MINUTE OF
ARGYLL & BUTE HEALTH & SOCIAL CARE PARTNERSHIP (HSCP)
INTEGRATION JOINT BOARD
held on Wednesday 26 September 2018 at 1.30pm in the Council Chamber, Kilmory, Lochgilphead

Present:

Robin Creelman	NHS Highland Non-Executive Board Member (Chair)
Councillor Kieron Green	Argyll & Bute Council (Vice Chair)
Joanna MacDonald	Chief Officer, Argyll & Bute HSCP
David Alston	NHS Highland Chair
Alex Taylor	Head of Children and Families & Criminal Justice
Lesley MacLeod	Interim Chief Financial Officer, Argyll & Bute HSCP
Denis McGlennon	Independent Sector Representative
Dr Angus MacTaggart	GP Representative, Argyll & Bute HSCP (VC)
Sandra Cairney	Associate Director for Public Health, Argyll & Bute HSCP
Fiona Thomson	Lead Pharmacist
Elizabeth Rhodick	Public Representative
Heather Grier	Unpaid Carer Representative
Stephen Whiston	Head of Strategic Planning & Performance - Argyll & Bute HSCP
Fiona Broderick	Staff Representative, Argyll and Bute HSCP
Kirsteen Murray	CEO, Third Sector Interface
Sarah Compton-Bishop	NHS Highland Non Executive Board Member (VC)
Gaener Rodger	NHS Highland Non Executive Board Member (VC)
Kevin McIntosh	Staff Representative – Argyll & Bute Council (VC)
Councillor Aileen Morton	Argyll & Bute Council
Councillor Gary Mulvaney	Argyll & Bute Council (VC)
Councillor Sandy Taylor	Argyll & Bute Council

In Attendance:

Lorraine Paterson	Head of Adult Services
Phil Cummins	Interim Head of Adult Services
Sandy Wilkie	Head of People and Change
David Ritchie	Communications Manager, Argyll & Bute HSCP
Laura Blackwood	Executive Support Officer, Argyll & Bute Council

Apologies:

Catriona Spink	Unpaid Carer Representative

ITEM	DETAIL	ACTION
1	**WELCOME**	
	The Chair welcomed everyone to the meeting and introductions were made around the table.	
2	**APOLOGIES**	
	Apologies were noted from:-	

	Catriona Spink – Unpaid Carer Representative It was also noted that Maggie McCowan, Public Representative, had tendered her resignation and the IJB passed on their thanks for her valued contribution.	
3	**DECLARATIONS OF INTEREST**	
	No declarations of interest were intimated.	
4	**APPROVAL OF MINUTE OF INTEGRATION JOINT BOARD HELD ON 1 AUGUST 2018 AND ACTION NOTES**	
	The minute was agreed as an accurate record and the updates on the action plan noted (appended to the minute).	
5	**BUSINESS**	
5.1	**IJB Improvement Plan Update**	
	Report from Chief Officer providing an update on progress against the Improvement Plan, which was approved by IJB on 1st August, and presentation of the proposed monitoring framework that will enable a high overview of progress across the plan, was circulated. Arising from discussion the following points/comments were made in respect of the plan:- <u>Action 1c – Integration Scheme Review</u> – concern noted about the lack of progress. D Alston advised that the name of a suitable legal representative to sit on the SLWG on behalf of NHS Highland would be forthcoming within the week. <u>Action 2i</u> - Concerns were raised about the general pace of change/implementation of actions within the plan, including the lack of progress in respect of putting in place arrangements for the Senior Officers Members Group. It was agreed that steps would be taken to confirm membership and have the first meeting by end October 2018. <u>Action 2c</u> – IJB Development Session – the Chair encouraged attendance at the meeting scheduled for 4th October, which will be facilitated by the Improvement Service. <u>Governance</u> – agreed that it would be useful for a report to be tabled at the IJB which provides a visual representation/details of the linkages between the various Boards/Groups (e.g. between Strategic Planning Group and IJB) to assist an overall understanding of the reporting arrangements that are in place.	**D Alston** **J MacDonald** **All** **S Whiston**

	The IJB also agreed:- • *To note the progress made across the range of actions contained within the IJB Visible Changes Improvement Plan;* • *that the briefer RAG rated table will be brought to future meetings of the IJB as the monitoring framework which will enable a high level status of actions contained within the Improvement Plan to be monitored; and* • *that recommendation 3 within the paper, which proposed "detailed reporting across 1-2 of the aims within the plan at each IJB meeting, with the monitoring framework providing the high level overview of progress across the totality of the plan" would be revised to take account of concerns raised about this approach and the preference to focus on exception reporting/those areas that are red with appropriate supporting narrative.*	**J MacDonald** **S Whiston / J MacDonald**
5.2	**1st Year Review of Children and Young People's Service Plan**	
	Report from Head of Children and Families & Criminal Justice providing an update on progress made during 2017/18, information on developments that have taken place since the plan was published, and the key plans for the year ahead, was circulated. A revised version of the performance report was also circulated as the "status" was omitted for some of the PIs within the original papers. Arising from discussion the following observations were made:- PIs 1.8 and 1.9 - noted that the data for these indicators is not presented correctly as the actual performance figures reflect the uptake of reviews rather that the percentage of children reaching their developmental milestones. It was agreed that this requires to be corrected prior to the final report being published. PI 2.7 – noted that this indicator is marked as red, however the actual performance (64.90%) is above the target of 50% so should be changed to green. In respect of indicators 5.4 and 5.5 it was noted that the year 3 target was used rather than year 1 and this should be corrected. It was agreed that future performance reports should focus on the red measures and invite support from the IJB, where required, to address any issues. In addition it was also agreed that it would be helpful for benchmarking data to be included within future reports to allow a comparison against other authorities. Subject to the above comments/changes the IJB agreed:- • *To note that both NHS Highland and Argyll and Bute Council are jointly and equally responsible for children's services planning;* • *To approve the Argyll and Bute's Children and Young People's Services Plan 2017-20 Year 1 Review for the period*	**A Taylor** **A Taylor** **A Taylor** **A Taylor**

	2017/18,; and • *that the Year 1 Review be submitted to the Scottish Government as per the legislative requirement.*	**A Taylor**
5.3	**Finance**	
	(a) <u>Audited Annual Accounts 2017-18</u> Report from Interim Chief Financial Officer detailing the Audited Annual Accounts for 2017-18 was circulated. The IJB:- • *Noted that Audit Scotland have completed their audit of the annual accounts for 2017/18 and have issued an unqualified independent auditor's report; and* • *Agreed that the Audited Annual Accounts for 2017/18 be signed for issue.* (b) <u>Budget Monitoring Report</u> Report from Interim Chief Financial Officer setting out information on financial performance up to August (Month 5) 2018/19, progress on implementing measures to achieve savings, and the projected forecast outturn position for the financial year, was circulated. The IJB:- • *Agreed that the funding offers from NHS Highland and Argyll & Bute Council should be accepted by end of month 6.* • *Noted that budgets have been set based on the funding offers made;* • *Noted that projected expenditure exceeds the funding offers by £12.2m;* • *Noted that a savings plan of £10.6m is in place, however a budget gap of £1.6m remains;* • *Noted that slow progress is being achieved with regard to delivery of recurring savings;* • *Noted that the year – end forecast outturn is currently for a £4.2m overspend; and* • *Instructed Officers to put in place measures to minimise discretionary spend and in year overspends, with authority delegated to the Quality and Finance Programme Board to monitor the position and provide update reports to the IJB, which should be a standing item on the agenda.* • *Agreed that a report regarding the arrangements for the budget consultation process should be discussed at the next Quality and Finance Programme Board in October, rather than waiting until the next meeting of the IJB.*	**L Macleod** **L Macleod** **L Macleod** **S Clark** **L Macleod**

	• *Agreed that all future reports to the IJB should contain clear recommendations for agreement, with timescales attached where appropriate.*	**All**
5.4	**Staff Performance Review Process**	
	Joint report from Head of Improvement and HR (ABC) and Head of People and Change (ABHSCP) setting out the approach currently taken by both the Council and the NHS in relation to annual performance review, and proposed improvements and changes underway to these systems, was circulated. It was noted that there currently appears to be different targets and approaches adopted across the partnership with regard to PRDs and the aim is to have a single target for all staff and to ensure that the various methods of engagement with staff are captured/recorded appropriately on the systems once streamlined. The IJB:- • *Noted that the current performance review processes in place for both Council and NHS staff across the HSCP;* • *Noted that there is a review of the Council PRD process underway; and* • *Noted that the ongoing roll out of the TURAS system for NHS staff, with a link to our CIRCLE values, will help increase engagement and participation; and* • *Agreed that a progress report would come back to the IJB in May/June 2019.*	**S Wilkie / J Fowler**
5.5	**Public Health**	
	(a) NHS Highland Tobacco Strategy Report from Associate Director of Public Health presenting the NHS Highland Tobacco Strategy for 2018-2023, which outlines a comprehensive and planned approach to tobacco cessation, protection, and prevention, was circulated. The IJB:- • *Endorsed the NHS Highland Tobacco Strategy 2018-2023;* • *Noted the breadth of work already underway to implement the Tobacco Strategy; and* • *Noted plans for further development.* • *Agreed that the Strategy Actions for Argyll and Bute should be circulated to the IJB; and* • *Agreed that a paper would be brought to the next IJB meeting recommending that the Board sign up to support the ASH Scotland Charter for a tobacco free generation.* (b) A&B Alcohol and Drugs Partnership Report	**S Cairney** **S Cairney** **S Cairney**

	Report from Associate Director of Public Health setting out proposals for revised governance arrangements for the Argyll & Bute Alcohol and Drugs Partnership (ADP), including accountability, joint working, reporting, and chairing arrangements, was circulated. The IJB:- • *Noted Scottish Government directions that ADP funding and functions have been delegated through health boards to Integration Authorities;* • *Noted the consequent change to Argyll & Bute ADP governance arrangements;* • *Approved the revised governance and the requirement to update the Terms of Reference and developing a scheme of delegation to enable the ADP to be responsive and timely in its actions, within an agreed strategy direction set by the IJB;* • *Approved the recommended process for the appointment of the ADP Chair; and* • *Directed officers to progress the implementation of the revised ADP governance arrangements.*	**S Cairney**
5.6	**Chief Officer Report**	
	Report from Chief Officer was circulated and the following points noted:- <u>Argyll and Bute HSCP Strategic Plan</u> – the IJB noted their appreciation of all staff who took the time to cascade/deliver presentations on the consultation across the partnership. <u>Staff input/successes</u> – details of good news stories will be included within future reports to ensure that the excellent contribution of HSCP staff is being recognised and promoted. <u>Leadership Team</u> – in order to increase the visibility of the leadership team across Argyll and Bute, plans are being put in place to have a central diary to show where each member of the team will be on a month to month basis to enable staff the opportunity to meet with them when they are in their local area. It was agreed that a progress report will be brought to a future meeting of the IJB to update on the roll out of this approach.	**J MacDonald**
5.7	**British Sign Language Strategy 2018-2024**	
	Report from Associate Director of Public Health introducing the British Sign Language Strategy 2018-2024, and associated action plan, which has been prepared jointly between Argyll and Bute Council, NHS Highland Board and LiveArgyll, was circulated. The IJB:-	

	• *Noted Argyll and Bute Council and NHS Highland Board's duties as named Public Bodies to produce the British Sign Language Local Plan following public consultation 6 yearly in both written English and BSL. The first report is to be published by October 2018 and again in 2024; and* • *Noted the Argyll and Bute Council Plan, which incorporates the actions from the NHS Highland Plan that are pertinent to the HSCP.*	
5.8	**IJB Meetings 2019**	
	Proposed dates for IJB meetings during 2019 were circulated and noted.	
	Date of Next Meeting: Wednesday 28 November 2018 at 1.30pm in the Council Chamber, Kilmory, Lochgilphead	

