in Cowal is detailed in the table below and demonstrates that the spare capacity which has been a longstanding feature in Cowal has now shifted significantly. There is now very little capacity for people who require care home placements in Cowal. It is important to remember that individuals and families make decisions about placements usually based on family and individual choice. Some families decide to agree placements mainly in Inverclyde, Renfrewshire or Glasgow. Erskine hospital is also a popular choice with individuals with a military history.

Ardenlee	33	Currently Full
Ardnahein	30	Currently Full
Ashgrove	65	3 Vacancies
Invereck	28	Currently Full
Total	**156**	
Struan Lodge	11 + 1 Respite Bed	Currently Full

5. NEXT STEPS (June 2017 to February 2018)

5.1 The original proposal to set a timescale for the implementation of a new enhanced community hub at Struan Lodge cannot proceed at this time for the reasons already discussed within the body of this report. The current

bed capacity at Struan Lodge is required to maintain the availability of local care home placements.

5.2 Work now needs to continue in the locality with the appropriate groups to develop a re-design plan that addresses the need to shift the balance of care and release resources to develop services that will meet the future needs of adults and older people across Cowal. Re-design work needs to address issues relating to Intermediate Care(step up/ down capacity), delayed discharge and community pull through to ensure a range of personalised services are available to support people to live at home for longer. Tackling isolation and loneliness remains a key challenge and priority.

5.3 A re-design group will be set up to develop the model of care in Cowal that fits with the key objectives of the strategic plan. Areas of work relate to the future model of care detailed in 5.2. This group will include staff, community reps, Trade unions, SLDG and other individuals identified as key stakeholders with an active interest and role in health and social care services locally and will identify an implementation plan, with associated timescales by February 2018.

6. CONTRIBUTION TO STRATEGIC PRIORITIES

6.1 Re-design work across Cowal will align to the strategic priorities as outlined in our Strategic plan.

7. GOVERNANCE IMPLICATIONS

7.1 Financial Impact

There will be no financial savings in 2017/18 relating to the re-design of Struan Lodge. Alternative savings need to be identified to address this gap.

7.2 Staff Governance

There are no issues relating to staff governance at this time.

7.3 Clinical Governance

There are no issues relating to clinical governance at this time.

8. EQUALITY & DIVERSITY IMPLICATIONS

8.1 This work draws on a series of public engagement events planned and delivered across Dunoon and Cowal between December 2016 and the end of February 2017.

9. RISK ASSESSMENT

9.1 It is not possible to implement the original re-design proposal which included ceasing provision of 24 hour care at Struan Lodge due to lack of capacity within the care home sector in Cowal currently. The loss of beds

would result in delays in hospital and a narrowing of choice for families. This would significantly increase the likelihood of families needing to secure placements out-with Cowal due to lack of placements locally.

10. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

10.1 A programme of conversation café/drop in events were organised during December 2016 and February 2017 to secure feedback from communities across Dunoon and Cowal regarding proposed changes to the services delivered at Struan Lodge.

11. CONCLUSIONS

11.1 The current and future need for care home placements in Cowal has led to the recommendation that the proposal for the re-design of Struan Lodge cannot go ahead as originally planned at this time. There is clearly no longer sufficient care home capacity locally to cease providing 24 hour care home placements at Struan Lodge in the short term.

11.2 Planned savings associated with the re-design of Struan Lodge will therefore not be achieved in 2017/18. Alternative savings options will need to be identified to fill the gap this will create within the Quality and Finance Plan.

11.3 Further planning and engagement work with communities across Cowal needs to be taken forward to develop and deliver a re-design that the community understands and supports in relation to community services. The case for change needs to be further explained and developed by the management team with a wide range of stakeholders including the SLDG.

11.4 Re-design work needs to now focus on the development of community services that ensures people have access to a wider range of personalised support options to live at home for longer. Tackling the issues of loneliness and isolation for adults and older people remains a key challenge and priority which can be addressed by the development of an enhanced community hub in Dunoon which is linked to our rural communities.

Allen Stevenson
Head of Adult Services (East)
Acting Chief Social Work Officer (CSWO)

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.6

Date of Meeting: **31 May 2017**

Title of Report: **Clinical and Care Governance**

Prepared by: **Liz Higgins, Lead Nurse / Fiona Campbell, Clinical Governance Manager**

The Integration Joint Board is asked to :

Note content of report, the risks identified and the risk management plans

1. EXECUTIVE SUMMARY

Report detailing:

1. Complaints Procedures
2. Midwifery Supervision
3. Falls Prevention
4. Oban Laboratory Update
5. Infection Control

2. INTRODUCTION

Clinical and care governance is the system by which Health Boards and Local Authorities are accountable for ensuring the safety and quality of health and social care services, and for creating appropriate conditions within which the highest standards of service can be promoted and sustained.

Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation – built upon partnership and collaboration within teams and between health and social care professionals and managers.

It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening

This report outlines current Clinical & Care Governance issues that require to be noted by the IJB and outlines action taken to address performance.

3. DETAIL OF REPORT

3.1 Complaints Procedures

Background

Following a review of Public Sector Complaints Handling Procedures undertaken by the Scottish Public Services Ombudsman (SPSO), Complaints Standard Authority (CSA), the model complaints handling procedure (CHP) for social work and the model complaints procedure (CHP) for NHS Scotland was introduced on 1 April 2017. From that date, each local authority and NHS Board was required to ensure that their procedure fully complied with the model CHPs.

The key elements of each model CHP is the same for all public sectors and include:

- A shared definition of what is and what is not a complaint
- A **two** stage process where complaints are resolved as close to the frontline as possible
- Frontline resolution of complaints within five working days
- An investigation stage of 20 working days, which provides the organisation's final decision
- Recording of **all** complaints
- Active learning from complaints through reporting and publicising complaints information.

Appendix 1 Summarises the Complaints Handling Procedure

Implementation and Development

Each organisation was required to undertake a self-assessment of compliance and submit this to the SPSO together with confirmation that they had adopted the model CHP from 1 April. In respect of Argyll and Bute HSCP, NHS Highland developed and submitted a model complaints procedure for health complaints which has been confirmed by the SPSO as being compliant. A social work model complaints procedure for Argyll and Bute Social Work complaints was submitted to SPSO by Christina West, Chief Officer, along with a 'Public Facing' Argyll and Bute HSCP Complaints Procedure and a self assessment. Confirmation of compliance is awaited from the SPSO.

A complaint handling procedure for complaints relating to the Integrated Joint Board is being developed (based on the template CHP for IJBs published by the SPSO) and will be submitted to the Complaints Standard Authority by 03 July 2017, as is required.

Information to reflect the revised complaints procedures is available on NHS Highland website including the Argyll and Bute HSCP page and Argyll and Bute Council website.

Prior to introduction of the model complaints handling procedure on 01 April, an initial awareness raising session was held with Senior Managers with the requirement for cascade of information to frontline staff.

Further complaints procedure awareness raising and development sessions are being planned in each of the localities.

All complaints that are brought to the attention of the Feedback Teams are assessed and recorded in terms of whether they are to be handled as Stage 1 or Stage 2 complaints.

Further staff training and development of recording system is required to ensure the capture of Stage 1 Complaints.

3.2 Midwifery Supervision

On 31 March 2017, regulatory supervision of midwifery was removed from statute to be replaced by a restorative model of *non statutory* clinical supervision in an employee led model.

Supervision is no longer carried out by NHS Boards, who were the Local Supervising Authority (LSA) in Scotland on behalf of the NMC, and the NMC have now assumed direct control of regulatory activities. This brings midwives into line with other regulated healthcare professionals.

Following high profile cases NMC made decision that rather than to remediate areas where supervision was not functioning, it would remove its regulatory function which has existed since 1902. Following extensive consultation a new model that retains the positive aspects of supervision from the public, midwives and organisational perspectives was arrived at with recommended minimal auditable standards.

All aspects of new structure in terms of training and audit will be in place by 18 January 2018 but supervision in a new form still applies to all clinical midwives.

Current supervisors will continue in their role however there is no need for supervisor to be a manager or team lead and new appointments will be through the head of midwifery accountable to the nurse director.

While the minimum standard is for annual group supervision with a maximum ration of 1:10, one to one will also be promoted in order to meet the main restorative, reflective aims.

Recommendations

Recommended Outcomes from the consultation will be :

- midwives are able to advocate for women
- midwives are mentored and coached
- midwives can evidence their education and training
- midwives can meet consistent national standards
- women will have continuity of relationship based care
- women will be listened to within their family and social context
- women's rights to make decisions regardless of outcome are supported
- midwives are able to undertake difficult conversations.

All supervision episodes will be recorded on the NHS Highland templates and in individual midwives eportfolio.

All episodes will have agreed ground rules and confidentiality respected and signed.

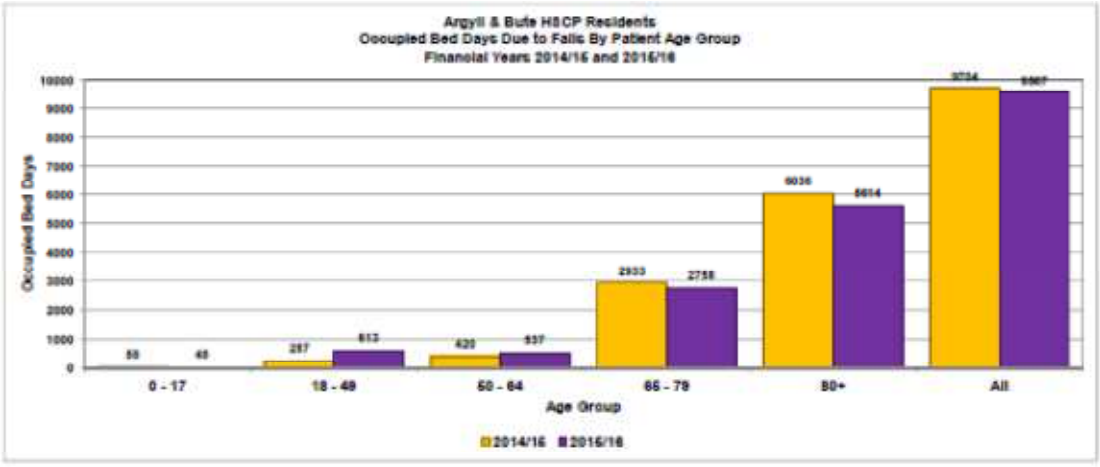
This will be audited with the minimum expectation being for a planned schedule of 1:1 meetings for each midwife to review caseload and challenges and access support and a schedule of group supervision meetings.

3.3 Falls Prevention

Community

Emergency admissions to hospital due to falls are one of the Integration Indicators that Argyll and Bute HSCP has to report on annually. ISD figures show a decrease in admissions for people in Argyll and Bute over 65yrs of age admitted due to fall with the rate of admission per 1000 reduced from 24/1000 -22 / 1000 admissions. Rates of admission per 1000 in the over 85 age group shows a reduction of 86/1000 to 68/1000. These decreases are against the background of an ageing population and a national 3% increase in admission due to falls in Scotland as a whole.

Argyll and Bute Occupied Bed Day data demonstrates a reduction in occupied bed days due to falls but shows the prevalence of occupied bed days due to falls in the over 80's. This data and charts are further broken down by each area and reports can be provided.



Data Source: NSS BI Reporting NHS Scotland: ACaDME Data Universe (SMR01) as at 30th March 2017

Ongoing work in all areas in Argyll and Bute with key stakeholders aims to embed a systematic, integrated, co-ordinated and person centred approach to falls prevention outlined in **The Prevention and Management of Falls in the Community. A Framework for Action for Scotland 2014-16.** Key actions for health and social care services are described in four stages and represent the minimum standard of care an older person should expect to receive regardless of where and when they present to statutory services.

The number of people who fall and are admitted to hospital in the over 80's age group is a particular concern in Argyll and Bute and new ways of working with people with frailty and falls are being tested to support people to remain at home where possible.

Care Homes

The Integrated Care Fund in every locality supported a bid in 2016-17 to embed the Care Inspectorate and NHS Scotland good practice resource for falls prevention in Care Homes. Twenty care homes were supported to use quality improvement methodology over a one year period with local and project support for each care home. Data shows significant improvements and a poster of this work has been selected for the 2 day NHS Scotland Event Transforming Health and Social Care.

Inpatient

Across NHS Highland there is a focus on ensuring targets of 25% reduction for falls set by the Scottish Patient Safety Programme in 2014 are reached. Test sites in A&B continue to show random variation and the Nurse Director has requested an increased focus on this work. The SPSP work is now at a critical point with new documentation for bundles of care to provide evidence based interventions ready to be taken to scale across A&B in every ward.

3.4 Oban Laboratory Update

Further to previous reports in relation to inspections of Oban Laboratory and resulting improvement work, Appendix 2 provides a revised and updated improvement plan

3.5 Infection Control

Infection Outbreaks

In last January, Auchinlee Care Home in Campbeltown experienced an outbreak of viral gastroenteritis, subsequently identified as norovirus. 7 residents and 1 staff member were affected.

Struan Lodge in Dunoon was closed to admissions from 1st to 13th March following an outbreak of influenza A. 7 residents and 6 staff members were affected.

Both outbreaks were managed with the assistance of the Health Protection Team in Inverness who have responsibility for managing infection outbreaks in community settings.

S*taphylococcus aureus* bacteraemia (SAB) including MRSA up to end March 2017

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	TOTAL
MRSA	0	0	0	0	0	0	0	0	0	0	0	1	1
MSSA	1	0	0	1	1	0	1	0	2	1	1	0	8
Total SABs	1	0	0	1	1	0	1	0	2	1	1	1	9

SABs **1st April 16 – 31st March 17** **TOTAL SABs** **<u>9</u>**	**Preventable** **Not preventable**	**<u>1</u>** of the infections reported **<u>may</u>** have been preventable as the patient had a long term venous access device in place to facilitate chemotherapy administration. As a result, education sessions were scheduled with the community team to ensure optimal management of these devices in community settings. **<u>8</u>** of the infections reported were not considered preventable following enhanced surveillance by the clinical and Infection Control Teams. Sources of infection included community acquired endocarditis, spinal disc infection, and delayed (15 years) infection in a vascular graft.
	Hospital Acquired	None of the SABs identified were acquired in hospital
	Community Acquired	8 of the SABs (those reported as not preventable above) were acquired in the community. No link to any healthcare intervention was identified.
	Healthcare Associated (infection arising in the community but associated with recent hospital admission or other healthcare intervention)	1 SAB may have been associated with the insertion of a venous access device as detailed above. This patient recovered from the infection.
	Contaminated Blood Sample	No samples were identified as false positives due to contamination of the blood culture sample.

Throughout NHS Highland, a total of 76 SABs were identified during the reporting year, breaching the HEAT target of 60. Those identified in A&B represent 11.8% of the total.

***Clostridium Difficile (*CDI) up to end March 2017**

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	TOTAL
Ages 15-64	0	0	0	0	0	0	0	1	0	1	0	1	3
Ages 65 plus	0	0	1	0	2	2	1	2	0	3	0	2	13
Ages 15 plus	0	0	1	0	2	2	1	3	0	4	0	3	16

NB – the 4 cases in January and 3 in March were fully investigated and were unrelated in time or place.

CDI **1st April 2016 to 31st March 2017** **TOTAL – 16** **N.B Infections affecting 13 patients.**	**Healthcare Associated** (infection arising >48 hours after hospital admission, or up to 4 weeks following hospital discharge)	**7** infections (5 patients) were identified as healthcare associated CDI. 1 patient had 2 infection recurrences within the 5 months following initial infection.
	Community Associated (infection arising in the community in patients with no history of hospital admission in the preceding 12 weeks OR infection arising <48 hours following hospital admission)	**8** infections (7 patients) were identified as community associated CDI. 1 patient had a second infection 9 months after the initial infection.
	Unknown (infection arising in patients discharged from hospital between 4 – 12 weeks previously in whom it is not possible to reliably attribute the source of infection)	One patient developed CDI approximately 6 weeks after discharge from hospital. It was not possible to define the source of infection.

Recurrence of CDI is not uncommon following antibiotic therapy at any time after the initial infection. Some sources state the risk of re-infection to be as high as 50%.

All infections were subject to enhanced surveillance and no evidence of cross infection within healthcare settings was identified.

Throughout NHS Highland, a total of 77 CDIs were identified during the reporting year, within the HEAT target of 78. Those identified in A&B represent 20.7% of the total.

ONGOING CHALLENGES & RISKS

Challenges

- Despite previous indications that the ICNet (infection control software) project would be fully complete by the end of November 2016, automated electronic transfer of microbiological data from NHS Greater Glasgow & Clyde is still outstanding. Weekly

meetings are held with ICNet, NHSH & NHS GGC E-Health teams and the Infection Control Manager to progress this issue and we understand that live testing of the data feed has commenced. NHSH has logged a complaint with ICNet in relation to the timeframe for completion which is now being indicated as summer 2017. Whilst we await completion, the risk remains that human factors might result in errors and delays in infection control information being received in a timely and accurate manner, due to the reliance on manual data inputting and dissemination of laboratory results.

- National surveillance of *Escherichia coli* bacteraemia (ECB) became a mandatory requirement in April 2016. This is placing additional workload pressure on the Infection Prevention and Control team which is being monitored by the Infection Control Manager and Infection Prevention and Control Doctor.

- The HAI Quality Improvement facilitator post appointed on a fixed term contract will end on the 31st March 2017. The postholder provided excellent support to the Infection Control Nurses, particularly with improvement related to CDI prevention and treatment. The loss of this post will result in the cessation of some of the current work streams being undertaken to improve compliance and reduce healthcare associated infections; other areas will be absorbed by the existing Infection Prevention and Control Nursing team resulting in an additional work load.

- The Data analyst post (based in Inverness) appointed on a fixed term contract ended on the 31st March 2017. The loss of this post has resulted in a reduction of a dedicated review of healthcare associated infection cases, and the associated information generated from this post. The loss of this post and its role and responsibilities can only be absorbed on a limited basis by the Infection Control Team and due to the specialised requirements of this role it cannot be fulfilled to the same level as it previously was.

- The HAI HEAT targets for 2016/2017 remain unchanged, and have been challenging to meet on a Board wide basis. We are currently unable to calculate our *Staphlyococcus aureus*, and *Clostridium difficile* HEAT target performance due to the data quality and completeness issues relating to NHS Highland bed occupancy data (see Item 2 below).

Risks

- **The IJB are asked to note** that due to staffing issues in the Oban laboratory, microbiology samples normally processed there are all currently being processed by NHS GGC at the Queen Elizabeth University Hospital. This affects samples obtained in hospital and community in North Argyll and Mull, Mid Argyll and some of Kintyre. The reporting of samples to the A&B Infection Control Nurses and the NHSH Infection Control Doctor is in process via an email system and regular delivery of hard copy reports. The system is complex, human dependent, subject to error and compounds the existing problems with real time infection and outbreak surveillance in the absence of automated microbiology data feed described above. This situation is acknowledged on the Risk Register.

4 CONTRIBUTION TO STRATEGIC PRIORITIES

Robust governance arrangements are key in the delivery of strategic priorities

5 GOVERNANCE IMPLICATIONS

5.1 Financial Impact
Potential for financial impact

5.2 Staff Governance
Nil highlighted in the report

5.3 Clinical Governance

Some issues identified

6 EQUALITY & DIVERSITY IMPLICATIONS

There are no equality and diversity implications

7 RISK ASSESSMENT

Risks articulated within the report.

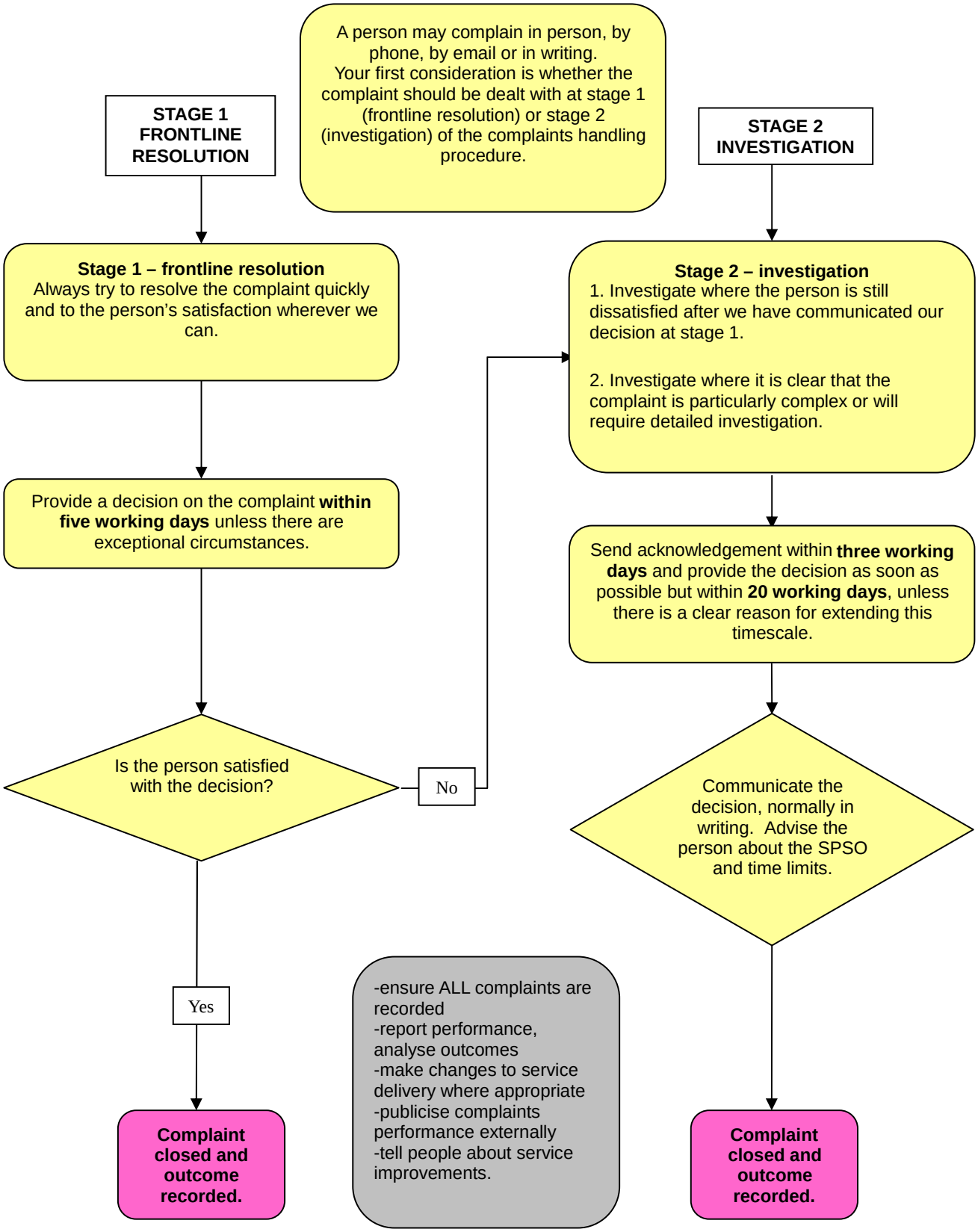
8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The membership of the Clinical and Care Governance Committee and the Health and Safety Group includes public representation

9. CONCLUSIONS

The report provides updates and information about some key areas of work in relation to clinical and care governance.

Appendix 1 - The complaints handling procedure



Appendix 2 OLI Laboratory Meeting Governance Action Plan 11th April 2017

(Action2 : Laboratory improvement plan is available as a detailed separate plan)

Action Number	Action - Governance	Who	When	Red Amber Green Status R= Incomplete A= Started and end date agreed & on track G= complete
1	Establish SLWG	Alex Javed, A&B Planning rep (TBA), A&B Finance rep (TBA) Geoff Day, Caroline Henderson or Annie Macleod, Mark Ashton, Quality Manager (NHSH), Clinical Leads Inverness tba	SLWG established. Regular meetings held and planned for 2017. Alex Javed meeting with senior locality team beforehand. Monthly meetings established across NHS Highland and inclusive of NHS Greater Glasgow & Clyde Consultants	
2	Action plan developed for all lab non conformances and monitoring of 133 outstanding actions (85 actions are CPA related)	Geoff Day (interim lab manager). Monitoring in place through weekly meetings.	All non conformances submitted to UKAS for re Inspection end of Feb 2017.	
3	Future of OLI lab governance & define structure for Lab user manual	Caroline Henderson & Alex Javed	New organisational structure agreed, with clear Clinical Governance arrangements. **The only post not filled is Lab Director**. Memorandum of understanding agreed with NHS Greater Glasgow & Clyde for clinical Consultant input to the Lab from Glasgow. Clear Roles & Responsibilities agreed.	
4	Appointment of Clinical Director	Alex Javed	Meeting took place with NHS Greater Glasgow & Clyde on the 22nd February 2017. Glasgow informed us that they could not provide a Clinical Director. On previous discussions with Glasgow, they felt that this was possible.	

			As LIH has now withdrawn from CPA and UKAS not applied for as this stage – AJ proposing not submitting UKAS application until April 2017 at which point CD has to be nominated. LIH consultants not able to take on post. 20th March - AJ to pursue CD role from Inverness and access to telepath IT system from Inverness. Ensure review MOU with Glasgow when CD appointed. Rod Harvey meeting with Mike Hall and locality team 12th April 2017	
5	Line Management of Geoff Day By Alex Javed to comply with governance arrangements	Alex Javed	Completed. Lab Quality BMS has also got accountability now to NHS Highlands quality manager for Labs. Sustainable lab management meeting planned end April 2017. Investigation report awaited.	
6	Quality Management – transfer from Qpulse to Ipassport	Linda (Raigmore)/Roland	By end of September	
7	Define clinical input for microbiology and biochemistry	Mark Ashton/Alex Javed	Completed. Memorandum of understanding complete around Consultant role in and out of hours. Microbiology transferred to Glasgow until further notice due to staff sickness. Long term provision of microbiology at LIH to be reviewed (AJ).	
8	Haematology and transfusion service consultant input	Caroline Henderson, HSCP planning team and GGC planning team	Completed. Two new Haematologists appointed. Lab responsibilities outlined in memorandum of understanding wth GGC.	
9	Update organisational chart when clinical structure confirmed.	Geoff Day	13th December 2016 – Clinical Director role outstanding (see action 4)	

10	Service Planning between NHSH, A&B & Glasgow – detailing schedules in SLA with GGC	Stephen Whiston	SLA Complete, awaiting sign off from Glasgow.	
11	E Health – Appraisal of IT to support quality management from NHSH and GGC – initial discussions held through SLWG and further detail to be agreed	Alex Javed and Linda Brady	To be superseded by Ipassport. Timeline to be agreed	
12	SLA – current total £1.2m (diagnostics and LIMMS alone) – Alex to provide matrix of what SLA value should be on a population basis. Geoff to provide overview of all current activity and LIMS.	Alex Javed & Geoff Day	Completed	
13	Independent investigation of MHRA submission (blood compliance report) to comply with MHRA	Caroline Henderson/ Mike Hall	External review carried out and report sent to MHRA. Report highlighted • good clinical practice. • Highlighted that this should have been addressed when Argyll & Clyde Health Board ceased. Lessons learned to be added to be highlighted to Strategic Management Team – Mike Hall	
14	MHRA Inspection and action plan	Alex Javed & Caroline Henderson	MHRA inspection carried out over 2 days. Report received. Action plan to address the gaps submitted - further information requested from LIH 11th April 2017 for return within 14 days.	
15	CPA inspection 22nd & 23rd Feb 2017	Alex Javed & Geoff Day	Following visit, we agreed to voluntarily resign from CPA accreditation and resubmit another application for UKAS ISO 15189. This was discussed with inspector at the time, and she felt we would get a	

			pre-inspection in October 2017 and formal inspection January 2018.	
16.	HSE joint visit with Raigmore Hospital 8th & 9th Nov 2016.	Geoff Day/ Bob Summers/Carolyn Taylor	Formal response submitted from NHS Highland to HSE. Action plan in place to include	
17.	HSE inspection results to be monitored via monthly management meeting.	Alex Javed & Geoff Day	Formal response submitted. Following to be addressed: • Ensure adherence to lone working policy. • Ensure Wet Working Occupational Health policy implemented. This is being reviewed across NHS Highland. • Onerous on call to be reviewed • Team stress assessment to be carried out in April/May 2017	
18.	Trainee role currently in non-accrediated lab	Caroline Henderson	AJ has asked head of education – awaiting response. Oversight to be given from Raigmore	
19	Implementation of use of Datix	Alex Javed.	To be embedded into the lab. Alex Javed has access to Oban laboratory incidents	
20	Training of blood transfusion to be compliant in Mid Argyll	Kate MacAulay		
21	Staff sickness/Stress and morale	Alex Javed/Caroline Henderson	Locums x 3 appointed to cover immediate gaps Referrals to occupational health made H&S carrying out staff stress risk assessment may 2017	
22	Sustainable and On call rota compliant with working time directive	Alex Javed/Caroline Henderson	Draft rotas to be sourced from other areas	

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.7

Date of Meeting: 31 May 2017

Title of Report: Public Health – Early Years

Presented by: Elaine C Garman

The Integration Joint Board is asked to:

- **Note the paper**

1. EXECUTIVE SUMMARY

The public health paper this month covers the early years of childhood and in particular child development, immunisation, breast feeding, parenting and oral health. All are important aspects of our service and programme delivery within the HSCP.

2. INTRODUCTION

Early years interventions are some of the most effective public health programmes. Inequalities are apparent in this age range but are also amenable to change through targeted work. It is important when providing essential universal services such as health visiting that practice is as sensitive to inequalities as possible. It can be seen in the oral health performance both work on universal services and targeted provision has had good impact. Likewise immunisation is well delivered but we continue to strive to improve breast feeding and effective delivery of parenting programmes.

3. DETAIL OF REPORT

Universal Health Visiting Pathway

The Universal Health Visiting Pathway was implemented across NHS Highland for all pregnant women (to commence antenatal contact) from 1st October 2015 and new babies born from 1st May 2016. The Pathway presents a core home visiting programme offered to all families by Health Visitors as a minimum standard.

Along with the core home visits Health Visitors also exercise the function of Named Person whereby they require to be available and responsive to parents to promote,

support and safeguard the wellbeing of children by providing information, advice, support and help to access services.

The Pathway is based on the following underlying principles:-

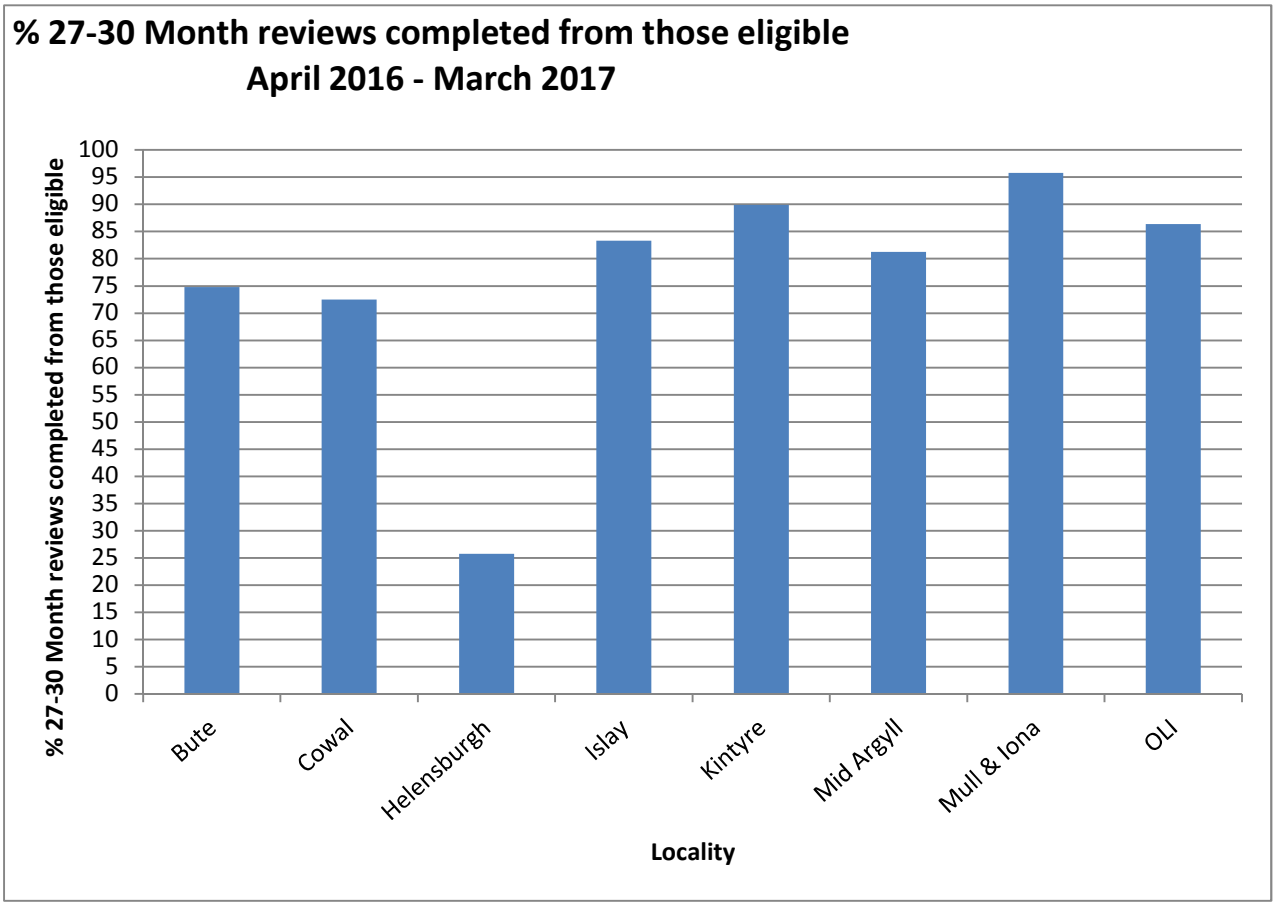
- Promoting, supporting and safeguarding the wellbeing of children
- Person-centeredness
- Building strong relationships from pregnancy
- Support during the early weeks and planning future contacts with families
- Focusing on family strengths, while assessing and respectfully responding to their needs.

The programme consists of 11 home visits to all families spanning the antenatal - preschool period. The families receive eight visits within the first year of life and three Child Health Reviews between 13 months and 4-5 years.

The Pathway ensures the opportunity for Health Visitors, children and their parents to 'connect' and provides the platform for ensuring a unique family/Health Visitor relationship, which ultimately provides Health Visitors with a sound foundation for their role as the Named Person from birth. We are currently developing the monitoring of the uptake of home visits and if they have been delivered in the family home. In June 2017 we will commence the first Child Health Screening Programme 13 – 15 month review with data being collected through the national Information Statistics Division (ISD).

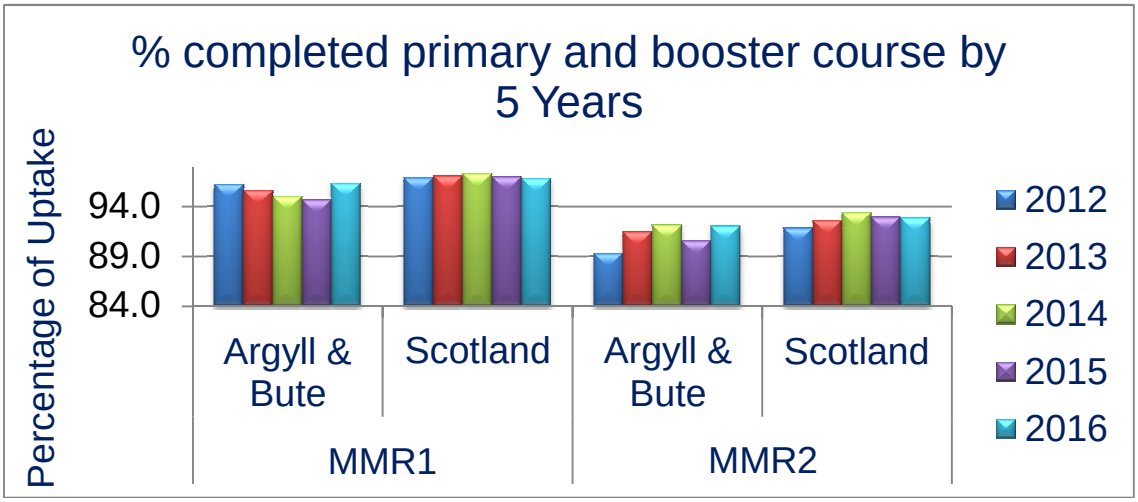
Graph 1 shows the uptake at 27 – 30 month reviews over the last year. The aim is an uptake rate of 85%. Appendix 1 shows the detail of locality performance. Work is underway using improvement methods to increase uptake.

Graph 1: 27-30 month reviews



Immunisation

Immunisation is one of the most effective public health interventions. A significant number of deaths and disabilities are prevented with such programmes. Currently the performance of the HSCP is good with regard to immunisation uptake. Not all children will be able to receive vaccination due to medical conditions. Therefore 100% immunisation is not expected. In order to protect those children who are unable to receive vaccination the rates have to be maintained at 95% or above. Across Scotland these rates are generally achieved and NHS Scotland no longer monitors the MMR1 data (see graph 2 below) as part of the HEAT targets or standards. However internally we continue to monitor this and all the other vaccinations which can be found in Appendix 2.