ACTION LOG – INTEGRATION JOINT BOARD 26-09-18

	ACTION	LEAD	TIMESCALE	STATUS
1	Development Session on Homecare to be arranged	A MacColl-Smith	2018	Still to be arranged. Agreed that Chief Officer would arrange for a timescale to be put on this one ahead of next meeting.
2	Strategic Risk Register topic for Development Session	Chief Financial Officer	To be advised	Progressing with internal auditors to agree a date
3	Review of Carer's Centres to ensure the criteria of the Carer's Act is being managed	Linda Currie / Heather Grier / Catriona Spink	Ongoing	Data collection from centres will be collated on the template due to be issued from Scottish Government. Following the presentation to IJB this morning, further reports in regard to young carers will be tabled at future meetings.
4	Update Visible Changes IJB draft Implementation Plan	Chief Officer	Ongoing	Standing agenda item
5	Complaints report	E Higgins	Future report to IJB to include trends and graphs, benchmarking	

			against other peer partner-ships	
6	Report on eKSFs & PRDs to IJB	S Wilkie	Sept 2018	On agenda
7	Updated HSCP Workforce Plan	S Wilkie	Jan 2019	
8	Visible Changes Improvement Plan – report on mapping of values and link to Visible Changes Improvement Plan	S Wilkie	Early 2019	

Integration Joint Board **Agenda item : 5.1**

Date of Meeting : 28 November 2018

Title of Report : IJB Improvement Plan Update

Presented by: Joanna MacDonald, Chief Officer

The Integration Joint Board is asked to :

- **Note** the progress made across the range of actions contained within the IJB Visible Changes Improvement Plan

1. EXECUTIVE SUMMARY

The Visible Changes IJB Improvement Plan was developed in response to a range of feedback and issues experienced by the IJB at the beginning of the year, including staff, community and political feedback in relation to service change and transformation across health and social care services within Argyll & Bute Health and Social Care Partnership.

The briefer RAG (red, amber, green) is agreed as the monitoring framework which will enable a high level status of actions contained within the Improvement Plan to be monitored.

The Improvement Plan, was approved by the IJB on 1st August, and that updates on progress be brought to every IJB meeting, through a standing agenda item.

The Board are also provided with detailed reporting across 1-2 aims within the Improvement Plan at each meeting, this is detailed in the current agenda.

2. INTRODUCTION

The IJB have responsibility for assuring high quality, safe and sustainable models of care delivery within the available resources. In response to feedback received about the approach taken thus far to identifying and implementing areas for service change, the improvement plan details a range of improvement

work and support from partners required to implement visible changes to local arrangements.

3. DETAIL OF REPORT

Appendix 1 provides an update on progress since the last IJB meeting. The Board are also asked to note the progress at this stage.

Progress continues to be made across the range of actions contained within the Improvement Plan.

All items in the improvement plan are now rated amber or green, which indicates progress from the last board meeting. As with the previously reported progress for section 3 this is now indicated in all other areas. Reporting is by exception.

Section 1e has some indicated continued scoping due to impact on resource and section 1f is progressing through the initial stages of new joint working.

Section 2 continues to progress on target and will see fruition by the next IJB.

Section 3 is represented in depth in today's agenda. Timeframes for start have been met, 3f aligned with the transformation programme.

Section 4 is being progressed with significant resource directed at quality service delivery within financial balance that meets the needs of communities.

Section 5 seeks cultural change in a multidisciplinary partnership organisation. In alignment with the transformational program the change is being embedded to enable staff to work collaboratively to the best benefit of communities.

Chief Officer progressing section 6.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

The IJB improvement plan seeks to ensure effective governance, leadership and communication arrangements are in place across the Health and Social Care Partnership, acknowledging that these will positively impact on the delivery of the strategic objectives of the Partnership.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

Any financial impact or benefit will be reported as the IJB Improvement Plan is implemented, financial implications associated with specific actions will require to be identified.

5.2 Staff Governance

The IJB Improvement Plan acknowledges the requirement for effective collective leadership and opportunities for staff engagement to inform and influence the approach to service change and transformation locally.

5.3 Clinical Governance

All areas for improvement which positively impact on the organisation's culture and leadership behaviours have the potential to positively impact on the care delivery experience of people across Argyll and Bute.

6. EQUALITY & DIVERSITY IMPLICATIONS

This will continue to be reviewed as part of ongoing improvement, nothing to report at present.

7. RISK ASSESSMENT

The IJB Improvement Plan has been developed to address a range of feedback and issues experienced by the IJB, which have negatively impacted on the reputation of the IJB to deliver the required service change and transformation across health and social care services across Argyll and Bute.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

There are specific actions identified within the IJB Improvement Plan which seek to achieve improved service user, staff and partner involvement and engagement.

9. CONCLUSIONS

The Improvement Plan will be reported as agreed at each IJB meeting with updates by exception.

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IJB Visible Changes Improvement Plan

Appendix 2

	Actions Required	Lead	Timeframe	Partner Support Required	Progress	Status
1	**Aim: Ensure the areas of service change aimed at delivering the objectives of the IJB Strategic Plan are understood by the partner organisations, NHS Highland and Argyll and Bute Council, and that support is aligned to priority areas with the aim of achieving shared success.**					
1a	Collaborative Leadership meetings held regularly	CEOs of NHS Highland and Argyll & Bute Council, CO of IJB	Ongoing	Health Board and Local Authority senior leadership, with a focus on supporting service change.	COMPLETED. Meeting held 16.5.18 and calendar of quarterly meetings now finalised.	Green
1b	Corporate Service redesign and realignment	Head of Strategic Planning and Exec Director for Customer Services	Scoping extended January 2019	Support from Health Board and Local Authority to scope potential areas of redesign and realignment of corporate services across organisations.	Local Authority and HSCP Transformation Boards established: work progressing across catering and co-location, further opportunities to be identified	Amber
1c	Integration Scheme review	Short Life Working Group (SLWG) to be established to lead work.	Feb 2019- review process to be completed	SG Integration team support to facilitate/ support review process.	SLWG to be chaired by the Council's Exec Director for Customer Services.	
1d	Scope, facilitate and support a review of IT systems and processes	Head of Strategic Planning, Head of Customer and Support Services, CO.	Once scope agreed, timeframe to be agreed	IT colleagues across Health Board, Local Authority and HSCP to agree the scope and undertake a review	Skype for Business integrated comms business case in development - potential pilot site LIH, Oban	
1e	Workforce transition process (new roles required to deliver new service models)	Head of People People and Change	timeframe to be revised	HR and Finance colleagues from Health Board and Local Authority Issues identified by SLWG to be fed into groups supporting national health and social care workforce planning	Meeting held 28th August chaired by NHS Deputy Director of HR- high level discussion re key principles	
1f	Asset mapping across localities	Heads of Service and Head of Strategic Planning	March 2019 to complete review of asset mapping	Health Board, Local Authority and HSCP officers to review previous asset mapping undertaken as part of CPP work plan, identifying opportunities to further reduce footprint.	Council commissioning team to support review process	
2	**Aim: The IJB to undertake self evaluation activity aimed at identifying areas to inform a programme of improvement work which will assure effective governance and leadership to transform health and social care services in Argyll and Bute.**					
2a	Initial induction of new IJB members.	CO	May-18		COMPLETED: 15.5.18	Green
2b	Development session with IJB to discuss and inform Visible Changes IJB draft improvement plan and identify next steps	CO	May-18		COMPLETED : Updated Improvement Plan to IJB 1.8.18	
2c	Development Programme for IJB, informed by a self evaluation process to be developed	CO, Head of People and Change	August 2018	Areas which would benefit from input from Local Government Improvement Service and Integration Team of SG to be discussed and agreed by IJB.	Improvement Service self asessment questionnaire distributed. Action planning 4.10.18. Development Programme by end Oct.	
2d	Review frequency and format of meetings between members of the IJB and Chair and vice Chair	CO, Chair and vice-Chair	July/Aug 2018		Dates being identified for a Senior Members/Officers Group (SMOG) to enable early discussion between the IJB and members of SLT re policy development	
2e	Shadowing opportunities for all IJB members including IJB Chair, vice Chair, CO	CO, Chair and vice-Chair	July/Aug 2018	Integration team of SG to identify Partnerships facing similar challenges to maximise potential for shared learning	CO discussing arrangements with SG Integration Team	Amber
	Induction and support programme for service user and				Induction materials in development	

IJB Visible Changes Improvement Plan

Appendix 2

	Actions Required	Lead	Timeframe	Partner Support Required	Progress	Status
2f	carer reps on statutory groups to be developed (IJB, Strategic Planning Group, Locality Planning Groups)	Engagement Team	Jun-18		Final Induction pack will be presented rescheduled to January IJB	
2g	As part of IJB development programme, invitations to be extended to colleagues from other areas to come and share areas of good practice	CO, Chair and vice Chair	Nov-18		Programme to be developed	
2h	Support IJB members to operate strategically and undertake an ambassadorial role	CO	Oct 2018		IJB Development Programme to be informed by self assessment process	
2i	Regular meetings between senior officers and IJB to ensure appropriate information available to inform IJB decision making.	CO, Chair and vice Chair	Aug-18		Dates being identified for a Senior Members/Officers Group meetings	Green
2j	Seminar/ Development sessions to be organised prior to significant areas of work, with opportunities for informal networking of IJB members optimised	CO	Sept/Oct 2018		In development	
3	**Aim: Review and refocus communication and engagement strategy to improve understanding by communities and all staff of the case for change across health and social care services and provide opportunities for community feedback to influence the change.**					
3a	Revised communications and engagement plan to be developed based on Transforming Together message	Head of Service Strategic Planning and Associate Director of Public Health		Joint support and leadership across the Health Board, Council and IJB to ensure consistent messaging and collective responsibility.	COMPLETED: Engagement Strategy paper approved at IJB 30.5.18. Update to IJB 1.8.18.	
	Proactive communications and engagement with communities, which describes case for change and positive achievements			Support from SG to communicate policy messages re integration and service change alongside HSCP staff.	SG Integration Team to attend IJB. Date still to be identified	
3b	Information re Transforming Together programme to be shared with all staff and communities, linked to the review of the Strategic Plan and budget consultation process	Head of Service Strategic Planning, Associate Director of Public Health, Chief Financial Officer	June- Oct 2018		Engagement Strategy approved IJB 30.5.18 Update paper re engagement plan IJB 1.8.18 Engagement Timeline developed. Strategic Plan Consultation process underway involving wide range of stakeholders. Presentations delivered and questionnaire capturing feedback. Stage 1 focussing on Informing and Consulting on the Strategic Plan.	
3c	Support for Locality Planning Groups	Head of Service Strategic Planning and Associate Director of Public Health	end Jun 2018	SG identify and share areas of good practice from other Partnerships	Participatory workshop planned to evaluate the effectiveness of LPGs. Option appraisal methodology to be utilised to inform and strengthen arrangements. Findings and recommendations to November IJB.	
3d	Proactive communication across all stakeholders following IJB decision making at meetings	Associate Director of Public Health	Aug 2018		Engagement Framework approved at IJB in May 2018 Over-arching Comms & Engagement Group (reps from comms & engagements groups and the Scottish Health Council) advised on the approach to the Strategic Plan consultation. A Communication Framework in development. The Framework will complement the Engagement Framework and be supported through an annual delivery plan.	

IJB Visible Changes Improvement Plan

Appendix 2

	Actions Required	Lead	Timeframe	Partner Support Required	Progress	Status
					Partners have agreed to be members of a HSCP Strategic Engagement Advisory Group. This group will advise on the the HSCP strategic approach to service user, carer and partner engagement. First meeting to be held in September.	
3e	Focussed work with clinicans and social work staff so that they can engage effectively with communities re the case for change	Heads of Service and Associate Director of Public Health.	Sep-18		Staff side and People & Change involved in engagement sessions for staff July- September 2018. Staff comms and engagement learning sessions being delivered across localities. LMs and LAMs currently facilitating engagement with their teams and capturing comments/views to inform the next Strategic Plan.	Green
3f	Locality based work with all staff groups which clarifies the governance and decision making processes	Heads of Service and Head of People and Change-	Aug- Sept 2018		Work to commence October	
3g	Proactive messaging from the IJB to address any perceived division between health and council staff groups within the HSCP	Associate Director of Public Health and Head of People and Change.	Aug-Sept 2018		A new newsletter has been developed, first edition distributed in August.	Amber
					Pilot underway, inviting staff to feedback on what and how they would like to be engaged.	
4	**Aim: Ensure consistent communication of the case for change across the HSCP and leadership capacity aligned to priority areas for change.**					
4a	Strategic Management Team structure to be strengthened	Head of People and Change.	Sept/Oct 2018		Management Structure changes approved IJB 1.8.18 Job Descriptions undergoing revision and evaluation process- anticipate advertising vacancies early October	Green
4b	Exec Sponsors for worstreams within Transforming Together programme to develop Strategy/Policy documents which will underpin the changes going forward Support from the Improvement Service and HIS to enhance capacity and capability.	Head of Strategic Planning, Assoc Director of Public Health	Oct 2018	Integration team of SG provide contacts to share examples of good practice	Project Managers in post, Executive Sponsors identified, Transformation Board established Strategy Document outlining key principles of each area of service change to IJB in November HIS support for developing alternative housing models progressing Improvement Service issued self assessment survey. Action planning meeting 4.10.18	
4c	Prioritise internal benchmarking analysis of areas/trends in pay and non-pay expenditure for SMT to support focussed performance management.	Chief Finance Officer	Jul-18	Support from Health Board and Local Authority to progress alignment of the finance teams and integrated financial reporting Integration Team of SG to facilitate work with CFOs, including Argyll and Bute, to identify the potential to realise shift in resource from large acute settings to local community settings	Management structure paper approved at IJB 1.8.18. Potential for shared management arrangements over finance teams to be explored Links with 4d below	

IJB Visible Changes Improvement Plan

Appendix 2

	Actions Required	Lead	Timeframe	Partner Support Required	Progress	Status
4d	Continue to focus on delivering Commissioning Intentions notified to NHS GG&C, with resulting reduction in value of Service Level Agreement (SLA)	Head of Service Strategic Planning, Chief Finance Officer		Support from Integration Team of SG to review the costing model between NHS Board delivering services and Board of patient's residence.	Meeting between CO and GG&C colleagues being arranged to assert impact of commissioing intentions to value of SLA.	
	Re-negotiate terms of SLA to reflect IJB requirements and ensure timely agreement of payment value.			Review of how costing model influences commissioning intentions and resulting resource release.	Cross boundary flow model shared with SG colleagues	
4e	Focus of all managers in HSCP on budget to enable services to operate within budget while addressing increasing demand	Chief Finance officer	Jun-18	Support from NHS and Council finance teams -to monitor progress and identify variance from plans.	Sessions held across the HSCP to focus efforts and ensure consistency of approach.	
				Close scrutiny and monitoring of trajectory of savings to allow corrective action to be taken.	Budget challenge process completed.	
					Integrated financial reporting project plan to be taken forward, with trajectory re monthly reduction in spend identified	
					Managers have led sessions with local teams with consistent messages	
5	**Aim: To develop a shared culture and identity across the HSCP, underpinned by a model of collective leadership.**					
5a	Enhanced leadership visibility of SLT	Head of People and Change-	June 2018.		Start the Year sessions undertaken April/May. Feedback to be issued with structured approach to increasing visibility and engagement of SLT	
	To be further cascaded by local managers engaging with their teams					
5b	SLT to identify different ways of working to ensure effective delivery of Transforming Together programme.	CO	May-18		COMPLETED. Range of actions identified including: establishing an adult services management team across Argyll and Bute, team development to be facilitated through action	Green
5c	Develop programme of two way communication with managers across the organisation	Heads of Service, Lead Nurse, Head of People and Change	Jun-18	Organisational development resource from Health Board and Local Authority to support programme development.	Session with LMs and LAMs held June. Feedback will inform proposed management redesign, communication structures and any future development programme by Oct 2018.	
5d	Refresh shared values of the HSCP and embed within processes of the organisation.	Head of People and Change	Aug-18		Refreshed values and behaviour framework approved by IJB 1.8.18 Incremental team based roll out. To be incorporated into recruitment, appraisal processes by Oct.	Amber
5e	HSCP branding to facilitate staff having shared sense of identity and belonging	Assoc Director of Public Health	Sept/Oct 2018	Branding and identity development will require support from Health Board and Council.	Information on options to IJB Development session 26.9.18	Green
6	**Aim: to provide an opportunity for local MSPs and MPs to be regularly briefed about areas of service change and factors impacting on care delivery across Argyll and Bute, along with issues highlighted to them by constituents**					
6a	Regular formal communication and briefings with A&B political representatives by CO, Chair and vice-Chair	CO	June onwards	Integration Team of SG to provide initial support for meetings with MSPs - held in Edinburgh to facilitate attendance	CO to discuss arrangements with SG Integration Team.	

A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.2

Date of Meeting: **28 November 2018**

Title of Report: **Building on Experience-A vision for Mental Health Servicesin Argyll and Bute. The Re-Provision of an Acute Inpatient Facility**

Presented by: **Lorraine Paterson, Head of Adult Services**

The Integration Joint Board is asked to:

Agree the recommendations within this paper and its presentation to NHS Highland Board :

- The Mental Health Inpatient unit in Mid-Argyll Hospital and Integrated Care Centre is agreed to be the permanent facility.
- To formally progress with the closure of the Argyll and Bute Hospital.
- Make these recommendations to NHS Highland Board.
- To inform Scottish Government that there is no longer a requirement to proceed with a business case for a new built facility.
- Undertake ongoing engagement to inform of the new status.

1. EXECUTIVE SUMMARY

Improving Mental Health services is a priority for the Scottish Government and Argyll and Bute HSCP.

On 2nd June 2009 a paper was presented to NHS Highland Board, describing the background to the Redesign and Modernisation of Mental Health Services in Argyll and Bute. It presented an overview of the process that was undertaken and a summary of the progress with a request for a recommendation to implement the preferred option, option 4.

The preferred option was detailed as enhanced local community services and a single local inpatient unit, requiring the closure of the existing A&B hospital in Lochgilphead and a redesigned bed configuration in a modern environment in Lochgilphead.

NHS Highland Board agreed the recommendation.

During the intervening period considerable work and progress has taken place to implement option 4.

The protracted case has been the establishment of an affordable modern in patient unit.

On 26th July 2017 the inpatient facility relocated to a redesigned vacant area within Mid Argyll Community Hospital and Integrated Care Centre (MACHICC).

This has been fully evaluated during the past year, and Argyll and Bute HSCP are now recommending it is designated as the permanent Mental Health In patient Unit and we progress with the closure of the Argyll and Bute Hospital.

2. INTRODUCTION

A comprehensive review of mental health services is being undertaken in Argyll and Bute commencing in 2007 and continuing to the present day.

The outcome of a full consultation process was agreed by NHS Highland Board and the preferred option 4 was recommended to progress.

Completed work to date includes:

- The provision of enhanced and integrated community services offering a broad range of interventions to treat severe and enduring mental illness and complex needs in the community.
- A transport and retrieval service from the localities to the inpatient facility.
- A review of clinical services encompassing, Electro-Convulsive Therapy (ECT) provision within in-patient services, Workforce and Workload Planning for In-patient Services, Bed Modelling, Medical Consultant model, In-patient activity review and Governance and quality.

One component of the review which has been delayed is the provision of a modern inpatient environment.

The inpatient mental health provision in Argyll and Bute was historically housed in the Argyll and Bute Hospital, which included a Psychiatric Intensive Therapy Care Unit, acute wards and dementia wards. Due to the decaying nature of the building and the fact that the environment was no longer appropriate as a therapeutic environment for modern mental health care, it was necessary to consider alternative accommodation.
The dementia wards were relocated to available space within MACHICC some years ago.

The requirement for long term dementia beds reduced and the space within MACHICC became vacant again.

During this time an outline business case for a new build for the acute adult in patient service was being pursued, for submission to the Scottish Capital Investment Group.

This received approval from the Cabinet Secretary for Health. Unfortunately the business case failed to meet the financial requirements and was stalled.

Due to the continuing depreciation of the Argyll and Bute Hospital it became necessary to relocate the inpatient unit into the vacant area within MACHICC following an upgrade and full safety alterations being undertaken.

Due to staffing and quality concerns the Psychiatric Intensive Therapy Care Unit was amalgamated with the acute unit. This amalgamated service relocated to MACHICC on 26th July 2017.

The unit within MACHICC has been operational for over 1 year now and an evaluation of the suitability of the unit has been completed.

3. DETAIL OF REPORT

The acute adult mental health in patient service is now located in a fully upgraded environment on the lower ground floor of the MACHICC.

It has 21 acute beds, housed in a mixture of 13 single en-suite rooms, and 2 x 4 bedded en suite bays.

There is an Occupational therapy area and dedicated secure outdoor areas. We have capability to deliver electro-convulsive therapy to in and out patients in a purpose designed area.

Due to the lack of specialist consultant expertise, we no longer have a designated Psychiatric Intensive Therapy Care unit and are unable to admit forensic cases. These are few in number and we are progressing communications with Greater Glasgow and Clyde regarding this patient group.

We have undertaken extensive staff and patient evaluation of the unit and some feedback is provided.

Benefits highlighted by staff and patients

- The new environment provides 13 single en suite rooms and 2 four bedded areas. The single rooms are a valued addition along with each room having an en-suite.
- Integration of services to community hospital, “being a part of something bigger”
- More input from the wider Hospital for physical issues/physical crisis on ward
- Violence and Aggression response to wider hospital provided by mental health staff
- Improving triage for A and E patients by Mental Health doctors within the hospital
- Improved environment has been highlighted within an unannounced visit by Mental Health Welfare Commission

- Functionalised medical model of care with dedicated inpatient Consultant provides more responsive experience for patients.
- Reduction of stigma by being in the community hospital
- Allows Occupational Therapy to be more included in day to day ward activity and decision making, closer Multi Disciplinary Team working.
- Patients enjoy having the cafe upstairs for accessing and for visitors
- Staff more visible on ward floor – releasing time to care
- Uniforms, gives an identity and easily seen/sought out.
- Clean bright environment
- Feel happier at work now
- Feeling of professional identity strengthening.

Challenges

- Reduced interview rooms for Multi Disciplinary Team, reviews and patient one to ones
- No space to site the gym/physical equipment from old unit – big miss for patients
- Reduced inside and outside space from previous ward environment for patients to access.
- Ward above has patio area which overlooks the courtyard
- Access to outside space reduced and visible to wider hospital, patients who have issues with paranoid thoughts find this a challenge, privacy and dignity issues.
- Space was refurbished rather than planned for a MH ward, therefore not as would be laid out in a new build.
- Observations on ward are more challenging due to lay out of ward
- Limited visitor space and no child friendly spaces.
- Too clinical an environment – not homely enough
- Feeling of loosing identity to wider hospital services
- Stigma felt by other wider hospital patients
- No dedicated reception area for direction of ward clerk
- Ward entrance opens into the middle of the ward
- Not enough to do for recreational activity

The challenges that have been raised are being addressed to make further improvements.

The majority of the physiotherapy equipment has been relocated and outside space is also available in Blarbuie Woodland area, with a green gym facility.

There will continue to be ward conversation facilitated by Acumen, and ongoing staff engagement as we move forward.

The success of this new environment is evidenced in this report. The recommendations are that the unit is now designated as the permanent inpatient mental health unit and we proceed with formal closure of the Argyll and Bute Hospital.

We will inform Scottish Government that we will not be progressing further with the business case for a new build facility.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

Delivering Integrated Care
Delivering Person Centred Care
Delivering Safe and Effective Services
Delivering Efficient Services
Delivering services with a quality and improvement approach.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

The overall financial impact is positive due to the removal of a requirement for a £12m new build and the additional revenue costs that would be associated with that. In addition, the closure of Argyll and Bute hospital will achieve recurring savings from rates, heat, light and power, and property maintenance of £220,000 per annum.