Graph 2: % completed MMR immunisations by 5 years of age

Scottish Government has commenced a programme of change for the delivery of immunisation programmes. As part of the reform of Primary Care there is a desire to modernise the role, function and responsibilities of GPs. Part of this agenda includes, amongst other things, moving responsibility for the delivery of vaccinations away from Primary Care to appropriate other parts of the NHS.

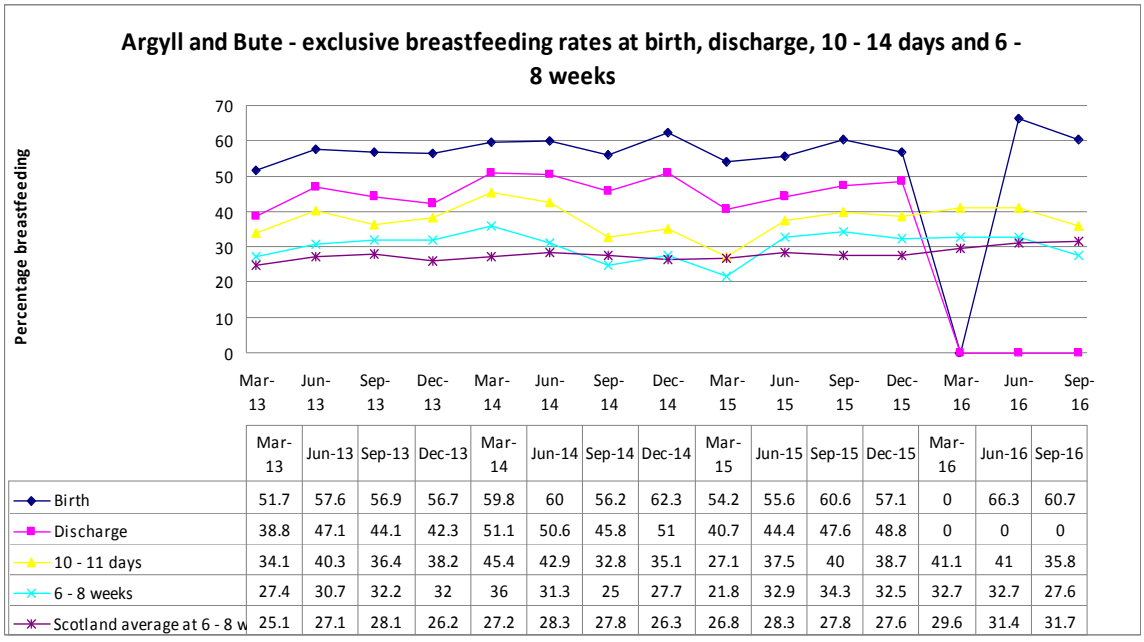
At the same time, the Scottish Government has recognised the need to modernise the delivery of vaccinations. This is in response to the increasing complexity in the vaccination schedule, and in relation to the challenges associated with having to negotiate with GPs on regular basis around the introducing of new vaccination programmes, or for the continued delivery of existing programmes. The national solution of Primary Care as preferred provider for vaccinations has served Scotland well for many years, but is now out-dated. A programme of work has started to examine how vaccinations can be delivered differently in future.

The new delivery models are likely to require additional staff and we may experience difficulty in recruitment. As a rural area and particularly for our more remote populations we would still want to have the option of delivery by GPs. Centralised travel vaccination centres in Glasgow will be inconvenient and extraordinarily expensive to create in rural areas. IT linkage and sharing data safely are crucial so that GPs know the immunisation status of a child presenting with a rash. Patients have established trusting relationships with GPs. From experience we know that especially where

immunisation is controversial and there are vaccine scares, discussion and provision by GPs has been invaluable. Our concern is that uptake will decline with a change in provider and all these aspects have been communicated to Scottish Government. The plans that are put in place will work directly to mitigate these risks.

Breast Feeding

UNICEF baby friendly initiative forms part of the Maternal and Infant Nutrition Framework (MINF). Argyll and Bute have maintained full UNICEF Baby Friendly accreditation over that last three years with reaccreditation due to take place in June 2017. Additional breastfeeding support and advice is provided through breastfeeding key workers, clinics, volunteer support workers working in the community and social media facebook pages. From March 2015 up to July 2016 32.5% of babies in Argyll and Bute were exclusively breastfed at 6-8 weeks compared to 27.3% of babies in Scotland. However in September 2016 the number of women who initiated breastfeeding dropped by 6% which affected the Argyll and Bute breastfeeding rate at 6-8 weeks and reduced it to 27.6%. The drop off rates at set points between birth and first visit and first visit to 6-8 weeks have now been maintained at a constant since March 2015 due to the improvement work already carried out. However it is recognised that breastfeeding rates fluctuate throughout the course of the year and further improvement work has commenced to identify how higher rates can be achieved and maintained in the long-term with priorities on initiation and discharge from hospital. The graph suddenly drops off to 0 at discharge in 2016 because ISD are no longer providing the data. However we are collecting it locally and hope to start reporting on it again in the near future.



	Mar-13	Jun-13	Sep-13	Dec-13	Mar-14	Jun-14	Sep-14	Dec-14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16
Birth	51.7	57.6	56.9	56.7	59.8	60	56.2	62.3	54.2	55.6	60.6	57.1	0	66.3	60.7
Discharge	38.8	47.1	44.1	42.3	51.1	50.6	45.8	51	40.7	44.4	47.6	48.8	0	0	0
10 - 11 days	34.1	40.3	36.4	38.2	45.4	42.9	32.8	35.1	27.1	37.5	40	38.7	41.1	41	35.8
6 - 8 weeks	27.4	30.7	32.2	32	36	31.3	25	27.7	21.8	32.9	34.3	32.5	32.7	32.7	27.6
Scotland average at 6 - 8 w	25.1	27.1	28.1	26.2	27.2	28.3	27.8	26.3	26.8	28.3	27.8	27.6	29.6	31.4	31.7

Parenting

A crucial part of healthy child development is provided by good parenting. Within Scotland, NHS Education Scotland (NES) has developed *Psychology of Parenting Programme* (PoPP). In discussion with NES it was agreed we would work to recruit 22 families in the six month period January – June 2017 to be eligible for the next phase of PoPP. These figures were based on previous delivery and Argyll and Bute's 'personal best'.

It was suggested to reach this number of families we could either run two PoPP groups (if we enrolled 10-11 families in each group), or three PoPP groups (if we enrolled 7-8 families in each group). The latter figure was based on local PoPP data that demonstrates on average we have been able to recruit eight families to each PoPP group run in Argyll and Bute.

Compared to large urban areas, the rural local authorities have experienced difficulties in delivering these programmes. A staff development day highlighted difficulties in delivering parenting programmes, these included:-

- Staff capacity to commit, a number of staff trained were not given the dedicated time by their managers to allow them to spend time recruiting families
- Natural wastage – a number of staff trained on the programme were no longer in post
- Difficulties in recruiting the number of families required for a group
- Accessing suitable accommodation
- Securing crèche workers for the duration of the programme

Child Smile

Child Smile is delivered in all areas of Argyll and Bute HSCP. Child Smile Core for Nursery and School are well established in our education establishments with success due to the commitment and joint working between education and oral health staff. Child Smile Practice provides support for families referred by the health visiting team at 6-8 weeks. When children are around three months old families receive early advice from an Oral Health Support Worker on the importance of looking after the primary dentition. Children are also supported to register with dental services to receive a programme of care, tailored to meet the needs of the individual child. Child Smile is promoted through the work of Argyll and Bute Family Pathway.

Scotland's Dental Action Plan (2005) set a target for 55% of 0-2 year olds registered with a dentist. A&B HSCP = 52.8% with Scotland's average = 48.4%.

Child Smile Core Nurseries target = 100%: A&B HSCP 99%
Child Smile Core Primaries target = 20%: A&B HSCP 90%

The performance outcomes across the whole Child Smile programme of dentistry can be found in Appendix 3.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

This paper contributes to all three of the aims below.

- Better health is to ensure that people live longer healthier lives through promoting wellbeing and equality of treatment
- Better care is to support individuals and their families at times when and where they need our help
- Better value is to maximise the use of all the resources available to us to deliver high quality care to our population

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

Continued investment in early years reduces the need for expenditure in later life.

5.2 Staff Governance

Nothing identified at this time.

5.3 Clinical Governance

Effectiveness of programme delivery needs to be maintained.

6. EQUALITY & DIVERSITY IMPLICATIONS

As plans begin to emerge for new models of vaccination delivery these will require to be considered against principles of equality and diversity.

7. RISK ASSESSMENT

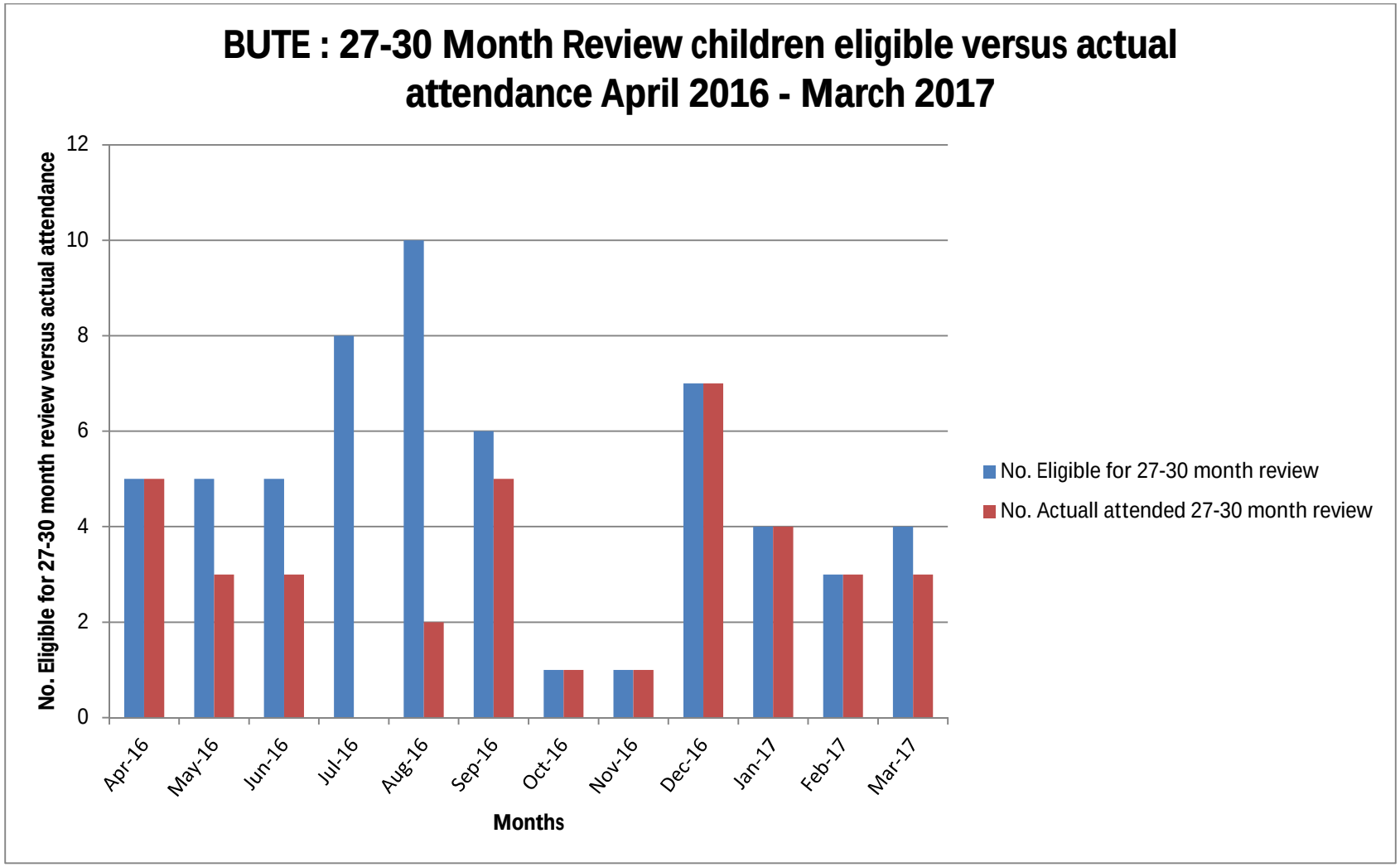
Potential risks identified with regard to new models of vaccination delivery.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Nil at this time.

9. CONCLUSIONS

Across the area of early years progress continues to be made. Breast feeding and the delivery of parenting programmes remain the most challenging to effectively deliver. The IJB is asked to note this paper.


BUTE : 27-30 Month Review children eligible versus actual attendance April 2016 - March 2017
No. Eligible for 27-30 month review versus actual attendance
12
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Apr-16
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Jul-16
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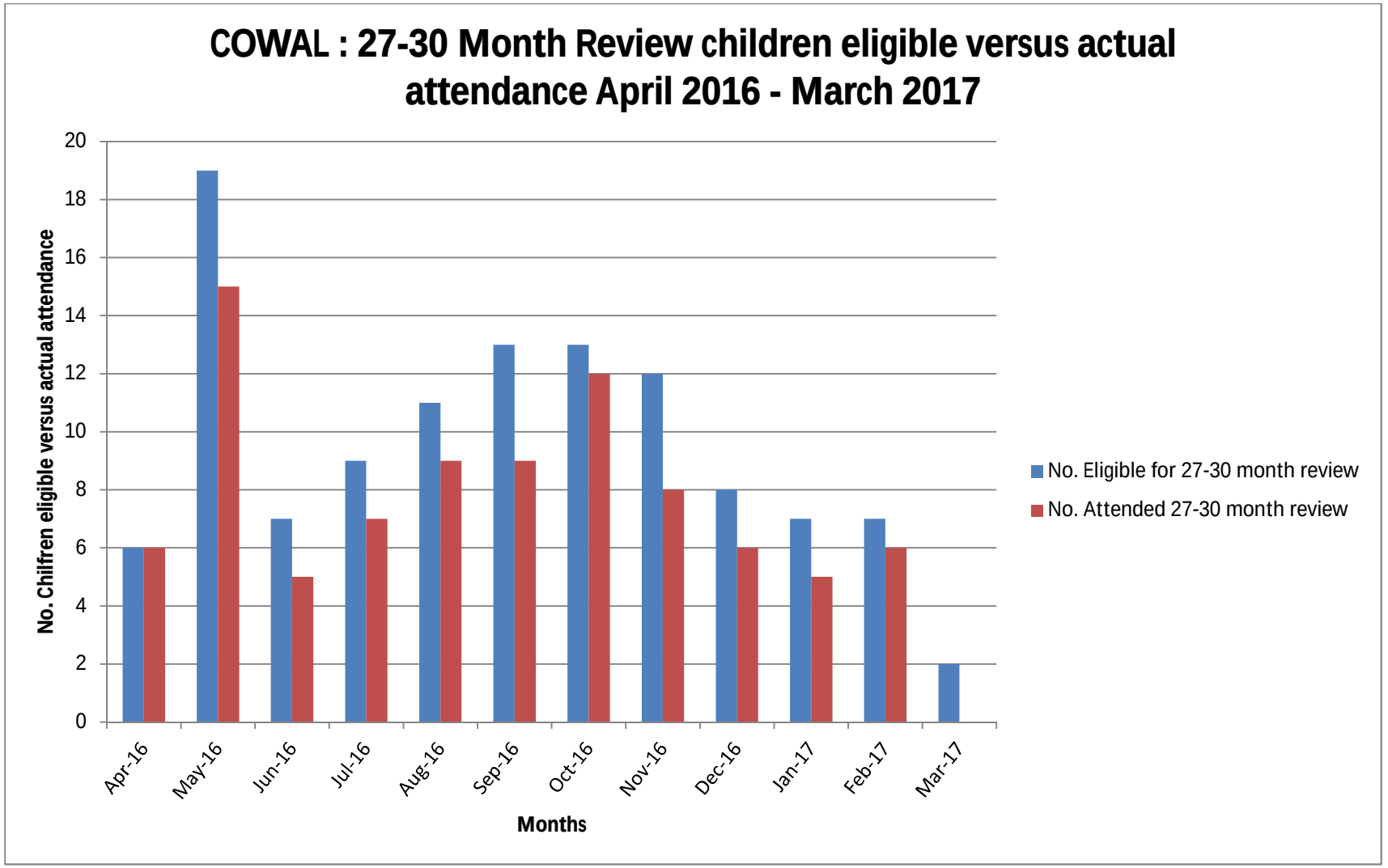
Feb-17
Mar-17
Months
No. Eligible for 27-30 month review
No. Actuall attended 27-30 month review


COWAL : 27-30 Month Review children eligible versus actual attendance April 2016 - March 2017
No. Chilfren eligible versus actual attendance
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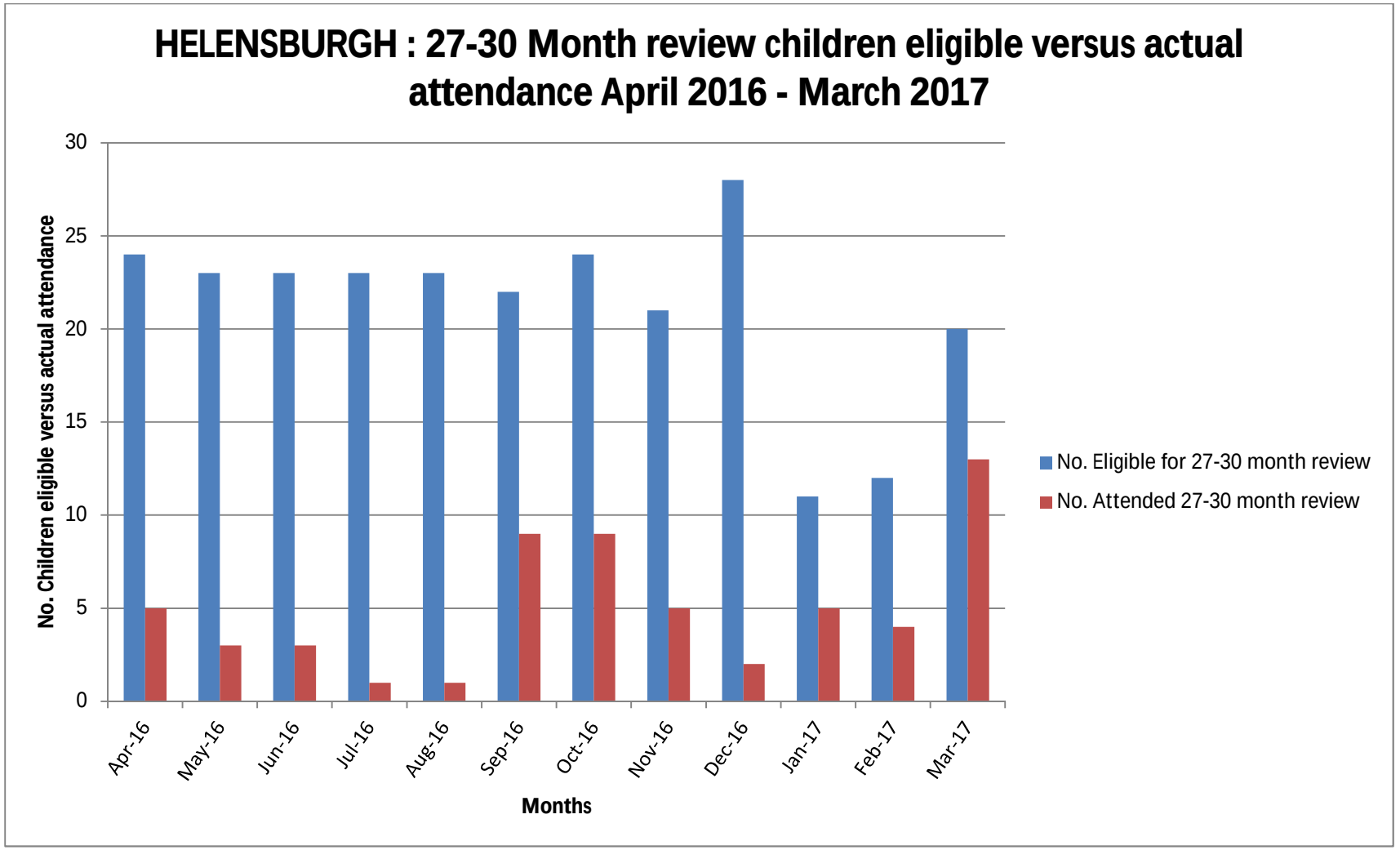
Mar-17
Months
No. Eligible for 27-30 month review
No. Attended 27-30 month review


HELENSBURGH : 27-30 Month review children eligible versus actual attendance April 2016 - March 2017
No. Children eligible versus actual attendance
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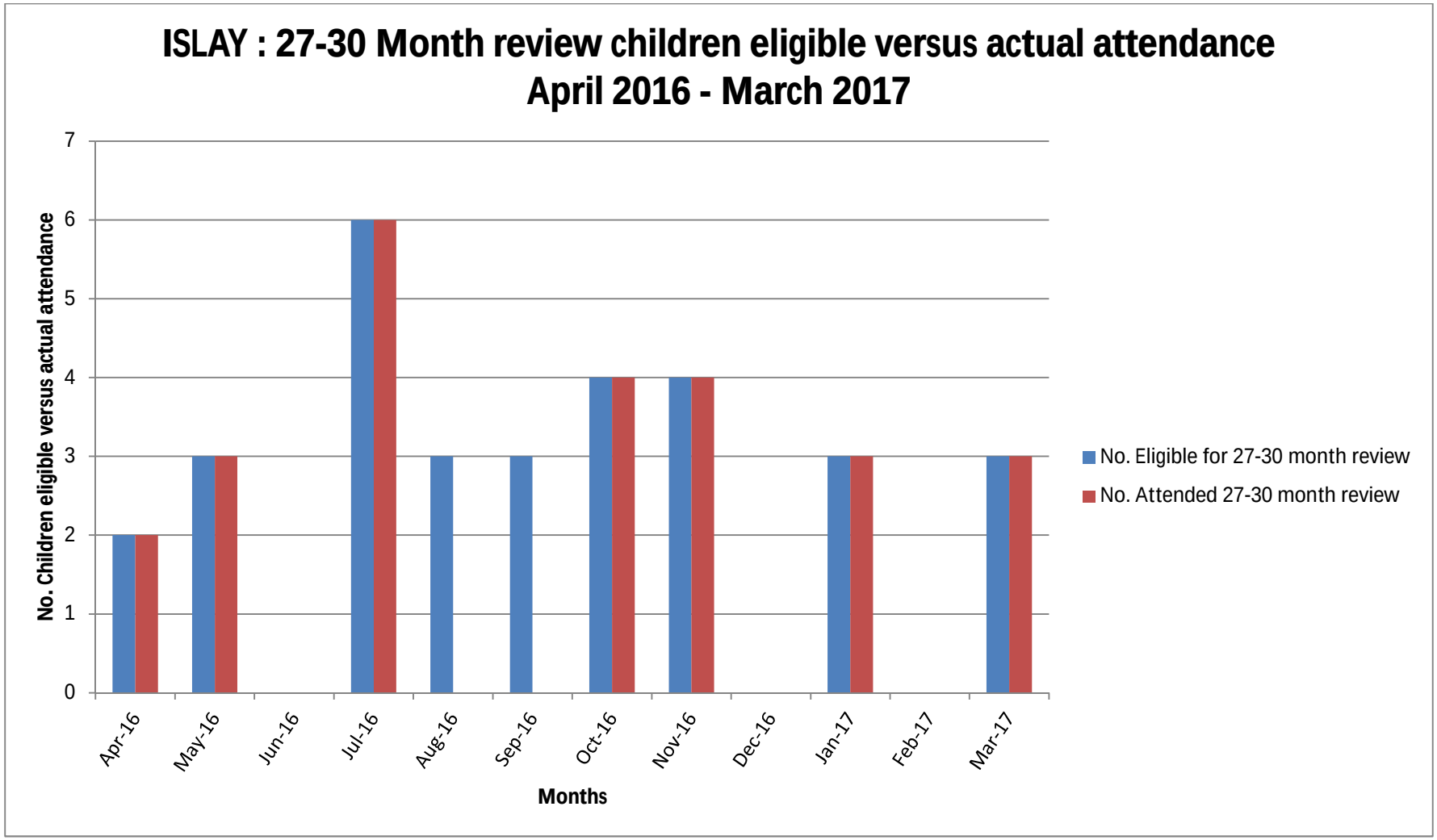
Months
No. Eligible for 27-30 month review
No. Attended 27-30 month review


ISLAY : 27-30 Month review children eligible versus actual attendance
April 2016 - March 2017
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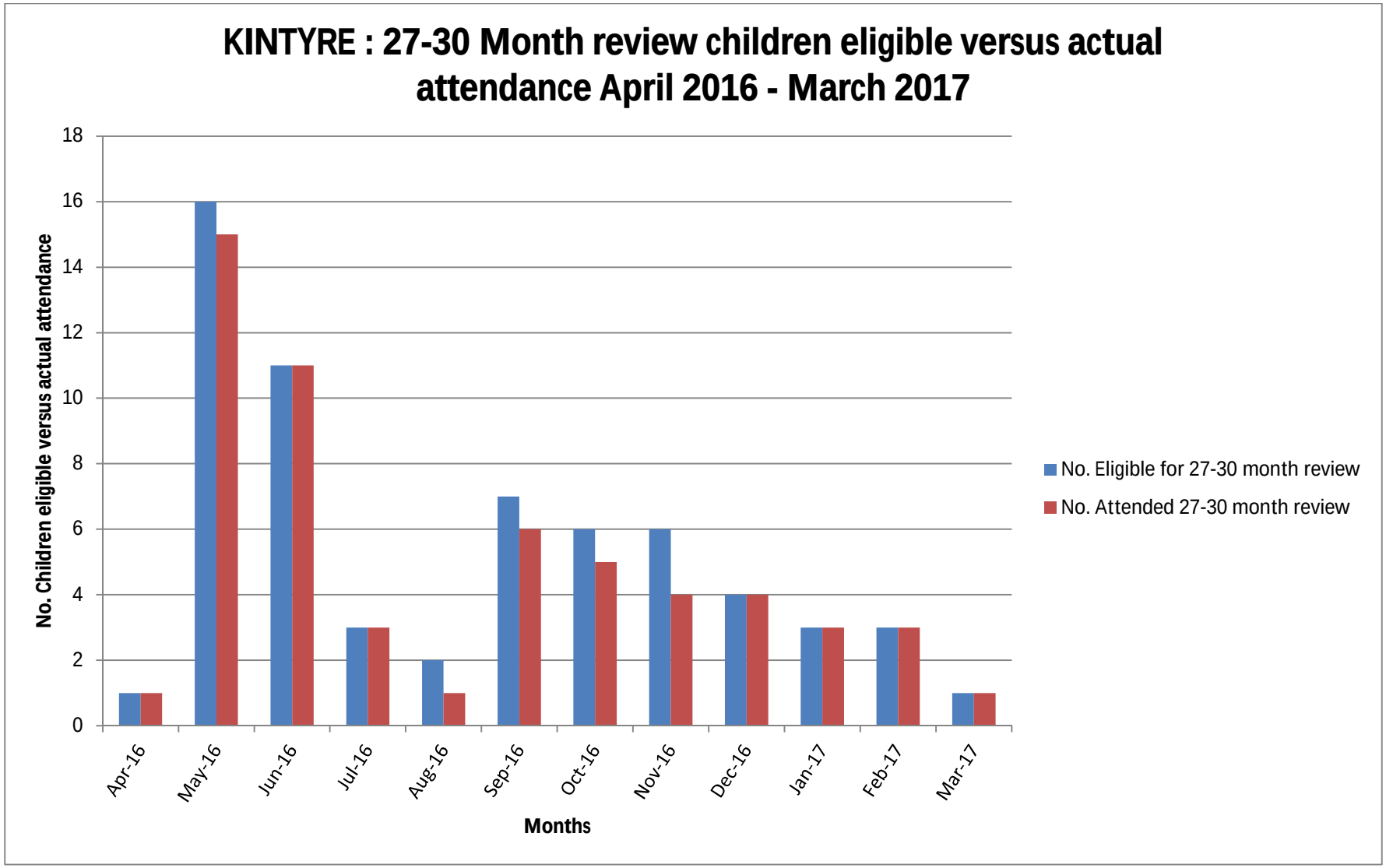
Feb-17
Mar-17
Months
No. Eligible for 27-30 month review
No. Attended 27-30 month review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No. Children eligible versus actual attendance
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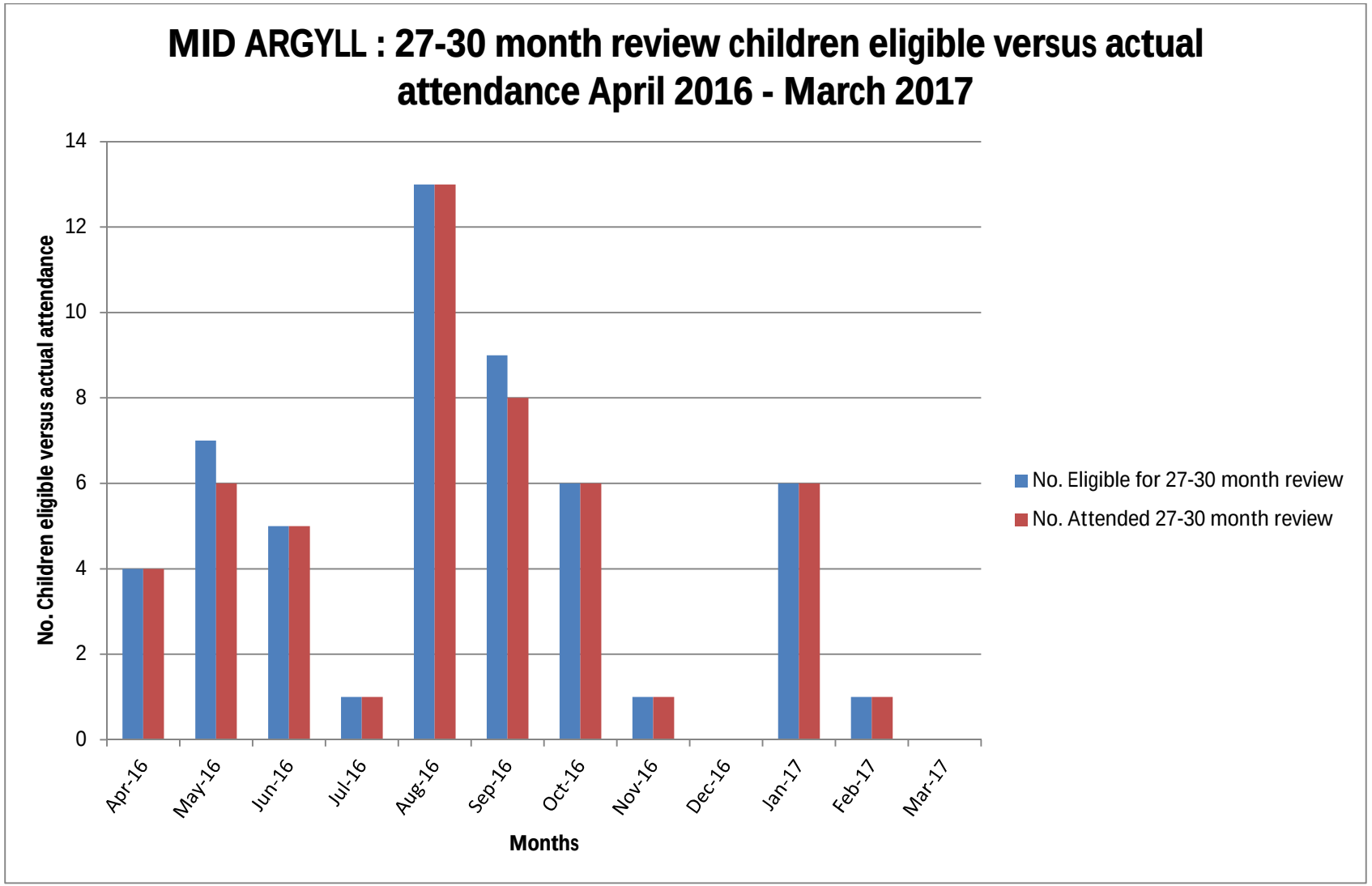
Months
No. Eligible for 27-30 month review
No. Attended 27-30 month review


MID ARGYLL : 27-30 month review children eligible versus actual attendance April 2016 - March 2017
No. Children eligible versus actual attendance
14
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Apr-16
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Sep-16
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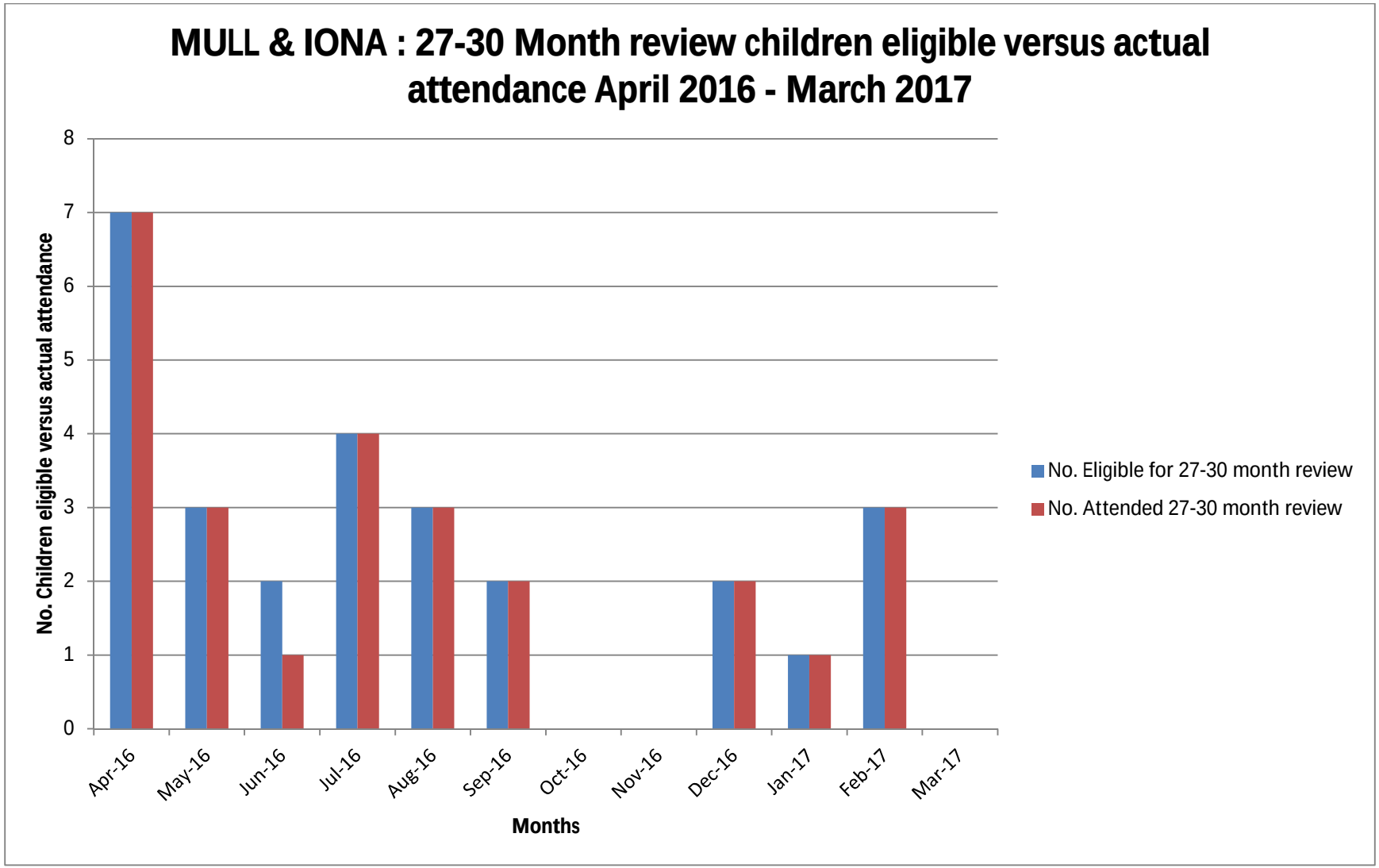
Jan-17
Feb-17
Mar-17
Months
No. Eligible for 27-30 month review
No. Attended 27-30 month review


MULL & IONA : 27-30 Month review children eligible versus actual attendance April 2016 - March 2017
No. Children eligible versus actual attendance
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Apr-16
May-16
Jun-16
Jul-16
Aug-16
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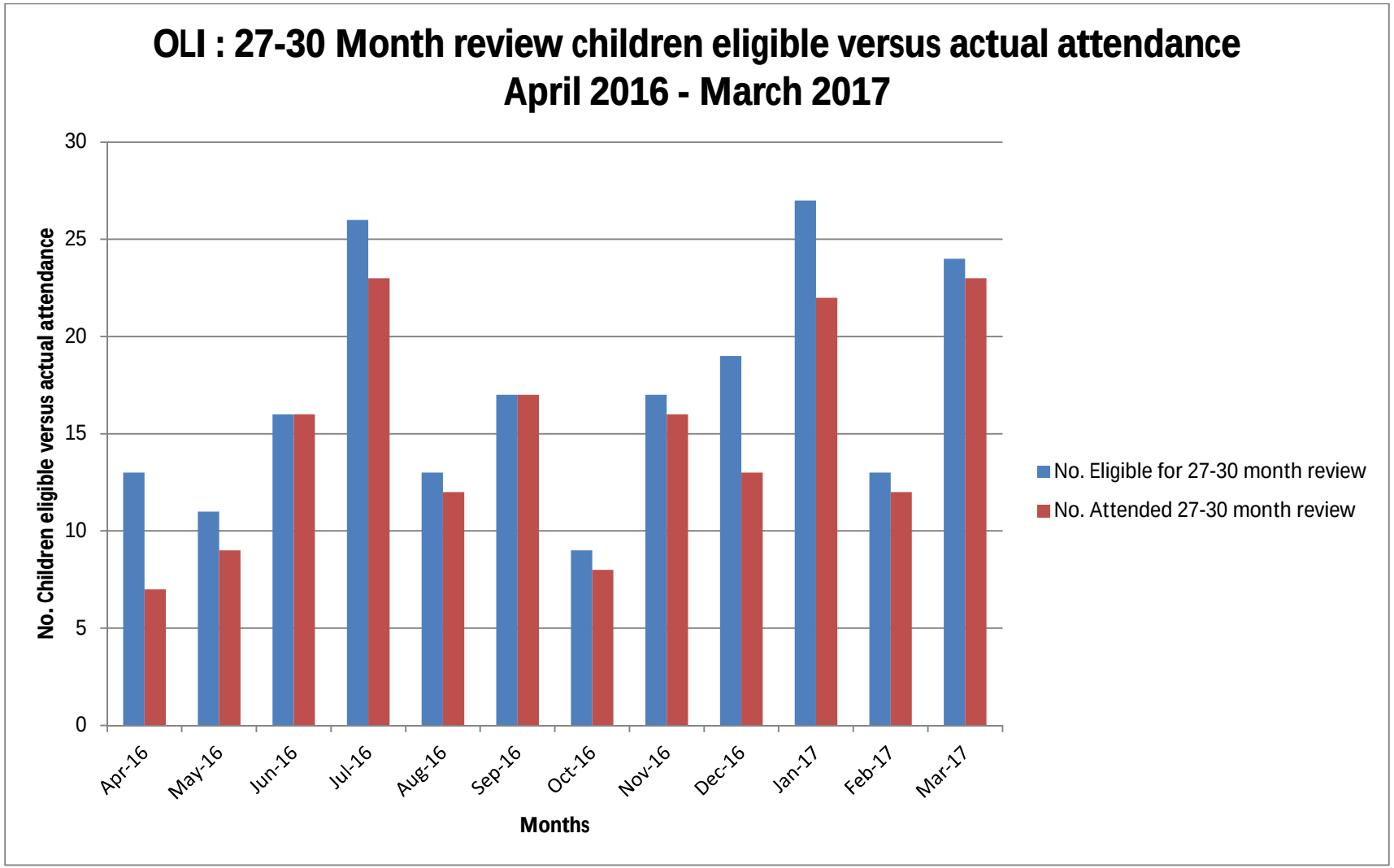
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Months
No. Eligible for 27-30 month review
No. Attended 27-30 month review


OLI : 27-30 Month review children eligible versus actual attendance
April 2016 - March 2017
No. Children eligible versus actual attendance
30
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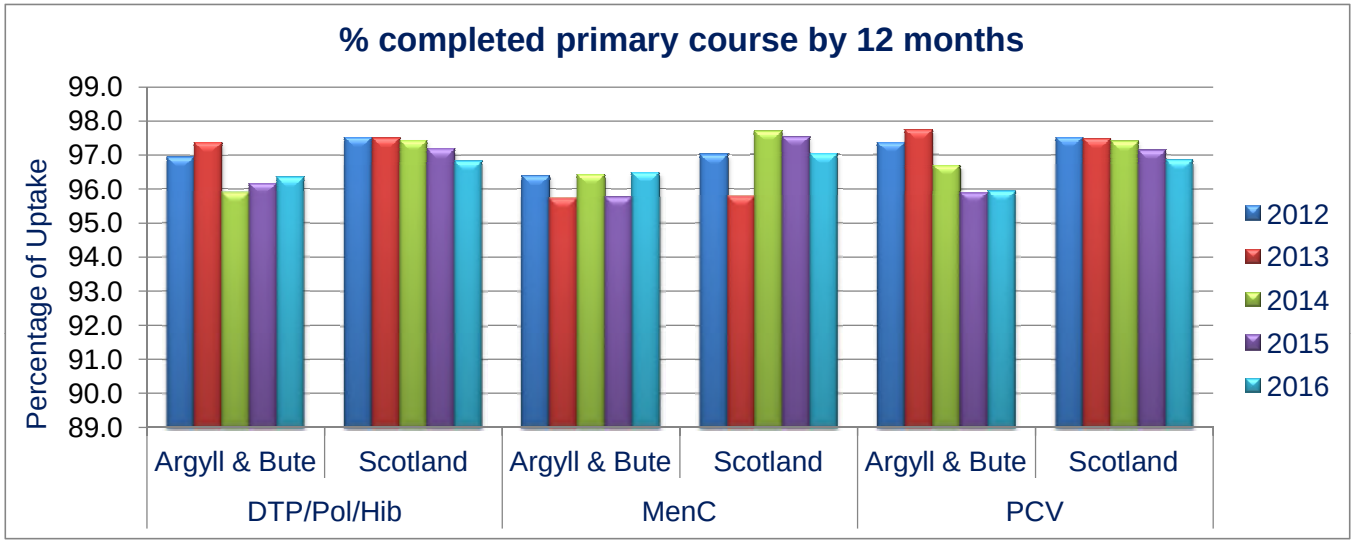
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Months
No. Eligible for 27-30 month review
No. Attended 27-30 month review

Source: http://www.isdscotland.org/Health-Topics/Child-Health/publications/data-tables.asp

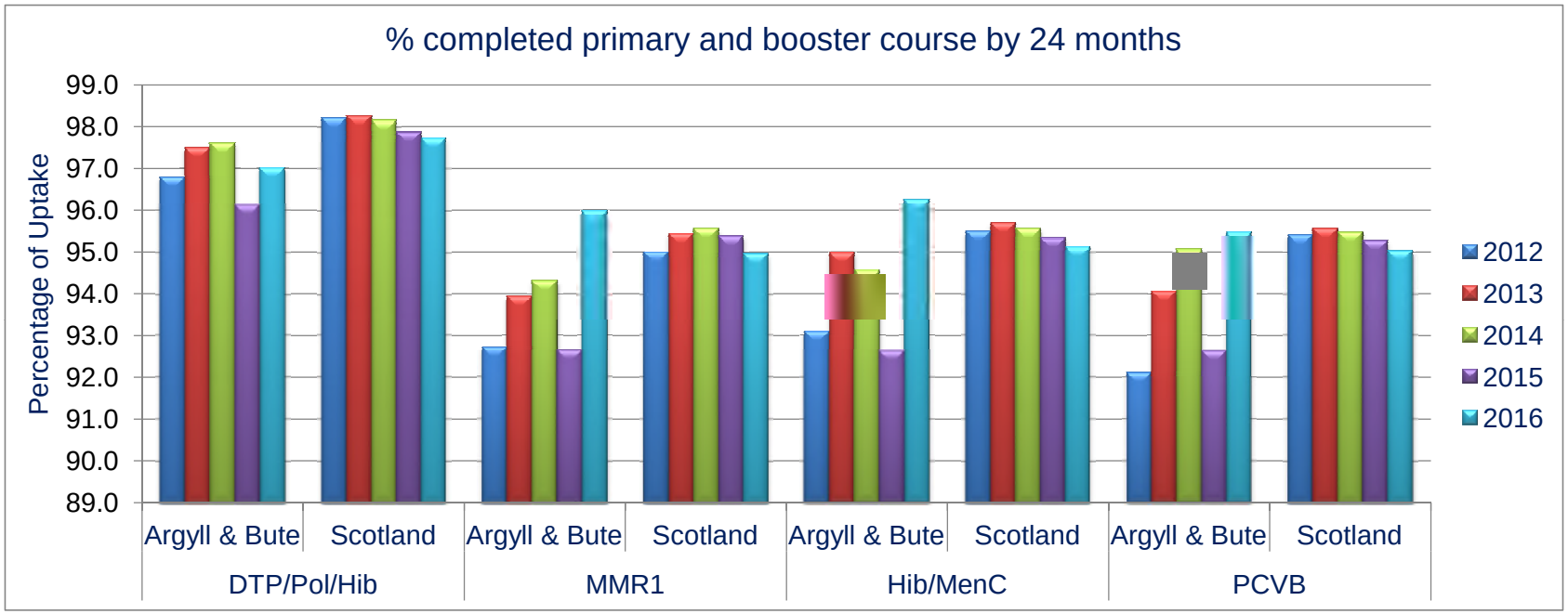
	DTP/Pol/Hib		MenC		PCV		Cohort[2]	
	Argyll & Bute	**Scotland**	Argyll & Bute	**Scotland**	Argyll & Bute	**Scotland**	Argyll & Bute	**Scotland**
2012	96.9	**97.5**	96.4	**97.0**	97.4	**97.5**	718	**58,644**
2013	97.4	**97.5**	95.7	**95.8**	97.7	**97.5**	793	**58,347**
2014	95.9	**97.4**	96.4	**97.7**	96.7	**97.4**	754	**56,357**
2015	96.2	**97.2**	95.8	**97.5**	95.9	**97.1**	755	**57,054**
2016	96.3	**96.8**	96.5	**97.0**	95.9	**96.8**	738	**55,696**
Average (mean)	96.5	**97.3**	96.1	**97.0**	96.7	**97.3**	752	**57,220**



DTP	Diptheria, Tetanus, Pertussis
Pol	Polio
Hib	Haemophilus influenza b
MenC	Meningitis C
PCV	Pneumococcal Vaccine
MMR	Measles, Mumps, Rubella

Source: http://www.isdscotland.org/Health-Topics/Child-Health/publications/data-tables.asp

	DTP/Pol/Hib		MMR1		Hib/MenC		PCVB		Cohort[2]	
	Argyll & Bute	**Scotland**	Argyll & Bu	**Scotland**	Argyll & Bute	**Scotland**	Argyll & Bute	**Scotland**	Argyll & Bute	**Scotland**
2012	96.8	**98.2**	92.7	**95**	93.1	**95.5**	92.1	**95.4**	810	**58,971**
2013	97.5	**98.3**	93.9	**95.4**	95.0	**95.7**	94.1	**95.6**	758	**58,917**
2014	97.6	**98.1**	94.3	**95.6**	94.6	**95.6**	95.1	**95.5**	790	**58,636**
2015	96.1	**97.9**	92.6	**95.4**	92.6	**95.3**	92.6	**95.3**	773	**56,844**
2016	97.0	**97.7**	96.0	**94.9**	96.2	**95.1**	95.5	**95.0**	771	**57,436**
Average (mean)	97.0	98.0	93.9	95.3	94.3	95.4	93.9	95.3	780	58,161



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Pol	Polio
Hib	Haemophilus influenza b
MenC	Meningitis C
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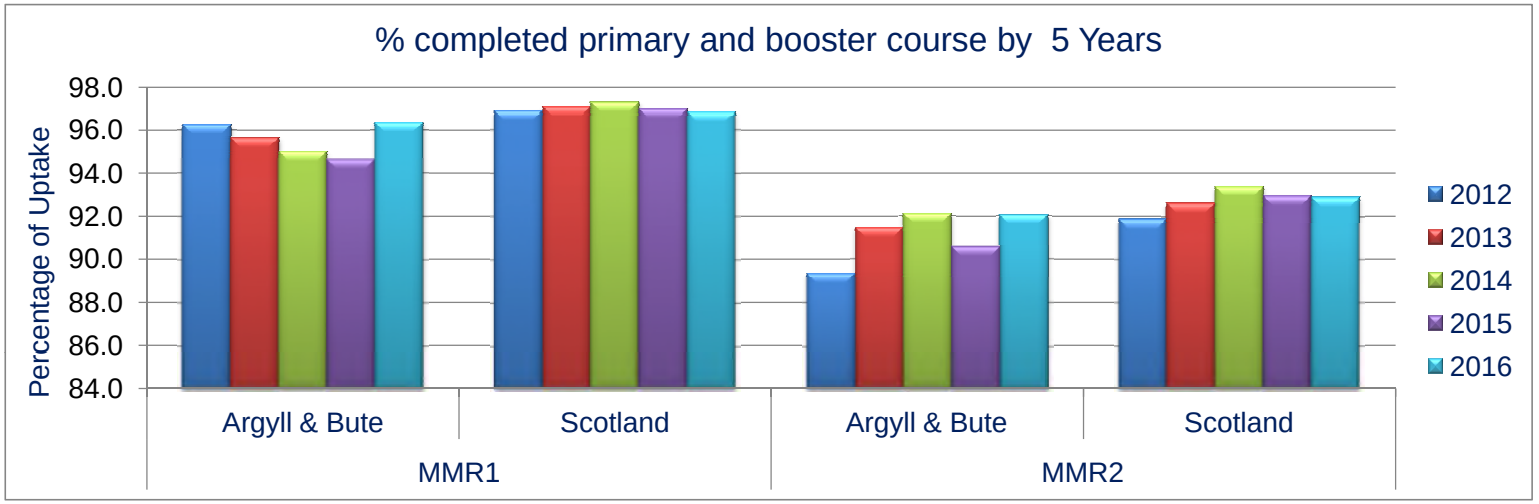
Source: http://www.isdscotland.org/Health-Topics/Child-Health/publications/data-tables.asp

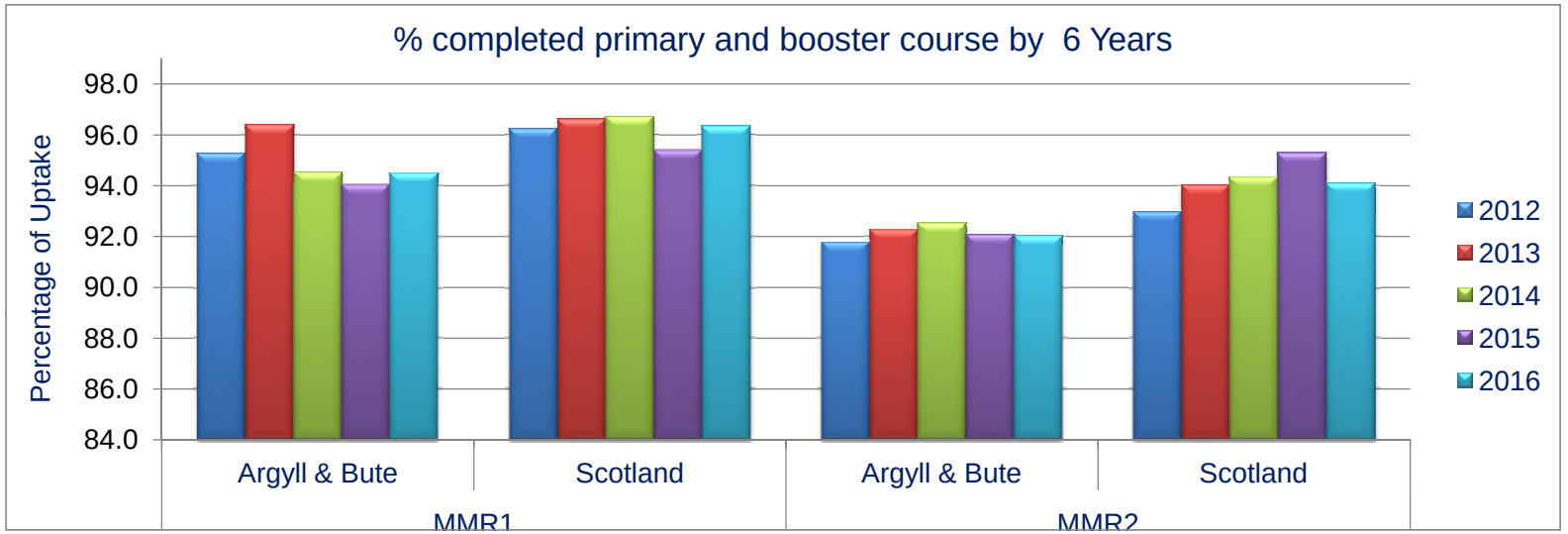
	MMR1		MMR2		Cohort[2]	
	Argyll & Bute	**Scotland**	Argyll & Bute	**Scotland**	Argyll & Bute	**Scotland**
2012	96.2	**96.9**	89.3	**91.8**	824	58,474
2013	95.6	**97.1**	91.5	92.6	843	**59,971**
2014	95.0	**97.3**	92.1	**93.4**	863	**59,719**
2015	94.6	**97.0**	90.6	**92.9**	859	**59,647**
2016	96.3	**96.8**	92.0	**92.9**	792	**59,678**
Average (mean)	95.6	97.0	91.1	92.7	836	59,498



DTP	Diptheria, Tetanus, Pertussis
PoI	Polio
Hib	Haemophilus influenza b
MenC	Meningitis C
PCV	Pneumococcal Vaccine
MMR	Measles, Mumps, Rubella

Source: http://www.isdscotland.org/Health-Topics/Child-Health/publications/data-tables.asp

	MMR1		MMR2		Cohort[2]	
	Argyll & Bute	**Scotland**	Argyll & Bute	**Scotland**	Argyll & Bute	**Scotland**
2012	95.3	**96.2**	91.8	**93.0**	802	**57,050**
2013	96.4	**96.6**	92.3	**94.0**	825	**58,829**
2014	94.5	**96.7**	92.5	**94.3**	856	**60,347**
2015	94.0	**95.4**	92.1	**95.3**	870	**56,844**
2016	94.5	**96.3**	92.0	**94.1**	888	**60,052**
Average (mean)	94.9	96.2	92.1	94.1	848	58,624



DTP	Diptheria, Tetanus, Pertussis
PoI	Polio
Hib	Haemophilus influenza b
MenC	Meningitis C
PCV	Pneumococcal Vaccine
MMR	Measles, Mumps, Rubella

OUTCOME FRAMEWORK
OUTCOMES & PERFORMANCE MEASURES (DENTISTRY)
CHILDSMILE
2015/2016

NHS BOARD: NHS Highland **Reporting Period: 2015/16**

National Outcomes (children with no signs of dental disease**)**

- 75% of P1 children with no signs of dental disease by 2022.
- 80% of P7 children with no signs of dental disease by 2022.

NHS Board Outcomes (children with no signs of dental disease**)**

- 10% increase on 2014 (P1) NDIP result from each NHS Board by 2022.
- 10% increase on 2015 (P7) NDIP result from each NHS Board by 2022.

2014 (P1) NDIP

% with no obvious decay experience in primary teeth (2014)	10% increase on baseline (%)	Desired outcome: % with no obvious decay experience in primary teeth (by 2022)
70.1% **A&B 68.3%**	7.0% **6.8%**	77.1% **75.1%**

2015 (P7) NDIP

% with no obvious decay experience in permanent teeth (2015)	10% increase on baseline (%)	Desired outcome: % with no obvious decay experience in permanent teeth (by 2022)
81.2% **A&B 73.1%**	8.1% **7.3%**	89.3% **80.4%**

CHILDSMILE CORE TOOTHBRUSHING PROGRAMME AND DENTAL PACKS

1. Free flow cup distribution. (Reporting period: Allocations for 2015/16 year of contract)
Source: local data

	Cohort	Packs distributed Cups	Percentage of allocation	**Target**
Health Visitors **A&B HSCP**	**675**	**856**	**100% +**	**100%**
Comment **January 2015 – December2015**				

2. Pack distribution. (Reporting period: Allocations for 2015/16 year of contract). Please comment if opportunistic packs are provided outwith the national contract. Childsmile Practice packs include any distributed to GDPs and to families by other staff.
Source: local data

	Cohort	Packs distributed	Percentage of allocation	**Target**
Health Visitors **A&B**	**675**	**856** **(Jan – Dec 2015)**	**100%+**	**100%**

A&B				
Nurseries	**3017**	**3017 (April/Oct 2015)**	**100%**	**100%**
Primary 1	**917**	**917 (Oct 2015)**	**100%**	**100%**
Childsmile Practice	**11PDS 11GDS**	**902**	**100% +**	
Opportunistic packs		**608 HV 250 OHSW**		
Comment				

3. Percentage of all[1] pre-school establishments offering daily supervised fluoride toothbrushing programmes. (Reporting period: July 2015 – June 2016*)*
Source: Childsmile National Headline Report
Please comment if offered more extensively than target, e.g. in breakfast clubs, playgroups etc

	Pre-school establishments (Total number)	Number of pre-school establishments toothbrushing	Percentage of total	**Target**
Nurseries Highland **A&B**	286 **73**	262 **72**	91.6% **99%**	 **100%**
Comment				

4. Percentage of supervising nursery/school staff trained and supported to deliver the toothbrushing programme. (Reporting period: July 2015 – June 2016*)*
Source: local data

	Supervising staff in establishments (Total number)	Number of staff trained and supported	Percentage of total	**Target**
Nurseries **A&B**	**298**	**291**	**98%**	**100%**
Schools **A&B**	**238**	**238**	**100%**	**100%**
Comment				

[1] Total lists of pre-school establishments as at the end of the 2015/2016 academic year provided by Childsmile teams in NHS Boards

5. Percentage of local authority primary schools[2] offering daily supervised fluoride toothbrushing programmes. (Reporting period: July 2015 – June 2016)
Sources: local data and Childsmile National Headline Report

	Baseline: Percentage of local authority primary schools brushing in 2014/15	Local authority primary schools (N)	Number of these schools toothbrushing	Percentage of N	**Target**
Schools in the 20% highest need, as defined locally		**29**	**29**	**100%**	**100%**
All Schools total	55.8%	259	153	59.1%	20%
A&B	**90%**	**82**	**74**	**90%**	**20%**
Comment					

6. Percentage of Additional Support Needs schools, units and classes supported to deliver supervised toothbrushing programmes. (Reporting period: July 2015 – June 2016)
Source: local data

	Number of each type (N)	Number of these toothbrushing	Percentage of N	**Target**
Additional support needs schools **A&B**	**1**	**1**	**100%**	**100%**
Additional support needs units (not counted above) **A&B**	**2**	**2**	**100%**	**100%**
Additional support needs classes (not counted above)				100%
Comment A&BThere are children in mainstream education with additional support needs, these children are included in mainstream schools figures				

[2] Highest need as defined by SIMD distribution of participating schools based on school postcode or school included in Childsmile School programme

CHILDSMILE NURSERY AND SCHOOL – FLUORIDE VARNISH

(Reporting period: July 2015 – June 2016)

7. Percentage of establishments in fluoride varnish (FV) programmes.
Source: Childsmile National Headline Report

	Total number of establishments	Number of establishments in FV programme	Percentage of total	**Baseline: % of establishments participating in FV in 2014/15**
Nurseries	286	93	**32.5%**	**32.1%**
A&B	**73**	**29**	**40%**	**40%**
Schools	259	78	**30.1%**	**29.6%**
A&B	**77**	**26**	**34%**	**34%**
Comment				

8. Targeted children in participating nursery and school establishments reported as a percentage of the population in nursery and the population in P1-P4 combined
Source: Childsmile National Headline Report

Total nursery population	Targeted children in participating establishments – nursery		
	Number	Percentage of total	**Target**
6,640	3,826	57.6%	**20%**
Total P1 – P4 population	Targeted children in participating establishments: P1 – P4		
	Number	Percentage of total	**Target**
13,729	6,919	50.4%	**20%**

Comment

A&B 2015			
Total Nursery Population	**1292**	**834**	**64.5%**
Total School Population	**3289**	**1944**	**59%**

9. Delivery of fluoride varnish programmes measured via consent and fluoride varnish application (FVA) rates
Source: Childsmile National Headline Report

	Total number of targeted children in participating establishments	Total number children with consents	As a percentage of total targeted	Total number children receiving at least one FVA	As a percentage of total targeted	As a percentage of total with consents
Nursery	3,826	3,132	81.9%	2,538	66.3%	81.0%
A&B	**1003**	**868**	**86.5%**	**750**	**74.8%**	**86.4%**
School: P1-P4	6,919	6,293	91.0%	6,035	87.2%	95.9%
A&B	**2140**	**1924**	**90%**	**1862**	**87%**	**96.7%**

School: all ages	10,873	9,647	88.7%	9,218	84.8%	95.6%
A&B	**2732**	**2450**	**89.6%**	**2371**	**86.7%**	**96.7%**

10. Nursery – fluoride varnish applications Source: Childsmile National Headline Report						
	one FVA		two or more FVA		Total	
Children who received FVA (number and % of targeted nursery children)	1002 (26.2%)		1536 (40.1%)		2538 (66.3%)	
A&B	**334 33.3%**		**413 41.1%**		**748 74.4%**	
SIMD distribution	two or more FVA by local SIMD					
	1	2	3	4	5	Unknown
Nursery Baseline population (N)	1,610	1,285	1,160	1,279	1,306	-
A&B	**299**	**204**	**198**	**79**	**96**	**10**
Number of children who received two or more fluoride varnishes	611	327	224	220	139	15
A&B	**247**	**179**	**169**	**67**	**78**	**8**
% of children who received two or more fluoride varnishes (percentage of N)	38.0%	25.4%	19.3%	17.2%	10.6%	-
A&B	**33%**	**23.9%**	**22.6%**	**9%**	**10.4%**	**1.1%**

11. School (P1-P4) - fluoride varnish applications Source: Childsmile National Headline Report						
	one FVA		two or more FVA		Total	
Children who received FVA (number and % of targeted P1-P4 children)	686 (9.9%)		5349 (77.3%)		6035 (87.2%)	
A&B	**228 10.7%**		**1636 76.4%**		**2665 87.4%**	
SIMD distribution	two or more FVA by local SIMD					
	1	2	3	4	5	Unknown
P1-P4 Baseline population (N)	3,122	2,595	2,556	2,680	2,776	-
A&B	**2564**	**1262**	**894**	**811**	**621**	**70**
Number of P1-P4 children who received two or more fluoride varnishes	2,204	1,066	823	690	510	56
A&B	**693**	**375**	**385**	**163**	**228**	**20**
% P1-P4 children who received two or more fluoride varnishes (percentage of N)	70.6%	41.1%	32.2%	25.7%	18.4%	-
A&B	**37.1%**	**20.1%**	**20.6%**	**8.7%**	**12.2%**	**1%**
Comment						

CHILDSMILE PRACTICE

(Reporting period: April 2015 – March 2016)

12. Delivery of Childsmile Practice programme measured via HV referral; DHSW activity and Dental Practice activity

12.1. HV referral to Childsmile

Source: Childsmile National Headline Report

6-8 weeks	Number of reviews	Number of referrals	Percentage referred
April 2015 – Sep 2015	1,260	264	21.0%
Oct 2015 – March 2016	1,215	198	16.3%

Comment

12.2. DHSW activity

Source: Childsmile National Headline Report

	Children referred to DHSW	Children successfully contacted by DHSW	Children with a Childsmile dental appointment arranged	Children registered/will register with own dentist
Number	1,005	1,115	821	323

Comment

12.3. Childsmile Delivery in Dental Practice – Quality Indicators topical fluoride (44g)

Source: ISD data provided to health boards. (HBs to fill in.)

	Total	Red <30%	Amber >=30% and <60%	Green >=60%
Non-salaried GDS				
Public Dental Service				

Comment

13. Registration and participation rates within NHS GDS (Reporting period: quarter ending *month and year*)

Source: to be determined, may require data request to ISD

	0	1	2
Children registered Number and percentage (of population)	(%)	(%)	(%)
Children participating Number and percentage (of those registered)	(%)	(%)	(%)

NHS Board: Argyll and Bute HSCP ~ NHS Highland Date: 2.3.17

Argyll & Bute Health & Social Care Partnership

Integrated Joint Board

Agenda item : 5.8

Date of Meeting: **31 May 2017**

Title of Report: **Argyll & Bute HSCP- Performance Report National Health and Well-Being Outcome indicators**

Presented by: **Stephen Whiston, Head of Strategic Planning & Performance**

The SMT is asked to:

- Note the HSCP performance against National Health and Well Being Outcomes 9 & CS (Customer Services) for Quarter 4
- Note the actions identified to address deficiencies in performance as detailed in the exception reports
- Update on the new performance indicators prescribed for the HSCP across 6 domains for performance monitoring in 2017/18

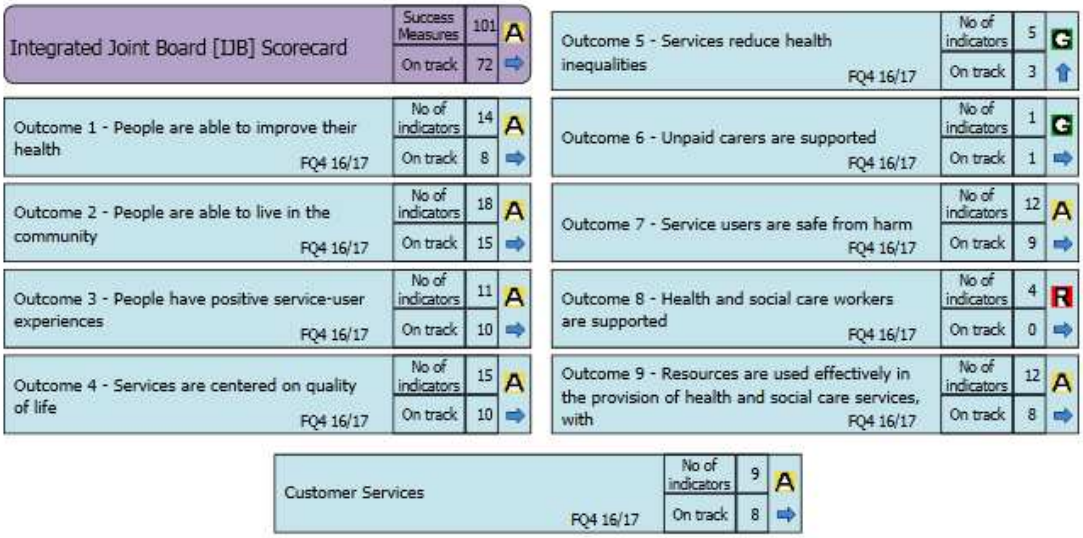
1 Background

The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. These suites of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals.

Currently there are 9 key National Health and Wellbeing Outcomes (NHWBO) and 23 sub-indicators which form the basis of the reporting requirement for the HSCP.

2 HSCP Performance against the NHWB outcomes for Financial Quarter 4 16/17

Figure 1 below provides a summary of the performance on the pyramid reporting system, noting the 101 scorecard success measures and of these 72 are currently reported as being on track for FQ4



The IJB has requested that it has visibility of all indicators which are off track and a summary schematic on page 4&5 of the exceptions report details this.

3 Detailed Performance Report Outcome Indicators 9 & Customer Services (CS)

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

There are 12 indicators being measured against this outcome, 8 are on track, 4 are off track and red flagged.

- *Falls rate per 1,000 population aged 65+-*
- *Criminal Justice - CJ65 – Average hours per week taken to complete CPO (Community Payback Order) Unpaid Work/ CS (Community Service) Orders*
- *SCRA43 - % of SCRA (Scottish Children's Reporters Administration) reports submitted on time*
- *% of SMR01 (Scottish Morbidity Records) returns received*

Outcome CS – Customer Services

There are 9 indicators being measured against this outcome, 8 indicators are on track.

1 Indicator is off track and red flagged.

- *% of NHS simple complaints – achievement against 20 days*

The exception report attached provides the detail of the performance against each of the indicators and the action in hand to rectify performance.

4 Integration Authorities Performance Indicators 2017/18

The Ministerial Strategic Group for Health and Community Care (MSG) has agreed that for 2017/18 it will direct Integration Authorities to monitor progress across the following domains:

- Reduce unplanned (Emergency) admissions – by increasing anticipatory care activity in the community and in primary care
- 10% reduction in occupied bed days for unscheduled care (emergency);

- A&E performance;- meet the 4 hour target and reduce unnecessary attendance
- Delayed discharges – reduce the amount of time (occupied bed days) patients are delayed in hospital
- End of life care – increase the provision of patient end of life care in the community
- The balance of spend across institutional and community services by 2021 have the majority of the health budget being spent in the community

The Health and Social Care Delivery Plan (http://www.gov.scot/Resource/0051/00511950.pdf) sets a clear objective of reducing the use of hospital based unscheduled care by around 10% over the next financial year including making further progress on delayed discharge across the NHS in Scotland. This objective moves the focus from being purely about discharge to being about the whole pathway of care and the use of anticipatory planning and action to prevent admission in the first place.

The HSCP is still validating the initial information received from ISD and with NHSGG&C with regard to its SLA commissioning intentions.

- This includes presenting this activity information at locality level split by NHS Greater Glasgow and Clyde hospitals as well as Argyll and Bute hospitals.
- Agreeing locally appropriate targets across the domains reflecting the reality of provision in each acute setting, to ensure it is meaningful for clinicians and locality planning groups.

The HSCPs improvement targets in the performance domains at HSCP scale for 2017/18 is detailed in the table below:

Indicator & Trajectory	Indicator	Target	Frequency	Period	Latest Data	Indicative Target
Unplanned Admissions	Total number of admissions*	Reducing bed days up to 10% by 2017/18.	Monthly Data	Feb 17	673	606
	A&E conversion rate			Feb 17	37.40%	
Unplanned bed days	Total number of bed days acute specialities *	Reducing bed days by between 1-10%.	Monthly Data	April 16 - Feb 17	56,069	50,462-55,508
	Total number of bed days mental health specialities *			April- Dec 16	10,333	9,333
A&E performance	Number of attendances	Remain at current levels of performance	Monthly Data	Feb 17	1143	
	% seen within 4hrs			Feb 17	95.20%	
Delayed discharges	Total number of bed days occupied	Reducing delayed discharges occupied bed days by 10%.	Monthly Data	Jan 17	511	460
	Reason for delay - Code 9 Exemptions			Jan 17	62	
	Reason for delay - H&SC Reasons			Jan 17	344	
	Reason for delay - Patient /Family			Jan 17	105	
End of Life Care	Percentage of last six months of life by setting community & hospital	Remain at current levels of performance	Annual Data	2015/16	90%	
	Occupied bed days during last six months of life			2015/16	20749	
Balance of care	Percentage of population in community or institutional settings	By 2021 have the majority of the health budget being spent in the community **	Annual Data	-	-	-

Note:

**** Data includes NHSGG&C and Argyll and Bute Hospital activity***

***** Not yet available***

The MSG is expecting to receive a quarterly overview on progress across the whole Health and Social Care system and the HSCP will be providing objectives and activity targets on that basis in the performance areas identified and incorporating this into the IJB performance report.

5 Governance Implications

5.1 Contribution to IJB Objectives

The PPMF is in line with the IJB objectives as detailed in its strategic plan.

5.2 Financial

There are a number of NHWBO indicators which support the quality and financial performance of the HSCP including productivity, value for money and efficiency.

5.3 Staff Governance

A number of indicators under outcome 8 are pertinent for staff governance purposes

5.4 Planning for Fairness:

The NHWBO indictors help provide an indication on progress in addressing health inequalities.

5.5 Risk

Ensuring timely and accurate performance information is essential to mitigate any risk to the IJB governance, performance management and accountability.

5.6 Clinical and Care Governance

A number of the NHWBO indicators support the assurance of health and care governance and should be considered alongside that report

5.7 Public Engagement and Communication

A number of the NHWBO indicators support user and patient experience/assessment of the HSCP services and planning processes

Argyll & Bute Health and Social Care Partnership

Performance Exception Report for Integrated Joint Board
Outcomes 9 & CS – May 2017

Performance & Improvement Team

"People in Argyll and Bute will live longer, healthier, happier, independent lives"

Exception Reporting & Briefing Frequency

The Integrated Joint Board will receive this performance and exception report on a 6 weekly basis, this will be taken from a live snapshot of the current overall HSCP performance; focussing on those measures showing as below target performance. The layout of the report is designed to give IJB members a quick easy-read overview of exception across the IJB Scorecard, the format of the report uses the key aspects of the Pyramid Performance Management System in order to ensure continuity and consistency. Trend indicators are included within the report to ensure that performance variance and movement is reflected against the most recent reporting episodes.

This exception report format will be used to communicate performance across the HSCP and key stakeholders including its host bodies. The table below notes the groups and briefing frequency:

Group	Briefing Frequency
Local Authority –PR Committee	Quarterly
NHS Board	Quarterly
Community Planning Partnership *	Quarterly
Area- Community Planning Partnerships*	Quarterly

The following indicators under Outcome 9 & CS (Customer Service) are reported as off track for Q4 16/17 and are included with associated exceptions report for visibility and scrutiny by IJB.