The use of the MACHICC maximises the use and financial efficiency of a PFI building.
The upgrading works were completed in the previous financial year. There will be some requirement to make the improvements to the area as indicated in the challenges.
The negotiation with NHS Greater Glasgow and Clyde regarding intensive care/forensic patients may have a cost implication for the SLA and this will be referenced outwith the scope of this paper.

5.2 Staff Governance

The overall feedback from the staff is positive and they are keen to progress with further service and environment improvements.

The staff feel part of a larger team and have moved to wearing the NHS Scotland nursing uniforms with a very positive result.

The recent appointment of a Senior Charge nurse will improve staff supervision and appraisal.

5.3 Clinical Governance

To ensure a high level of clinical governance the following groups have been established:

- Clinical quality group
- Mental Health governance group

- Mental Health planning group
- Regular Heads of department meetings.
- Regular team meetings.

Mental health and Dementia services are identified as key areas of focus within the HSCP's Transforming Together agenda. There is an established steering group with various short life working groups to continue to progress and evaluate this ingoing redesign.

6. EQUALITY & DIVERSITY IMPLICATIONS

None

7. RISK ASSESSMENT

A full risk assessment has been completed and is regularly reviewed.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

As this forms part of the full consultation that was undertaken with this project there is no requirement for further public engagement. This is completion of the original agreement to proceed with Option 4.

Patients, staff and carers have been involved in the review of the new environment and their views are included in the benefits and challenges.

An "Emotional Touchpoints" exercise was also undertaken, with staff and patient feedback. Some quotes from the exercise include:

"comfortable, feel valued"
"patients feel safe and confident to approach me"
"maybe not enough quiet areas"
"just knowing I am appreciated and valued"

9. CONCLUSIONS

The interim in patient mental health environment has been tested for over 12 months. It has been fully risk assessed against national standards and meets the requirements
.
The staff, patients, carers and the Mental Health Welfare Commission have all provided positive feedback with regards to the environment and service.

The move to utilise vacant space within an existing building is cost efficient.

The HSCP requests that the IJB accept the recommendations to approve the Mental Health inpatient unit in Mid Argyll Hospital and Integrated Care Centre as the permanent facility, formally progress the closure of the Argyll and Bute Hospital and make this recommendation to NHS Highland Board to inform Scottish Government that there is no longer the requirement to proceed with a business case for a new built facility.

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Integration Joint Board **Agenda item : 5.3**

Date of Meeting: **28 November 2018**

Title of Report: **Staff Governance Report**

Prepared by: **Charlie Gibson, Fiona Sharples, NHS People & Change, Jane Fowler, Jo McDill, Council HR & OD**

Presented by: **Charlie Gibson and Jane Fowler**

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 Leadership Team and Joint Partnership Forum. This report will be presented to the IJB on a quarterly basis. This report includes updates on:

- HSCP Values & Practices Framework (CIRCLE)
- iMatter Wave 2 results
- Staff Wellbeing Survey
- Workforce Planning
- Update on Integrated HR issues
- Organisation Change & Service Redesign issues
- Recruitment & Redeployment activity
- Statutory & Mandatory Training
- Workforce performance trends.
- Work planned over the next 3 months

The figures represent data for Quarter 2 (Jul-Sep 2018).

3. HSCP VALUES & PRACTICES FRAMEWORK (CIRCLE)

Following work with staff and other partners to develop our new HSCP Shared Values & Practices (CIRCLE), the framework was approved by the IJB on 1st August.

Adoption of CIRCLE will make a significant contribution towards integrated teamworking, improved employee engagement and the emergence of a shared culture across NHS Highland and Argyll & Bute Council staff within the HSCP.

The SLT agreed CIRCLE should be rolled out in an incremental way rather than launched. This process will start with a small group of LAMs and Team Leads in MAKI in October.

4. iMATTER WAVE 2 RESULTS

iMatter is a continuous improvement tool designed with staff in NHS Scotland to help individuals, teams and Boards understand and improve staff experience. In 2017 all HSCP staff (Council and NHS) were asked to participate in the iMatter survey.

The key timescales for wave 2 of iMatter this year were as follows:

- **Communication and Preparation** (March-April 2018)
- **Team Confirmation** (Monday 30th April to Friday 25th May 2018)
- **Questionnaire** Monday 28th May to Monday 18th June – 3 weeks)
- **Reports** (issued Monday 2nd July)
- **Action Plans** (12 week deadline - Friday 21st September)

By the end of the confirmation stage there were a number of teams that had not been confirmed by their manager, so some employees did not get to participate.

By the end of the questionnaire stage, there was a 50% response rate for the HSCP: 1119/2026 via email and 57/321 via paper. This is lower than the 61% in 2017.

The iMatter results and Engagement Scores (EEI) were released to the team managers and teams on 2nd July 2018. The 2018 12 week action plan figure was 18% for the HSCP, Action plans were created for 34/186 teams down from 29% in 2017. In NHS Highland it was 50% (up from 29% in 2017).

We will continue to offer support and guidance to managers to assist them to acknowledge staff participation and engagement with the iMatter process and to create action plans. There is evidence to suggest that morale in several parts of the HSCP is low at the moment, so there is a need to improve staff engagement. The aim is to review what went well and what lessons we can learn from this year to improve for 2019. This should increase confidence in this (now annual) national process as a feedback & action-planning mechanism and help to lift levels of employee engagement across the HSCP.

5. STAFF WELLBEING SURVEY

Following the Q4 Staff Wellbeing Survey across the HSCP, the results have been analysed by our Health Improvement colleagues. A short-life working group was established to identify key themes and develop an action plan around supportive interventions. This will be reported in the Q3 Staff Governance Report.

Part one of a paper went to the September SLT with part two due in December that will include recommendations to improve health and wellbeing. There are two elements to the approach of Promoting Attendance/Maximising Attendance: Improving the application of the relevant policies and a preventative approach to improving staff health and wellbeing. There are benefits of improving the health and wellbeing of staff to the organisations, employee and service users. Both are needed to improve attendance at work and reduce sickness absence.

6. WORKFORCE PLANNING

The first HSCP Workforce Plan for 2018/19 was developed iteratively, focusing primarily on Adult Services. The final version was approved at the August IJB.

The Plan includes actions to improve the process of workforce planning including reviewing the outcome of the ihub work around how and when the simulation tool adds value, as well as actions to bridge the gap. Service specific integrated workforce plans will need to be developed as service redesigns are progressed for the six areas reporting to the Transformation Board. The next annual Workforce Plan for 2019/20 will need to complement this and include information about all services and encompass more detail about the role of the third-sector, voluntary organisations, community networks and other commissioned providers who support the HSCP. This will align with the HSCP's 3 year Strategic plan for 2019-22.

7. UPDATE ON INTEGRATED HR ISSUES

There were no significant integrated HR issues to report for Q2.

8. ORGANISATIONAL CHANGE & SERVICE REDESIGN ISSUES

The Transformation Board has agreed the project scope for the Clinical and Corporate themes with support from People & Change and the Council HR & OD teams on the relevant project steering groups. We anticipate a growing number of service redesign proposals as the Transforming Together projects gather pace over the coming months.

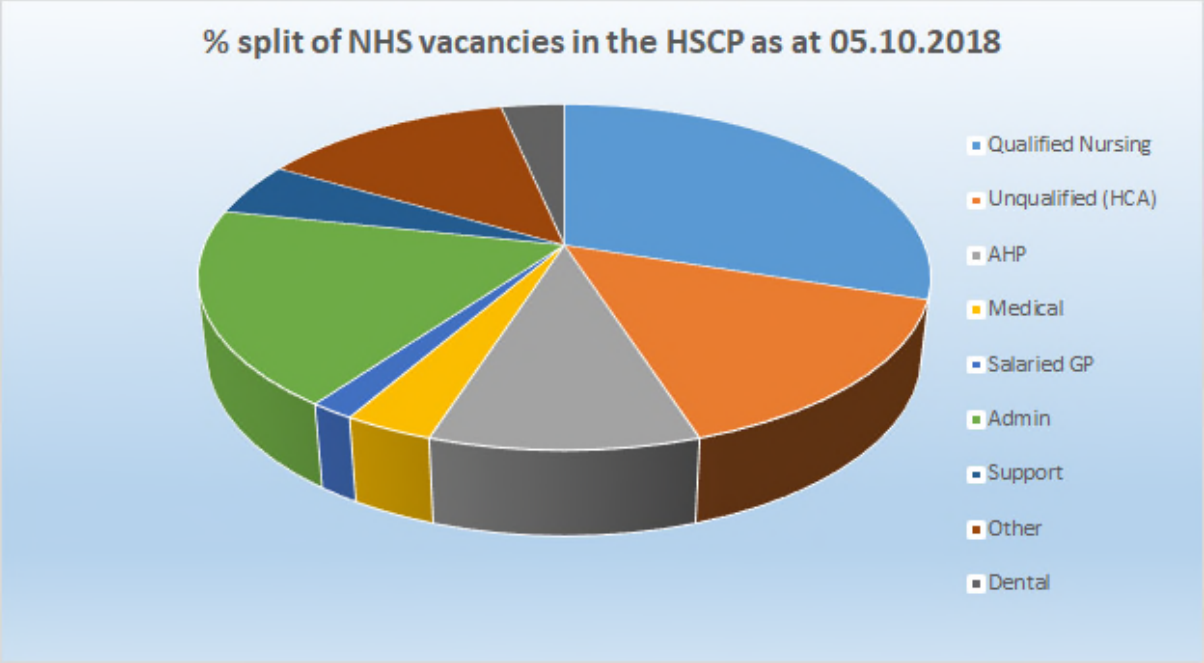
The Partnership has agreed governance procedures for engagement with Trade Unions and Staffside on these redesign proposals that include TU/SS involvement in Short Life Working Groups to develop proposals, TU/SS involvement in the Transformation Board and the Staff Liaison meeting which oversees all change proposals, once in their final draft format, before moving to implementation in accordance with the respective employer procedures.

9. RECRUITMENT & REDEPLOYMENT ACTIVITY

NHS Vacancies

	July		August		September	
	New	**Re-Ad**	**New**	**Re-Ad**	**New**	**Re-Ad**
A&B Adult Services – East	12	6	3	3	7	4
A&B Adult Services – West	15	11	14	10	23	18
A&B Children & Families	3	3	2	3	1	3
Corporate Services	4	0	2	1	1	3
Totals	**34**	**20**	**21**	**17**	**32**	**28**
	54		**38**		**60**	

The breakdown of current NHS vacancies by Job Family is as follows:



The local employment market in Oban has recently become challenging, with the planned expansion of retail sector jobs. This is impacting on recruitment to home care and care home vacancies in the locality and we have seen a significant number of vacancies for registered nurses in Lorn & Islands Hospital.

Local data identifies the HSCP is 5.7% below establishment as at end June 2018, which equates to around 80 vacancies across a range of professional groups.

Council Vacancies

For the month of **July 2018**, there were **7** internal job adverts for HSCP Council Posts, and **21** external job adverts.

For the month of **August 2018**, there were **5** internal job adverts for HSCP Council Posts, and **7** external job adverts.

For the month of **September 2018**, there were **16** internal job adverts for HSCP Council Posts, and **11** external job adverts.

There are now 32 staff on the NHS primary redeployment register (a decrease of 7) and 28 on the secondary register (an increase of 2). The decrease this quarter reflects a number of people being matched into posts in the Estates department.

No Social Work staff are currently on the redeployment register.

10. STATUTORY & MANDATORY TRAINING

The recording of Statutory & Mandatory Training for NHS staff is being migrated from locally held spreadsheets & lists to the LearnPro system. Many of these local records are incomplete. We will have a more complete picture of compliance later in 2018.