Outcome 9 – Resources are used effectively in the provision of Health and Social Care services

Outcome CS – Customer Services

Outcome / Performance Indicator		Target	Actual	Trend	Period	Responsible Manager
9	Falls rate per 1,000 population aged 65+	21	22	→	FQ4	Lorraine Paterson
9	CJ65 - Average hrs per wk taken to complete CPO Unpaid Work/CS Orders	8hrs	4hrs	↓	FQ4	Alex Taylor
9	SCRA43 - % of SCRA reports submitted on time	75%	64%	↓	FQ4	Alex Taylor
9	% of SMR1 returns received	95%	86%	↑	FQ4	Lorraine Patterson
Outcome / Performance Indicator		**Target**	**Actual**	**Trend**	**Period**	**Responsible Manager**
CS	% of NHS simple complaints - achievement against 20 days	80%	0%	↓	FQ4	Elizabeth Higgins

FQ4 16/17 Other NHWBO indicators currently off track presented for IJB reference

Outcome/Performance Indicator	Target	Actual	RAG	Trend & Previous	In charge
Outcome 1					
AC1 - % of Older People receiving Care in the Community	80%	74 %	●	⇓ (75%)	Allen Stevenson
AC15 - No waiting more than 12 weeks for homecare service - assessment authorised	6	13	●	⇑ (23)	Allen Stevenson
No of alcohol brief interventions in line with SIGN 74 guidelines	1024	857	●	⇑ (651)	Lorraine Paterson
No of ongoing waits >4 wks for the 8 key diagnostic tests	0	41	●	⇑ (49)	Lorraine Paterson
NHS-H7 - Proportion of new-born children breastfed - STANDARD	33.30%	30.0 %	●	⇒ (30.0%)	Louise Long
% >18 type 1 Diabetics with an insulin pump	12%	6 %	●	⇒ (6%)	Lorraine Paterson
Outcome 2					
AC5 - Total No of Delayed Discharge Clients from A&B	12	17	●	⇓ (14)	Allen Stevenson
Falls rate per 1,000 population aged 65+	21	22	●	⇒ (22)	Lorraine Paterson
Outcome 3					
No of patients with early diagnosis & management of dementia	890	804	●	⇓ (824)	Lorraine Paterson
Outcome 4					
No of outpatient ongoing waits >12 wks	0	217	●	⇓ (138)	Lorraine Paterson
% of patients on the admissions waiting lists with medical unavailability	2.0%	3.2%	●	⇓ (1.9%)	Lorraine Paterson
Outcome 7					
CP16 - % of Children on CPR with a completed CP plan	100%	91%	●	⇑ (84%)	Alex Taylor
CP15 - % of Children on CPR with no Change of Social Worker	80%	76%	●	⇓ (85%)	Alex Taylor

Outcome/Performance Indicator	Target	Actual	RAG	Trend & Previous	In charge
Outcome 8					
Social Work staff attendance	3.8 days	3.9%	●	⇑ (4.1 days)	Allen Stevenson
% of NHS sickness absence	4.00%	5.52%	●	⇑ (6.57%)	Lorraine Patterson
Health & Social Care Partnership % of PRDs completed	90%	52%	●	⇓ (59%)	Allen Stevenson
% of NHS staff with a completed & recorded KSF/PDP review	80.00%	28.85%	●	⇑ (12.55%)	Lorraine Patterson

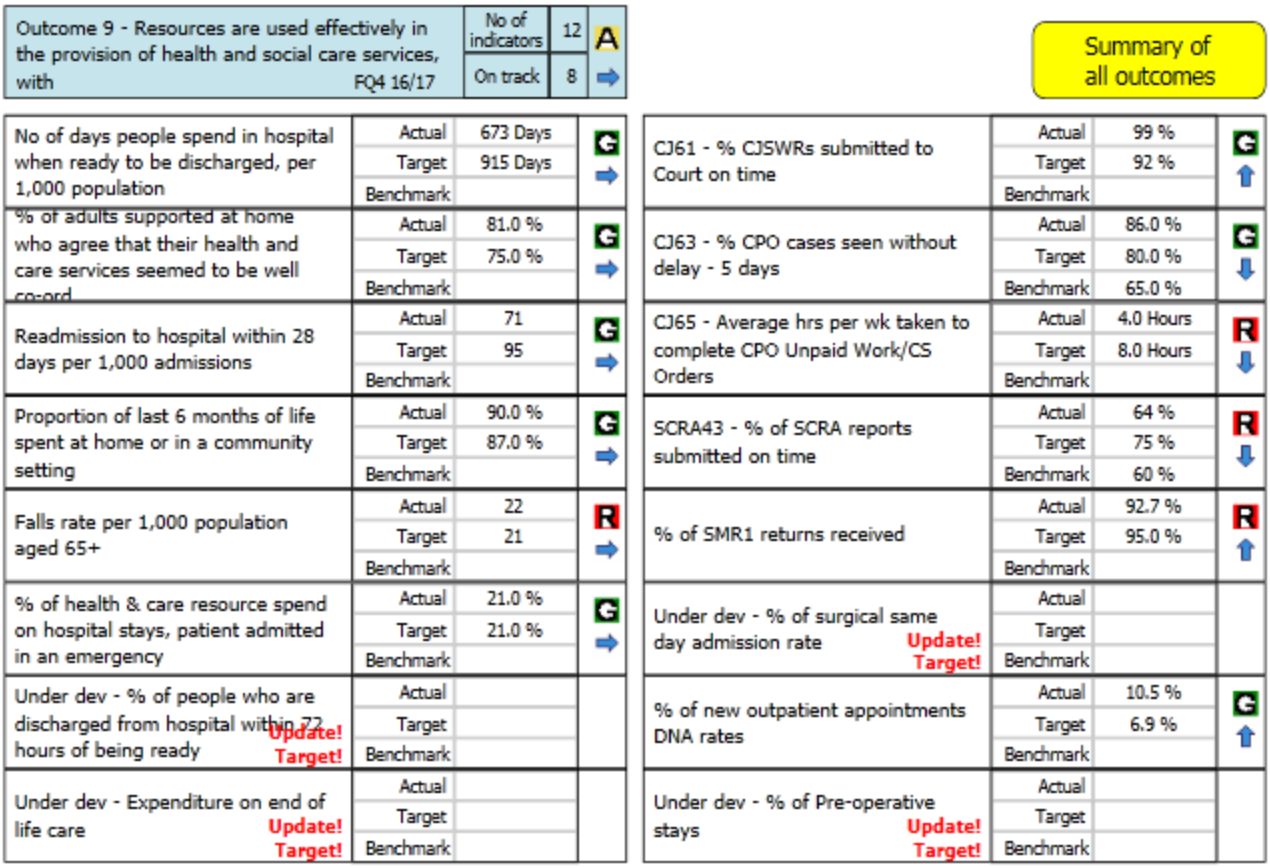
Note:

⇓ = performance declining i.e. further from target

⇑ = performance improving i.e. closer to target

⇒ = no change

Outcome 9 – Resources are used effectively in the provision of Health and Social Care services



Outcome 9 - Resources are used effectively in the provision of health and social care services, with FQ4 16/17	No of indicators	12	A
	On track	8	⇒

Summary of all outcomes

No of days people spend in hospital when ready to be discharged, per 1,000 population	Actual	673 Days	G ⇒
	Target	915 Days	
	Benchmark		
% of adults supported at home who agree that their health and care services seemed to be well co-ord	Actual	81.0 %	G ⇒
	Target	75.0 %	
	Benchmark		
Readmission to hospital within 28 days per 1,000 admissions	Actual	71	G ⇒
	Target	95	
	Benchmark		
Proportion of last 6 months of life spent at home or in a community setting	Actual	90.0 %	G ⇒
	Target	87.0 %	
	Benchmark		
Falls rate per 1,000 population aged 65+	Actual	22	R ⇒
	Target	21	
	Benchmark		
% of health & care resource spend on hospital stays, patient admitted in an emergency	Actual	21.0 %	G ⇒
	Target	21.0 %	
	Benchmark		
Under dev - % of people who are discharged from hospital within 72 hours of being ready Update! Target!	Actual		
	Target		
	Benchmark		
Under dev - Expenditure on end of life care Update! Target!	Actual		
	Target		
	Benchmark		

CJ61 - % CJSWRs submitted to Court on time	Actual	99 %	G ⇑
	Target	92 %	
	Benchmark		
CJ63 - % CPO cases seen without delay - 5 days	Actual	86.0 %	G ⇓
	Target	80.0 %	
	Benchmark	65.0 %	
CJ65 - Average hrs per wk taken to complete CPO Unpaid Work/CS Orders	Actual	4.0 Hours	R ⇓
	Target	8.0 Hours	
	Benchmark		
SCRA43 - % of SCRA reports submitted on time	Actual	64 %	R ⇓
	Target	75 %	
	Benchmark	60 %	
% of SMR1 returns received	Actual	92.7 %	R ⇑
	Target	95.0 %	
	Benchmark		
Under dev - % of surgical same day admission rate Update! Target!	Actual		
	Target		
	Benchmark		
% of new outpatient appointments DNA rates	Actual	10.5 %	G ⇑
	Target	6.9 %	
	Benchmark		
Under dev - % of Pre-operative stays Update! Target!	Actual		
	Target		
	Benchmark		

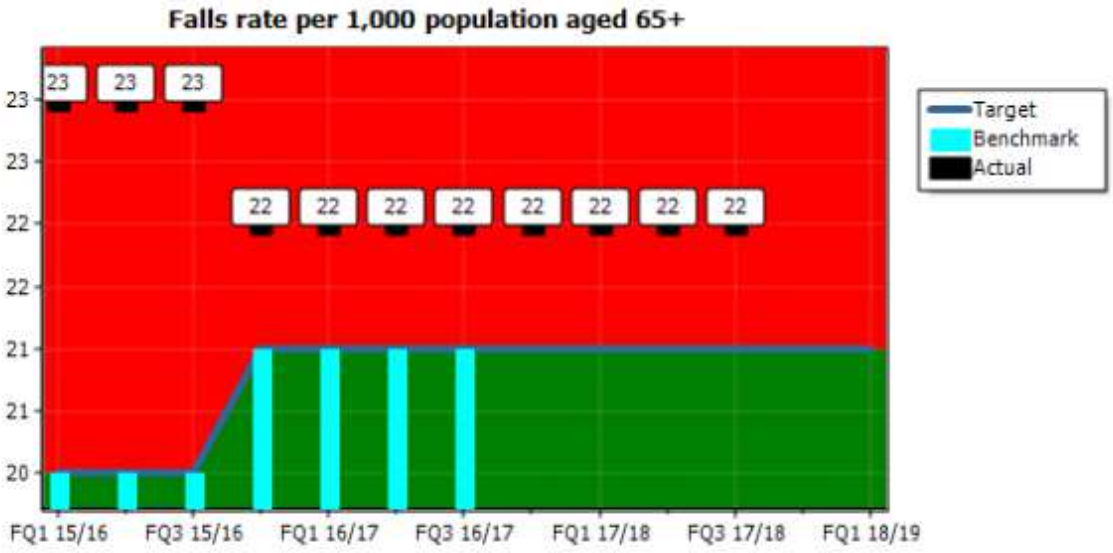
There are 12 indicators being measured against this outcome, 8 are on track, 4 are off track and red flagged.

- Falls rate per 1,000 population aged 65+-
- CJ65 – Average hours per week taken to complete CPO Unpaid Work/ CS Orders
- SCRA43 - % of SCRA reports submitted on time
- % of SMR1 returns received

Management Exception Reporting

Performance Indicator: Outcome 9 Falls rate per 1,000 population for adults aged 65+	**Responsible Manager:** Lorraine Paterson
Target: 21 Actual: 22	Date of Report: FQ4 16/17

Description of Exception



QUARTERLY CONVERSION – Shows annual values

The focus of this indicator is the rate per 1,000 population of falls that occur in the population (aged 65 plus) who were admitted as an emergency to hospital.

Data source: ISD published updated FY15/16 data Feb 2017. 22.3 rate per 1000 (65+) based on 475 Falls episodes against 65+ population of 21324. (NRS 2015 mid-year estimates)

Linked to IJB Outcome 2, 4, 7 and 9.

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

Work has taken place supported by the ICF across all localities to meet the requirements of the national minimum standard for prevention and management of falls in the community. The national framework for prevention and management of falls in the community has 4 stages -

Stage 1 is around active ageing and self-management and there are a number of resources available for the public on the NHS Highland Public site –

http://www.nhshighland.scot.nhs.uk/YourHealth/Falls/Pages/Welcome.aspx

In the past year leisure services have trained staff to deliver exercise programmes to prevent falls and we will be working to work across services to promote exercise to reduce

falls and frailty.

Stage 2 is identifying people at risk with a Level 1 conversation (which all staff in health and social services are recommended to do with older people) and directing to Level 2 screening to identify modifiable risk factors. This screening is taking place across localities but we are struggling to collect data on the number of Level2 screens completed due to electronic systems.

Stage 3 involves responding to an individual who has fallen and requires immediate assistance. We are currently involved in a Quality Improvement Project with Healthcare Improvement Scotland and the Scottish Ambulance service to develop responding services to keep people at home and avoid unnecessary conveyance to hospital. Equipment has been provided to local community teams and training has taken place.

Stage 4 is coordinated management, specialist assessment and pathways are in place to ensure people receive evidence based interventions and are provided with a plan and intervention to reduce their risk of falls.

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Community teams will be required to keep local action plans current and to work with the falls prevention coordinator to implement measures across the 4 stages of the national framework. These plans will be monitored through the quality pathways group.

Additional Support Requirements Identified

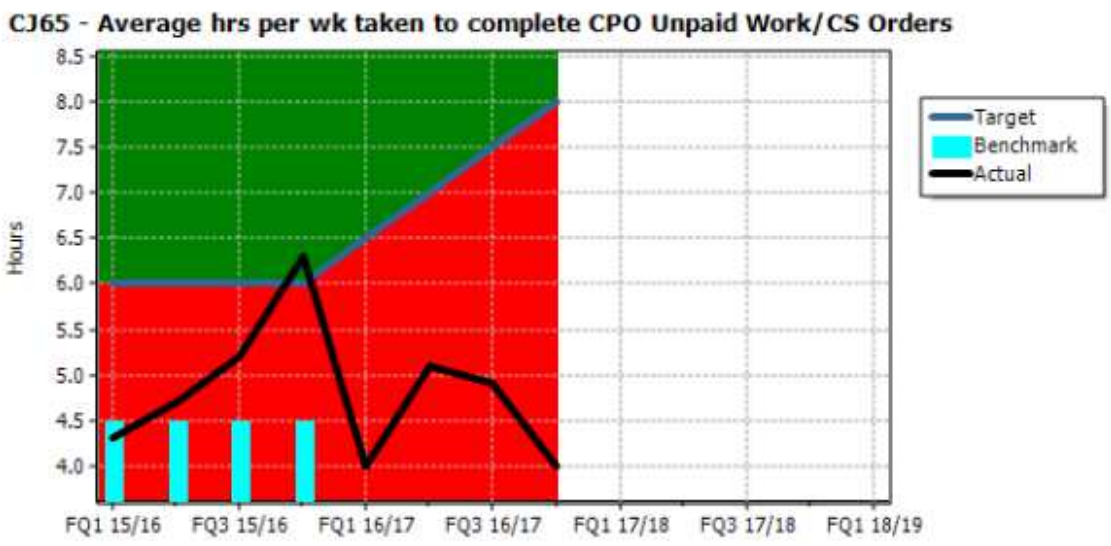
Training needs have been identified and requirements are being explored. In particular the Level1 conversation and basic awareness training needs developed for all health and social care staff in contact with older people.

Improvement Forecast Date:	Review Date:
October 2017	November 2017

Management Exception Reporting

Performance Indicator: Outcome 9 CJ65 – Average hours per week taken to complete CPO Unpaid Work/ CS Orders	Responsible Manager: Alex Taylor
Target: 8hrs Actual: 4hrs	Date of Report: FQ4 16/17

Description of Exception



Average hours per week taken to complete CPO Unpaid Work/CS Orders.

SM: Average hours per week taken to complete Community Payback Order (CPO) Unpaid Work/Community Service orders (CJ65).

Target: 8hrs per week by March 2016. Benchmark: FQ1 2014/15=6.5hrs. Linked to the ICSP 2014 - 2017, Outcome 6.

Data source: CareFirst Linked to IJB Outcome 9

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

Target has been reviewed and reduced to 6 hrs per week to reflect a more realistic alignment with work squad availability. The number of squads available is dictated by financial resources and currently we run all the squads that can be budgeted for. Any significant increase in numbers reduces the frequency of attendance on a squad and the reduced target will still be a challenge

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Closer attention will now be paid to unit cost, the attendance of offenders and the scheduling of the squads to ensure maximum participation.

Additional Support Requirements Identified

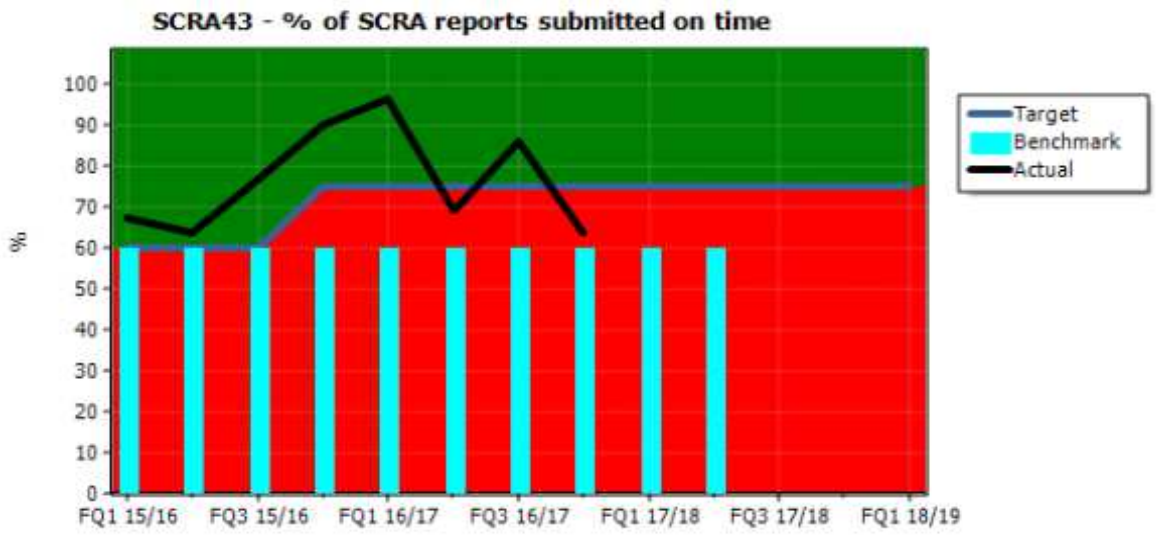
Not at this stage.

Improvement Forecast Date:	Review Date:
FQ1	FQ1

Management Exception Reporting

Performance Indicator: Outcome 9 SCRA43 - % of SCRA reports submitted on time	**Responsible Manager:** Alex Taylor
Target: 75% Actual: 64%	Date of Report: FQ4 16/17

Description of Exception



The percentage of Initial Assessment Reports (IAR's) and Social Background Reports (SBR's) completed and returned to the Scottish Children's Reporters Administration (SCRA) within a 20 working day time interval. This time interval is referred to by SCRA as TI3. A&B count reports by the individual child and SCRA count all the applicable children in a family as a single report. To accommodate data latency SCRA build in a reporting lag of several weeks into the production of all information, including Time Interval 3 (TI3) statistics.

Linked to IJB Outcome 9. 2016/17 Target 75% Benchmark 60% LT Data Source - CareFirst

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

This measure is under investigation. Initial enquiries have identified inputting errors. However, the underlying trend is not acceptable and corrective management action has been taken to ensure Practice Leads adopt a more proactive stance in monitoring the progress and completion of the reports within time intervals.

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

The production of SCRA reports will be closely monitored by the Locality Managers in which the completion of reports will be prioritised.

Additional Support Requirements Identified

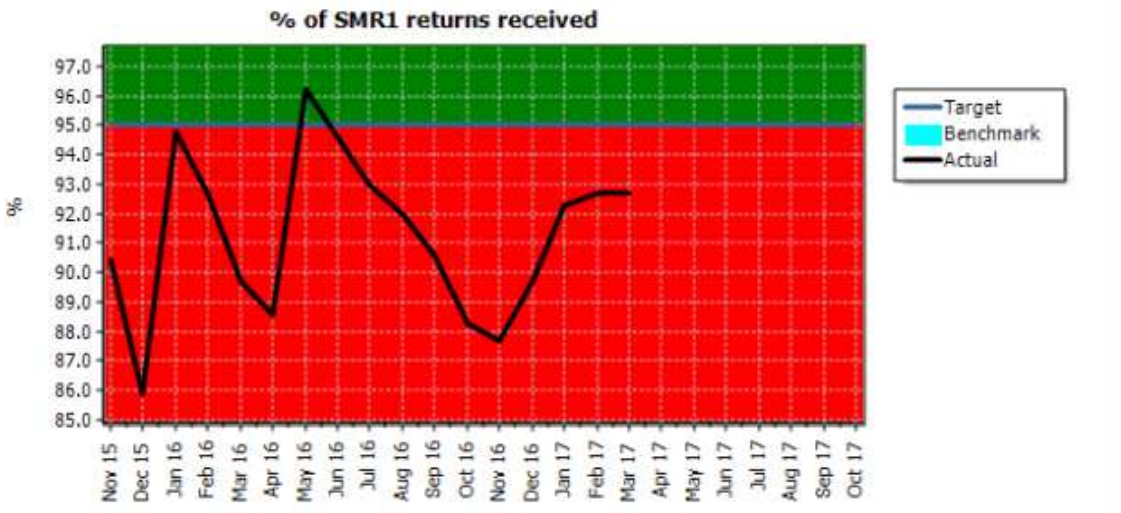
None at this stage.

Improvement Forecast Date:	Review Date:
FQ1	FQ1

Management Exception Reporting

Performance Indicator: Outcome 9 % of SMR1 returns received	**Responsible Manager:** Lorraine Patterson
Target: 95% Actual: 92.75%	Date of Report: FQ4 16/17

Description of Exception



The percentage of SMR01 (Scottish Morbidity Records – General/Acute Inpatients & Day Cases) returns received. The purpose of this indicator is for NHS data providers to know how complete their SMR submissions are and the monitor impact and extent of any backlog. SMR data is expected to be received by ISD 6 weeks (42 days) following the end of the month of discharge / clinic date. ISD calculates backlog as data which is received after 6 weeks following the end of the month of discharge / clinic date.
National target is 95% complete in 6 wks from end of discharge.

Published data: NHS Highland Balanced Scorecard Target: 95% Linked to IJB Outcome 9

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

There was a backlog of coding in Campbeltown due to staff shortages, which will have contributed to this decrease. This has now been resolved and this is evident in improving performance across Q4 period, where the reported performance has improved.

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

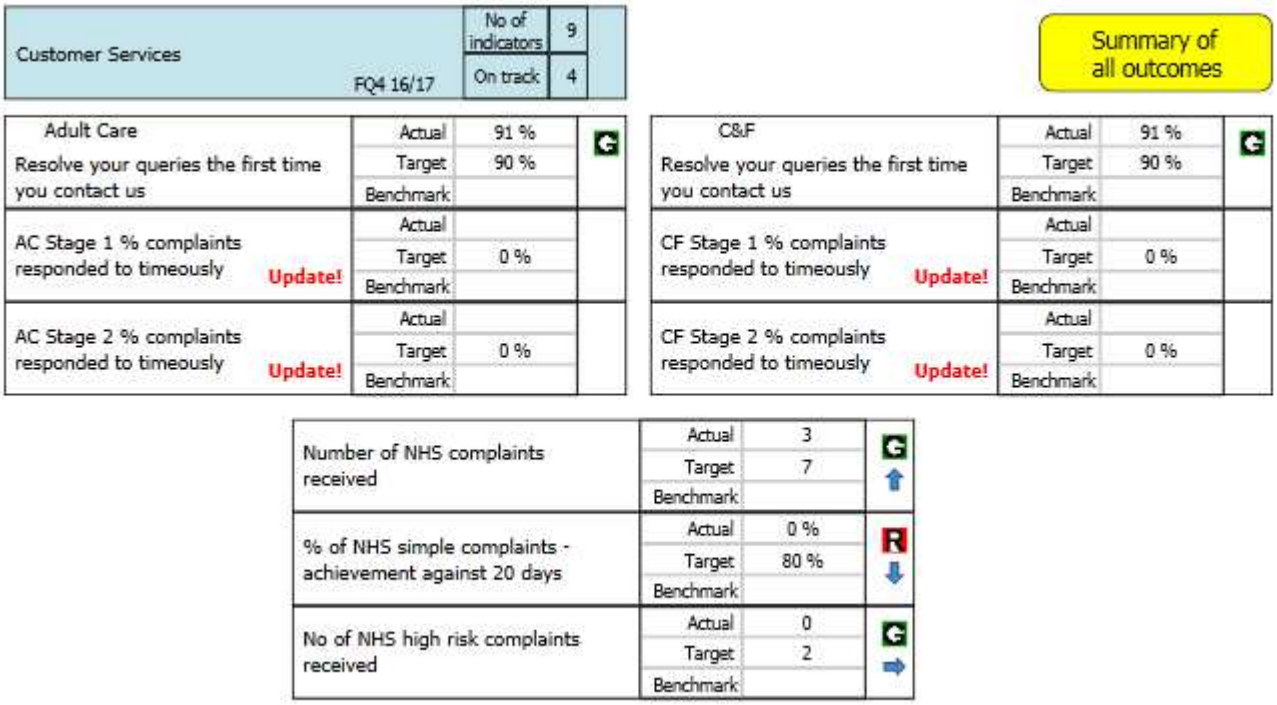
Our performance in relation to this measure is just below the target. Further improvements will be made for timeliness and accuracy with staff and managers. Lorn & Islands Hospital, Oban are scheduled to undertake an on-site audit to check the data from ISD matches local data.

Additional Support Requirements Identified

None at this time

Improvement Forecast Date:	**Review Date:**
Quarterly	Quarterly

Outcome CS – Customer Services



Customer Services FQ4 16/17	No of indicators	9
	On track	4

Summary of all outcomes

Adult Care – Resolve your queries the first time you contact us	Actual	91 %	G
	Target	90 %	
	Benchmark		
AC Stage 1 % complaints responded to timeously Update!	Actual		
	Target	0 %	
	Benchmark		
AC Stage 2 % complaints responded to timeously Update!	Actual		
	Target	0 %	
	Benchmark		

C&F – Resolve your queries the first time you contact us	Actual	91 %	G
	Target	90 %	
	Benchmark		
CF Stage 1 % complaints responded to timeously Update!	Actual		
	Target	0 %	
	Benchmark		
CF Stage 2 % complaints responded to timeously Update!	Actual		
	Target	0 %	
	Benchmark		

Number of NHS complaints received	Actual	3	G ↑
	Target	7	
	Benchmark		
% of NHS simple complaints - achievement against 20 days	Actual	0 %	R ↓
	Target	80 %	
	Benchmark		
No of NHS high risk complaints received	Actual	0	G →
	Target	2	
	Benchmark		

There are 9 indicators being measured against this outcome, 1 is off track and red flagged.

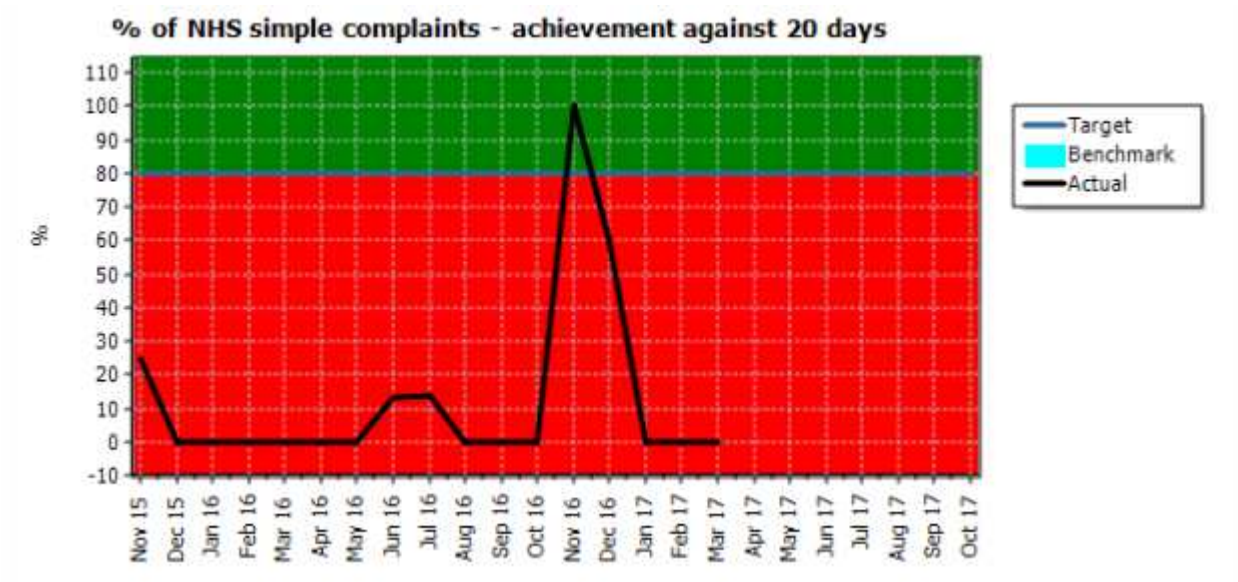
- % of NHS simple complaints – achievement against 20 days

4 indicators require updating. Work is ongoing to align HSCP Social Care Complaints processes to Argyll and Bute Council's Corporate Complaints procedures

Management Exception Reporting

Performance Indicator: Outcome CS % of NHS simple complaints - achievement against 20 days	**Responsible Manager:** Elizabeth Higgins
Target: 80% Actual: 0 %	Date of Report: FQ4 16/17

Description of Exception



Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

It is anticipated that with the implementation of the new complaints procedure that our performance against the targets will improve. Stage 1- local resolution will reduce the 'hand offs' currently within the system in health.
Training and awareness raising sessions on new procedure, combined with development session for local managers regarding their role and responsibility in ensuring a timely, person centred response to complaints is required and will be planned for Summer 2017

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Quality assurance of formal complaints responses requires to move away from the Clinical Governance to localities management teams. CG and Professional leads input will be at later stage in process.

Additional Support Requirements Identified

Training on new complaints procedure

Improvement Forecast Date:	**Review Date:**
August 2017	June 2017

Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item : 5.9**

Date of Meeting : 31 May 2017

Title of Report : Staff Governance Report – Quarter 4 to end March 2017

Prepared by : Moira Newiss, Head of HR (HSCP) & Jane Fowler, Head of Improvement & HR (A&B Council)

Presented by : Stephen Whiston, Head of Strategic Planning & Performance

The Integration Joint Board is asked to :

Note the content of this quarterly report on the staff governance performance in the HSCP.

1. EXECUTIVE SUMMARY

This paper sets out performance data and current key issues for staff governance in the Health & Social Care Partnership. As the IJB is aware the HSCP does not employ staff, this remains the statutory responsibility of Argyll and Bute Council and NHS Highland respectively.

The elements detailed in this paper provide the IJB with information on the staff governance issues which the HSCP and its respective employer bodies are addressing to:

- Support staff in their work and development.
- Assess workforce performance and identify issues
- Establish staff partnership and trade union relationship and operation
- Ensure compliance with terms and condition and employing policies
- Adopt best practice from both employers
- Identify service change implications for the workforce and compliance with the above.

2. INTRODUCTION

This report provides an overview of the staff governance issues identified above as raised and discussed at the Strategic Management Team and Joint Partnership

Forum. This report will be presented to the IJB on a quarterly basis. This report includes updates on:

- Employee Survey (Council) & iMatter (NHS)
- Organisation Change and Service Redesign issues
- Employee redundancy and redeployment position
- Roll out of eEES, the electronic employment support system (NHS)
- Workforce Planning
- Terms & Conditions
- Workforce performance including attendance management, turnover, vacancies, suspension, disciplinary and grievance statistics.

The majority of the data in this report relates to Quarter 4 (January to March 2017).

3. DETAIL OF REPORT

3.1 Employee Survey & iMatter

iMatter, the new NHS staff experience survey, is being rolled out during June 2017. and will cover all staff in the HSCP (both health and council employees).

iMatter is a continuous improvement tool designed with staff in NHS Scotland to help individuals, teams and Boards understand and improve staff experience. This is a term used to describe the extent to which employees feel motivated, supported and cared for at work. It is reflected in levels of engagement, motivation and productivity. Understanding staff experience at work is the first step to putting in place measures that will help to maintain and improve it. It will benefit employees, and the patients, their families and other service users that they support.

The iMatter tool is a short survey completed annually by individuals confidentially which results in a Team Report which is then discussed to develop a team Action Plan. It is the action plan element that is the key to identifying and managing change and improvements in the workplace.

3.2 Statutory & Mandatory Training

3.3 Workforce Planning

Support is being provided from the national iHub improvement team (http://ihub.scot/) who have provided the HSCP with consultancy support from Red Hen. The work developing a workforce planning tool has been completed in Oban. The tool helps the locality see visually how changes in various dynamics including turnover, recruitment and skills development will help to deliver the Locality Plan. Discussions are planned with iHub over the next month to request additional support to roll the tool out to other localities.

3.4 NHS and Council Terms & Conditions

3.4.1 NHS Terms and Conditions Issues New Policies

3.4.1.1 NHS National Band 1 Review

The band 1 review work has progressed well and is almost complete. Virtually all staff across NHS Highland have had an offer of a band 2 post. There are still a few staff that we are waiting to hear back from on their offer. In Argyll & Bute there are several staff who have decided not to accept the offer and who wish to remain on band 1.

3.4.1.2 Whistle Blowing PIN Policy

The new Whistle Blowing PIN Policy was approved in March at the Highland Partnership Forum and will be put on the intranet.

3.4.2 Council Terms and Conditions issues

Nothing to report.

3.5 Integrated HR Issues

3.5.1 Integrated HR Processes

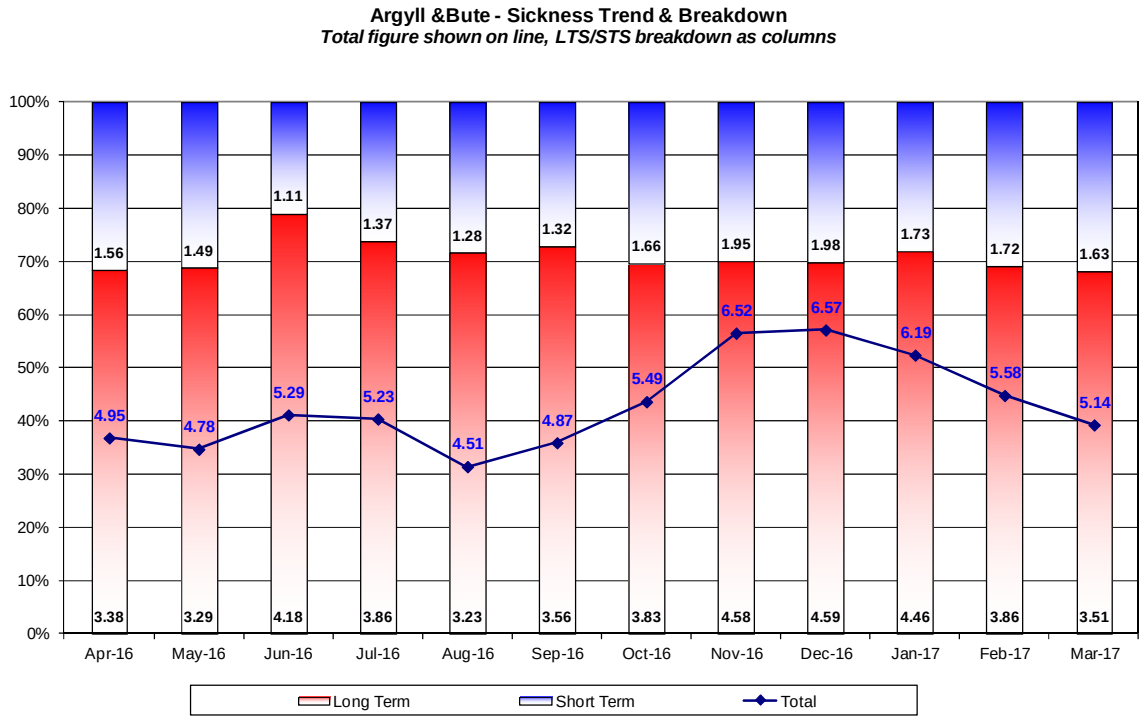
Work has been ongoing to try to develop integrated HR processes to support managers recruiting and managing a joint workforce. The Staff Liaison Group is up and running with a draft terms of reference alongside the newly formed HSCP Organisational Change Group which will monitor and ensure appropriate use of Council and NHS Redesign and Organisational Change Policies.

There is agreement to recruit to a new full-time post of Head of Human Resources for the HSCP and a support post of Workforce & Organisational Development and Staff Engagement Manager. These posts will be hosted in the NHS and have responsibilities across the HSCP.

3.6 Workforce

3.6.1 Attendance Management (NHS)

This report is based on the quarter to the end of March 2017. All Operating Management Units remain above the national target of 4%. There had been a significant rise in sickness absence across all areas in the months running up to January 2017 and with the actions being taken by the HR Team to support operational managers there has been success in substantially reducing this back to a normal level of activity for Argyll & Bute.