Both the NHS and the Council offer a range of training opportunities for staff. Some of these are directly required for registration purposes, others are related to PRDs or to mandatory training requirements, such as equalities or GDPR.

The Council's SQA accredited training centre delivers SVQ courses in a range of social care subjects from SVQ levels 1-5 and support social work degree level courses through the Open University. The centre also delivers modern apprenticeships and foundation apprenticeships. All social work training is reported through the Social Work Training Board, which has an allocated budget for training. This is prioritised for mandatory, registration related training.

Four managers from the HSCP were recently inducted into the Argyll and Bute Manager Programme and four more HSCP managers were presented with their Argyll and Bute Manager completion certificates at the Learning Awards on 25th October.

The following training was completed within Q2 and gives a total of **96** courses completed by HSCP staff. This excludes completion of e-learning, of which there are over 200 courses available on LEON, the Council's e-learning system.

Numbers of Council Employees Completed Training Required by Role or PRD/Council						
	July 2018		August 2018		September 2018	
	Role	Council PRD	Role	Council/PRD	Role	Council/PRD
Adult Care West	20	0	8	0	19	7
Adult Care East	0	0	0	0		1
Children and Families and CJ	0	0	38	0	1	2
Strategic Planning and Performance	0	0	0	0	0	0
TOTAL	**20**	**0**	**46**	**0**	**20**	**10**

Numbers of Council Employees Completed Training September 2018	Training Required for Role	Training required by Council/PRD
Adult Care West	19	7
Adult Care East	0	1
Children and Families and CJ	1	2
Strategic Planning and Performance	0	0
TOTAL	**20**	**10**

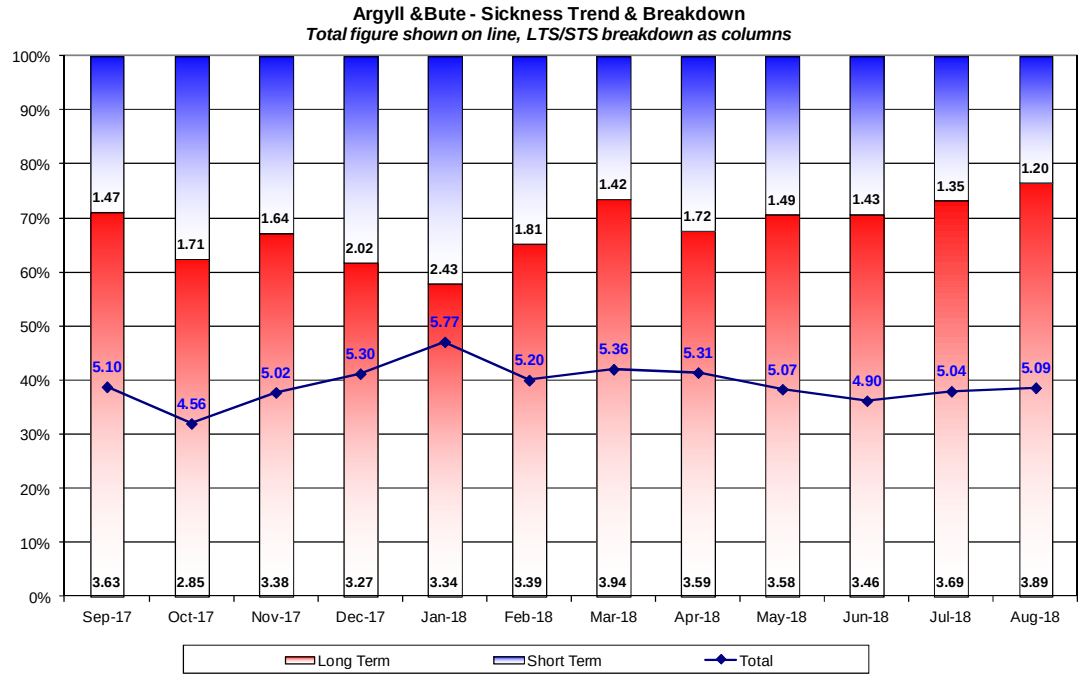
Qualification	Numbers of HSCP staff enrolled in Accredited courses run through the Council Training Centre
Business and Administration Level 3	2
Medication unit	2
Social Services and Healthcare Level 4	1
Leadership and Management Level 4	1
Working with Offending Behaviour Level 3	2
PDA Telehealthcare	4
Assessor Award	1
Social Services and Healthcare Level 2	5
Social Services (Children and Young People) Level 3	3
Social Services and Healthcare Level 3	3
Social Services and Healthcare Level 4	2

11. WORKFORCE PERFORMANCE TRENDS

11.1 Attendance Management

Most NHS Boards/HSCPs remain above the national target of 4% for sickness absence, with the national average for 2017/18 at 5.38%[1].

Sickness absence for NHS employees within Argyll & Bute had a seasonal peak of **5.77%** in January 2018, but had fallen to its lowest this year to **4.90%** in June 2018 before rising just above **5%** in the first 2 months of Q1 (September data not yet available).



The Council measures sickness absence as working days lost as per the required SPI for local government. The average number of working days lost per FTE Council employee working within social work/care area of the Partnership is **5.41** against a target of **3.78**. This data is Q2 (June-Sept 2018).

FQ2 18/19	Target	Average days lost	
HR1 - Sickness absence ABC	2.36 Days	2.94 Days	R ↓
Health & Social Care Partnership Attendance - SW only	3.78 Days	5.41 Days	R ↓
Adult Care West Attendance [from April 2016]	4.10 Days	5.90 Days	R ↑
Adult Care East Attendance [from April 2016]	4.10 Days	6.87 Days	R ↓
Children & Families Attendance [from April 2016]	3.15 Days	3.51 Days	R ↓
Office based	3.78 Days	5.09 Days	R ↓
Office based Adult Care West Attendance [from April 2016]	4.10 Days	6.11 Days	R ↑
Office based Adult Care East Attendance [from April 2016]	4.10 Days	5.92 Days	R ↓
Office based Children & Families Attendance [from April 2016]	3.15 Days	3.51 Days	R ↓
Non-office based	3.78 Days	6.86 Days	R ↑
Non-office based Adult Care West Attendance [from April 2016]	4.10 Days	5.44 Days	R ↑
Non-office based Adult Care East Attendance [from April 2016]	4.10 Days	11.95 Days	R ↓

Area data	FTE No of employees	Target	Average days lost	
B&C	189	3.78 Days	5.59 Days	R ↑
H&L	82	3.78 Days	5.42 Days	R ↓
MAKI	206	3.78 Days	4.33 Days	R ↑
OL&I	177	3.78 Days	6.46 Days	R ↓

This gives an annual forecast outturn of 21.64 days lost per employee. This is well above the overall Council forecast outturn of 11.76 and well above the national average for LGE employees.

See Section 5 – there are two elements to the approach of Promoting Attendance/Maximising Attendance: Improving the application of the relevant policies and a preventative approach to improving staff health and wellbeing.

In the next table completion rates for Return to Work (RTW) interviews for Council employees are shown across the partnership. The target is 100% completion within 3 days of the employee returning to work. This interview may be conducted by phone or face to face. The processes around RTW interviews in the NHS are being reviewed as part of the approach referred to above and will be reported later in the year.

Evidence shows that the sooner the interview takes place after the absence, the greater the benefit gained for both manager and employee and the greater the impact on future absence levels. HR can offer support to managers who wish to build their confidence in the RTWI procedure if this is a barrier to carrying them out.

	July 2018		August 2018		Sept 2018	
	% RTWI Complete	**Average time taken to complete (days)**	**% RTWI Complete**	**Average time taken to complete (days)**	**% RTWI Complete**	**Average time taken to complete (days)**
Adult Care West	21%	3	40%	5	32%	6
Adult Care East	10%	2	26%	3	22%	3
Children and Families and CJ	57%	11	43%	4	22%	4
Strategic Planning and Performance	-	-	-	-		
TOTAL	**29%**	**5**	**36%**	**4**	**29%**	**4**

11.2 Fixed Term contracts

NHS employees

There are **31** staff currently on fixed term contacts (FTCs), a decrease of 8 from Q1. This decrease is due to a number of FTCs expiring after the summer. Proposals developed through the Transforming Together change programmes is likely to see these figures rise in the coming months as the use of FTCs enables flexibility when progressing service redesign.

Adult Care West	**11**
Adult Care East	**8**
Corporate	**8**
Children & Families	**4**
TOTAL	**31**

People & Change department will continue to closely monitor the use of FTCs ensuring they are used in accordance with NHS Highland policy.

Council employees

There continues to be approximately 10% of all employees in temporary or fixed term posts. This can be as a result of temporary cover for absence or other leave such as maternity/paternity or can be as part of a management approach to minimising the impact of service redesign. It is important to recognise the importance of ongoing communication with staff in temporary posts regarding future planning, as uncertainty can lead to unnecessary stress and the potential for absence.

Employees on T/PS contracts	July 2018		August 2018		September 2018	
Type	PS	T	PS	T	PS	T
Adult Care West	16	33	13	33	12	27
Adult Care East	11	23	11	22	9	22
Children and Families and CJ	17	12	14	12	11	16
Strategic Planning and Performance	0	0	0	0	0	0
TOTAL	**44**	**68**	**38**	**67**	**32**	**65**
OVERALL TOTAL	**112**		**105**		**97**	

11.3 Turnover

Monthly turnover for NHS staff across July and August 2018 was **1.35%** and **1.30%** respectively. This is a significant rise from June 2018 of 0.50%. Annual Turnover for August 2018 was **11.02%** which is up from **10.66%** in May 2018.

The Stability Factor for our NHS staff, the number of staff in post 12 months ago who are still in post, decreased marginally from **90.09%** (June 2018) to **89.98%** (August 2018).

Turnover in Council posts remains very low, with an overall retention rate of 98%.

11.4 Employee Relations Cases

NHS

June 2018	Grievances Live	Conduct Live	Capability Live	B&H Live
Adult West	3	6	3	1
Adult East	0	0	1	1
Children & Families	0	0	0	0
Corporate	0	0	0	0
Total	**3**	**6**	**4**	**2**

This quarter has seen a decrease in the total number of NHS cases from **20** (June 2018) to **15**. This reflects the appointment of our new HR Business Partner, which has provided welcome additional resources to support Locality Managers and Local Area Managers with their cases.

As there is a tripartite responsibility for dealing with Employment Relations (ER) cases, i.e. Management, staff-side/trade unions and HR, impending discussions will explore the informal resolution or using mediation rather than formal route, and the length of time taken to progress and conclude all ER cases with a view to providing solutions to improving existing timescales. Initial analysis of open cases as of end of October 2018 shows in the table below.

NHS ER Case Timescales (Live)

Oct 2018	Grievances Live	Conduct Live	Capability Live	B&H Live	**Total**
Less than 3months	2	0	1	0	**3**
3 to 5 months	0	2	2	1	**5**
6 to 9 months	1	1	0	0	**2**
Over 9 months	0	3	1	1	**5**
Total	**3**	**6**	**4**	**2**	**15**

Council

Argyll & Bute Council is committed to managing its employees with fairness and consistency. If a concern arises in relation to an employee's conduct, the Council prefers to deal with this through informal action initially. However, where such informal action is inappropriate or does not lead to the required improvement, the Council will normally undertake an investigation under the terms of their Disciplinary Procedures, the outcome of which may be formal disciplinary action up to and including dismissal. Mediation is also currently in use as a tool to manage employee relations issues.