March 2017	**STS**	**LTS**	**Total**
Adult West	1.48%	3.78%	5.27%▼
Adult East	1.91%	3.09%	5.00%▼
C&F	0.99%	4.96%	5.95%▼
Corporate (incl Dental)	2.02%	2.58%	4.60%▼
A&B Total	**1.63%**	**3.15%**	**5.14%▼**

STS = Short Term Sickness, LTS = Long Term Sickness

3.6.2 Attendance Management (Council)

The Council has a system in place that records accurate and live absence information by use of a Sickness Absence telephone line that ensures all absence is recorded by the HR team into the HR and payroll database.

This information is available to managers through MyView at their desktops. Automated emails are also generated to inform managers of the start or end date of absence in their teams.

The Council measures sickness absence as working days lost as per the required SPI for local government. The data available for this report is for Quarter 4 ending in March 2017. In Q4 the total number of working days lost per FTE employee was **4.07** against a target of **3.78.**

Table 1 Absence – Work Days Lost per FTE - April 2016 to March 2017

Service	Target WDL lost per FTE per Employee 16/17	WDL per FTE employee 16/17	WDL per FTE employee 15/16	% change 15/16 - 16/17	Service
Adult Care	16.40	17.49	17.79	-1.67%	Adult Care
Children & Families	12.60	12.33	13.28	-7.17%	Children & Families
TOTAL HSCP	**15.12**	**15.87**	**15.82**	**0.30%**	**TOTAL HSCP**

Children & Families has met their target for this financial year.

Adult Care has not met their target this year although there is a small improvement in their absence compared to the same period last year.

Table 2 Percentage of return to work interviews completed by each Service in March 2017

March 2017	% RTWI Completed	Average time taken to complete (Days)
Adult West	64%	5.2
Adult East	71%	4.75
Children and Families	69%	6
Strategic Planning and Performance	n/a	n/a
GRAND TOTAL	**68%**	**6.32**

The percentage of Return to Work Interviews completed in this month is considerably below the Council's target of 100% and a number of RTWIs are taking more than 10 days to complete.

Monthly reports are provided on absence and further improvements need to be put into place to ensure RTWIs are being carried out in line with the Council's Managing Attendance Procedures.

3.6.3 Recruitment

(NHS) Employment Services reported 37 vacancies being advertised (March 2017). There are 35 vacancies currently being processed by department (recruitment process started but not yet complete). A new monitoring process is now in place allowing detailed scrutiny of the time taken to recruit and any delays in the process.

3.6.4 Redeployment

(NHS) There are 31 staff on the primary re-deployment register (decrease of 2) and 26 on the secondary re-deployment register (decrease of 1) (April 2016).

(Council) There were no employees on the redeployment register in March 2017.

3.6.5 Fixed Term contracts

(NHS) There are 38 staff currently on fixed term contracts (an increase of 6). Split by locality Cowal & Bute – 6, Helensburgh – 6, Mid-Argyll, Kintyre & Islay – 3, Oban, Lorn & Isles – 11, Corporate – 6 and Children & Families – 3.

(Council)

The following shows the number of fixed term/temporary posts in place in March 2017:

Table 3

Adult Care West	**41**
Adult Care East	**33**
Children and Families	**25**
Strategic Planning & Perf	**1**
TOTAL	**100**

Reasons for fixed term contracts include: the development of Modern Apprenticeships in Children & Family Services; changes in the structure of the Criminal Justice Partnership and service redesign work requiring temporary staffing structures prior to a final permanent solution.

3.6.6 Personal Development Plans & KSF (Knoweldge & Skills Framework)

(NHS) Percentage of staff reviews completed and recorded on e-KSF from 1 April 2016 to 31-03-17 was 30% (across A&B HSCP for NHS staff covered by Agenda for Change).

Table 4

								12 Months	
Department	Posts	Outlines Assigned	No Review	Review Started	Review Not Signed Off	Review Complete	Review as a %	Review Complete	As a %
Argyll and Bute HSCP	2085	2084	1999	43	4	38	1.82	622	29.83
NHS Highland									26.00

(Council) Personal Development Plans – 2016/17 (Year End)

Adult West: 37%

Adult East: 26%

Children and Families: 95%

Strategic Planning and Performance: 50%

Council Overall Total: 52% Complete

Adult Care and Strategic Planning and Performance were significantly below the target of 95% completion of PRDs at the end of Quarter 4, whilst Children and Families met the target for this period.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

The staff governance paper sets out the issues relating to staff that support or have an effect on the delivery of the HSCP strategic priorities.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact – N/A

5.2 Staff Governance – this is the staff governance report.

5.3 Clinical Governance – N/A

6. EQUALITY & DIVERSITY IMPLICATIONS

These issues are picked up within the NHS and Council HR departments as appropriate when policies and strategies are developed.

7. RISK ASSESSMENT

Risk assessment will be addressed at individual project level. There are HR issues flagged up in the A&B HSCP Strategic Risk Register.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT – N/A

9. CONCLUSIONS

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.10 (a)

Date of Meeting : **31 May 2017**

Title of Report : **Budget Monitoring: Year-end 2016-17**

Presented by : **Caroline Whyte, Chief Financial Officer**

The Integration Joint Board is asked to :

- **Note** the overall Integrated Budget Monitoring report for financial year 2016-17 and the overall underspend of £0.479m, this amount will be allocated to the IJB reserves
- **Approve** the earmarking of the £0.451m of reserves to fund the re-instatement of project funds from 2016-17 to be spent during 2017-18
- **Approve** the updated Directions to NHS Highland and Argyll and Bute Council finalising the financial allocations to deliver services in 2016-17

1. EXECUTIVE SUMMARY

1.1 This report provides information on the financial position of the Integrated Budget as at the end of financial year 2016-17, the outturn position is an overall underspend of £0.479m, this consists of an underspend in Health delivered services of £0.703m, partly offset by an overspend in Council delivered services of £0.224m.

1.2 There was a shortfall in delivery of the £8.5m of savings outlined in the Quality and Finance Plan with £3.6m of savings not delivered during 2016-17. This shortfall was offset by non-recurring underspends in services, the implementation of a financial recovery plan and a moratorium on non-essential spend.

1.3 As per the Scheme of Integration the IJB may retain any underspend to build up reserves and the £0.479m underspend will be allocated to reserves, this will result in a closing reserve balance of £0.479m. The recommendation is to earmark £0.451m of this underspend to reinstate unspent SGHD specific project funds from 2016-17, this will allow the cost pressure included in the budget outlook to be reduced and will reduce the remaining budget gap for 2017-18.

2. INTRODUCTION

2.1 This report outlines the year-end position for 2016-17 for Integration Services. Provisional outturn information has been provided from both NHS Highland and Argyll and Bute Council and has been consolidated into the integrated outturn position. Is should be noted that this position represents the unaudited position which may be subject to change following the external audit of NHS Highland and Argyll and Bute Council financial statements. Any change following the external audit process would be brought back to the IJB.

3. DETAIL OF REPORT

3.1 INTEGRATED BUDGET YEAR-END SUMMARY

3.1.1 This main overall financial statement for 2016-17 is included as Appendix 1. This contains an objective (service area) financial summary integrating both Health and Council services, with a reconciliation of the overall split of the budget allocation. This also contains a summary of the movement in the funding from the approved budget at the start of the financial year.

Outturn Position – Underspend - £0.479m

3.1.2 The year-end outturn position is an actual underspend against budget of £0.479m. This position is split between a year-end underspend in Health services of £0.703m and a year-end overspend of £0.224m in Social Care services. Separate budget outturn statements for Health and Council services are included in Appendices 2 and 3. The main areas contributing to the overall position are noted below:

Adult Care – Overspend £4.7m

- Agreed savings as part of the Quality and Finance Plan for 2016-17 not being achieved or achieved in full, for Adult Care these totalled £3.1m. The main areas are:
    - £1.5m community hospital bed reductions
    - £0.3m Cowal Out of Hours
    - £0.3m for homecare services
    - £0.4m delays in closure of Aros and Argyll and Bute Hospital
    - £0.2m for the redesign of services at Struan Lodge
    - £0.2m for sleepovers

  These service changes have all rolled forward into the Quality and Finance Plan for 2017-18 to 2018-19.
- Overspend in Locum costs totalling £1.5m, relating to Lorn & Islands Hospital, Argyll & Bute Hospital, Cowal Community Hospital, Mull GP practice and Garelochhead GP practice.
- Overspend of £0.6m in relation to Care Home Placements which reflects increased demand for services
- Overspend of £1m for Supported Living services in relation to physical and learning disabilities, this reflects the increased demand for services from new clients and the increasing need of existing clients. Targeted piece of work as part of the Quality and Finance Plan is expected to significantly

reduce these costs and ensure the services can be delivered from within the budget in future.

Chief Officer – Underspend £0.7m

- Underspend in relation to the additional funding set aside for the investment in Community Based Care (£0.6m) and the requirements of Continuing Care (£0.1m). These funds were uncommitted in 2016-17 to offset the projected overspend position, both of these are now committed for 2017-18 as part of the Investment Fund and the baseline budget for Children and Families for Continuing Care.

Children and Families – Underspend £1.0m

- Underspend of £0.2m in health services mainly in relation to additional vacancy savings
- Fostering and Kinship services overall underspend of £0.3m which reflects the level of demand for Kinship services and a one-off benefit from accrued costs from 2015-16 which did not arise. This budget has been reviewed together with the cost pressure for Continuing Care to ensure there is no ongoing recurring uncommitted budget going into 2017-18 and there will be reduction in the cost pressure reflected in the updated budget outlook.
- Underspend of £0.2m in supporting young people leaving care due to the delay in the development of a new multi-disciplinary team to support young people leaving care, this team is now in place.
- In School Hostels and Children's Houses there is an overall underspend of £0.2m in relation to staff vacancies and the delayed implementation of changes to overnight services
- In the main the overall underspend in Children and Families services is non-recurring, a review of the outturn position together with the cost and demand pressures for service delivery has been undertaken and any uncommitted budget will be highlighted as part of the process to balance the budget for 2017-18.

Budget Reserves and Project Funds – Underspend £2.5m

- Underspend in budget reserves totals £2.0m in addition there is a year-end underspend of £0.5m in the Integrated Care Funding. Given the previously forecast overspend position during the 2016-17 financial year the decision was taken not to commit these budgets as part of the financial recovery plan. The underspends in budget reserves include Technology Enabled Care, mental health bridging funding, delayed discharge funding, the Primary Care Transformation Fund, Mental Health Fund and a number of other small uncommitted allocations.
- These underspends are all non-recurring, a review of budget reserves was undertaken as part of the development of the Quality and Finance Plan for 2017-18 to 2018-19 and any recurring underspends are planned to be removed as efficiency savings.
- Included in the previous budget outlook was a total of £0.451m of project funds, these are reflected as part of this underspend and will require to be reinstated in 2017-18. The funds have conditions attached and require to be spent in line with specific project parameters and therefore would have to be returned if not spent in line with these conditions, the requirement to reinstate the funding was reflected in the previous budget outlook report.

3.1.3 There are a number of smaller underspends across other service areas including management and corporate services, community and dental services, public health, strategic planning and performance and commissioned services. A financial recovery plan was approved by the IJB on 4 August 2016 to address the forecast £1.5m overspend as at the June 2016 period. This was subsequently followed by an instruction issued by the Chief Officer to all budget managers in January 2017 to put in place a moratorium on spend across the integrated budget. There was to be no commitment of discretionary budgets and any non-clinical or non-front line posts were not to be filled until after 1 April 2017. These actions had an impact on the 2016-17 financial position and although will not be not solely responsible for the final year-end position they have positively contributed to achieving financial balance for the year.

3.1.4 In summary financial balance has been achieved through:

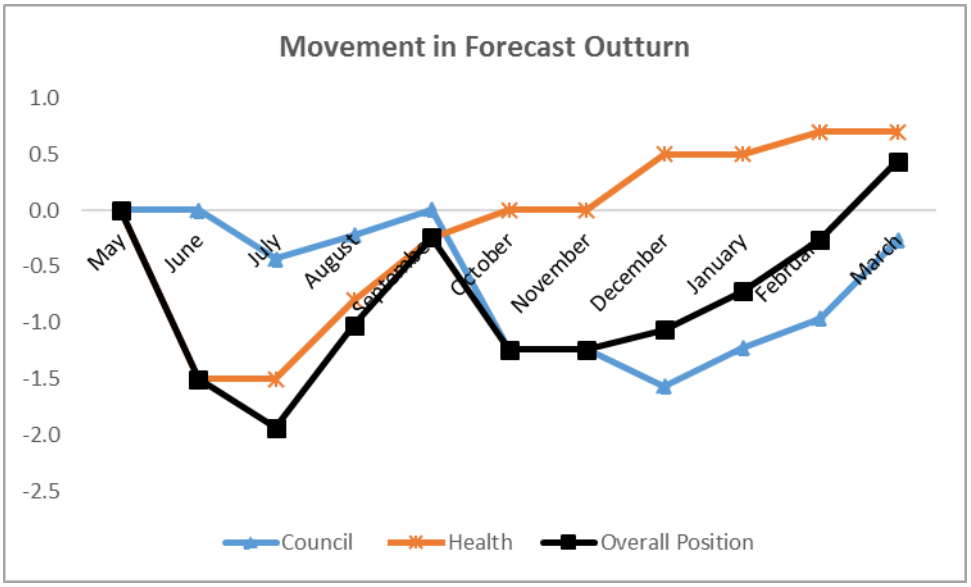
- The implementation of the recovery plan and moratorium on non-essential spend, these actions may have had an impact on service delivery and an absolute restriction on spend is not sustainable in the longer term
- Underspends in project funds including income received for specific projects which require to be reinstated in 2017-18 and an overall underspend in the Integrated Care Fund, mainly due to underspends from locality allocations
- Non recurring underspends in services due to reduction in demand for services, most notably within Children and Families

3.1.5 This positive outturn position should not be perceived as being an indication of the financial position moving into 2017-18. There were significant savings included in the Quality and Finance Plan totalling £3.7m which were not achieved during the year, it is fortunate there were uncommitted budgets particularly in relation to project funding which could be re-directed, lower demand in some service areas and a recovery plan and restrictions on expenditure which offset this position. These funds will not be available in 2017-18 as where any recurring underspends have been identified these have been included in the Quality and Finance Plan for 2017-18 and 2018-19 as savings and budgets will be reduced accordingly.

Movement in Forecast Outturn Position in 2016-17:

3.1.6 The table and chart below show the movement in the forecast outturn position during the 2016-17 financial year:

Period	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Council	0.0	0.0	(0.4)	(0.2)	0.0	(1.2)	(1.2)	(1.6)	(1.2)	(1.0)	(0.2)
Health	0.0	(1.5)	(1.5)	(0.8)	(0.3)	0.0	0.0	0.5	0.5	0.7	0.7
Overall Position	**0.0**	**(1.5)**	**(1.9)**	**(1.0)**	**(0.2)**	**(1.2)**	**(1.2)**	**(1.1)**	**(0.7)**	**(0.3)**	**0.5**



3.1.7 There have been significant movements in the forecast outturn position throughout the financial year. Notable points are:

- Council position assumed to be small overspend or breakeven until October when it was recognised that savings from Q&F would not be delivered in full. Council forecast outturn position varied from forecast position, even towards year-end.
- Restriction on spend mainly for Health services was implemented in August, at this point the estimated overspend reduced and moved to an expected year-end underspend, overall year-end position generally in line with forecast from December onwards.
- Improvement from January due to moratorium on spend, although probably not all as a direct result of this

3.1.8 It should be noted that given that many services are demand driven and some can be high cost that it will never be possible to determine the year-end position in advance with absolute accuracy. However further work is required to ensure consistency between Health and Council services in forecasting the outturn position to ensure the reliability of figures that decision making can be based on for 2017-18. This will be undertaken together with engagement with budget managers to ensure there are tight financial management controls in place.

3.2 QUALITY AND FINANCE PLAN 2016-17

3.2.1 It has been noted previously that there was a significant risk around the deliverability of the Quality and Finance Plan for 2016-17. Progress for 2016-17 with the individual budget reductions outlined in the Plan is detailed in Appendix 4. Progress on the delivery of savings is summarised in the table below:

Original Risk Category	Number	Budget Reduction £000	Achieved to March 2017 £000	Shortfall £000
RED	8	2,250	561	1,689
AMBER	24	3,712	2,105	1,607
GREEN	31	2,536	2,148	388
TOTAL	**63**	**8,498**	**4,814**	**3,684**

3.2.2 Savings totalling £8.5m were included on the Quality and Finance Plan and to the financial year-end there was a shortfall of £3.7m, therefore £4.8m of savings were delivered on a recurring basis. The table above illustrates that the majority of the undelivered savings were highlighted as being higher risk at the start of the year.

3.2.3 These undelivered savings have in the main been reinstated in the Quality and Finance Plan for 2017-18 and 2018-19, with total savings of £11m to be delivered in 2017-18. The progress with savings in 2016-17 highlights the significant challenge facing the Health and Social Care Partnership in delivering the level of savings required in 2017-18. However lessons have been learned from 2016-17 and there is an investment plan sitting alongside the Quality and Finance Plan to lever the change and SMT have implemented a consistent project management approach for service changes which will ensure that there is clear governance and ownership for service changes and any impact on not delivering the expected savings is reported at the earliest opportunity.

3.3 RESERVES

3.3.1 The Scheme of Integration states that "Argyll and Bute Integration Joint Board may retain any underspend to build up its own reserves and the Chief Financial Officer will develop a reserves policy for Argyll and Bute Integration Joint Board". Therefore the underspend of £0.479m for financial year 2016-17 will automatically be credited to IJB reserves.

3.3.2 Included in the budget outlook for 2017-18 is a cost pressure of £0.451m which relates to the reinstatement of unspent budget in relation to project funds which were not fully committed and require to be re-provided in the budget for 2017-18. These were funds specifically provided by the Scottish Government for specific projects and there is an expectation that the funds would be utilised for the purpose allocated, regardless of the timing of expenditure. The re-provisions are:

- Technology Enabled Care £0.208m
- Primary Care Development Fund £0.065m
- Mental Health Fund £0.066m

- Primary Care Transformation Fund £0.112m

3.3.3 The Reserves Policy outlines that the balance of reserves will normally comprise of three elements one of which is the earmarking of funds set aside for particular purposes which would include future use of funds for a specific purpose agreed by the IJB or reserves for unspent revenue grants or contributions. As the unexpected year-end underspend and resulting reserve balance is partly due to the underspends from these funds it is recommended that £0.451m of this balance is earmarked for these projects in 2017-18, this will therefore reduce the cost pressure and budget gap for 2017-18.

3.3.4 There will be clear and transparent reporting for earmarked reserves included as part of the routine budget monitoring report with the Board being in a position to review this position and the continuing requirement to earmark the balance. The overall position for reserves is noted below:

	£m
Opening Balance 1 April 2016	0.000
Underspend 2016-17	0.479
Closing Reserve Balance at 31 March 2017	**0.479**
Proposed Earmarked Reserves	(0.451)
Closing Unallocated Reserves at 31 March 2017	**0.028**

3.4 DIRECTIONS

3.4.1 The Integration Joint Board are required to issue Directions to NHS Highland and Argyll and Bute Council and these must specify the payment to be made to each partner. Formal Directions were approved by the IJB on 28 September 2016 and these outlined the sums allocated at the start of the financial year, the Directions require to be updated for the 2016-17 year-end position. The additional Directions to NHS Highland and Argyll and Bute Council are included as Appendix 5.

3.4.2 NHS Highland and Argyll and Bute Council are required to treat the IJB as a Joint Venture in their annual accounts and recognise a share of the overall surplus or deficit of the IJB for the year. As health boards are required to produce their annual accounts much earlier than local authorities the financial position of the IJB had to be provided much earlier than the Council would normally require to finalise expenditure for the year. The position provided to NHS Highland on 27 April 2017 was an overall year-end underspend of £0.440m, this position will have been incorporated into the NHS Highland unaudited accounts. Following this the final unaudited position for the IJB has changed to an underspend of £0.479m, this overall movement is not material and NHS Highland colleagues have been advised of the updated position.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

4.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery, monitoring and managing this budget through the financial year is key to ensuing a balanced budget position.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

5.1.1 The unaudited position for 2016-17 is an overall underspend of £0.479m across the Integrated Budget. This amount will be credited to IJB reserves with a recommendation that £0.451m of this is earmarked to fund the re-instatement of specific project funding in 2017-18.

5.2 Staff Governance

None

5.3 Clinical Governance

None

6. EQUALITY & DIVERSITY IMPLICATIONS

None

7. RISK ASSESSMENT

7.1 There was a financial risk of delivering financial balance in 2016-17 and this has been achieved, however there remains a significant financial risk going forward into 2017-18. There are significant financial risks in relation to the demands on service delivery and significant risks in relation to the delivery of the Quality and Finance Plan, the financial position will be closely monitored and regular budget monitoring reports will be presented to the IJB throughout the year and this will include an assessment of financial risks.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None

9. CONCLUSIONS

9.1 This report summarises the financial position of the Integrated Budget as at the 2016-17 year-end, the unaudited position is an overall year-end underspend of £0.479m. There was an overspend position projected through the year and this has changed due to fluctuations in demand for services and as a result of the impact of the financial recovery plan.

9.2 There was a significant shortfall in the delivery of savings agreed as part of the Quality and Financial Plan, these undelivered savings have been incorporated into the plan for 2017-18. There remains a significant risk of achieving financial balance in future years and there should not be an assumption that as financial balance was achieved in 2016-17 that this will be repeated. There is a significantly higher budget gap in 2017-18, partly due to savings in 2016-17 not being delivered, many of the budget areas contributing underspends to offset the shortfall in savings in 2016-17 have been removed from the budget in 2017-18 as savings and therefore will no longer be available to offset the position.

9.3 This outturn position reflects the unaudited position for NHS Highland and Argyll and Bute Council and is subject to change following the external audit of their financial statements, any change to this position will be reported to the IJB.

APPENDICES:

Appendix 1 – Integrated Budget Monitoring Summary – Year-End 2016-17
Appendix 2 – Overall Budget Outturn Statement – NHS Highland
Appendix 3 – Overall Budget Outturn Statement – Argyll and Bute Council
Appendix 4 – Quality and Finance Plan Progress to Year-End 2016-17
Appendix 5 – Updated Directions to NHS Highland and Argyll and Bute Council

INTEGRATED BUDGET MONITORING SUMMARY - YEAR-END 2016-17

	Actual £000	Budget £000	Variance £000	Variance %
Service Delegated Budgets:				
Adult Care	131,803	127,103	(4,700)	-3.7%
Alcohol and Drugs Partnership	1,265	1,294	29	2.2%
Chief Officer	645	1,352	707	52.3%
Children and Families	18,840	19,816	976	4.9%
Community and Dental Services	3,978	4,108	130	3.2%
Integrated Care Fund	1,621	2,090	469	22.4%
Lead Nurse	1,275	1,348	73	5.4%
Public Health	1,139	1,268	129	10.2%
Strategic Planning and Performance	3,582	3,704	122	3.3%
	164,148	162,083	(2,065)	-1.3%
Centrally Held Budgets:				
Budget Reserves	0	1,956	1,956	100.0%
Depreciation	2,600	2,649	49	1.8%
General Medical Services	15,481	15,472	(9)	-0.1%
Greater Glasgow & Clyde Commissioned Services	58,410	58,130	(280)	-0.5%
Income - Commissioning and Central	(1,224)	(1,173)	51	-4.3%
Management and Corporate Services	1,843	2,163	320	14.8%
NCL Primary Care Services	8,508	8,508	0	0.0%
Other Commissioned Services	3,406	3,863	457	11.8%
Resource Release	4,897	4,897	0	0.0%
	93,921	96,465	2,544	2.6%
Grand Total	**258,069**	**258,548**	**479**	**0.2%**

Reconciliaton to Council and Health Partner Budget Allocations:

	Actual £000	Budget £000	Variance £000	Variance %
Argyll and Bute Council	61,011	60,787	(224)	-0.4%
NHS Highland	197,058	197,761	703	0.4%
Grand Total	**258,069**	**258,548**	**479**	**0.2%**

FUNDING RECONCILIATION - YEAR-END 2016-17

Partner	£000	£000	£000
Argyll and Bute Council:			
Opening Funding Approved		55,553	
Annual Budget at March 2017		60,787	
Movement		**5,234**	
Details:			
Transfer of funds from NHS Highland			4,580
Non-recurring drawdown of budget from Reserves			573
Reduction due to re-alignment of Utility Budgets across the Council			(21)
Transfer of Budget outwith Integration for Helensburgh Office receptionist			(8)
Additional Funding approved by Council for the Living Wage			110
			5,234
NHS Highland:			
Opening Funding Approved:			
Core NHS Funding	195,868		
Additional SG Funding	4,580		
Opening Funding Approved		200,448	
Annual Budget at March 2017		197,761	
Movement		**(2,687)**	
Details:			
Transfer of funds to Argyll and Bute Council			(4,580)
Budget Carry Forwards (ICT, TEC & ADP)			716
New Medicines Funding			771
Other SG funding increases/decreases			2,486
Transfer to Health Board for Central Services			(2,080)
			(2,687)

Expenditure Analysis to 31st March 2017

Annual Plan			Position to Date			Forecast Outturn		Prev month	
Financial Plan £000	Current Plan £000	Detailed Expenditure Argyll & Bute HSCP	Plan to Date £000	Actual to Date £000	Variance to Date £000	Forecast Outturn £000	Variance from Current Plan £000	Forecast Variance £000	Movement in month £000
46,318	54,155	Adult Services - West	54,155	56,359	(2,204)	56,359	(2,204)	(2,200)	(4)
16,782	27,571	Adult Service - East	27,571	28,346	(775)	28,346	(775)	(810)	35
4,855	6,138	Children & Families Services	6,138	5,929	209	5,929	209	240	(31)
54,976	58,130	Services Commissioned from NHS Greater Glasgow & Clyde	58,130	58,410	(280)	58,410	(280)	(200)	(80)
4,880	3,863	Services Commissioned from Other Providers	3,863	3,406	457	3,406	457	330	127
14,637	15,472	General Medical Services	15,472	15,481	(9)	15,481	(9)	0	(9)
4,194	4,108	Community & Salaried Dental Services	4,108	3,978	130	3,978	130	100	30
8,221	8,508	Dentists, Chemists & Opticians	8,508	8,508	(0)	8,508	(0)	0	(0)
4,861	4,897	Resource Transfer	4,897	4,897	(0)	4,897	(0)	0	(0)
0	2,090	Integrated Care Fund	2,090	1,621	469	1,621	469	553	(84)
1,258	1,294	Alcohol and Drugs Partnership	1,294	1,265	28	1,265	28	25	3
1,254	1,268	Public Health	1,268	1,139	129	1,139	129	110	19
1,387	1,348	Lead Nurse	1,348	1,275	73	1,275	73	70	3
20,070	2,163	Management Services	2,163	1,843	320	1,843	320	300	20
1,861	3,325	Strategic Planning & Performance	3,325	3,225	99	3,225	99	80	19
2,368	2,649	Depreciation	2,649	2,600	49	2,600	49	45	4
11,746	1,956	Budget Reserves	1,956	0	1,956	0	1,956	2,000	(44)
(1,259)	(1,173)	Income	(1,173)	(1,224)	51	(1,224)	51	57	(6)
198,407	**197,761**	**Net Budget Position**	**197,761**	**197,058**	**703**	**197,058**	**703**	**700**	**3**

Overall Budget Outturn Statement - Argyll and Bute Council Integration Services

Service	Subservice	2016-17 Position			
		Current Forecast Expenditure	Budget	Forecast Variance	Variance %
CHIEF OFFICER					
Chief Officer	Social Work Central Support	405,325	356,020	(49,305)	(13.85%)
	Health and Social Care Partnership HQ	239,533	263,294	23,761	9.03%
	Unallocated Additional Funds	0	735,494	735,494	100.00%
	Vacancy Savings	0	(2,333)	(2,333)	100.00%
	Totals	**644,857**	**1,352,475**	**707,617**	**52.32%**
STRATEGIC PLANNING AND PERFORMANCE					
Service Development	Service Development - Management	213,445	218,033	4,588	2.10%
	Service Development - Best Value	143,795	160,931	17,136	10.65%
	Totals	**357,240**	**378,964**	**21,724**	**5.73%**
CHILDREN AND FAMILIES					
Looked After Children	Adoption	141,340	133,087	(8,253)	(6.20%)
	Fostering	1,544,622	1,883,630	339,008	18.00%
	Family Placement Team	329,837	312,102	(17,735)	(5.68%)
	Residential Placements	1,006,340	972,501	(33,839)	(3.48%)
	Hostels	1,089,114	1,154,746	65,632	5.68%
	Children's Houses	1,540,475	1,539,031	(1,444)	(0.09%)
	Care and Reviewing Officers	236,769	230,291	(6,478)	(2.81%)
	Supporting Young People Leaving Care	487,256	714,608	227,352	31.82%
	Consultation Support Forum	25	10,000	9,976	99.76%
	Totals	**6,375,778**	**6,949,997**	**574,219**	**8.26%**
Child Protection	Children and Families Area Teams	2,791,140	2,715,991	(75,150)	(2.77%)
	Child Protection Committee	246,911	257,699	10,788	4.19%
	Early Intervention Project	52,877	56,310	3,433	6.10%
	Early Intervention	1,818	2,000	182	9.10%
	Fusions	28,453	28,053	(400)	(1.43%)
	Contact and Welfare	244,764	253,074	8,310	3.28%
	Totals	**3,365,963**	**3,313,127**	**(52,837)**	**(1.60%)**
Children with a Disability	Children with a Disability	158,216	268,898	110,681	41.16%
	Ardlui Respite Facility	102,937	103,973	1,036	1.00%
	Other Residential Respite	106,819	30,824	(75,995)	(246.55%)
	Home Based Respite Kintyre	113,992	116,292	2,300	1.98%
	Third Sector Grants	275,402	260,065	(15,337)	(5.90%)
	Totals	**757,366**	**780,052**	**22,685**	**2.91%**
Criminal Justice	Criminal Justice Partnership	(87,315)	(39,538)	47,777	(120.84%)
	Criminal Justice Offenders	134,345	133,692	(653)	(0.49%)
	Totals	**47,029**	**94,154**	**47,124**	**50.05%**
Central Management Costs	Children and Families Management	108,708	220,468	111,760	50.69%
	Integrated Care - Area Teams	1,450,337	1,481,619	31,282	2.11%
	Service Strategy and Regulation	260,678	246,306	(14,372)	(5.84%)
	Integrated Care - Strategic Support	544,712	592,495	47,783	8.07%
	Totals	**2,364,436**	**2,540,888**	**176,453**	**6.95%**
	Service Totals	**12,910,572**	**13,678,216**	**767,644**	**5.61%**

APPENDIX 3

Service	Subservice	Current Forecast Expenditure	Budget	Forecast Variance	Variance %
ADULT CARE					
Older People	Assessment & Care Management	2,857,788	2,832,574	(25,214)	(0.89%)
	Care Home Placements	8,993,681	8,352,576	(641,105)	(7.68%)
	Homecare	12,045,225	11,981,105	(64,120)	(0.54%)
	OP Other	2,364,685	2,410,735	46,049	1.91%
	Progressive Care	149,841	174,167	24,326	13.97%
	Residential Units	4,423,209	4,276,488	(146,721)	(3.43%)
	Respite	29,843	59,486	29,643	49.83%
	Sheltered Housing	106,850	103,590	(3,260)	(3.15%)
	Totals	**30,971,121**	**30,190,720**	**(780,402)**	**(2.59%)**
Physical Disability	PD Assessment & Care Management	100,663	125,579	24,916	19.84%
	PD Other	374,658	196,176	(178,482)	(90.98%)
	PD Residential Care	70,255	44,117	(26,138)	(59.25%)
	PD Respite	6,476	18,058	11,582	64.14%
	PD Supported Living	1,328,996	1,053,320	(275,676)	(26.17%)
	Totals	**1,881,047**	**1,437,250**	**(443,798)**	**(30.88%)**
Learning Disability	Assessment & Care Management	689,917	620,888	(69,029)	(11.12%)
	Joint Residential	2,102,486	2,253,679	151,193	6.71%
	LD Other	(35,104)	(33,447)	1,657	(4.95%)
	Resource Centres / Day Services	2,338,113	2,360,279	22,166	0.94%
	Respite	115,238	123,208	7,970	6.47%
	Supported Living	7,231,552	6,447,445	(784,107)	(12.16%)
	Totals	**12,442,202**	**11,772,052**	**(670,150)**	**(5.69%)**
Mental Health	Addictions / Substance Misuse	372,584	367,755	(4,829)	(1.31%)
	Assessment & Care Management	349,135	381,274	32,139	8.43%
	MH Other	722,646	670,596	(52,050)	(7.76%)
	MH Residential	82,230	104,055	21,825	20.97%
	Supported Living	756,612	767,508	10,896	1.42%
	Totals	**2,283,208**	**2,291,188**	**7,981**	**0.35%**
Central Management Costs	Adult Protection	58,669	67,625	8,956	13.24%
	Central/Management Costs	(538,295)	(381,613)	156,683	(41.06%)
	Totals	**(479,626)**	**(313,988)**	**165,639**	**(52.75%)**
	Service Totals	**47,097,952**	**45,377,222**	**(1,720,730)**	**(3.79%)**
	Integrated Services Totals	**61,010,621**	**60,786,877**	**(223,745)**	**(0.37%)**

INTEGRATION JOINT BOARD **APPENDIX 4**

QUALITY AND FINANCE PLAN PROGRESS - YEAR-END 2016-17

New Ref	Service Area	Description	Lead	Target Budget Reduction £000	Achieved 2016-17 £000	Balance £000	Progress	ORIGINAL Risk of Delivery (RAG)
1	Prescribing	Targeted focus on safe, effective, appropriate cost effective prescribing, as well as reducing waste. Argyll and Bute Medicines Management Group re-established to take forward actions.	Fiona Thomson	500	400	100	Savings achieved include use of scriptswitch, dose optimisation, change to generics, patient access scheme rebates, primary care rebate scheme, formulation changes and implementation of pharmacists advice by practices.	RED
2	NHS GG&C Service Level Agreement	Participate in a review of the costing and activity model to review tariff and activity levels. Take action to reduce admission rates and speed discharge up to local services and reduce outpatient follow up appointments.	Stephen Whiston	500	500	0	Full saving achieved through impact of the West of Scotland Cross Boundary Flow in terms of the fluctuations in patient activity.	AMBER
3	Commissioned Services	Review individual placements out of the area and where possible re-negotiate tariffs/contracts.	Stephen Whiston	250	250	0	Fully achieved through completion of care packages and a reduction in charges from the Golden Jubilee Hospital for cardiology services.	GREEN
4	Speech & Language Therapy Services	Re-align services to focus on delivering capacity building and a universal approach in partnership with Education.	Linda Currie	140	125	15	Balance of £15k will not be delivered, this has been removed from the Q&F Plan for 2017-18.	GREEN
5	Rural Cowal Out of Hours Service	Carry out review of service delivery model and implement service re-design.	Allen Stevenson	300	0	300	No progress made to release savings.	RED
6	Re-design Community Hospital - Cowal	Re-design provision of services across the Argyll and Bute area, with a focus on quality outcomes and aligning service provision to capacity and current service delivery requirements. By shifting the balance of care as a result of reduced length of stay, reduced Delayed Discharges and reduced energy admissions.	Allen Stevenson	500	123	377	Reduction in the number of beds by 6 from 20 to 14, achieving a recurring saving on nurse staff costs of £123k.	RED
7	Re-design Community Hospital - Victoria Hospital, Bute		Allen Stevenson	250	0	250	Beds have reduced by 5 from 13 to 8. However no saving has been released and the overall budget is overspent.	RED
8	Re-design - Lorn and Islands Hospital		Lorraine Paterson	500	288	212	Reduced the bed compliment from 42 to 34, a reduction of 8. This achieved savings on nursing pay costs.	AMBER
9	Re-design Community Hospital - Mid Argyll		Lorraine Paterson	500	350	150	This target relates to savings on nurse staff costs from a reduction of 17 beds in the lower ground floor dementia ward. The previous configuration was 29 beds in 3 discrete areas and this has been reduced to 12 beds in a single area. This saving should be achieveable in the longer term as the delay in implementation for 2016-17 was due to low staff turnover.	GREEN
10	Re-design Community Hospital - Kintyre	Re-design provision of services across the Argyll and Bute area, with a focus on quality outcomes and aligning service provision to capacity and current service delivery requirements. By shifting the balance of care as a result of reduced length of stay, reduced Delayed Discharges and reduced energy admissions.	Lorraine Paterson	250	18	232	The initial plan was to reduce by 4 beds, this has now been changed to reduce staffing levels while maintaining the existing bed complement. To deliver additional savings in 2017-18 there would need to a reduction in bed numbers and the staffing levels further.	RED
11	Re-design Community Hospital - Islay		Lorraine Paterson	250	20	230	A review of nurse staffing has produced a small saving.	RED
12	Argyll and Bute Hospital Staffing	Transfer of inpatient mental health services from Argyll and Bute Hospital to MACHICC.	Lorraine Paterson	300	300	0	Savings achieved from staffing reductions in nursing, domestic services and administration.	GREEN

INTEGRATION JOINT BOARD **APPENDIX 4**

QUALITY AND FINANCE PLAN PROGRESS - YEAR-END 2016-17

New Ref	Service Area	Description	Lead	Target Budget Reduction £000	Achieved 2016-17 £000	Balance £000	Progress	ORIGINAL Risk of Delivery (RAG)
13	Closure of West House	A number of support services for Argyll and Bute Hospital are provided from this building, staff would be relocated to other available accommodation.	David Ross	500	230	270	Some savings achieved from partial closure of the site, full saving will not be realised until building fully closes. Plans are in place to relocate the majority of staff and services from West House to Succoth and MACHICC.	AMBER
14	Closure of AROS	A number of support services including HR and Finance are provided from this building, staff would be relocated to other available accommodation.	David Ross	150	0	150	Saving will be achieved on the closure of AROS. Work to re-locate staff will have to be pushed forward to ensure the full saving can be achieved in 2017-18.	RED
15	Kintyre Medical Group	In the longer term it is anticipated that the operation of the services will be taken on by Campbeltown Medical Practice, a transitional plan is in development to support this change.	Lorraine Paterson	75	0	75	No saving achieved.	GREEN
16	Management & Corporate Staffing	Level of staffing review, reduced with no or limited impact on service delivery.	George Morrison	200	127	73	Savings achieved to date are the removal of a post from the finance team and reductions to legal and consultancy costs.	AMBER
17-20	Locality General Savings 1%	Efficiency savings target applied across localities.	Allen Stevenson/ Lorraine Paterson/ Louise Long	602	602	0	Primarily achieved through savings in travel and transport, energy costs and other sundries and supplies.	AMBER
21	Review Day Hospital Services for Older People with Dementia	Re-design of traditional day services.	Lorraine Paterson	25	0	25	No savings achieved, dependant on the closure of the day hospital service in Campbeltown.	AMBER
22	IT Services	Productivity gains and telephony cost reduction.	Stephen Whiston	50	0	50	Business case developed for longer term savings in telephones and IT, this includes plans to extend the Lync system across the HSCP. The investment required may be significant but may also deliver significant savings.	RED
23	AHP Service Redesign Helensburgh for Dietetics and Podiatry	Identify opportunities and deliver re-design within the community mental health team.	Allen Stevenson	42	15	27	The podiatary target has been achieved but the dietetics target will not be achieved and has been removed from the Q&F Plan for 2017-18.	AMBER
24	CMHT Nursing Redesign Helensburgh		Allen Stevenson	11	11	0	Complete	GREEN
25	Islay - Reduction in Patient Travel	Investigate and where possible provide appropriate services locally to reduce travel.	Lorraine Paterson	30	30	0	Complete	GREEN
26	Public Health Services Redesign		Elaine Garman	35	35	0	Complete	GREEN
27	Kintyre Patient Transport Redesign	Investigate and where possible provide appropriate services locally to reduce travel.	Lorraine Paterson	25	0	25	Savings would require reducing air travel and the number of patient escorts, potential to increase the uptake of road travel. Local management are currently exploring options.	AMBER
28	Mid Argyll/A&B Hospital Catering Services	Relocation and Conversion to Cook/Freeze	Lorraine Paterson	50	50	0	Complete	GREEN
29	Mid Argyll Operational Teams Redesign	Re-design and restructure community teams to deliver single system approach to care delivery	Lorraine Paterson	20	0	20	Will be implemented in 2017-18.	AMBER
30	Child Health	Review of child health medical staffing levels.	Louise Long	10	10	0	Complete	GREEN
31	Learning Disabilities	Review the provision of day services considering external provision.	Lorraine Paterson	25	0	25	Will be implemented in 2017-18.	AMBER
32	Clinical Governance	Review of clinical governance team workload and staffing.	Liz Higgins	20	0	20	Will be implemented in 2017-18.	AMBER
33	Infection Control	Review of infection control team workload and staffing.	Liz Higgins	10	10	0	Complete	AMBER
34	Child Protection Services	Review of child protection services budget.	Liz Higgins	20	20	0	Complete	GREEN
35	Medical Physics	Review provision of medical physics services to Argyll and Bute.	Lorraine Paterson	15	15	0	Complete	GREEN

INTEGRATION JOINT BOARD **APPENDIX 4**

QUALITY AND FINANCE PLAN PROGRESS - YEAR-END 2016-17

New Ref	Service Area	Description	Lead	Target Budget Reduction £000	Achieved 2016-17 £000	Balance £000	Progress	ORIGINAL Risk of Delivery (RAG)
36	Community Dental Service	Review of community dental services and staffing levels.	Euan Thomson	25	25	0	Complete	GREEN
37	Custodial Healthcare	Anticipated cost reduction in the provision of out of hours services in the Cowal and Helensburgh areas.	George Morrison	20	30	-10	Complete	GREEN
38	Review of Budget Reserves	Review of uncommitted and discretionary spend budgets held in reserve. This relates to budgets where either Scottish Government funding has been received and not yet allocated or locally established budgets relating to forecast cost increases or service developments. For these monies the funds aren't released to managers until there is a clear spending plan, where these do not come forward the budget reserves can be undercommitted.	George Morrison	300	300	0	Savings achieved through removal of inflationary increase for resource release payment and other specific funds which were assessed as not being required on a recurring basis.	GREEN
39	Older People's Services	Undertake a longer term review of Council owned care homes across Argyll and Bute during 2016-17 with a view to reducing placement costs.	Allen Stevenson/ Lorraine Paterson			0	No specific target. References 55 to 57 are options to take this work forward.	
40	Learning Disabilty Service	Undertake a longer term review of Council run Learning Disability Day Services/Resource Centres during 2016-17 to establish demand in each locality and develop options for person-centred service re-design.	Allen Stevenson/ Lorraine Paterson			0	No specific target.	
41	Social Work Administration Staffing	Removal of vacant and temporary posts, will be implemented as part of a review of the administration services across the whole partnership.	Louise Long	100	100	0	Complete	GREEN
42	Reduce Printing and Postage Costs	Will be delivered through increased use of electronic communication such as email	Stephen Whiston	18	18	0	Complete	GREEN
43	Public Dental Service	Recurring allocations are included in the Health offer of funding. There has been a confirmed reduction to the Public Dental Service allocation which represents a 5% reduction. There has been a roll back of provision in advance of this reduction and the budget is forecast to be underspent by £205k in 2015-16. The reduction can be met through non-filling of vacant posts.	Euan Thomson	176	175	1	Complete	GREEN
44	Reduction to Outcomes Framework Allocations	Recurring allocations are included in the Health offer of funding. A number of previous allocations issued separately have been rolled up into a new Outcomes Framework Allocation. This includes for example eHealth, Effective Prevention, GIRFEC, Policy Custody, Dental Services. The total funding was £2.2m in 2015-16 and the reduction represents a 5.5% reduction. A plan will be drafted for a targeted approach to a reduction from the Outcomes Framework allocations with a focus on reducing discretionary/non-recurring costs.	Liz Higgins Stephen Whiston Euan Thomson Elaine Garman	124	153	-29	Complete	GREEN
45	Ardlui Respite Facility	Services at Ardlui have consistently been charged for at the intensive service cost rate. Cost reductions could be achieved by reviewing the rates paid to the supplier to ensure that the appropriate rate is paid for each child.	Louise Long	10	0	10	The non-achievement of this saving has been offset by reductions in the forecast demand/cost pressure previously assessed against the Children's Houses and children with a disability on a recurring basis.	GREEN
46	Other Residential Respite	Although an unpredictable budget, regular monitoring and control of services and costs could yield a cost saving over the year unless a high dependency case arises which uses up the funds available.	Louise Long	10	0	10	Not delivered due to demand for services for 2 high need clients. Expected to be delivered for 2017-18 as one of the two current high cost service users using this budget will transition to Adult Services.	GREEN
47	Adoption	Review the payments made to adoptive parents where they are continuing to receive payments equivalent to the foster care rates in order to produce cost savings.	Louise Long	10	0	10	Not delivered due to increased demand for the service.	GREEN
48	Children's Houses	Review the rotas operating in the children's houses to negate the affect of absence and assist with the additional support required by several high dependency young people. One area to consider is increasing the pool of staff to avoid anyone working beyond 37 hours per week drawing overtime costs.	Louise Long	30	30	0	Complete	GREEN

INTEGRATION JOINT BOARD **APPENDIX 4**

QUALITY AND FINANCE PLAN PROGRESS - YEAR-END 2016-17

New Ref	Service Area	Description	Lead	Target Budget Reduction £000	Achieved 2016-17 £000	Balance £000	Progress	ORIGINAL Risk of Delivery (RAG)
49	Foster Care	Review one external foster care placement and move child to Shellach View/internal foster carer in order to reduce costs.	Louise Long	30	30	0	Complete	GREEN
50	Residential Placements	Arrange to transfer three existing externally placed young people into the Council's children's houses at the earliest opportunity in order to reduce costs. Additional savings may be available within this activity but may be required to support Kinship Care Payments dependant upon the uptake of the new Kinship Care Orders.	Louise Long	22	0	22	Due to two new unplanned placements into external residential care this saving was not realised in 2016-17. Plans are being developed to repatriate as many children back to Argyll as possible which should produce a saving in 2017-18.	GREEN
51	Supporting Young People Leaving Care	Likely cost avoided from lead time to implement Alternatives to Care project.	Louise Long	17	22	-5	Complete	GREEN
52	Consultation Support Forum	Likely cost avoided from lead time to implement revised service model.	Louise Long	5	5	0	Complete	GREEN
53	Children Affected by Disability	Cost avoided due to clients transferring to Adult Services.	Louise Long	15	15	0	Complete	GREEN
54	Homecare Review	Comprehensive re-design to incorporate: - Integrating reablement services for assessment and care management - homecare procurement and external providers - change delivery model from time and task to outcome focussed - integrate external providers into assessment and care management process - delivering services on a patch basis to reduce unproductive time	Allen Stevenson/ Lorraine Paterson	375	193	182	The Commissioning Team are working on rolling out a patching model for service distribution across Argyll. Savings have been delivered in East Argyll but no progress has been made in West Argyll to date. It is likely that all of the savings will be achieved on a recurring basis as the patching is rolled out across all areas.	AMBER
55	Struan Lodge Service Re-design	Re-design the service provided by the teams at Struan Lodge Care Home and Struan Day Service to end residential care on the site and instead create a community support hub which provides reablement, drop-in, assessment and review and day/social support to older people, including people with dementia, in the Cowal area. This would include a review of the vehicles used by the new service to support the provision of a community transport service for all client groups across Cowal (for example taking patients home from hospital etc.). As staff turnover allows, divert funds to support befriender schemes in Cowal to improve services in the community, supported from the hub. The lead in time for delivering on this could be significant as the service is re-designed.	Allen Stevenson	175	0	175	No saving delivered in 2016-17 following decision taken at Special IJB meeting on 2nd November to pause implementation.	AMBER
56	Thomson Court Day Service	Review model of dementia day service provision including the balance of funding to provide befriender services in and around Rothesay.	Allen Stevenson	10	0	10	No saving delivered in 2016-17 following decision taken at Special IJB meeting on 2nd November to pause implementation.	AMBER
57	Tigh a Rudha Care Home	Realign capacity to match the level of service provision required, staffing is reduced in a stepped basis based on registration requirements. Review will look at usage of Hospital beds and will ensure that there is capacity for an element of growth.	Lorraine Paterson	18	18	0	Complete	AMBER
58	Gortonvogie Care Home	Realign capacity to match the level of service provision required, staffing is reduced in a stepped basis based on registration requirements. Review will look at usage of Hospital beds and will ensure that there is capacity for an element of growth.	Lorraine Paterson	18	0	18	A review of the staffing structure is underway which is expected to deliver some savings most likely from 2017-18 onwards, the extent of which is still to be established. For 2016-17, the unit has over-recovered on income but this cannot be relied upon in future years.	GREEN

INTEGRATION JOINT BOARD **APPENDIX 4**

QUALITY AND FINANCE PLAN PROGRESS - YEAR-END 2016-17

New Ref	Service Area	Description	Lead	Target Budget Reduction £000	Achieved 2016-17 £000	Balance £000	Progress	ORIGINAL Risk of Delivery (RAG)
59	Bowman Court Progressive Care Centre	Review overnight provision to share staffing resource across the progressive care centre and adjoining hospital. Increase the pool of bank staff based at the unit/work jointly with external providers to provide absence cover, eliminating unfunded overtime and mileage costs. Review grades and tasking of existing staff group to bring them into line with agreed homecare grades.	Lorraine Paterson	80	0	80	Discussions are ongoing regarding savings proposals put forward by the local management team. A staffing redesign is underway and although this will avoid excess costs, it may not facilitate a reduction in budget. Work is ongoing in relation to the review of the grades of existing senior staff at the unit.	AMBER
60	Sleepover Provision	Review overnight support services where it is deemed safe to do so and replace with telecare equipment and the local responder provision.	Allen Stevenson/ Lorraine Paterson	150	0	150	No savings delivered in 2016-17. Work has been ongoing to review existing sleepover packages with a view to replacing with alternative care. Additionally, the Commissioning Team are reviewing how sleepovers are delivered to high risk clients going forward with a view to sharing support/moving to block arrangements where possible. Due to the cost implication of new sleepover rates which address the National Living Wage and European Working Time Directive, significant savings require to be delivered to accommodate these costs and deliver the £175k saving.	AMBER
61	Internal Mental Health Support Team	Review the level of provision available from the community support team and the role of the internal mental health support worker to consider it if meets the requirements of the service and provides best value. Proposed saving reflects the underspend produced in 2015/16, this is expected to be recurring.	Allen Stevenson/ Lorraine Paterson	60	0	60	No saving delivered in 2016-17.	GREEN
62	Assessment and Care Management Financial Assessments	Replace four para-professional LGE8 care managers with four LGE6 finance assistants and transfer responsibility for the completion of all financial assessments to the new staff group. Review of current posts including opportunities for accomodating through vacancies or natural turnover.	Allen Stevenson/ Lorraine Paterson	12	0	12	There were no temporary posts available to provide an opportunity to deliver this saving during 2016-17.	AMBER
63	Assessment and Care Management Reduction	Remove 2 FTE para-professional care managers across Argyll to reflect the increased pool of staff within the partnership available to undertake assessment and care management work. This would also allow us to protect professional grade staff to ensure that there is capacity to meet the partnership's obligations in relation to adult protection. This cost reduction would capitalise on the benefit of Integration and economies of scale in terms of the staff resource, there would be training requirements but these would be addressed during implementation.	Allen Stevenson/ Lorraine Paterson	30	0	30	There were no temporary posts available to provide an opportunity to deliver this saving during 2016-17.	AMBER
64	Mid Argyll Dementia Day Service	Review service management arrangements for the Dementia Day Service in Mid Argyll and transfer responsibility to the manager at Ardfenaig. This could be achieved by temporarily redeploying the postholder to the MAKI HCPO post to cover 1 year secondment or into the Kintyre HCO post - both have been advertised.	Lorraine Paterson	18	10	8	Partly delivered for 2016-17, service will fully achieve in 2017-18.	AMBER

INTEGRATION JOINT BOARD **APPENDIX 4**

QUALITY AND FINANCE PLAN PROGRESS - YEAR-END 2016-17

New Ref	Service Area	Description	Lead	Target Budget Reduction £000	Achieved 2016-17 £000	Balance £000	Progress	ORIGINAL Risk of Delivery (RAG)
65	Support for Carers	Review the allocation of funding to carers support groups, establish how the funding is used, identify what supports are provided, ensure resources are targeted to support vulnerable carers, establish if best value is being delivered, disinvest during 2016/17 to gather resources for use in 2017/18 to support the introduction of the Carers Act. This would be a review of how this money is currently invested to ensure that value for money is being achieved and potentially achieving efficiencies.	Allen Stevenson/ Lorraine Paterson	75	9	66	Funding allocation for one group reduced in 2016-17, remaining saving was not delivered. This saving was always intended to be a non-recurring saving for 2016-17 as the budget is required for investment in support for carers from 2017-18 onwards, this saving has been removed.	AMBER
66	Supported Living Services	Review existing supported living services to ensure that services are providing best value, are consistent with the partnership's priority of need eligibility criteria and that the non-residential care charging policy is being applied appropriately and consistently. Re-assessments would be carried out to ensure the appropriate level of service is being delivered, it is expected that this would deliver efficiencies and cost reductions.	Allen Stevenson/ Lorraine Paterson	100	0	100	No savings achieved in 2016-17. The service and commissioning team are confident that they can achieve this saving going forward into 2017-18.	AMBER
67	Learning Disability Day Services	Review internal day support provision for learning disabled clients.	Allen Stevenson/ Lorraine Paterson	110	49	61	The saving achieved for 2016-17 is as a result of vacant posts, the remainder of the savings will be achieved in 2017-18.	GREEN
68	Homecare Packages	Review small number of high cost homecare packages to ensure that person centred care needs and outcomes are met but on an affordable basis through packages that provide value for money. This would involve looking at packages on a case by case basis and ensuring that processes are put in place to ensure best value whilst balancing this with meeting the need of individual clients.	Allen Stevenson/ Lorraine Paterson	200	103	97	Savings have been delivered in East Argyll. The remainder of savings are included in the Q&F Plan for 2017-18.	AMBER
			Total Budget Reduction	**8,498**	**4,814**	**3,684**		

ARGYLL AND BUTE INTEGRATION JOINT BOARD (THE "IJB")

WRITTEN DIRECTIONS TO ARGYLL AND BUTE COUNCIL

This Direction is issued under sections 26 and 27 of the Public Bodies (Joint Working) (Scotland) Act 2014

This Direction will be for the period from 1 April 2016.

1. FUNCTIONS AND SERVICES TO BE DELIVERED BY ARGYLL AND BUTE COUNCIL

Argyll and Bute Council will carry out the functions specified in Annex 1a of Directions dated 28 September 2016.

Argyll and Bute Council will deliver the services to which those functions relate. These services are specified in Annex 1b of Directions dated 28 September 2016.

2. DELIVERY OF FUNCTIONS AND SERVICES

Argyll and Bute Council will carry out the functions and deliver the services in a way which complies with all legal and regulatory requirements and having regard to:-

(a) the Integration Delivery Principles,
(b) the National Health and Wellbeing Outcomes,
(c) the Integration Scheme; and
(d) the Argyll and Bute HSCP Strategic Plan 2016/17 to 2018/19

3. FINANCE

The payment that will be made to Argyll and Bute Council for the period 1 April 2016 to 31 March 2017 will be £61,011,000. This is in respect of the following:

Argyll and Bute Council Requisition	£56,207,000
Additional Funding Allocation 2016-17	£ 224,000
Integration Fund	£ 4,580,000

The cash amount in relation to the additional funding allocation for 2016-17 will be allocated to Argyll and Bute Council in a future financial year, therefore a debtor should be recognised by Argyll and Bute Council. The amount in relation to the Integration Fund is to be transferred from NHS Highland during the 2016-17 financial year.

This payment was approved by the Integration Joint Board on 31 May 2017.

ARGYLL AND BUTE INTEGRATION JOINT BOARD (THE "IJB")

WRITTEN DIRECTIONS TO NHS HIGHLAND

This Direction is issued under sections 26 and 27 of the Public Bodies (Joint Working) (Scotland) Act 2014

This Direction will be for the period from 1 April 2016.

1. FUNCTIONS AND SERVICES TO BE DELIVERED BY ARGYLL AND BUTE COUNCIL

NHS Highland will carry out the functions specified in Annex 1a of Directions dated 28 September 2016.

NHS Highland will deliver the services to which those functions relate. These services are specified in Annex 1b of Directions dated 28 September 2016.

2. DELIVERY OF FUNCTIONS AND SERVICES

NHS Highland will carry out the functions and deliver the services in a way which complies with all legal and regulatory requirements and having regard to:-

(a) the Integration Delivery Principles,
(b) the National Health and Wellbeing Outcomes,
(c) the Integration Scheme; and
(d) the Argyll and Bute HSCP Strategic Plan 2016/17 to 2018/19

3. FINANCE

The payment that will be made to NHS Highland for the period 1 April 2016 to 31 March 2017 will be £197,058,000. This is in respect of the following:

NHS Highland Requisition	£ 202,341,000
Less Budget Underspend 2016-17	£ 703,000
Less Integration Fund	£ 4,580,000

The amount in relation to the budget underspend for 2016-17 of £703,000 will be allocated to IJB reserves. The amount in relation to the Integration Fund is to be transferred to Argyll and Bute Council during the 2016-17 financial year.

This payment was approved by the Integration Joint Board on 31 May 2017.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.10 (b)

Date of Meeting : **31 May 2017**

Title of Report : **Updated Quality and Finance Plan 2017-18 and 2018-19**

Presented by : **Caroline Whyte, Chief Financial Officer**

The Integration Joint Board is asked to :

- **Note** the impact of the proposed amendments to the budget outlook position including the 2016-17 outturn position, the review of cost and demand pressures and increased savings from the Quality and Finance Plan
- **Note** the overall update to the budget outlook position and resulting budget gap for 2017-18 of £10.1m and 2018-19 of £8.4m, a cumulative total of £18.5m
- **Note** the remaining budget gap of £2.0m and £4.1m, a total of £6.1m across the remaining two years of the Strategic Plan and the resulting financial risk of the unidentified savings
- **Approve** the updated Quality and Finance Plan for 2017-18 to 2018-19
- **Approve** the approach to achieving financial balance for 2017-18 which includes potential savings from the NHS GG&C Acute Services SLA and the remainder from in-year identified service efficiencies
- **Approve** the delegation to the Chief Officer to issue Directions to Argyll and Bute Council and NHS Highland in relation to financial allocations for 2017-18, these will be in line with the budget position agreed by the IJB

1. EXECUTIVE SUMMARY

1.1 The IJB approved the Quality and Finance Plan for 2017-18 and 2018-19 at the meeting on 29 March 2017. At that time there was a remaining budget gap of £2.8m for 2017-18 and a further £5.6m for 2018-19, a total of £8.4m across the two years. This resulted in a requirement for further work to identify additional savings or cost reductions to ensure a balanced budget position.

1.2 Services have been working on identifying additional service changes and potential areas where cost and demand pressures can be reduced to improve the budget gap with a focus on balancing the budget position for 2017-18. This report provides an update on progress, there is now a remaining unidentified budget gap of £2.0m in 2017-18 and a further £4.1m in 2018-19, a total of £6.1m. Services have not been able to develop plans to produce a balanced budget for 2017-18. A realistic approach has been taken to what services have confidence in being deliverable in 2017-18 and it has been particularly difficult to identify service changes in the timescale that would be in line with the

strategic objectives and priorities of the IJB. Therefore the main changes that have improved the estimated financial position are the impact of the favourable year-end outturn for 2016-17, an overall reduction in cost and demand pressures, a small increase on the savings deliverable for the savings already noted on the Quality and Finance Plan and potential new service changes deliverable in 2017-18. These are partly offset by the requirement to provide additional financial support for Auchinlee Care Home.

1.3 The remaining budget gap of £2.0m for 2017-18 is proposed to be managed in two ways:

- Ongoing negotiations with Greater Glasgow and Clyde Health Board to agree the SLA value for Acute Health Services. GG&C are aware of the commissioning intentions of the Health and Social Care Partnership and that there is a plan to achieve financial savings from a reduction in activity. As negotiations are ongoing and a formal offer in respect of the SLA has not yet been received any potential saving cannot be quantified at this stage.
- Ongoing efficiency savings to be managed by services in-year, the remaining budget gap represents 0.8% of the overall Integrated Budget. Services will be supported to deploy tight financial management controls to identify opportunities on an ongoing basis to bridge this gap. Progress will be monitored through the ongoing budget monitoring process.

1.4 There is a financial risk to the IJB and the Council and Health Board partners as a result of the shortfall in identified savings. It has also been previously acknowledged that there is a significant risk around the delivery of the approved Quality and Finance Plan for 2017-18 to 2018-19. As noted in the budget monitoring report for 2016-17 total savings of £4.8m were delivered on a recurring basis during 2016-17, a shortfall of £3.7m from the plan. The Plan for 2017-18 totals £8.1m plus an additional £2.0m of savings to be identified in year, this quantifies the scale of the challenge for 2017-18 to deliver financial balance.

2. INTRODUCTION

2.1 The updated budget position for 2017-18 and 2018-19 is set out in the report. There are significant cost and demand pressures to be funded together with reductions in the funding available and these give rise to the overall budget gap. A Quality and Finance Plan for 2017-18 and 2018-19 has been previously approved and this report provides an update to that previously approved position.

3. DETAIL OF REPORT

3.1 UPDATED FINANCIAL POSITION 2017-18 TO 2018-19

3.1.1 The previously reported position from 29 March 2017 is noted below:

Previously Reported Position 29 March	2017-18 £m	2018-19 £m
Baseline Budget	256.111	258.885
Cost and Demand Pressures	7.924	4.741
Inflation	2.017	2.619
Total Expenditure	266.052	266.245
Total Funding	(258.885)	(257.276)
Budget Gap	**7.167**	**8.969**
Quality and Finance Plan 2016-17	3.135	0.000
Projected Outturn 2016-17	0.260	0.000
Reinstate Project Funds	0.451	0.000
Updated Budget Gap	**11.013**	**8.969**
Cumulative Budget Gap	**11.013**	**19.982**
Approved Savings Q&F Plan	8.197	11.565
Remaining Budget Gap (cumulative)	**2.816**	**8.417**
In year	**2.816**	**5.601**

3.1.2 The updated position together with the movement is noted in the table below:

	UPDATED POSITION		MOVEMENT	
Updated Position 31 May	2017-18 £m	2018-19 £m	2017-18 £m	2018-19 £m
Baseline Budget	256.111	258.885		
Cost and Demand Pressures	7.757	4.467	(0.167)	(0.274)
Non-recurring Cost and Demand Pressures	0.000	(0.279)		(0.279)
Inflation	2.017	2.619		
Total Expenditure	**265.885**	**265.692**	**(0.167)**	**(0.553)**
Total Funding	(258.885)	(257.276)		
Budget Gap	**7.000**	**8.416**	**(0.167)**	**(0.553)**
Quality and Finance Plan 2016-17	3.135	0.000		
Projected Outturn 2016-17	0.000	0.000	(0.260)	
Reinstate Project Funds	0.000	0.000	(0.451)	
Updated Budget Gap	**10.135**	**8.416**	**(0.878)**	**(0.553)**
Cumulative Budget Gap	**10.135**	**18.551**	**(0.878)**	**(1.431)**
Approved Savings Q&F Plan	8.153	11.721	(0.044)	0.156
Additional Savings	0.000	0.695		0.695
Remaining Budget Gap (cumulative)	**1.982**	**6.135**	**(0.834)**	**(2.282)**
In Year	**1.982**	**4.153**	**(0.834)**	**(1.448)**

3.1.3 The table above highlights that the remaining budget gap has been reduced by £0.834m in 2017-18 and by a further £1.448m in 2018-19. The individual changes that contribute to this overall position are outlined in the paragraphs that follow.

Cost and Demand Pressures

3.1.4 A further review of cost and demand pressures has been carried out following the conclusion of the 2016-17 financial year-end. The complete list of updated cost and demand pressures is included in Appendix 1. The movements are summarised in the table below:

	IMPACT	
	2017-18 £m	**2018-19 £m**
Cost and Demand Pressures:		
NDR Revaluation	(0.200)	
Continuing Care	(0.080)	
Sleepovers - Children's Services	(0.116)	0.096
Auchinlee Care Home	0.229	
Provision of New Service in Kintyre		(0.370)
	(0.167)	**(0.274)**
Non-recurring Cost and Demand Pressures:		
Criminal Justice Services		(0.050)
Auchinlee Care Home		(0.229)
	0.000	**(0.279)**

3.1.5 The original estimated increase in relation to the NDR revaluation was £0.250m, this was a high level estimate as the full implications of the NDR revaluation were not clear. This cost pressure can be reduced to £0.050m following the completion of the revaluation.

3.1.6 The cost pressure in relation to the extension of Continuing Care for Looked After Children can be reduced by £0.080m. The full year estimated cost pressure for 2017-18 is £0.615m this was offset by £0.115m already provided in the budget to provide a net cost pressure of £0.500m. This can further be reduced by £0.080m based on a review of the budget outturn for Fostering and Kinship services during 2016-17 and the identification of uncommitted budget which can be contributed to partly offset these costs.

3.1.7 The cost pressure in relation to sleepovers for 2017-18 was £0.116m in total, this can be removed in full for 2017-18. There has been a delay in implementation and the service has sufficient resource to fund the expected part-year cost in 2017-18. The pressure requires to be reinstated in 2018-19 to account for the full year impact, although a reduced amount can be provided based on the assessment that the service can make a further contribution to the cost.

3.1.8 At the meeting on 29 March 2017 the IJB agreed to fund additional costs to support Crossreach to operate Auchinlee Care Home until 31 March 2018. The 15 month cost from January 2017 to March 2018 was estimated to be £0.291m and this was to be funded either by requesting additional funding from Argyll and Bute Council or to be added to the Quality and Finance Plan for 2017-18. A request was issued to Argyll and Bute Council by the Chief Officer and a response received communicating that the view of the Council was that the IJB would be expected to meet these costs from the additional one-off funding of £2.137m allocated to the IJB in 2017-18. It may be that the new Council has a different view, however at this stage it would be prudent to assume that the costs will require to be funded from within existing resources. The cost pressure of £0.229m reflects the estimated cost for the 12 month period in 2017-18, the costs for January to March 2017 were accounted for in the 2016-17 financial year. As this cost pressure is for one year only an adjustment is reflected to remove this from the budget from 2018-19.

3.1.9 A reduction of £0.370m is noted for 2018-19 in relation to the cost pressure for the establishment of the new service in Kintyre at Lorn Campbell Court, this is the correction of a presentational error in the figure in the previous report, where the full cost of service provision in 2018-19 was noted in error instead of the year on year incremental cost.

3.1.10 A further reduction of £0.050m can be allocated to Criminal Justice Services in 2018-19, this reflects the removal of a cost pressure approved by the IJB in 2016-17 to reflect additional Scottish Government funding to fund Criminal Justice transition, 2017-18 is the final year of this funding and therefore this can be removed from the budget from 2018-19 onwards.

Impact of 2016-17 Outturn

3.1.11 There is a separate detailed budget monitoring report for the 2016-17 financial year which is also presented to the Board. During the 2016-17 financial year there was a projected overspend reported for the Integrated Budget. To reflect the arrangements as set out in the Scheme of Integration Scheme whereby the IJB would require to repay any overspends to the Council and/or Health Board in future years there was an adjustment to the budget gap position for 2017-18 to reflect the repayment of the projected overspend. The latest reported position at that time was for the February reporting period and was a projected overspend of £0.260m. The actual year-end outturn position for 2016-17 has now been determined and the overall position is an underspend of £0.479m, therefore there is no requirement for repayment and this cost pressure can be removed.

3.1.12 As part of the financial recovery plan for 2016-17 there were underspends in relation to project funding which were not fully committed. As the funds were provided by the Scottish Government for specific projects there is a requirement to re-provide these in 2017-18, these total £0.451m. This was added to the overall budget gap on the basis that there was an overall projected overspend position, however given that there is an unplanned year-end underspend of £0.479m for 2016-17, and these underspends contributed to that position, there is a recommendation in the year-end budget monitoring report to earmark £0.451m from IJB reserves to fund the re-provisions in 2017-18. Therefore the budget pressure reflected to reinstate these funds can also be removed.

Quality and Finance Plan

3.1.13 The service changes outlined in the Quality and Finance Plan have been reviewed following the 2016-17 outturn position to identify any areas where the target savings can be increased. Following this two of the approved savings in the plan can be increased, these are:

- Efficiency saving - Equipment Depreciation, saving can be increased from £0.030m to £0.050m, an increase of £0.020m
- AC05 - Learning Disability Services – Estimated savings can be increased by £0.2m in 2018-19. The previous savings estimate was adjusted to accommodate the projected overspend position in Supported Living services for 2016-17, the year-end position is an improvement of £0.2m from the projected overspend position. The target savings cannot be increased until 2018-19 as it is not expected that this will deliver additional savings in 2017-18 and will only allow Supported Living services to be delivered from within budget in 2017-18.

3.1.14 Included in the approved Quality and Finance Plan 2017-18 to 2018-19 was an efficiency saving of £0.064m in relation to General Medical Services Enhanced Services. This was considered to be an efficiency saving and included on the plan on the basis that the cost of these services is greater than the funding provided by the Scottish Government, and the plan would be to implement restrictions to ensure costs could be contained within the allocation. However in reality it would be very difficult to remove this funding as the costs are activity driven and unless there is a reduction in activity or an agreement to reduce unit cost the saving will not be realised. To implement this change would require consultation and engagement with GPs and for this reason it is recommended that this saving of £0.064m is removed from the Quality and Finance Plan. The updated Quality and Finance Plan for 2017-18 to 2018-19 incorporating all changes is included as Appendix 2.

3.1.15 There are additional savings of £0.695m noted for 2018-19, these are new service changes not currently contained in the Quality and Finance Plan. These are new areas proposed by services which will not be delivered until 2018-19. The detail of these proposals will be shared with the IJB as part of the process for further development of the Quality and Finance Plan for 2018-19, the figure is for noting at this stage as an indication of progress made to identify further savings opportunities.

Remaining Budget Gap

3.1.16 The table below summarises the position following these adjustments:

	2017-18 £m	**2018-19 £m**	**Cumulative Total £m**
Budget Gap	10.135	8.416	18.551
Approved Savings Q&F Plan	8.153	3.568	11.721
Additional Potential Savings	0.000	0.695	0.695
Remaining Budget Gap	**1.982**	**4.153**	**6.135**

3.1.17 The remaining budget gap and unidentified savings pose a significant financial risk for the partner bodies, i.e. the Health Board and Council, as any overspend from integration services will require to be funded by additional payments from the partners in the short term. It is not the intention to focus on balancing the position in terms of the same level of resource being allocated back to fund Health and Social Care services, it is however important to understand and quantify the risk for each of the partners of the remaining budget gap. If there was an assumption that the same level of resource was allocated back to each partner then the remaining unidentified budget gap would be split as follows:

	2017-18 £m	**2018-19 £m**	**Cumulative Total £m**
Health Services	0.314	(0.591)	(0.277)
Social Care Services	1.668	4.744	6.412
Remaining Budget Gap	**1.982**	**4.153**	**6.135**

3.1.18 The table above shows that overall across the two years the estimated Health position would result in an overall £0.277m surplus and for Council delivered Social Care services an overall remaining budget gap of £6.412m. This illustrates the impact of shifting the balance of care in the Quality and Finance Plan which has resulted in greater savings planned to be delivered from Health services and also the difficulty in identifying and releasing savings from Social Care services given the significant cost and demand pressures for delivering the services.

3.2 ADDRESSING THE REMAINING BUDGET GAP

3.2.1 There is an estimated remaining budget gap of £2.0m for 2017-18, this is planned to be addressed by further negotiations with NHS Greater Glasgow and Clyde around the SLA value for acute services and through the identification of in-year efficiency savings.

3.2.2 There are ongoing negotiations with NHS Greater Glasgow and Clyde re the SLA value for Acute Health Services. GG&C have been advised of the commissioning intentions of the Health and Social Care Partnership and the intention to release resource through a targeted reduction in the number of bed days occupied for delayed discharge and emergency admissions. At this point negotiations are ongoing and a formal offer in respect of the SLA has not yet been received therefore the planned savings cannot be quantified at this stage. This could significantly impact on our budget position and would be entirely in line with our strategic direction, however there will remain a risk to deliver these savings as action will have to be taken locally to reduce the number of bed days utilised to enable the savings to be realised as it is likely that there will be penalties from GG&C if the planned reductions to activity levels are not achieved.

3.2.3 It has not been possible to bring forward further service changes which are in line with the delivery of the Strategic Plan and would be deliverable in 2017-18. The remaining budget gap will require to be managed through ongoing efficiency savings identified by services in-year. The financial position and

demand for services changes through the financial year, the opportunities for further savings may be a combination of both recurring and non-recurring savings, where there are any implications for service delivery these will be brought back to the IJB for approval. The remaining budget gap represents 0.8% of the overall Integrated Budget and it is planned that this will reduce following any savings identified from GG&C. There were significant shortfalls in planned savings delivered in 2016-17, significant costs for locum and agency staff and additional demand for services which were all managed within the overall budget for 2016-17, this was as a result of actions taken to manage the projected overspend position in-year. It should be noted that there will not be the same opportunities to identify unallocated budget in 2017-18 as any recurring budget underspend areas will have already been removed as part of the Quality and Finance Plan for 2017-18, however there will be an element of ongoing efficiencies and slippage in spend in services and projects. Services will be supported to deploy tight financial management controls to identify opportunities on an ongoing basis to bridge this gap. Progress will be monitored through the routine budget monitoring process.

3.2.4 There remains a significant remaining budget gap for 2018-19 of £4.1m, and where non-recurring efficiencies are used to address the budget gap for 2017-18 there will be a greater value of recurring savings required to be delivered in 2018-19. The Integration Joint Board will require to commence planning at the earliest opportunity the further service changes that require to be added to the Quality and Finance Plan to address this gap. A proposed approach to balancing the budget for 2018-19 will be brought to the IJB meeting in August.