The Council recognises most employees work within our policies and procedures for most / all of their employment and do not set out to contravene these deliberately. We also recognise jobs are important to people and that employees do not jeopardise these lightly, either intentionally or inadvertently. Everyone involved in these procedures, therefore, whatever their role, is expected to follow these procedures with consideration, co-operation and the highest degree of confidentiality, and to ensure matters are progressed as quickly as possible to reach an appropriate resolution. The Council's Employee Relations Team carries out all disciplinary investigations, but managers are responsible for investigating grievances. The following cases were/are for Q2 FY 18/19:

July 2018	**July 2018**		**August 2018**		**September 2018**	
	Disciplinaries Live	**Grievances Live**	**Disciplinaries Live**	**Grievances Live**	**Disciplinaries Live**	**Grievances Live**
Adult Care W	1	0	1	0	0	0
Adult Care E	0	1	0	1	0	1
C&F & CJ	4	0	4	0	4	0
SPP	0	0	0	0	0	0
Total	**5**	**1**	**5**	**1**	**4**	**1**

11.5 Performance Management (TURAS/PRDs)

A joint paper went to the September IJB meeting outlining how participation rates for NHS Knowledge & Skills Framework (KSF) Personal Development Planning & Process and Council Performance Review & Development plans will be improved across the HSCP. An update on this will be given in a future report.

Update on Council PRDs (Performance Review and Development)

PRDs tend to be completed in the period January to March so that they align with service planning for the year ahead and are assessed as an annual measure.

PRD Completions	**Data below is Q1 18/19 (extracted 10/07/18) This is an annual measure**		
	No of employees	**No of PRDs complete**	**% of PRDs complete**
Adult Care East	132	33	25%
Adult Care West	205	63	31%
Children and Families and CJ	175	113	65%
Strat Planning & Performance	8	5	63%
HSCP % of PRDs completed	**520**	**214**	**41%**

12. PLANS FOR NEXT 3 MONTHS

- Looking at the results of the Staff Health & Wellbeing Survey and some initial recommended actions will be drafted and tested with staff and continue improving the application of the Promoting Attendance policy
- An assessment of support needs across the LM/LAM management levels within Adults Services and Children's & Families Services is in progress; a programme of leadership development support will be designed.
- Continue to offer support and guidance to managers to assist them to acknowledge staff participation and engagement with the iMatter process and to create action plans. Start to review what went well and what lessons we can learn from this year to improve staff experience and iMatter
- Continue to offer support and guidance to managers and staff to assist them to utilise LearnPro and Turas
- CIRCLE, our new HSCP Values & Practices framework, will start to be rolled out in an incremental way, initially with a small group of LAMs and Team Leads in MAKI in October.
- Complete the review of the Council PRD process
- Progress the review of Council Maximising Attendance policy and procedures.
- Progress the review of Council Redundancy Policy and Procedures.
- Start gathering views on the impact of the Council HROD redesign, which included a 25% resource reduction.

13. 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.

14. GOVERNANCE IMPLICATIONS

14.1 Financial Impact – N/A

14.2 Staff Governance – this is the staff governance report.

14.3 Clinical Governance – N/A

15. EQUALITY & DIVERSITY IMPLICATIONS

These issues are picked up within the NHS People & Change and Council HR & OD teams as appropriate when policies and strategies are developed. An EQIA is also completed as standard practice within the Transforming Together projects.

16. RISK ASSESSMENT

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

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

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Integration Joint Board **Agenda item: 5.4a**

Date of Meeting: **28 November 2018**

Title of Report: **NHS Highland Director of Public Health Annual Report Adverse Childhood Experiences, Resilience and Trauma Informed Care: A Public Health Approach to Understanding and Responding to Adversity**

Presented by: **Sandra Cairney, Associate Director of Public Health**
Sally Amor, Child Health Commissioner/Public Health Specialist

The Integration Joint Board is asked to:

- Note the importance of offsetting the effect of childhood adversity as detailed in the 2018 Director of Public Health Annual Report on Adverse Childhood Experiences (ACEs).
- Support the principle of the Argyll and Bute Health and Social Care Partnership working as a trauma informed and trauma responsive health and social care service.

1. EXECUTIVE SUMMARY

The attached report details how experience of adversity from birth to adolescence, in the absence of safe buffering relationships, shapes the health and wellbeing of babies, children, young people and adults across the life course and inter-generationally, with a corresponding influence on family and community wellbeing. The effects of adversity can be offset by supporting resilience and by a 'whole system approach' to the development of trauma informed and trauma responsive services.

2. INTRODUCTION

The key messages from the Director of Public Health Annual Report on Adverse Childhood Experiences are summarised below.

3. DETAIL OF REPORT

From epidemiological studies it would be expected that eleven in every hundred adults across NHS Highland to have experienced more than four of the ten sentinel markers used in research studies of adverse childhood experiences. An individual who has experienced more than four of these events is at a higher risk of experiencing poorer health and wellbeing, specifically:

- 9.5 times more likely to have felt suicidal or self harmed
- 5.8 times more likely to develop problematic alcohol use
- 4.4 times more likely to have type 2 diabetes

- 3.7 times more likely to develop anxiety
- 3.2 times more likely to have coronary heart disease.

The key messages from the report can be summarised as follows:

3.1 Adverse childhood experiences are common to many of us: they reflect key stressful events from before birth, to the age of 18. There should be no shame in having experienced adversity.

3.2 The impact of adverse childhood experiences can be offset by safe, secure responsive adult relationships that buffer the effects of stress/adversity and support the development of resilience, a key mechanism to make sense of, and recover from threat and fear.

3.3 'Chronic toxic stress' can have a lasting effect on physical and mental health and wellbeing from birth to the older years. These effects can be passed on to further generations, which can cause inter-generational harm.

3.4 The impact of adverse childhood experiences can be mitigated throughout the lifespan: there is always hope and opportunities for recovery in childhood, adolescence, into adulthood, and even in the latter years.

3.5 The human costs of adverse childhood experiences are considerable for individuals, families and communities, both in the moment and from inter-generational effects. Environmental and community adversity, combined with the experience of adversity at an individual level, has been described by the phrase a 'Pair of ACEs' as their effect is cumulative.

3.6 A public health approach to adverse childhood experiences seeks to influence the experience of adversity, with benefits for all. This includes working within services to intervene, and to respond where there is evidence of harm and the development of trauma-informed systems and services.

3.7 By taking a preventive approach to adversity in childhood we can reduce the costs to health, education, social care, police and justice services of responding to the impact and consequences of adverse childhood experiences.

3.8 Being trauma aware and trauma informed is 'everyone's business'.

3.9 In practice, to be trauma informed requires a cultural shift from 'What's wrong with you?' to 'What happened to you?'' and to follow through with 'How has this affected your life?' and 'Who is there for you?'

3.10 Routine enquiry is an approach to understanding and responding to an individual's experiences of adverse childhood experiences. It is a tool that can be built into practice with training, support and supervision.

3.11 Community Planning Partnerships have the potential to be a transformational mechanism, working through a strength-based approach, to understand and respond to adverse childhood experiences.

3.12 The GIRFEC Child's Plan and Wellbeing Indicators are an important example of a 'strengths based approach' for use with babies, children, young people and their families.

4. RELEVANT DATA AND INDICATORS

There are currently no specific reportable HSCP indicators for ACE's.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The Report invites the HSCP to consider how ACEs can be reflected in the Strategic Plan in light of the information detailed with regard over the impact of adversity across the life course with opportunities to respond to mitigate the effect by supporting resilience and the development of trauma informed and trauma responsive services.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

There are no financial implications identified in the report.

6.2 Staff Governance

There is likely training/awareness raising implications for staff.

6.3 Clinical Governance

There are no clinical governance implications identified in the report.

7. EQUALITY & DIVERSITY IMPLICATIONS

The report is believed to address and reduce inequalities. Whilst it is hoped that this report is accessible to and considered informative by the community, stakeholders and more generally the wider public, it is not considered policy/service/practice/decision and therefore does not require a full Equality Impact Assessment.

Any policies or practices which result from this report to prevent Adverse Childhood Experiences or mitigate their negative impacts would have to be screened again and consideration given to whether it would be appropriate to conduct a full Equality Impact Assessment.

8. RISK ASSESSMENT

There are no identifiable risks identified at this point in time.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The development of the Report has involved engaging with a wide stakeholder group with representation from Non Executive Directors, Directors, Senior Managers and front line staff.

An external group of Technical Advisors were invited to comment on drafts of the report from National Health Scotland, NES Scotland, and the Violence Reduction Unit, Glasgow.

Local authority colleagues have taken action to disseminate messages about adverse childhood experiences and their ongoing work to make schools trauma informed.

10. CONCLUSIONS

The Director of Public Health Annual Report on Adverse Childhood Experiences details the influence and impact of adversity for babies, children, young people, families, adults and communities across the life course and with intergenerational effects. This knowledge asks our systems and services to reflect on how the effects of adversity can be buffered and offset from birth to adolescence, how resilience can be supported in individuals, families and communities and how the development and implementation of trauma informed and trauma responsive approached contribute to health and wellbeing and reduce the associated costs to individuals and services.

Integration Joint Board **Agenda item: 5.4b**

Date of Meeting: **28 November 2018**

Title of Report: **Scotland's Charter for a Smoke Free Generation**

Presented by: **Sandra Cairney, Associate Director of Public Health**
Laura Stephenson, Senior Health Promotion Officer

The Integration Joint Board is asked to:

Sign up to Scotland's Charter for a Smoke Free Generation and:

1. Recognise the harmful effect smoking has on the health of our population.
2. Be personal advocates for a smoke-free generation.
3. Recognise the importance of front line service delivery shifting toward preventing problems from arising and the contribution stopping smoking has on improving health and wellbeing.

1. EXECUTIVE SUMMARY

Smoking is the biggest avoidable cause of death in Scotland and contributes to ill health, disability and impoverishment of thousands of people every year. Childhood exposure to second-hand smoke is associated with ill-health, reduced educational attainment and smoking imagery can influence children to take up cigarette smoking.

The Scottish Government has set out to achieve a tobacco-free generation (5% prevalence or less) by the year 2034 and reduce the proportion of children exposed to second-hand smoke (SHS) in their home from 12% in 2012 to 6% by 2020.

Scotland's Charter for a Tobacco Free Generation was established in 2015. It aims to reduce the harm caused by smoking and create a tobacco-free generation. By adopting the Charter, Argyll and Bute HSCP will be contributing to a civic movement for social responsibility across Scotland and be in the

company of 250 other Charter signatories throughout Scotland. These signatories include NHS boards, other HSCPs. Local Authorities, football clubs, colleges and housing associations.

2. INTRODUCTION

This paper introduces the Charter, its key principles and why it is important. The Charter invites organisations to sign up to the key principles and submit their actions to demonstrate ongoing work towards a tobacco-free generation.

NHS Highland is already a signatory to the Charter and sign up by the IJB would demonstrate a strong unified approach across the HSCP to the Government's aim of reducing the harmful effects of smoking.

3. DETAIL OF REPORT

3.1 Smoking prevention and cessation aims to ensure that all young people grow and develop in an environment free from tobacco; prevent them from taking up smoking; and protect them from second hand smoke. The Charter introduces the importance of six principles; how organisations will be supported; and benefits from becoming a signatory.

3.2 The Aim of the Charter is to:

- Inspire organisations to take action to reduce the harm caused by tobacco;
- Raise awareness of the goal of creating a tobacco-free generation of Scots by 2034; and
- Support organisations whose work impacts on children, young people and families to address tobacco issues.

3.3 The Charter's principles include:

a) Every baby should be born free from the harmful effects of tobacco;

b) Children have a particular need for a smoke-free environment;

c) All children should play, learn and socialise in places that are free from tobacco;

d) Every child has the right to effective education that equips them to make informed positive choices on tobacco and health;

e) All young people should be protected from commercial interests who profit from recruiting new smokers; and

f) Any young person who smokes should be offered accessible support to help them to become tobacco-free.

3.4 Organisations signing up to the Charter are pledging to deliver at least three actions within the above. ASH Scotland provides a range of free resources to help promote these actions. Argyll and Bute's intended actions are:

- Support the annual delivery of the primary 7, Smoke Free programme and the S3 health drama programme and encourage schools to become a Smoke Free School.
- Offer Smoke Free Homes and Cars leaflets and smoking cessation signposting to kinship carers who have a family member smoking in their household.

- Support staff coming into contact with people who smoke to undertake the 2 hour Health Scotland online training in Raising the Issue of Tobacco.