3.2.5 The IJB are required to issue formal Directions to delegate resources back to the Council and Health Board for 2017-18, these will require to be caveated around the requirement to identify additional savings to balance the budget for 2017-18. The IJB is asked to delegate the authority to issue these Directions to the Chief Officer, any Directions issued will be in line with the position reported to and agreed by the IJB.

3.3 QUALITY AND FINANCE PLAN 2017-18 TO 2018-19 – MONITORING AND IMPLEMENTATION

3.3.1 The Quality and Finance Plan for 2017-18 to 2018-19 includes plans to deliver savings totalling £11.7m across the two years. A consistent project management and monitoring process has been put into place to enable progress on the delivery of the plan to be monitored both in operational and financial terms. Reports will be made to the IJB on a regular basis through the financial monitoring report and exception reports will be submitted to the IJB in line with the agreed safeguarding principles. This will provide an assurance to the Board over the progress with delivering savings and ultimately delivering services within the overall level of resources available.

3.3.2 A consistent approach to Project Management has been put into place by SMT which will ensure that there are clear lines of responsibility for projects, that there is clear oversight of the progress of all projects, risks and timelines are clearly identified and monitored and any deviations from plans or risks of non-delivery are identified at the earliest opportunity. This will allow SMT or the IJB to take corrective action where required.

3.3.3 An Investment Plan was agreed at the IJB meeting on 29 March 2017, services are in the process of deploying this resource to address gaps in Community Services and Project Management capacity. The total investment of £1.1m in addition to the central and locality allocations of the Integrated Care Fund are to be directed to lever the change and deliver on the service re-designs. Despite the remaining budget gap and shortfall in identified savings the investment fund should continue to be protected. Following on from lessons learned in 2016-17 where there were significant shortfalls in the delivery of savings there would be a greater risk of not committing this funding and therefore not delivering the savings in the Quality and Finance Plan.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

4.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery. The Quality and Finance Plan for 2017-18 and 2018-19 has been developed in line with delivering the strategic objectives. This report notes the changes to the financial position following the approval of the Quality and Finance Plan on 29 March 2017.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

5.1.1 The Quality and Finance Plan for 2017-18 and 2018-19 was approved by the IJB on 29 March 2017. This report is an update to the previously reported position, there is now an overall shortfall in savings identified with a remaining budget gap of £2.0m in 2017-18 and a further £4.1m in 2018-19. There are significant financial risks as a result of the unidentified savings and also around the delivery of the Quality and Finance Plan in light of the scale and pace of change required.

5.2 Staff Governance

The appropriate HR processes will required to be followed where staff are impacted by any service changes proposed in the Quality and Finance Plan.

5.3 Clinical Governance

None

6. EQUALITY & DIVERSITY IMPLICATIONS

Equality Impact Assessments will be carried out where required.

7. RISK ASSESSMENT

None, financial risks are noted in the report.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

8.1 Where required as part of the development and delivery of the proposed Quality and Finance Plan local stakeholder and community engagement will carried out as appropriate in line with the re-design of service provision.

9. CONCLUSIONS

9.1 The IJB approved the Quality and Finance Plan for 2017-18 to 2018-19 in March and since then services have been working on identifying further service changes and opportunities for further savings to bridge the remaining budget gap. In reality it has been very difficult to identify savings which would be in line with the Strategic Plan and deliverable in the 2017-18 financial year, some high level proposals have been suggested but these would not be deliverable until 2018-19.

9.2 The remaining budget gap has been reduced, mainly through the review of cost and demand pressures and the favourable 2016-17 budget outturn position. The remaining budget gap of £2.0m in 2017-18 will be managed through ongoing negotiations with NHS Greater Glasgow and Clyde in relation to the SLA for acute services and also the ongoing management of service budgets with opportunities for recurring and non-recurring savings being identified by services throughout the year. In addition there is nearly £10m of budget set aside for inflation and cost and demand pressures in 2017-18, some of this funding may be released if increases in demand and costs are not as expected. This may be perceived to be a high risk approach in terms of delivering financial balance in 2017-18 but through tight financial management including focused monitoring and reporting of the financial position and support to budget managers financial balance may be achievable in 2017-18.

9.3 The Integration Joint Board will be kept fully informed of the financial position during the year, including progress with the delivery of the Quality and Finance Plan and the forecast year-end outturn position to ensure that any intervention required to ensure financial balance can be taken at the earliest opportunity.

APPENDICES:

Appendix 1 – Updated Cost and Demand Pressures
Appendix 2 – Updated Quality and Finance Plan 2017-18 to 2018-19

COST AND DEMAND PRESSURES

APPENDIX 1

No	Cost/Demand Pressure	Description	2017-18 £000	2018-19 £000
1	Growth in Demand for Services for Older People	The number of older people is increasing and older people are living longer with significant health and support needs and significant expectations of the support they are entitled to receive. Demand pressure estimates 3% growth in homecare and care home placements.	600	600
2	Growth in Demand for Replacement Care for Younger Adults	There has been continuing increase in demand for care and support services for profoundly disabled younger adults (ie under 65) whose parents have historically provided care but are no longer able to as they enter old age.	300	300
3	Living Wage	Full year impact of payment of Living Wage to all social care workers from 1 October 2016 and additional cost of increasing Living Wage rate from £8.25 to £8.45 from 1 May 2017. Assume in 2018-19 there will be a further stepped increase to the rate to reflect the national commitment to reach a national living wage of £9.00 by 2020.	2,391	720
4	Extension of continuing care for Looked After Children.	Demand pressure for services for young people of continuing care for Looked After Children arising from the Children and Young People (Scotland) Act whereby the period of responsibility for care is extended. Full year estimated cost pressure for 2017-18 is £615k, reduced by £195k to reflect the amount already provided for in the budget.	420	735
5	Prescribing	Demand growth at 2%, assume this will be met from savings in precribing of at least this value, savings have been included in the Quality and Financial Plan.	386	386
6	New Medicines Funding	This was a cost pressure during 2016-17 which was accommodated by Scottish Government non-recurring funding, £500k of the cost relates to GG&C and £200k for LIH.	700	0
7	Commissioned Services/Care Packages	New and existing health care packages.	400	200
8	Apprenticeship Levy	New charge of 0.5% of payroll costs, cost pressure includes cost for both health and social care budget.	426	0
9	NDR Revaluation	Increased cost following outcome of NDR revaluation.	50	0
10	Remote and Rural Project	Ongoing recurring commitments post project funding from SGHD	197	0
11	£107m funding commitment - Veterans and Carer's Act	Provision for the Veterans and Carer's Bill pre-implementation, which have been included as a cost pressure on the basis of the share of additional £7m funding allocation.	130	0
12	Carer's Act	Carers Act will commence on 1 April 2018, high level estimate of cost. There are concerns re the Scottish Government fully funding the commitment and implications of the Act.	0	400
13	Sleepovers - Children's Services	Additional cost to bring sleepover rates in school hostels into line with National Living Wage.	0	96
14	Criminal Justice Services	New model of providing service on cessation of the Criminal Justice Partnership will result in additional costs. This may reduce in the future as funding is re-aligned incrementally across Scotland	60	0
15	Provision of new service in Kintyre	Establish a new adult care service at Lorn Campbell Court in Kintyre. Cost pressure allows for a lead in time for developing the service in 2017-18.	370	30
16	Mental Health Services	Unfunded discharges from Argyll & Bute Hospital	105	0
17	GG&C SLA	Additions to the GG&C SLA including pharmacy, H&L Community Mental Health Team, Laboratory Services and Homecare Pharmacy.	194	0
18	A&B Hospital Junior Doctors Rota	Increased payments to junior doctors for out of hours work	65	0
19	LIH Laboratory Services	Growth in supplies costs, activity related	30	0
20	ADP Funding Shortfall	To address current year shortfall in total budget allocation.	26	0
21	Consultant Outreach Clinics in Oban	Increased orthopaedic clinics	5	0
22	Interpretation Costs (syrian refugees)	Currently funded non recurringly by Home Office	30	0
23	Orthoptics SLA	Approved increase to SLA	11	0
24	Telehealth pod maintenance	Currently funded from TEC budget, project funding only covers initial equipment purchase costs and doesn't cover ongoing annual maintenance costs.	21	0
25	Cowal FME in hours contract	Increased cost arising from tendering exercise	43	0
26	Consultants discretionary points	Based on 2016-17 cost growth	16	0
27	NSD Service Developments	Funding for these services is top-sliced from Health Board allocations during the financial year. The cost pressure allows for new developments in 2017-18. Estimate based on previous years costs.	50	0
28	Lorn and Isles Hospital	General Surgery additional EPA payments	21	0
29	Children's Services	Physiotherapist increase	26	0
30	Cluster Quality Leads	New requirement	41	0
31	NHS Lothian - TAVI procedures	Growth in cardiac surgery procedures charged on a cost per case basis.	110	0
32	GG&C Growth - Laboratory services	Based on trend analysis	60	0
33	GG&C Growth - Hepatitis C	Based on trend analysis	40	0
34	Urology service development	Development of service at RAH to replace service at LIH.	204	0
35	New Health Pressures	Provision for new Health Cost and Demand Pressures in 2018-19, historic pattern of emerging pressures for health services which have not always been fully funded.	0	1,000
36	Auchinlee Care Home	Estimated cost of additional financial support for Auchinlee Care Home, agreed by the Integration Joint Board on 29 March 2017. This is a one year only cost pressure.	229	0
Total Cost and Demand Pressures			**7,757**	**4,467**

APPENDIX 2

Argyll and Bute Health and Social Care Partnership

Quality and Finance Plan 2017-18 to 2018-19

May 2017

CONTENTS

Introduction to the Plan

The Argyll and Bute Health and Social Care Partnership (HSCP) came into being in April 2016. The Health Board and Local Authority have delegated the responsibility for planning and budgeting for service provision for health and social care services to the Integration Joint Board. The Integration Joint Board are responsible for directing a total resource of £256m. Our Strategic Plan 2016—2019 outlines our ambitions and our local priorities for the next three years which will ensure that we deliver our vision that:-

"People in Argyll and Bute will live longer, healthier, happier independent lives".

The Argyll and Bute Health and Social Care Partnership has identifed six areas of focus in delivering our vision:

In December 2016, the Scottish Government published the Health and Social Care Delivery Plan which highlights the urgent need to address the rising demand being faced across health and social care services and the changing needs of an ageing population. Critical to this is shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes, when that is the best thing to do. This provides a clear

impetus to the wider goal of the majority of the health budget being spent in the community by 2021.

Our Quality and Finance Plan 2016-19 is key to supporting the delivery of the strategic plan and setting out our plans to deliver a shift in the balance of care. The ability to plan based on the totality of resources across the health and care system to meet the needs of local people is one of the hallmarks of integrated care. Financial planning is key to supporting this process and identifying the transformation which is required to provide safe and sustainable services to the local community over the medium term.

Case for Change

Argyll and Bute Health and Social Care Partnership is facing significant challenges as a result of our ageing population, challenges of recruitment and a reduced workforce, the cost of implementing new legislation and policies and financial pressures. If nothing else changes spend would need to increase by 11% by 2020. While not a new set of challenges for Argyll and Bute, the scale and pace of change which is required over the next two years is unprecedented, with a reduction in costs of £18.5 million required over the next two years.

The recent Report on Social Work in Scotland (Social Work in Scotland, Accounts Commission Sept 2016) recognised that current approaches to delivering health and social care are not sustainable in the long term. The report highlighted the significant level of challenges faced by Health and Social Care Partnerships because of the combination of financial pressures caused by a real-terms reduction in funding, increased demographic pressures and the cost of implementing new legislation and policies. Audit Scotland concluded that if Health and Social care Partnerships continued to provide services in the same way, spending would need to increase by 16-21% by 2020.

Increased demand for services linked to constraints in public sector funding and changing demographics are the most dominant challenges. It is estimated that between 2010 and 2035 the population of Argyll and Bute will decrease by 7% overall, the number of working age adults will decrease by 14%, whilst the number of people aged 75+ will increase by 74%. This leads to reduced Scottish Government funding allocations for both the Health Board and Local Authority, reduced workforce capacity and increased demand for services.

Within this local and national context it is essential that the Partnership develops and maintains a Quality and Finance plan to enable it to direct resources at the services which will deliver the greatest impact, support a shift in the balance of care and will set the context for annual budgets.

Some difficult decisions and choices need to be made which will understandably cause concern if people don't understand or accept the case for change.

National Priorities

The Scottish Government have outlined expectations from the integration of services which include:

- Commitment to shift the balance of care, so that by 2021-22 more than half of the NHS front line spending will be in Community Health Services
- Invest in prevention and early intervention, particularly in early years, with the expectation that work will continue to deliver 500 more health visitors by 2018
- Produce plans to minimise waste, reduce variation and duplication
- Reduce medical and nursing agency and locum expenditure as part of a national drive to reduce spend by at least 25% in-year
- Reduce unplanned admissions, occupied bed days for unscheduled care and delayed discharges therefore releasing resources from acute hospital services
- Shift the balance of spend from institutional to community services

Health and Social Care Partnerships are required to measure performance against nine National Health and Wellbeing Outcomes and for Argyll and Bute there are 23 sub indicators which sit below these outcomes to demonstrate the performance of the Partnership. In addition to these the Scottish Government will track:

1. Unplanned admissions
2. Occupied bed days for unscheduled care
3. A&E performance
4. Delayed discharges
5. End of life care; and
6. The balance of spend across institutional and community services

There is a focus on integrated services to deliver real change to the way services are being delivered, with a realism that the care system is broken and delivering services in the same way is not a viable option.

Our Approach

In considering these challenges the Partnership must redesign care, services and ways of working to ensure we deliver safe, high quality services which are sustainable and affordable. It is clear from the scale of the financial challenges faced that the current models of care are not sustainable. This will be a major challenge as doing more of the same will not deliver the scale of change required.

You said “We want to stay at home for as long as possible.” To support people to live in their homes for as long as possible, we need to provide more community based services and aim to do this by investing an additional £1.1 million in these services. This alongside the continuation of investment of specific funding allocations to drive forward integration work including the Integrated Care Fund, Technology Enabled Care and Delayed Discharge will lead to a total investment in transformational change of £3.5m.

This means we can reduce the number of beds in our hospitals but we will not compromise safety of patients and there will always be sufficient beds for those who do need a stay in hospital. Fewer people will need to be cared for in a nursing or care home as we provide a higher level of care to support people within their own homes.

Ensuring local access to care in the face of workforce challenges means urgently reviewing our use of technology to support people to access care and reduce the need for travel.

While service redesign and change is high profile, a focus on eliminating the waste and inefficiency in our systems is another way in which we can ensure the most effective use of both our workforce and our budget. Within the Partnership we are building our capacity and capability to use the tools of lean and quality improvement, while recognising that it is wholescale adoption of these approaches which will have maximum impact.

There are minimum requirements for the services delegated to Integration Joint Boards, which are broadly adult social care services, adult community health services and a proportion of adult acute services. In Argyll and Bute all health and social care services have been included in the delegations to the Integrated Joint Board, including children's services and all acute hospital services. This leaves the Argyll and Bute Integration Joint Board with full responsibility and resources for the whole of the care pathway. This puts us in a unique position to influence and take decisions based on a whole system approach and this is something that can be capitalised on when developing and implementing the Quality and Finance Plan, particularly when shifting the balance of care from hospitals or institutional settings to the community.

Pace of Change

We need to do more. The Scottish Government Health and Social Care Delivery Plan (December 2016) says we need to change services more quickly. The focus on preventing ill health, early intervention, reducing health inequalities and supported self—management mirror our local priorities but we know we need to do a lot more than we are now.

Across the country and beyond the challenges to bring in new models of care that are sustainable from both clinical and financials view points are significant. Here in Argyll and Bute we also face some additional pressures due to the remoteness and ruraility of some of our communities plus we have a higher proportion of older people. Many of our communities are therefore fragile. As an important partner in maintaining the social and economic vibrancy, concerns around health service quality or service changes can and do generate considerable attention from communities, local and national politicians as well as staff.

While there appears to be a general understanding and acceptance that the models of care have to change there are many views on what and where these changes should be. The biggest challenge we face is needing to speed up the pace of change while at the same time taking staff, communities and partners with us.

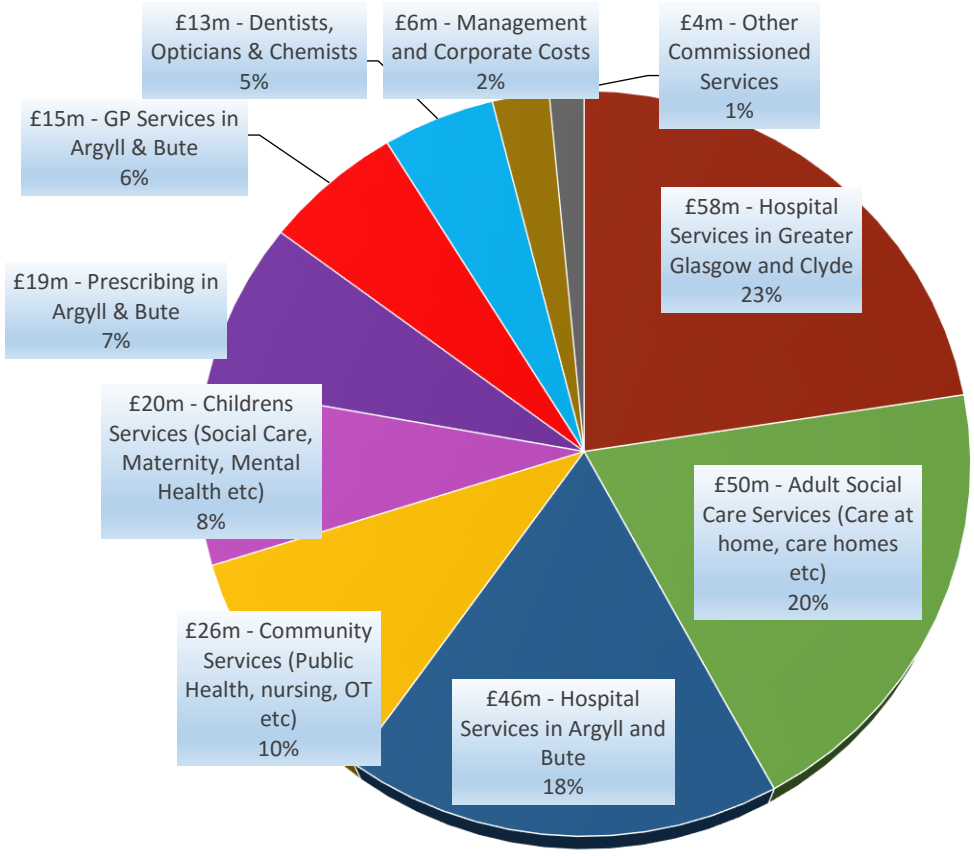
This plan sets out our committment to continue to transform care to deliver the best possible outcomes for the people of Argyll & Bute. Our transformational journey includes moving towards more people being cared for at home. These aspects will be delivered through a combination of prevention and anticpatory care, better use of technology and developing and embedding new models of care. It will also very much be a collaborative approach working with our statutory partners, voluntary and third sectors as well as our staff and local communities. Clearly wider work delivered through public health, primary care, children's services are ongoing and will shape improved outcomes in the longer term.

There are risks around the pace and scale of change being insufficient or delivery of change being compromised which may result in:

- No or little reduction in health inequalities, especially for those in poverty who experience the poorest health
- Continued focus on more acute care which will not reduce the numbers of people aquiring long term conditions
- A missed opportunity to improve the quality of life of those with long term conditions.

Integrated Budget – Key Facts

How do we spend our money just now?



This is summarised below:

Hospital Services	40%	£103m
Adult Social Care Services	20%	£50m
Community Services	10%	£26m
Prescribing	7%	£19m
GPs, Dentists, Opticians and Chemists	11%	£28m
Everything else	12%	£30m

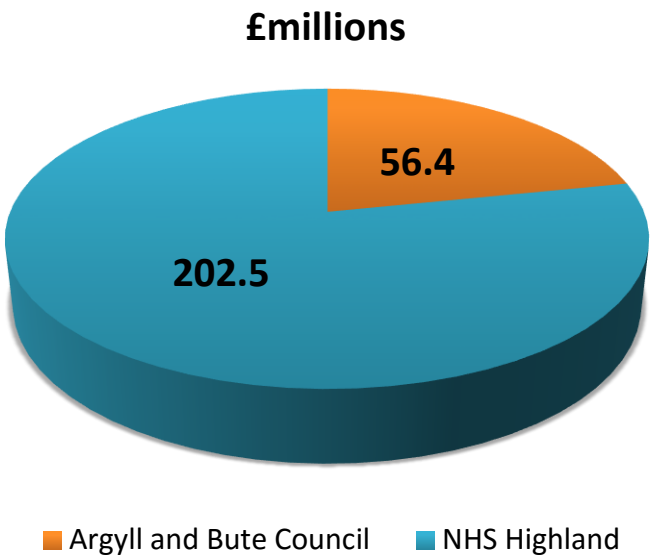
In Argyll and Bute a relatively small number of service users account for much of the activity and resource consumption in the health and social care system, with 50% of the resource spent on hospital and prescribing costs to provide services for 2% of the population. Across Scotland less than 4% of all service users account for 50% of total expenditure in health services, so this is consistent with the national picture. A better understanding of this group of service users and how they interact with health and social care services will help the Partnership better manage and commission services in the future and ensure an improved care experience and outcome for these people.

There is a clear direction from the Scottish Government that the integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes. By 2018 the national aim is to reduce unscheduled bed days in hospital care by up to 10 percent (i.e. by as many as 400,000 bed days) by reducing delayed discharges, avoidable admissions and inappropriate long stays in hospital. Actions taken by Integration Joint Boards to deliver on these targets will assist to reduce the growth in the use of hospital resources, support balance across NHS Board budgets and give clear impetus to the wider goal of the majority of the health budget being spent in the community by 2021.

Understanding the Financial Challenge

Funding

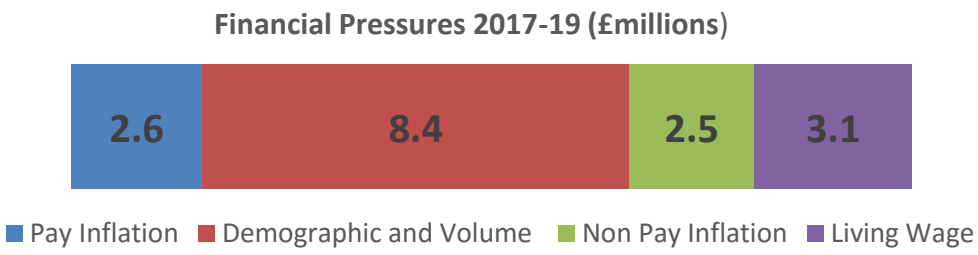
The Health and Social Care Partnership is funded through delegations from the Council and Health Board, the estimated funding for 2017-18 is illustrated below:



Partner contributions to the Health and Social Care Partnership are contingent on the respective financial planning and budget setting processes of the Council and Health Board and the financial settlements that they receive from the Scottish Government. There is uncertainty around funding available from 2018-19 onwards as both partners will set one year budgets for 2017-18 and the impact of the Scottish Government budget allocation and local spending decisions is not known. However funding assumptions can be made around the ongoing reductions to public sector funding and priorities.

Cost and Demand Pressures

A detailed analysis of the cost and demand pressures has been undertaken for the Partnership and assuming nothing else changes an additional £17m would be required to meet current and anticipated costs and demand over the next two years. These are illustrated below:



- The assumptions for pay inflation costs reflect the current inflationary assumptions of both partner bodies and the cost of the apprenticeship levy
- Demographic and volume pressures reflect increases across all service areas including amongst other areas healthcare packages, new medicines funding, growth in prescribing demand, growth in adult care services, younger adult supported living services and continuing care for children
- Non pay inflation includes anticipated increases to third party payments, including the expected uplift to NHS GG&C for acute services and cost increases for prescribing
- The Living Wage pressures include the full year implications of moving to the Living Wage from October 2016 and the increased rate for 2017-18, with an assumption the rate will increase year on year to reflect the national commitment to reach a national living wage of £9.00 per hour by 2020.

There are significant cost and demand pressures across health and social care services and these are expected to outstrip any funding uplifts and have a significant contribution to the overall budget gap for the Partnership.

The Budget Gap

The Integration Joint Board has a responsibility to set a balanced budget and to delegate resources back to the Council and Health Board for the delivery of services. The funding and cost estimates are prepared for each partner separately but these are consolidated and viewed as one integrated budget with one bottom line position for the delivery of health and social care services.

Taking into account the estimated funding and the pressures in relation to costs, demand and inflationary increases the estimated budget gap for the Partnership for the two years to 2018-19 is outlined below:

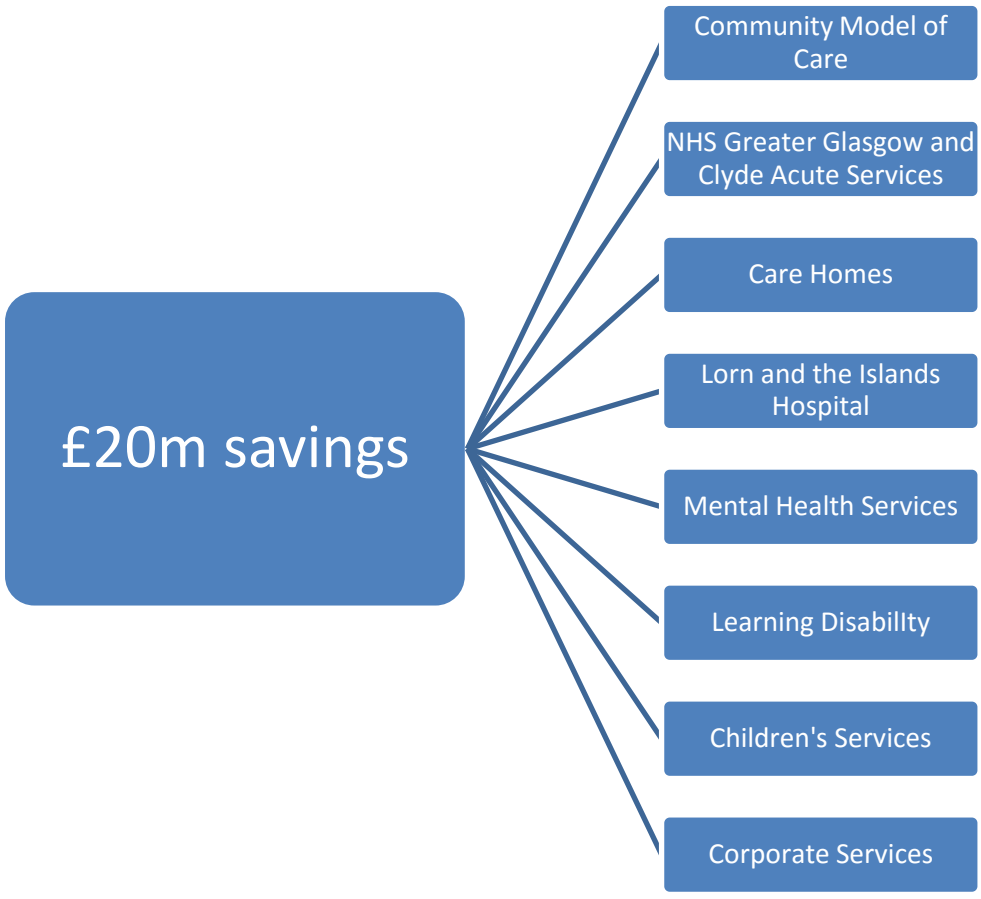
	2017-18 £m	**2018-19 £m**
Baseline Budget	256.1	258.9
Cost and Demand Pressures	7.8	4.2
Inflation	2.0	2.6
Total Expenditure	265.9	265.7
Total Funding	(258.9)	(257.3)
Budget Gap	**7.0**	**8.4**
Impact of 2016-17 Position	3.1	0.0
In-Year Budget Gap	**10.1**	**8.4**
Cumulative Budget Gap	**10.1**	**18.5**

The overall budget gap for the delivery of Health and Social Care services is £10.1m for 2017-18 and a further £8.4m in 2018-19, a total of £18.5m over the two years. The Quality and Finance Plan requires to outline service changes which will achieve these savings together with delivering on strategic objectives and outcomes.

Proposed Quality and Finance Plan 2017-18 to 2018-19

The Quality and Finance Plan has been in development since October 2016 when the process started with Locality Planning Groups identifying priority areas for service change to deliver on the strategic objectives and the required savings to deliver a balanced integrated budget for the two years 2017-18 and 2018-19.

The areas of focus identified as part of this process are illustrated below:



The Quality and Finance Plan is included as Annex A, this provides the detail around plans to change services in line with the areas of focus identified.

The key principles that have been identified through the process are:

- Requirement to plan over a longer period and produce a two year plan in line with the remainder of the Strategic Plan

- Build on lessons learned from the current year where there are a number of service changes that haven't progressed as planned
- Staff costs account for a significant proportion of the budget, we need to reduce our budget but also need to retain the staff skills and experience we have and implement service changes through workforce flexibility to deliver services in a different way
- View the budget gap as one bottom line position and develop plans around that, no assumption that same level of resource will be allocated back to partners for Health and Social Care services
- Acknowledge that an investment plan is required to build capacity in Community Teams to shift the balance of care and that project management support is required to drive forward the change agenda

The Quality and Finance Plan 2017-18 to 2018-19 builds on the service changes aimed at shifting the balance of care that commenced in 2016-17.

There are savings totalling £3.1m from 2016-17 which have not been delivered on a recurring basis and these will remain on the plan. In addition efficiency savings totalling £2m have been identified that can be removed from service budgets without any impact on front line service delivery.

The savings identified on the plan total £11.7m, with £8.2m planned to be delivered in 2017-18 and a further £3.5m in 2018-19.

The Quality and Finance Plan does not fully address the estimated budget gap with a shortfall in identified savings of £2.0m in 2017-18 and a further £4.8m in 2018-19, there will be a requirement for further service changes to be identified to bridge the remaining budget gap. There is a significant financial risk to the Health and Social Care Partnership and the Council and Health Board partners of not fully identifying savings. There is a risk that any further service changes may impact on the delivery and safety of services and the ability of the Integration Joint Board to meet strategic objectives and national expectations around service delivery.

Risks

There are major risks associated with the scale and pace of change required to deliver the service changes and recurring savings from the Quality and Finance Plan. There are a number of specific identified risks:

- Project management skills and capacity are not sufficient to deliver in the required timescales
- Evidence base and communications and engagement is insufficient to convince communities of the case for change in required timescale
- Demands on leadership and management capacity to lead transformational change while maintaining current services

- Evidence base and communications and engagement is insufficient to convince staff of case for change in required timescale
- Scale of efficiency requirements means some plans may not be in line with the Health and Social Care Partnership's strategic objectives

Investment Plan

The Argyll and Bute Health and Social Care Partnership has an ambitious strategic plan. In order to facilitate this additional funding has been provided by the Scottish Government which can be used to help transform services and to support integration. This additional funding is now recurring baseline funding for the Partnership. It is important to note that whilst the allocation of this funding is extremely useful in directing resource specifically to delivering the strategic plan, the totality of the HSCP budget is available to transform health and social care services.

The total investment resource available is £3.5m, which consists of £1.8m Integrated Care Funding, £0.6m Delayed Discharge Funding, £0.5m Technology Enabled Care and £0.6m set aside for community investment, from the additional £250m of Scottish Government funding allocated in 2017-18. £1.1m of this funding has been set aside specifically to deliver on the service changes outlined in the Quality and Finance Plan. The investment plan is included as Annex B. The ongoing allocations from the Integrated Care Fund and Delayed Discharge funding are currently being reviewed and will be included when allocations for 2017-18 and 2018-19 have been finalised.

The investment plan includes resource requirements for additional programme management support to deliver the service changes. One of the lessons learned from the current year is that there is limited capacity within service teams to deliver on the scale of service change required together with continuing to have a focus on operational service delivery. This investment will ensure that there is dedicated support to ensure the delivery of service changes and ultimately recurring budget savings.

Next Steps

This Quality and Finance Plan is a step in developing the Health and Social Care Partnership's strategy to meet the challenges of health and social care integration. The plan has been aligned to the objectives of the Strategic Plan and the performance outcomes and objectives. There will be a requirement to further develop the plan to add further savings to address the remaining budget gap. This work has already started and all services and the Integration Joint Board will be involved in developing plans to ensure we have a financial plan which is sustainable over the longer term.

Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
CHILDREN'S SERVICES:							
CF01	Redesign of Internal and External Residential Care Service	Minimise the use of external placements, increase the capacity of our residential units by adding satellite flats and developing a core and cluster model. Develop social landlord scheme to support 16+ young people moving from foster care or residential care. Further review and where possible bring back all 16+ year olds to local area, to do this we need: • to work with our education partners to support complex young people • to work closely with SCRA, who make decisions on placements, to evidence that our internal homes can provide better meet the needs of young people in Argyll than external placements. • to increase capacity through satellite flats by working with housing providers in Oban, Dunoon and Helensurgh • Work with foster carers to help them understand continuing care, work with adult services to develop a transitions protocol and understanding of where responsibility lies. This means: We need to develop a pilot model in Helensburgh for core and cluster to test the model, work to increase employment opportunities for young people to increase their links to local community.	Children and young people from Argyll and Bute live in Argyll allowing greater access to services as they grow older. We believe we are best equipped to supported our most vunerable however we need to increase our capacity and redesign the services to meet growing needs place on us by Children and Young People Act. Continuing care has 75% of individual young people costed to stay in their current placements as it is their legal right. If redesign successful then there will be opportunities to minimise the cost of continuing care for 16, 17 and 18 year olds. The current costs for continuing care in 2016-17 is £550k and is estimated to be £615k in 2017-18. Using the redesign this could be reduced by £300k in 2017-18 and a further £100k in 2018-19.	Social Work working with higher need young people impacts on Police, Education and SCRA. Volatile Budget based on need and influenced by decisions made by outside bodies, potential to over spend. Lack of capacity to undertake redesign of service. Funding is required to set up the pilot, without the pilot and a new model of care we will be unable to fulfil our statutory duty for continuing care under the CYP Act.	Potential risk impact unable to fulfill our statutory duty to deliver continuing care for 16-25 year olds if redesign increases the number of placements risks can be reduced significantly.	300	400
CF02	Redesign staffing structure across Children and Families service to cope with duty under CYP Act and government initiatives within NHS.	Scoping of children and Families staffing requirements as case load increases due to the requirements of the Children and Young People (Scotland) Act the service will be looking after children for longer. For the next 8 years there will be a steady increase only levelling out in 2026. Incrementally the service will require 5 additional social workers. Health visiting pathway requires additional Health Visitors, additional services for children in distress are required. Requirement to scope and cost a new staffing structure through consultation with staff and those who use the service, we will develop a programme board and look at front line staff and management structure to further develop integrated teams. Reviewing workloads and supporting third tier sector to undertake social care tasks.	Service should be better equipped to deal with service demands and legislation. Services potentially will be delivered by the third sector on behalf of the health and social care partnership in line with 3 year HSCP stategic plan Managing transformational change while meeting the current demands places risks on service delivery	Redesigned service as well as third sector providing services traditionally provided by health and social care partnership. Managing transformational change while meeting the current demands places risks on service delivery Capacity to undertake redesign of service Reputational risk if third sector do not deliver appropriate service. Reduction in public sector workforce Increased use of third sector partners	Reduction is suitably qualified staff will impact on ability to deliver health visiting, NHS, Social Work Services however this risk could be migtated by undertaking review of all childrens services where staff, young people and families will help to develop a new model of service delivery.	100	200
CF03	School Hostels - Explore the opportunities to maximise hostel income.	May be opportunities to actively market accommodation over holiday periods and use annexe accommodation to attract locums at a reduced cost. Although we have an income budget that we currently do not achieve we would hope to over recover income.	Opportunity to use HSCP assets to generate income in line with 3 year stategic plan	Lack of Use	No risk to statutory service.	0	10

Quality and Finance Plan 2017-18 to 2018-19

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Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
LORN AND THE ISLANDS HOSPITAL:							
AC01	Lorn and the Islands Hospital Future Planning to improve the local services and engage specialist services appropriately to deliver best possible care.	LIH group established with representation from public, community, third and independent sector working jointly to design services that will minimise or avoid all delayed discharges, offer excellent quality local care complemented by specialist care out of area as required. Prevention of admissions to be achieved by shfiting the overall balance of care and staff to ensure anticipatory care planning in place. Working wth the LIH group to explore clinical options and offer continued, consistent appropriate hospital care. Data collection and scrutiny to inform the service design. Recruitment and retention strategies to support the service.	Improved data collection and scrutiny will meet performance criteria for safety, quality and sustainability when considered alongside the shift in the balance of care and commitment to quality outcomes for patients. Positive outcomes relate to H&SC Delivery Plan and HSCP Strategic Plan. Improved clinical care should expedite discharges. Balance of care in the community will reduce acute admissions.	LIH planning group will produce range of options for wider consultation, with commitment to 24/7 emergency care. LIH Group will examine surgical and medical provisions, the shift in balance, and in full knowledge of GG&C plans as well as links with local hospitals.	None anticipated.	347	647
AC02	Further improvement and investment in the scope of OLI Community Wards to offer quality services and support on discharge and timely assessment and reablement.	Community staff further upskilled through training and understanding of scope of services. Resource to ensure that 'virtual wards' feel and give a service which is perceived as real and more effective than location based services.	This supports Clinical Strategy, HSCP Strategic Plan, H&SCP Delivery Plans. Major shift in community based care inclusive of all sectors working jointly to deliver improved care and experience and to minimise delayed discharge.	Shifting the balance fo care will require engagment, training and dialogue with community staff to develop ways in which a 24/7 community ward can be delivered to benefit patients. Alongside the LIH group will consider an enhanced consultant role eg for assessments.	Shifting care into the community has positive outcomes for patients and users of services,as well as SG Integration Performance measures eg unplanned admissions, unscheduled care, delayed discharges and A & E performance.	included above	included above
CARE HOMES:							
AC03	Putting environment, independent living and service user choice at the heart of care support by reviewing the current buildings and care service employed by Ardfenaig and Eader Glynn to deliver an improved environment, better choice and control.	Identify all options with partners to better provide support when care at home is no longer possible. Seek engagement to review all options with full regard for choices and control of people who use these services.	Priority is the choice and quality of care provision to those using services, and to fully utilise aspects of shifting balance of care to a homely setting in a safe and caring, sustainable environment.	Engagement will assist in stakeholder understanding of options of care available and of the choices of service users. Long term plan which consults appropriately at all stages. Potential for lack of interest from external providers. Lengthy timescale.	Future potential changes to registration status and scope of work (eg outreach). Investment would be in improved environment.	0	53
AC04	Identified demand for greater choice of support care on Tiree, currently and for future planning. .	Island demand to be quantififed, and provision reviewed in line with current and emerging demands.	Based on older people's views, advance the shift in balance of care to support independence and empowerment. Partner working with Curam to achieve best outcomes.	Engagement and understanding with stakeholders and close involvement.	Future potential changes to registration status and scope of work. Improved environment, potential greater support in the persons home.	0	46
LEARNING DISABILITY:							
AC05	Redesign of Learning Disability services including day services and support at home for adults across Argyll and Bute, the priority needs to be given to service user need and demand in each local area.	Utilise learning from Helensburgh redesign, and engage with stakeholders. Full account of service user views and the current and emerging needs, encouraging independence and shifting the balance of care.	Redesign the service to maximise the independence of service users. This should deliver a better service and improve the value for money. Shifting the balance of care in line with Strategic Plan and H&SC Delviery Plan, into communty settings which develop independence and choice for service user.	Families, carers and local support groups may resist the planned changes without a full understaning of the redesign. There may be a detrimental impact on existing staff in their current roles. Redesign must include engagement and understanding of families, carers, support groups and stakeholders. Staff to be consulted and engaged as the work progresses and all stakeholders kept fully informed. Redesign seeks to improve user otucomes whilst addressing overspends from a service no longer fit for purpose.	Potential changes to the type of registration with the Care Inspectorate. Positive impact on supporting independent living and improved environment.	175	525
COMMUNITY MODEL OF CARE:							
AC06	Repatriate top 15 high cost young adult care placements from outwith Argyll and Bute. This includes service users who are in residential care and some who are receving specialist supported living services outwith the area.	Identify then review top 15 adults outwith the area currently and undertake review with a view to bringing their care package back to Argyll and Bute. Need to link with housing providers and social care providers to identify capacity and cost to bring adults back to shared tenancy arrangements.	Returning service users to their own communities, closer to their roots and families. Delivering best value and support the local economy by bringing HSCP spend back to Argyll.	Families might be reluctant to move service users away from where they have been living. The partnership may not be able to access the range of services required to look after these people in Argyll or may be unable to source appropriate housing.	No anticipated impact.	73	194
AC07	Supported living is categorised into four categories. Critical (P1) and substantial (P2) needs will be met and others will be signposted to self-help and community resources.	Review existing supported living care packages to ensure that cases meet the priority of need framework. Promote use of SDS. Introduce Area Resource Groups to scrutinise adult care supported living and delayed discharge packages.	Ensuring that care packages are tailored to meet the needs and maximise the independence of service users as well as deliver value for money and deliver services in local communities. Introducing new Locality Monitoring Groups to ensure equality in the delivery of supported living for categories P1 & P2.	Families, carers and local support groups may resist the planned changes. Where the decision to make changes to packages is extended to carers and families, experience suggests that change is unlikely to be agreed. Risk in terms of deliverability of savings, savings are understated as there is a current year overspend to be addressed before savings can be released.	No anticipated impact.	0	460
AC08	Review the delivery of services for older people to consider alternative ways of delivering services for older people.	Ensure all new packages adhere to Value for Money principles. Consider alternative ways to deliver support/meet the assessed outcomes of service users.	To maintain people at home for as long as possible. to spread the limited resources available to the HSCP across as many service users as possible. Deliver value for money.	Non support of families. A shift in practice to ensure we deliver consistency in outcomes for individuals and families. Consistent approach adopted across all locations within Argyll and Bute.	No anticipated impact.	200	200

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Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
AC09	Redesign the provision of sleepovers provided by the HSCP.	Shift to new model of care using telecare/overnight response teams. Work with care providers to redesign unavoidable sleepover provision and look for opportunities to share provision across multiple service users.	Encouraging service users to be independent whilst maximising the opportunity to keep people living in the community for as long as possible. Deliver best value. Change to a new model of care provision that is safe, but person centred and improved independent living.	Families, carers and local support groups may resist the planned changes. Where the decision to make changes to packages is extended to carers and families, experience suggests that change is unlikely to be agreed. We have a current overspend and that needs to be addressed as we move ahead.	No anticipated impact.	200	200
AC11	Investment in 'Neighbourhood Team' approach to delivery of care at home for the community across Mid Argyll, Kintyre and islay. Putting service users at the heart of service design.	More responsive and person centred approach to delivery, better meeting needs. A best practice model, which is truly person centred, maintains independence and recognises dignity alongside independence, and improved outcomes.	Shift from time and task/silo working to team based approach to care provision. In line with clinical strategy, Health and Social Care Delivery Plan and HSP Strategic plan. Developed working with third and independent sectors to deliver care. Devised on best practice models of person centred care.	IT support required for community based models. Significant staff HR implications and organisational change. Unlikely to deliver any early savings however prioritises resources to support primary care and deliver services more efficiently and effectively initially, to then gain economies of scale from integrated teams.	Supports shift in balance of care to a genuinely person centred service which values the users and puts then at the heart of design. Supports independence, dignity, and assists reduction unplanned admissions. Built on local knowledge to improve outcomes for adult protection and carer support.		
AC12	Investment in 'Neighbourhood Team' approach to delivery of care at home for the community across Oban Lorn and the Islands. Putting service users at the heart of service design.	More responsive and person centred approach to delivery, better meeting needs. A best practice model, which is truly person centred, maintains independence and recognises dignity alongside independence, and improved outcomes.	Shift from time and task/silo working to team based approach to care provision. In line with clinical strategy, Health and Social Care Delivery Plan and HSP Strategic plan. Developed working with third and independent sectors to deliver care. Devised on best practice models of person centred care which maintains independnce and dignity.	IT support required for community based models. Significant staff HR implications and organisational change. Unlikely to deliver any early savings however prioritises resources to support primary care and deliver services more efficiently and effectively initially, to then gain economies of scale from integrated teams.	Positive shift in balance of care and supporting people to remain at home and reducing unplanned admissions to hospital. Improved leverage of local knowledge to improve adult protection and carer support.		
AC14	Modernise community hospital care in Campbeltown establishing a cross agency 'Planning for the Future' group, to actively review range of bed space uses and options. Aim to achieve community based, and community focussed hospital model linking seamlessly with enhanced community services.	Review group to identify and engage with stakeholders on best use of bed spaces to maintain a quality and responsive service 24/7 which supports patients appropriately and timeously. Improving community focus and hospital criteria aims to reduce or negate delayed discharges, improve prevention and anticipatory care planning. Potential for greater joined up working with other hospitals, and effective use of data assumed.	Enabling people to live independenty in their own homes, and avoid delayed discharges is key to improving community based care. Alongside better working with third and independent sectors to ensure person centred approach and quality outocomes, aligns with HSCP Strategy and H&SC Delivery Plan.	Improvements to IT support underpin imrpoved community care. Requires engagment with all stakeholders to achieve shared aims and understanding.	Nil anticipated	232	232
AC15	Improvements to community focussed care in Mid Argyll, with focus on improving the model of delivery and service in MACHICC. Improved responsive community services able to repsond 24/7 supporting patients in their own homes. Shifting the balance of care and ensuring effective and efficient use of hospital services.	Improvements and expansion of community based services in Mid Argyll to achieve reduced or nill delayed discharges, greater prevention and anticpatory care planning to enable people to live in their own homes, or return to their own homes as quickly aspossible.	Person centred, community focussed and maximising our resrouces to respond to what people tell us matters to them. Shifting balance of care aligns with HSCP Strategic Plan and H&SC Delivery Plan.	Improvements to IT support underpin improved community care. Requires engagment with all stakeholders to achieve shared aims and understanding.	Nil anticipated	170	170
AC16	Continue with the review and redesign in-patient ward in Cowal Community Hospital currently reviewing the acute observation beds, short term assessment beds, delayed discharges, prevention of admissions and A&E breeches. The review will include considering enhanced community care to prevent admissions.	Continue the current review and consider how we deliver community services in Cowal to provide 24/7 response to support patients at home.	Ability to maintain patients at home including some who would have been admitted to hospital, in line with strategic direction and developed working with third and independent sectors.	The delivery of IT support for community teams is a consideration. Recruitment issues for rural areas recognised as an issue.		537	537
AC17	Continue with the review and redesign GP in-patient ward in Victoria Hospital currently reviewing the acute observation beds, short term assessment beds, delayed discharges, prevention of admissions and A&E breeches. The review will include considering enhanced community care to prevent admissions.	Redesign of community services in Bute to provide 24/7 response to support patients at home. Community and staff engagement.	Ability to maintain patients at home including some who would have been admitted to hospital, in line with strategic direction and developed working with third and independent sectors.	IT support for community teams. Recruitment. Stakeholder understanding.		250	250
AC18	Improve and expand community based care on Islay through investment in preventative measures to address dealyed discharge and reduce admissions. Shifting the balance will include making better use of Islay Hospital and Gortanvogie Care home to meet community care demands.	Review use and need of community services on Islay to better support people to live at home with quality services. Enhancing community based care including using technology where appropriate, and consider use of alternative booking systems. Support from and engagment with both communities and staff to help shift balance.	Positive measures enable people to live as independently as possible, in their own homes or a homely setting and to provide care without unnecessary travel or hospitalisation. Meets Scotish Government performance measures.	Requires recruitment, engagment with stakeholders including local community and improved IT for staff.	Success of community care and support may in future require change of registration status.	330	330
AC19	Review of AHP Out-patient service delivery	Consider increasing protocol driven review of follow-up and domicilarry visits. Use of technology like VC and Flo. Review whether AHPs could offer review instead of trips to GG&C to see consultants. Extension of roles like Orthopaedic triage and 'First Contact' input into GPs.	Support repatriation activity and reduce travel and inconvenience for patients. Reduce GP/consultant appointment 'right clinician, right time, right place'. This review may release savings but may be more appropriate to use released resources for investment in new initiatives detailed eg increased support to GPs.	Ensuring the right clinical skills of clinicians to offer extended roles and ensuring patient compliance or outcomes are not impacted.			

Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
AC20	Seek to ensure care at home services offer flexibility and choice and are person centred and fit for purpose. Current in-house services are restricted and review would enable options to be explored with external providers to improve West Argyll service.	Neighbourhood teams with external providers give flexibility and should be considered within options following period of market testing. Would require input from procurement and commissioning staff to expand and improve the current care at home service.	Care at Home services are not fully able to meet demand particularly in rural areas. Better options require to be identified involving whole range of providers to review, test and implement change. Positive impact on outcomes offering person focussed service across in particular Kintyre area, with a developing and enhanced local service.	Clients to be engaged and consulted and helped to understand where a change of provider may occur, whilst benefitting from an improved service. Some risk of staff leaving prior to any transfer and thus staff need be kept informed and consulted. Whilst some savings can be achieved, the current service is failing its clients and not sustainable.	Reduced numbers of in house registered services.	0	160
AC25	In older people day resource centres improve and address issues of high levels of management structure to integrate and consolidate services within realistic opening hours based on client demand.	Review the management at HSCP operated day services. Consider a reduction in opening hours of adult day services. Evidence indicates shorter opening hours would be appropriate and acceptable in day services. Moreover, there is a high management resource which is capable of rationalisation. Engagement and consultation with service users and with staff to align needs and demands.	Service becomes more efficient, and is an effective use of resource. Service hours will reflect the needs and desired otucomes whilst meeting demand, Evidence supports this, and will be fully explored with service users and staff.	Organisational change which may take time to achieve and may not deliver savings in given timescale. Careful consideration to balance risk of reduced hours with potential home care need, review should highlight this.	Nil	50	208
MENTAL HEALTH SERVICES:							
AC21	Improve community based support and services for dementia to achieve shift in balance of care and respond to need and demand in person centred service.	Implement full review and scoped options for community models which meet user demand, support carers and person centred otucomes. Appraise neighbourhood model and scope options which shift balance of care.	Dementia Strategy is key to achieving aims which support the shift in balance of care, and offer person centred services as close to home as possible.	Models of care, once reviewed require stakeholder engagment and consultation, and understanding of option(s). Potential variance in future levels of specialist care as yet unresearched.	Potential impacts for support from detention and mental health officers.	250	250
AC22	Deliver improved mental health consultant support and create dedicated consultants to each locality Community Mental Health Team, and a dedicated consultant for inpatients. Better sharing of on call services, additional locality clinics and support for crisis response and places of safety.	CMHT services and patients would benefit from the redesign to support an improved model. Locality consultation and with CMHT's to support change, and achieve better outcomes.	This will achieve consistent care management which in turn can reduce hospital stays, assessment and review would be improved and locality services benefit from dedicated support. Joint and partnership working is an integral part of improving patient outcomes and these changes would achieve this.	No major risks, work to ensure recognised care pathways and effective communication is implemented and maintained throughout.	Nil anticipated		
AC23	Steps to ensure and maintain patient and community safety will be taken by redesignating and maintaining a secure locked environment for those with the most fragile mental health requiring extra care. This is based on the needs of service users, and experience from current Intensive Patient Care Unit.	Actions required pertain to legislation relevant to service delviery, which will be strictly followed. Work with staff to make changes to overall establishment and working practices and to agreee robust admission criteria. Some work with GG&C should needs arise for additional services.	No change to secure and safe locked environment for those needing this service.	Discussions with GG&C where a rare need arises which is chargeable, eg with forensic care.	Aligns with specialist services (eg acute surgical) provided by central specialist provision.	100	200
AC24	Further enhancement to community based care to ensure those with mental health issues have the same opportunities and choices. To include consideration of a step up / step down model for Lochgilphead and area service users.	Adopt community focussed approach, and use technology when possible, to review use of Ross Crescent to make this appropriate for a modernised mental health service. Ensuring patient choice and views are at the centre of service provision, with independence encouraged and supported.	Future needs should reflect less dependence on high care packages, and greater fous on community based support. Access to 'step up' when needed is maintained.	Prediction of mental health needs can be difficult, but use of reablement and community resources effectively should overcome any peaks within demand.	None anticipated.	45	45

Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
CORPORATE SERVICES:							
CORP1	Front line health and social care staff working together in same locations, and move corporate and support staff.	Co-locate staff into unused space in our hospitals, close the corporate support HQ building in Lochgilphead, move to other sites in Lochgilphead including council offices. Savings expected to be achieved from a range of departmental budgets including; finance, planning, IT, HR, pharmacy management, medical management, lead nurse and estates.	Front line services should benefit from a more joined up approach and a single point of contact from support services. There would ultimately be reduced workforce but this is offset by more efficient practices (see Corp 2 & 5) reducing duplication and improving communication	Not all support services are directly within the HSCP's control. There is a risk that partners (Council and NHS Highland) will not support any changes to the current arrangements as these are outside the scope of the integration scheme.	Nil anticipated	335	335
CORP2	Integrate health and social work administration, implement digital technology and centralise appointment systems.	Follow on from co-location CORP 1, a targeted piece of work would commence in 2017-18 to extend the review of social work administration and medical record keeping. The implementation of electronic solutions to improve efficiency and a move to electronic medical records would be required.	Moving to central booking and electronic records would reduce the need for as much local management. Reduced workforce for admin support, but should be accommodated from within a more efficient process, systems and new structure.	There will be a requirement for professional leadership and project management resource for fixed period. This will incur a cost.	Nil	120	325
CORP3	Management /Professional Leadership Review	Review the overall management structure.	Current structure has been in place for a period of time. A review could result in a reduction in management capacity and capability.	May not be significant savings, reduced management capacity could reduce ability to implement strategic development, to manage change in the culture, operational integration, workforce planning and delivery, staff partnership and public and political engagement and communication and realise financial and performance targets .	Any reduction to the management structure could lead to reduced capacity and capability to fulfil statutory duties.	tbc	tbc
CORP4	Rationalisation of Estates/Property-linked to CORP's 1 and 2.	Review of current property portfolio and opportunities to rationalise this. Review the current leases in place and find alternative accommodation to reduce costs.	Cultural change impact on staff and service users. May be a period of disruption if staff are displaced.	Any proposed changes to accommodation would require to follow a business case approach to ensure the benefits of any changes are transparent. Requires discrete expertise and project management resource. That may be a cost.	Nil	75	75
CORP5	Implement Lync/Skype for Business	Implement Skype for Business (Microsoft Lync) communications platform, this will reduce telephone and travel costs and improve communication and collaboration. Business case is due to be finalised It is required to maximise benefits in Corp 1 and Corp 2.	Will make operations more efficient with less time spent travelling, and with IT communication services being more efficient across both health and social care. Savings both in cost and in productivity clearly evidenced in other organisations. This will benefit services across the partnership	The infrastructure is not in place, and business case benefits may be difficult to quantify as efficiencies will be across the whole of the HSCP. Risk that financial benefits may not be achieved in the short term, with initial investment and a cultural shift required to fully realise potential.	Nil	0	0
CORP6	Catering and Cleaning and other Ancillary Services	Reduction in buildings occupied and opportunities to work with our partner organisations, take opportunities to reduce costs for catering and domestic services. Significant opportunities to share services and reduce costs.	This could result in significant changes to workforce rostering, operational delivery and quality of service and strategic partnership across public sector supplying a number of organisations catering requirements at locality level.	This will require a formal project process, centralising responsibility, with professional leadership over a fixed period.	Nil	505	505
CORP7	Vehicle Fleet Services	Explore opportunities for the centralisation of shared fleet service (as in part of NHS Grampian), look to share vehicles with partners, and a review of the provision of services.	More efficient fleet service, better aligned to service requirements.	Different governance arrangements with partners and loss of locality direct responsibility. May not be any significant savings.	Nil		
CORP8	The agreement with NHS Greater Glasgow & Clyde (NHSGG&C) provides hospital services outside Argyll and Bute.	Invest in community services and IT to reduce delayed discharges and patients length of stay in NHS GG&C hospitals, and commission NHSGG&C to reduce return appointments and follow up rates. Activity targets to be agreed based on national target for Scotland to free up 400,000 occupied bed days.	Front line services will benefit by only providing acute services in hospital and enhancing services in communities by facilitating rapid assessment and support and discharge to community/home with support. Any reduction in the agreement with GG& C would build capacity for community and care sector to expand to meet workload, and reduce beds in local hospitals.	Timescale for deliverability starts 1 April 2017 when GG&C will recharge us for extra activity. There may be other demand and cost pressures from acute services. We recognise a potential difficulty by NHSGG&C to change to meet our commissioning intentions.	Nil	TBC	TBC
CORP9	Capital projects - Dunoon GP practices new build, Bute Health and care campus, Care Home redesign, and new model of care relocation of Salen Surgery to Craignure & elements of CORP 4	Formal capital design projects at large and small scale, latter to be costed by March 2017 for inclusion in capital programmes for next 2 years. Large scale projects require formal processes and resource.	Front line services will benefit both as operational single point of contact and co-location advantages. New developments with suitable accommodation with greater energy, utilisation efficiency rating etc and other cost reductions.	We require to centralise the capital planning function with financial support and clear project management processes. Timescale for deliverability depends on the availability and accessibility of capital from the Council, NHS and Housing associations.	None at present as longer term projects	0	0

Quality and Finance Plan 2017-18 to 2018-19

ANNEX A

Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
CORP10	Alcohol and Drugs Partnership	The ADP will look to review and reduce costs being incurred in delivering alcohol brief interventions, supporting the voluntary sector and the ABAT statutory service sector. The reduction in 17-18 equates to 8% of the total budget for ADP.	More efficient use of resources.	Risk that ADP cannot reduce costs in line with reduced subsidy.		100	150
TOTAL						**4,494**	**6,707**

PREVIOUSLY APPROVED 2016-17 Q&F PLAN:			
Previous Ref	**Description**	**2017-18 £000**	**2018-19 £000**
STILL TO BE DELIVERED:			
1	Prescribing	100	100
5	Redesign of the Out of Hours Service for Cowal	300	300
13	Closure West House	100	100
14	Closure AROS	150	150
15	Kintyre Medical Group	25	25
27	Kintyre Patient Transport	25	25
45	Ardlui	10	10
51	Supporting Young People Leaving Care	17	17
52	Consultation Support Forum	5	5
59	Bowman Court Progressive Care Centre	80	80
61	Internal Mental Health Support Team	60	60
62	Assessment and Care Management	12	12
63	Assessment and Care Management	30	30
		914	**914**
FULL YEAR IMPACT:			
55	Struan Lodge (paused)*	0	175
56	Thomson Court (paused)*	0	10
58	Tigh a Rhuda	22	22
		22	**207**
ADDITIONAL DELIVERABLE SAVINGS:			
1	Prescribing	700	1,400
3	Further Savings from closure of Argyll and Bute Hospital	282	282
4	Kintyre Patient Transport	25	75
5	Redesign of the Out of Hours Service for Cowal	29	29
10	NHS GG&C contract / services	100	100
		1,136	**1,886**

* Decision taken at the IJB meeting on 2 November 2016 to pause implementation of these service redesigns to allow for additional period for consultation and engagement. No formal decision taken to reverse decision, therefore for financial planning purposes assume that full year saving will be realised in 2018-19. This position will be updated following outcome of communications and engagement process.

***NEW* EFFICIENCY SAVINGS:**			
Ref	**Description**	**2017-18 £000**	**2018-19 £000**
1	Commissioned Services	500	500
3	Budget Reserves	350	200
4	Equipment Depreciation	50	50
5	Increased Patient Services Income	50	50
6	Community Dental Services	20	20
7	Review of Podiatry Services Budgets	20	20
8	Helensburgh & Lomond Locality - recurring underspends	20	20
9	Medical Physics Department - supplies budget underspends	45	45
10	Energy Costs for Health Buildings (excluding A&B Hospital & AROS)	50	50
11	Oban, Lorn & Isles Locality - patients' travel	40	40
12	Review of Radiography Services Budgets	50	50
13	Mental Health Bridging Funding	0	400
14	HEI Budget - requirement will reduce in line with beds	0	50
15	Mid Argyll Social Work Office	10	10
16	Admin - Travel Reduction	3	3
17	Planning	51	51
18	Review MAKI Management Structure	130	250
19	Children and Families Service Efficiencies	40	40
22	Adult Services Fees and Charges	50	50
24	Adult Services Charging Order - Long Term Debt Adjustment	25	25
25	Social Work Utility Costs	33	33
26	Mull Medical Group - reduction in use of GP locums	50	50
		1,587	**2,007**

Theme	Investment Details	2017-18 £000	2018-19 £000
Implement New Community Based Models	Argyll and Bute Area Teams - Mobile devices	471	632
	Argyll and Bute West Sector - Develop capacity Neighbourhood/Community Team models		
	Helensburgh and Lomond Anticipatory/Emergency Nurses		
	Reablement update for providers		
	Cowal and Bute - Nurse Practitioner, admission prevention		
	Investment in Early Intervention		
Co-location of Teams	Co-location of staff in Cowal and Bute	260	-
	Co-location of staff in Kintyre		
	Co-location of staff in Islay		
Communications and Engagement	Communications	106	45
	Public Involvement Manager		
	Planning Support		
Project Management	Adult Service Redesigns	300	322
	Catering and Cleaning Services		
	Medical Records and centralised booking		
	Administration Services		
	Children's Services Redesigns		
	HR Support - organisational change		
		1,137	**999**

Meeting: **Audit Committee, Argyll & Bute Integration Joint Board**
Venue: **Cowal Community Hospital, Dunoon, A01 and by VC**
Date and Time **Wednesday 14th December 2016, 14:00 to 16:00**

IN ATTENDANCE:

Elaine Wilkinson (Chair)	IJB Member, Non Executive Member, NHS Highland Health Board
Cllr. Elaine Roberson (Vice Chair,VC)	IJB Member, Councillor, Argyll & Bute Council
David Alston (VC)	IJB Member, Chair NHS Highland Board
Cllr. Ann Horn (VC)	IJB Member, Councillor, Argyll & Bute Council
Heather Grier	IJB Member
David Eardley	Scott Moncrieff, Audit Director
James Thomson	Scott Moncrieff, Senior Consultant
David Meechan	Audit Scotland, External Audit
Morgan Kingston	Audit Scotland, External Audit
Christina West	Chief Officer
Caroline Whyte	Chief Financial Officer

No	Item	Action
1.	**APOLOGIES**	
	Apologies were noted from Betty Rhodick. The Chair welcomed everyone to the meeting and in particular introductions were made to our new Audit Scotland external audit team, David Meechan and Morgan Kingston.	
2.	**MINUTE OF MEETING ON 3 AUGUST 2016**	
	Minutes of the last meeting were agreed as an accurate record.	
3.	**AUDIT PLAN 2016-17 TO 2018-19**	**Action**

	The audit plan had been discussed in detail at the first Audit Committee meeting on 3 August 2016. There were changes requested at that meeting and the updated plan had been issued separately to audit committee members by email. This was brought to the audit committee again for final approval. The Audit Committee approved the updated plan, including the timescales for the audit activity.	
4.	**AUDIT REPORT – Corporate Governance**	**Action**
	David Eardley presented the Internal Audit Report for Corporate Governance. This is the first report to be presented to the Audit Committee, Scott Moncrieff are happy to take feedback and have a flexible approach to the format of reports. In undertaking the review internal audit have taken cognisance of the relatively early stage of the Integration Joint Board as an organisation. The report is broadly positive with the conclusion that roles and responsibilities of Board members and executive management are clearly defined and communicated and there is a clear linkage across the IJB and Committee forums and with the wider Council and Health partners. There are areas of good practice and also some areas for improvement. The three main areas for improvement are noted as: 1. Workforce Planning – recommendation to develop workforce plan as soon as possible to support strategic plan objectives and formalise processes for Board administration. 2. Ongoing Governance – schedule and timetable to be prepared to ensure key governance policies are reviewed regularly. 3. Governance statement – preparation of the Governance Statement for inclusion in the IJB annual accounts. Discussion took place around the report recommendations. In terms of workforce planning the LPGs have a responsibility to prepare a workforce plan for localities to achieve strategic objectives. Agreed a schedule of documents will be useful and would be useful for the IJB to be sighted on this. It would also be useful for us to gain an understanding of how governance arrangements are operating in other IJBs. Recommendations were accepted by management in the audit report together with agreed management actions. However it was noted that in future the management response should be clearer if management accept the recommendation by internal audit. The Audit Committee Chair expressed that she is encouraged that	

	the systems we have are well defined and we are on course. We need to see the effectiveness of them in use to ensure we are effective in carrying out roles. The governance statement will outline how we are tracking this. Question was raised around the follow up process for actions from internal audit reports to ensure there is a process in place to ensure management are taking actions forward. Scott Moncrieff will provide an annual report and this will cover progress with actions and an opportunity to escalate any issues to the IJB. This will also give Scott Moncrieff an opportunity to comment on progress made. In addition an action tracker will be developed which will be used operationally to ensure management actions are being taken forward, this will initially be presented to the Strategic Management Team and would come to the Audit Committee for an oversight on progress. Caroline will ensure this process is put in place.	CW
5.	**AUDIT ASSIGNMENT - Assurance Mapping**	
	The Assurance Mapping exercise is a work in progress and the work to date has not yet been discussed with management. However James Thomson from Scott Moncrieff gave a presentation to the audit committee to provide an overview of the progress to date. A report will come back to the Audit Committee in March, once Scott Moncrieff have spoken with management and agreed the next steps. The presentation gave the audit committee an overview of the levels of assurance and the three lines of defence model, the 1st line business unit (day to day risk management and internal controls), 2nd line risk and compliance (for example oversight and challenge on risk management by SMT, AC, CCG Committee) and 3rd line audit (to challenge, independent perspective). The strategic risk register for the IJB was then assessed against the three lines of defence to demonstrate where the IJB have coverage or assurance for key risk areas. High level initial conclusions are that assurance functions are not fully co-ordinated, which is not a surprise in a new organisation, that tolerances and thresholds for risk are not aligned, and that there is not a clearly defined risk appetite for the IJB. There are opportunities for improving reporting in relation to performance and IT, for example the risk based approach of not reporting all performance information and clarity on acceptable use of IT. Recommendations at this stage are to use assurance mapping to plan future work, consider how we can we better co-ordinate activity between partner assurance functions, clarity around roles and	

	responsibilities, align tolerances and thresholds and undertake lean process reviews to remove waste and improve effectiveness. From the initial work it is evidenced that the IJB have cover operationally for strategic risks but it is not as clear where we have cover from the 2nd and 3rd tiers of assurance. Assurance arrangements should be: • Balanced and proportionate • Risk based • Demonstrably adds value • Takes account of customer experience • Meets the needs of the business and those charged with governance • Lean reviewed processes and procedures Scott Moncrieff communicated the message not to panic at this stage around any potential gaps, this position is developing and we don't require coverage from all three lines of defence for all areas. Work is ongoing to develop the integrated risk register and this will be an iterative process. A risk management workshop is planned as a development session for the IJB in the future and this will further explore the risk thresholds and risk appetite. Further work on the assurance mapping exercise is required from both Scott Moncrieff and management before a report is brought back to the Audit Committee in March.	
6.	**DRAFT AUDIT PLAN: Financial Monitoring and Performance Management**	
	Noted that it was useful for draft plans to come to the Audit Committee for approval, agreed that internal audit is not a silver bullet to solving problems but it is in the interest of the IJB to drive improvement out through the work of the audit committee. The audit committee acknowledge that there are some problems with both financial monitoring and performance management information in terms of consolidating this and having a joined up integrated approach. Audit Committee would like to take opportunity within the scope of the audit to tease out any improvement recommendations. There are differences with each area of support services having two different systems and the current support is not in line with lean management, the aspiration is for completely integrated services. Request to update the business objectives to include an evaluation if the support frameworks in place support an integrated approach.	

		SM
7.	**DRAFT AUDIT PLAN: Engagement with Locality Planning Groups**	
	Locality Planning Groups are the engine room for integration. There is a level of anxiety around the audit in terms of how the LPGs are performing, but will be useful to guide improvement and recognise the level of support required by the LPGs.	
8.	**AOCB**	
	David Meechan from Audit Scotland expressed that they were delighted to attend the Audit Committee. David and Morgan will be the IJBs external audit team and are also the appointed external auditors for Argyll and Bute Council. David McConnell will be the Audit Scotland engagement lead and will sign the annual accounts for the IJB. Initial aim is to get an understanding of the IJB and key audit risks. Introduction meeting held with CO and CFO and going forward will also tie in with work of internal audit to avoid duplication. The annual audit plan will come to the audit committee in March. The annual accounts audit work will be carried out in May or early June to tie in with the timescale of Health Board accounts audit. The annual report will be presented to the audit committee in September. The plan presented to the audit committee in March will be slightly different in approach to last year, where the focus in 2015-16 was really on the financial statements for 2016-17 this will be a wider scope. The Code of Audit Practice requires Audit Scotland to focus on 4 key areas: • Financial Sustainability • Financial Management • Governance and Transparency • Value for Money These are the areas of focus for all public sector bodies. Audit Scotland look forward to working with the Audit Committee. Christina proposed that the risk management workshop for the IJB may be scheduled in to the May IJB meeting. Scott Moncrieff are to confirm if this is date is suitable.	SM
9.	**DATE AND TIME OF NEXT MEETING**	

	Caroline to circulate suggested date for next meeting, likely to be w/c 20 March 2017 in Dunoon with VC available.	CW

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.11

Date of Meeting: **31 May 2017**

Title of Report: **Chief Officer Report**

Presented by: **Christina West**

The Integration Joint Board is asked to :

Note the following report from the Chief Officer

Appointment of Head of Children & Families & Criminal Justice

Alex Taylor has been appointed as the Head of Service for Children, Families and Criminal Justice. Alex brings a wealth of experience to the role, combined with a commitment to improving services for children and families in Argyll and Bute.

Nursing Excellence Awards

The Lead Nurse office of the Health & Social Care Partnership (HSCP) this year launched a series of excellence awards for nurses and midwives working within the HSCP. The awards were presented on Friday 12th May which was very fitting as the 12th May was International Nurses Day.

As the awards were such as a success they will become an annual event and from next year it will be expanded to include all staff working for the HSCP.

Details of the members of staff who received the awards are as follows:

Nurse of the Year – Carol-Anne McDade (Helensburgh)

Health Care Assistant of the Year – Linda Black (Dunoon)

Patients Choice Award – Mid Argyll Extended Community Care Team (Rhona Larkin, Colette Morgan, Trevor Lines, Cathy Griffiths, Michelle Campbell)

Lead Nurse Award for Mentor of the Year – Joanne Hill (Dunoon)

Nurse Director's Award for Lifetime Contribution to Nursing (a nurse who is retiring in 2017) – Sheila Letford (Oban)

Team of the Year – Bute Midwifery Team (Ann McClean, Fiona Hood, Lesley McArthur, Fiona Maccallum)

Co-Workers Nursing Star Award – Tiree Team (Catriona Cowling, Mairi Maclean Storm Byfield, Alison Colthart)

Care Summit

A Care Summit was held on 22 May in the Argyllshire Gathering Halls in Oban. The event was arranged to help the HSCP develop and plan how it will implement innovative new models of care to support people to live long, healthy and independent lives within their local communities.

Over 100 people attended from across the public sector, private providers, the Third and Independent sectors as well as elected members. A number of guest speakers from the NHS, Healthcare Improvement Scotland, Care Inspectorate and the Independent Housing Sector gave presentations and contributed to the discussions and facilitated sessions.

1000 Voices

1000 Voices is the name for the Community Resilience work supported by the HSCP and 50% match funded by Big Lottery Scotland. Over time this has grown and developed to combat loneliness and isolation in our towns and our rural areas providing social connections, enabling independence, offering support and improving the quality of people's lives.

Over the last 12 months the reach has extended, thanks to Lottery support, and groups have been established in the most rural areas of Argyll. In total, around 3,000 people are supported and networks have grown considerably. None of this would have been possible without the early support of the HSCP and the shared commitment to maintaining people's independence and quality of life.

Child Protection Committee Protocol Getting it Right for Children affected by Parental Mental Health

On Tuesday 9th May the Argyll & Bute Child Protection Committee and the HSCP jointly launched a new pathway and protocol for children, parents and their carers affected by parental mental ill health.

The day combined presentations from key note speakers and workshops to help consider best practice working across children and adult services to understand mental health for children and their parents and to ensure that mental health support is visible and easily accessible.

This was also an invaluable opportunity to explore best practice strategies for prevention and early intervention and working together to ensure children, parents and carers have timely access to clinically effective mental health support when it is required.

ACHA Receives Healthy Working Lives Award

Argyll Community Housing Association was recently presented with their Healthy Working Lives Gold Award.

To achieve their award ACHA demonstrated an ongoing commitment to staff health by producing a three year HWL Strategy and action plan. Staff undertook various health promotion activities, including virtual pedometer step challenges from 'Land's End to John O'Groats' and 'climb a Munro' raising funds for charity.

In addition, staff took part in many national initiatives, such as Stress Awareness Day, Breathing Space Day, Go Sober for October and Dry January. Lifestyle checks were

offered to all staff and they were provided with information on a variety of health related topics in the staff monthly newsletter.

The Healthy Working Lives Award Programme supports employers and employees to develop health promotion and safety themes in the workplace.

New Day Case Unit to be Developed on Islay

The Health & Social Care Partnership is planning to invest in new services within Islay Hospital through the creation of a new day case unit which will provide additional services locally and will reduce the need for people having to travel to the mainland for treatment.

The GP team will continue to work closely with their colleagues in Glasgow to ensure safe and appropriate mechanisms are in place to maintain and build upon the high standard of care which patients receive.

Local Newspaper Features

The Health and Social Care Partnership is continuing to work closely with the Helensburgh Advertiser and the Oban Times to develop a series of regular features highlighting the work carried out by local health and social care professionals and how this links in with the integration agenda. The first of these features was published in the middle of May and they will continue to be published on a regular basis over the coming months.