3.5 Following sign-up to the Charter, a letter of commendation, an award certificate and a report of activity will be published on the Charter Awards webpage - https://www.ashscotland.org.uk/what-you-can-do/scotlands-charter-for-a-tobacco-free-generation/charter-signatories/

4. RELEVANT DATA AND INDICATORS

NHS Highland has a Tobacco Strategy Action Plan which includes key performance measures for smoking cessation and prevention. This is monitored by the Health Improvement Team and reported to the Highland Tobacco Strategy Group. Charter activity described above is included in this action plan.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

Effective smoking cessation and prevention will enable the HSCP to deliver the vision of the Strategic Plan which is to enable the people of Argyll and Bute to live longer, healthier, independent and happier lives.

Smoking cessation and prevention is also pertinent to the delivery of Argyll and Bute's Children's Services Plan.

Finally, the Charter aligns with the following outcomes of the Community Planning Partnership:

- Outcome 4, Children and Young People have the best possible start
- Outcome 5, People live active, healthier and more independent lives

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

There are no financial implications associated with signing the Charter. However, significant saving could be achieved from a reduction in smoking rates. Across Scotland smoking costs NHS Scotland £300 million each year. In Argyll and Bute 17% of our population are cigarette smokers, representing approximately 15,000 people. Stopping smoking is associated with improved health and wellbeing outcomes and less use of health and social care services.

6.2 Staff Governance

A unified approach to health and social care interventions on smoking cessation and prevention can be achieved by front line staff undertaking the Health Scotland learning resource – Raising the Issue of Tobacco.

6.3 Clinical Governance

No clinical governance issues arise from the HSCP signing this Charter.

7. EQUALITY & DIVERSITY IMPLICATIONS

The charter aims to address fairness and equity in relation to population groups disproportionally impacted by tobacco, planned actions will benefit families, babies, children and young people. No adverse effects have been identified in relation to protected characteristics defined in UK legislation. An Equality Impact

Assessment has already been carried out on the Highland Tobacco Strategy. We know that smoking rates are higher in socio-economically disadvantaged groups, therefore increased smoking prevention and support has the potential to reduce health inequalities between people who are well off and people who are not well off.

8. RISK ASSESSMENT

This report describes Scotland's Charter for a Tobacco-free Generation; there are no particular additional risks from this activity. Conversely, significant financial and health risks are likely if smoking cessation and prevention is not improved.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The Charter will be promoted through co-ordinated communications activity, for example, press releases to local newspapers and facebook posts. Progress with implementing the action plan for NHS Highland's Tobacco Strategy is reported through the Health and Wellbeing Partnership which has community representation.

10. CONCLUSIONS

Smoking is a serious cause of ill health and whilst smoking rates have fallen significantly over the past 20 years, 17% of people in Argyll and Bute continue to smoke and some of our young people start to smoke each year. We know that 10,000 people die of smoking related ill-health in Scotland each year. The Charter is one tool to raise the profile of smoking cessation and prevention. The HSCP and IJB can demonstrate commitment to the health and wellbeing of the people living in Argyll and Bute by signing up to the Charter.

Integration Joint Board **Agenda item: 5.5a**

Date of Meeting: **28 November 2018**

Title of Report: **Alcohol/Drug Dependency Services Correspondence Review**

Presented by: **Sandra Cairney, Associate Director of Public Health**

Laurence Slavin, Chief Internal Auditor

The Integration Joint Board is asked to:

- to review and endorse the report; and
- direct relevant Council officers and NHS officers to prepare and deliver an action plan to address the risks identified in the report.

1. EXECUTIVE SUMMARY

In early 2018 Audit Scotland received correspondence from member(s) of the public raising queries about the arrangements for procurement, performance monitoring and governance relating to Argyll & Bute Alcohol and Drug Partnership (ADP).

Audit Scotland reviewed the correspondence and met with Argyll and Bute Council's (the Council) Chief Internal Auditor (CIA) to discuss the content. It was agreed that the Council's internal audit department would conduct a review and Audit Scotland would place reliance on Internal Audit's work and conclusions.

2. INTRODUCTION

The audit was conducted in accordance with the Public Sector Internal Audit Standards and the conclusions are based on document review and discussions with council and NHS Highland officers.

The attached report presents the final report for the HSCP's consideration.

3. DETAIL OF REPORT

3.1 In early 2018 Audit Scotland received correspondence from member(s) of the public raising queries about the arrangements for procurement, performance monitoring and governance relating to Argyll & Bute Alcohol and Drug Partnership (ADP): In particular:

- Governance in relation to the operation and decision making of the ADP
- Contract/Service Level Agreement (SLA) management in relation to Addaction Scotland (Addaction) and Argyll and Bute Addictions Team (ABAT) including any contract extensions

- Procurement and extension of Children 1st contracts.

3.2 Audit Scotland reviewed the correspondence and met with Argyll and Bute Council's (the Council) Chief Internal Auditor (CIA) to discuss the content. It was agreed that the Council's internal audit department would conduct a review and Audit Scotland would place reliance on Internal Audit's work and conclusions.

3.3 Audit Scotland met with the correspondent(s) to discuss their concerns however, at the request of the correspondents, Audit Scotland have maintained their anonymity. The CIA has not seen the correspondence sent to Audit Scotland. The scope and objectives of this review were informed by the discussion between the CIA and Audit Scotland and e-mail sent to the CIA by Audit Scotland on 31 May 2018 which sets out the 'Heads of the Correspondence' as summarised by Audit Scotland. These terms of reference was agreed with Audit Scotland prior to the fieldwork commencing.

3.4 The scope of the audit was to consider and provide an evidence based respond to the queries raised by the correspondent(s) as summarised by Audit Scotland. The objectives of the audit were restricted to gathering sufficient audit evidence to form a conclusion on these queries. It does not constitute a wider review of the subject matters of procurement, performance monitoring and governance nor is it a detailed audit of the ADP, Addaction, ABAT or Children 1st. Any audit judgements on compliance with policy and/or procedure were made taking cognisance of the relevant policy and/or procedure at the time the event being queried took place. The audit report provides a response to each of the queries grouped by the associated 'body.' It also, where applicable, provides an audit conclusion on the appropriateness of the evidenced processes and procedures.

3.5 Overall the review has been graded as providing substantial assurance meaning the CIA's judgement is that internal control, governance and the management of risk is sound. However, there are some areas of weakness which put some system objectives at risk and specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale. The recommendations are summarised in paragraph 13 of the report with the action plan at appendix 1 of the report providing greater detail.

3.6 The report will be made available to the ADP Committee for their consideration.

4. RELEVANT DATA AND INDICATORS

Not applicable

5. CONTRIBUTION TO STRATEGIC PRIORITIES

Not applicable

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

There are no financial implications identified in the report.

6.2 Staff Governance

There are no staff governance implications identified in the report.

6.3 Clinical Governance

There are no clinical governance implications identified in the report.

7. EQUALITY & DIVERSITY IMPLICATIONS

Not applicable

8. RISK ASSESSMENT

Council officers and NHS officers have agreed responses and timescales in the associated action plan to address the risks identified in the report.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Not applicable

10. CONCLUSIONS

The appropriate Council officers and NHS officers have accepted the contents of the report and agreed responses and timescales in the associated action plan.

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Argyll and Bute Council

Internal Audit Report

September 2018

FINAL

Alcohol/Drug Dependency Services Correspondence Review

Audit Opinion: Substantial

	High	Medium	Low
Number of Findings	**0**	**2**	**3**

Contents

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1. Executive Summary

Introduction

1. In 2018 Audit Scotland received correspondence from member(s) of the public raising queries about the arrangements for procurement, performance monitoring and governance relating to the Argyll & Bute Alcohol and Drug Partnership (ADP), Addaction Scotland (Addaction), Argyll and Bute Addiction Team (ABAT) and Children 1st.

2. Audit Scotland reviewed the correspondence and met with Argyll and Bute Council's (the Council) Chief Internal Auditor (CIA) to discuss the content. It was agreed that the Council's internal audit department would conduct a review and Audit Scotland would place reliance on their work and conclusions subject to Audit Scotland's satisfaction with the work performed.

3. The audit was conducted in accordance with the Public Sector Internal Audit Standards with our conclusions based on document review and discussions with council and NHS Highland officers.

4. The contents of this report have been discussed with the appropriate council and NHS officers to confirm factual accuracy and appreciation is due for the cooperation and assistance received from all officers over the course of the audit.

Background

Alcohol & Drug Partnership

5. The ADP was established in 2009 to agree and manage an Argyll and Bute wide alcohol and drug strategy. As a partnership it incorporates a number of statutory and voluntary organisations with its duties carried out in accordance with an established constitution. The ADP reports into the Argyll and Bute Community Planning Partnership who have overall responsibility for ADP governance. The previous ADP structure was four tiered and included an ADP Executive Group and an ADP Delivery Group. That structure was simplified by the ADP Chair (the Chair) in 2016. There is now an ADP Committee (the Committee) with 21 members representing the NHS, the Council, Police Scotland, the Health and Social Care Partnership, Scottish Fire & Rescue, ADP forums from Cowal, Oban Lorn & The Isles, Helensburgh & Lomond, Islay, Bute, Mid Argyll, and Kintyre and third sector forums.

Addaction

6. Addaction is an external provider of community based adult addiction recovery services in Argyll and Bute. They were awarded a three year contract to deliver services commencing 1 January 2015 with the contract providing for a possible contract extension for up to two years subject to satisfactory performance. The invitation to tender (ITT) issued when the contract was tendered establishes the performance framework against which performance is assessed. An extension until 31 December 2019 was awarded in January 2018. The contract is between Addaction and the Council rather than Addaction and the ADP as the ADP is not a legal entity in its own right. The commissioning process culminating in the award to Addaction was carried out by the Council's procurement team in 2014.

ABAT

7. ABAT is a health and social work addiction team comprising staff employed by NHS Highland and the Council. It consists of nurses, social workers, support staff, office staff and a psychiatrist. The ADP engage ABAT to provide addiction recovery services. There is a service level agreement (SLA) between ABAT and the ADP with a base value of £1,036,407 (based on 2014/15 costs). The SLA establishes the services to be provided and a performance management framework against which performance can be assessed.

Children 1st

8. Children 1st is a national Scottish Charity working with the Council, NHS Highland and Argyll Voluntary Action to support families with children aged 0 to 8. They registered with the Council in 2008 and deliver services relating to advocacy and abuse & trauma recovery. Since 2008 these services have been delivered via an SLA (original SLA was from 2008-2011 however it has been extended annually using the 'Justification of Non Competitive Action' procurement option). The abuse and trauma recovery service element of the contract expired in September 2017 after which funding ceased. The advocacy service element expired in March 2018. From 2008 to 2018, including each extension, there has been a total of ten agreements with Children 1st for the delivery of advocacy and abuse & trauma recovery services. These total £847,357.

Scope

9. The scope of the audit was to consider and provide an evidence based response to the queries raised as summarised by Audit Scotland. The audit was limited to gathering sufficient audit evidence to form a conclusion on those queries. It does not constitute a wider review of the subject matters of procurement, performance monitoring and governance nor is it a detailed audit of the ADP, Addaction, ABAT or Children 1st. Any audit judgements on compliance with policy and/or procedure were made taking cognisance of the relevant policy and/or procedure at the time the event being queried took place. It also, where applicable, provides an audit conclusion on the appropriateness of the evidenced processes and procedures.

10. The scope and objectives were agreed by Audit Scotland prior to the audit commencing.

Audit Opinion

11. We provide an overall audit opinion for all the audits we conduct. This is based on our judgement on the level of assurance which we can take over the established internal controls, governance and management of risk as evidenced by our audit work. Full detail of the five possible categories of audit opinion is provided in Appendix 2 to this report.

12. Our overall audit opinion for this audit is that we can take a **substantial** level of assurance. This means that the internal control and governance is sound. However, there are areas of weakness which put some system objectives at risk and specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.

Key Findings

13. We have highlighted no high priority recommendation, two medium priority recommendations and three low priority recommendations where we believe there is scope for improvement. These are summarised below:

- clarity should be provided regarding authority to award/extend contracts and extension decisions, where required, should be informed by a completed contract review
- approval to commission services using non-competitive action should be obtained prior to any contracts being awarded
- engage with the ADP Committee to determine whether they are satisfied with the current performance monitoring and reporting arrangements
- the Chair should be subject to annual review in compliance with the job specification
- the ADP constitution should be updated to reflect current structures and practices.

14. Full details of the audit findings, recommendations and management responses can be found in sections 3-5 of this report and in the action plan at Appendix 1.

2. Objectives and Summary Assessment

15. The correspondents raised queries focused primarily on the following three areas:

- governance in relation to the operation and decision making of the ADP
- contract/SLA management in relation to Addaction and ABAT
- procurement and extension of Children 1st contracts.

16. In agreement with Audit Scotland, 14 specific queries were identified which were grouped into these three areas. For each query we have documented our findings, a conclusion and, where appropriate, areas for improvement. This is detailed in sections three to five of the report.

17. Exhibit 1 provides a summarised assessment against each of the three key areas.

Exhibit 1 – Summary Assessment of Key Area

	Key Area	Assessment	Summary Conclusion
1	ADP Governance	Substantial	Overall there are no material concerns about the governance of the ADP. The processes adopted to appoint the Chair and consider future options for the Chair are transparent and appropriate. The Chair has introduced changes to the ADP structure and consulted on these with relevant partners. The ADP constitution needs to be updated to reflect these changes and ensure it reflects current working practices. The ADP has implemented the recommendations in Audit Scotland's 2015 report and has a Committee approved process for considering applications and awarding funds. There are appropriate mechanisms in place for ADP members to raise concerns about ADP governance and clear evidence that these mechanisms have been utilised in the past. The ADP should ensure that, where required by the job specification, the Chair is subject to annual review.

2	Addaction and ABAT Contract / SLA Management	Substantial	The basis for the award of Addaction's contract extension was consistent with the terms of the original contract in that satisfactory performance had been demonstrated through regular performance monitoring. However there was a lack of clarity regarding responsibility for awarding the extension and the conclusion of the Addaction contract review post-dated rather than pre-dated the decision to award the extension. It is however recognised that the review, once complete, did not highlight any reason not to extend the contract. Whilst it is correct that the sole contractual target established for Addaction and ABAT is for 90% of clients to wait no longer than three weeks to receive drug or alcohol treatment, their performance is assessed against a wider range of factors and there are sound performance monitoring arrangements with regular reporting to the Committee. Performance reporting could be further strengthened if performance reports were closer aligned to the performance management framework however the Committee's view should be sought before making changes to performance management arrangements.
3	Children 1st - Procurement / Extension	Reasonable	Appropriate approval was in place for each of the seven extensions of the Children 1st contract awarded since 2013/14 however approval was often provided retrospectively. Where required by the Procurement Reform Act (Scotland) 2014 there was documentary evidence to support the extensions. Children 1st led on a bid for external funding between October 2016 and August 2017 however this bid was not completed and therefore no funding was received or benefit obtained by any party. Progress on this bid was reported to the Committee throughout this period.

3. ADP Governance

Q1 – Confirm whether the Chair, first appointed in 2015, has had his appointment extended, the decision making process to agree this and the partners involved in that process.

18. **Findings:** The Chair was appointed in late 2015 for a three year period and chaired his first committee meeting in December 2015. The appointment process was communicated and discussed with the ADP Executive Committee (as it was called in 2015) as evidenced by papers submitted to executive committee meetings. The three year contract is still to expire and, therefore, the appointment has not been extended yet. The Associate Director of Public Health is to present a paper to the Argyll and Bute Health & Social Care Partnership (HSCP) on 26 September to recommend revised governance arrangements for the ADP. This paper will consider the process for appointing the ADP Chair.

19. The current job specification for the Chair confirms the contract was for a three year period with an annual review. These annual reviews were not carried during the period of his appointment.

Action Plan 4

20. **Conclusion:** The process adopted to appoint the Chair was transparent and appropriately discussed with the Committee. The appointment has not been extended as the current appointment has not expired yet. The process for appoint the Chair is to be presented in a paper to be submitted to the HSCP on 26 September 2018. Annual contract reviews as required by the Chair's job specification were not carried out.

Q2 – Confirm whether the Chair has introduced material changes to the way the ADP operates and whether the ADP constitution has been updated to reflect those changes. Confirm whether ADP partners were consulted on those changes.

21. **Findings:** The Chair introduced changes to the structure of the ADP in the second half of 2016. In particular the ADP Executive Group and ADP Delivery Group were merged into the ADP Committee. This structural change was detailed in a paper presented to the Committee on 1 September 2016 as a part of a wider update on the key findings arising from the Chair's review of the ADP. The paper makes reference to engaging with the locality forums and other partner agencies however it does not specifically reference which forums and partners were included. However all locality forums are represented on the Committee and the minutes of the September 2016 meeting do not record any dissatisfaction with the structural change.

22. The ADP constitution has not been updated to reflect these structural changes. It was also noted that a number of the sub-groups named in appendix 4 to the constitution no longer exist. The constitution would benefit from a review to reflect these specific issues but also more generally to ensure it reflects current working practices.

Action Plan 5

23. **Conclusion:** The Chair has introduced material changes to the structure of the ADP and he consulted with relevant partners as part of a wider review of the ADP. It would have been better practice if the paper submitted to the Committee had been more explicit about the engagement carried out however the Committee was provided with appropriate opportunity to comment on the proposals when the paper was presented in September 2016. The ADP's constitution should have been updated to reflect the structural changes implemented.

Q3 - Confirm whether the ADP are applying the recommendations made by Audit Scotland in their 2015 report 'Review of the commissioning process undertaken on behalf of the ADP.

24. **Findings:** The recommendations in the Audit Scotland 2015 report that related to the ADP were:

- To demonstrate sound governance, minutes should be taken at all important meetings of the ADP and then agreed at the following meeting.
- Governance arrangements in the ADP should be improved to enhance openness and transparency. Allowing open discussion and debate on strategy, budgetary information, etc. will help members to contribute effectively to the work of the ADP. Delivering a robust improvement plan should help with communication difficulties.

25. Minutes are taken at all Committee meetings and agreed as a standard agenda item at the subsequent meeting (except where the subsequent meeting is not quorate in which case minute agreement is carried forward to the next meeting). Once agreed, minutes are published on the

ADP website. A review of all Committee minutes between 1 September 2016 and 14 May 2018 confirmed this practice is applied consistently and that committee members are provided opportunity to query the accuracy of minutes before they are agreed. The review also confirmed that issues relating to strategy and budgetary / financial information are discussed regularly including having regular agenda items for 'Co-ordinators Report', 'Lead Professional's Report', 'Locality Chair's Report' and 'Third Sector Report.'

26. In addition to the Committee there are seven local area forums all of which are represented on the Committee. The minutes of 25 forum meetings were reviewed with the sample covering all seven local area forums. This confirmed it was standard practice across all the forums for the minute of the previous meeting to be agreed. It also provided evidence that issues of operational, strategic and financial matters are openly discussed.

27. A three year ADP Delivery Plan and one year Improvement Plan were submitted to the Committee in July 2015 and August 2015 respectively. These included a series of actions with associated timescales to deliver improvement.

28. **Conclusion:** The ADP have implemented the recommendations in Audit Scotland's 2015 report.

Q4 – Confirm whether the ADP has appropriate procedures in place to consider funding applications and ensure awards are made in a manner which is transparent and equitable

29. **Findings:** The ADP has an 'algorithm' which is a flowchart showing how ADP funding flows from the Scottish Government, to NHS Highland then to the ADP. The majority of ADP funds are already committed (i.e. for the Addaction and ABAT contracts) however there can be non-committed funds available and the ADP has an established process to manage how they are awarded to applicants.

30. The ADP has a standard application form for potential parties to complete and a decision board is formed which usually consists of three people with at least one non committee member. The Chair and members of the ADP support team do not sit on decision boards. The decision board is responsible for reviewing applications and making a recommendation to the Committee. The process to consider applications was discussed with committee members at the December 2015 committee meeting.

31. This application process was followed in 2016/17 for funding awards. In 2017/18, rather than applying this process, a decision was taken to extend some of the awards made in 2016/17. These extensions were agreed by the Committee on 18 December 2017.

32. **Conclusion:** The ADP has an established process in place to help manage the funds available to it. Whilst this process was not applied in 2017/18 the alternative process adopted was appropriately discussed and agreed by the Committee.

Q5 – Confirm whether there is an appropriate mechanism for partner bodies to raise concerns about ADP governance and whether there is any evidence that partner bodies have such concerns including:

- **late provision of minutes**
- **minutes not accurately reflecting meetings and being subject to inappropriate amendments**
- **manipulation of meeting attendance to achieve a desired outcome.**

33. **Findings:** The mechanism for raising complaints about minutes would be at the subsequent Committee meeting. The review of committee and local forum minutes referenced at paragraphs 25-26 did not highlight any material concerns about late provision of minutes and there was evidence that, at both Committee meetings and local forum meetings, attendees are provided the opportunity to query any inaccuracies with previous minutes before agreeing them. Each forum has representation on the Committee providing them a clear opportunity to raise any concerns about ADP governance either singularly or collectively.

34. The dates and venues for committee meetings are circulated to all committee members with sufficient notice. For example, the meeting dates, times and locations for all meetings between June 2018 and June 2019 were circulated to members by e-mail on 15 May 2018. There are no exclusions in terms of invitations to committee members and members are entitled to send representatives on their behalf in the event they cannot attend.

35. There have been instances in the past where committee members have formally raised concerns about matters relating to the ADP and these have been investigated formally using the NHS Highland complaints procedure.

36. The minute of a forum meeting held in February 2018 highlighted a governance issue raised by an attendee relating to the process to appoint office bearers. In particular it suggested a possible manipulation of the meeting to achieve a desired outcome. The minute confirms the issue was discussed and that it received no support from other committee members. No formal complaint was raised in relation to this issue. The specifics of the issue are outwith the scope of this audit.

37. **Conclusion:** A mechanism exists for complaints to be raised about ADP governance. Committee members can raise issues at committee meetings and, if they deem it necessary, can issue a formal complaint using the NHS Highland complaints process. There is no substantial evidence of material concerns about late provision of minutes, minutes not accurately reflecting meetings or manipulation of meeting attendance.

4. Contract / SLA Management

Addaction

Q6 – The Addaction contract has been extended by two years. Confirm:

- **whether this extension was consistent with the terms and conditions of the original contract award**
- **how the decision to extend the contract was reached including whether appropriate information was made available to assist in that decision making process**
- **what partners were involved in the decision making process.**

38. **Findings:** The terms and conditions of the Addaction contract are adopted from the terms set out in the ITT when the contact was tendered. Section 63 (Contract Review) of the ITT confirms that a contract review will be led by council officers and paragraph 63.4 sets out the options at the end of the review. One of those options is *'Extend the term of this Contract for up to a maximum of two (2) years or such other period as is deemed appropriate in the circumstances*

with regard to the nature of the Services being provided.' This is the option that was adopted with Addaction informed of the extension on 23 January 2018.

39. There is, however, ambiguity in the ITT as section 10 (Duration of the Contract) states that '*The Contract may be extended for up to two further years until 30th September 2019 at the option of Argyll and Bute Council (on behalf of the ADP) subject to satisfactory performance of the contract and product discussions with the successful Tenderer(s).'* This section makes no reference to the need for that extension to be based on the conclusion of a contract review.

40. The Council reviewed the use of the 'Duration of the Contract' clause in ITTs in 2013 however both the duration clause and contract review clause were still in use in 2013 and 2014 which included the period the Addaction ITT was issued. A revised contract review clause which removes this conflict has been in use since 2016. As corrective action has already been taken to address this issue no further action is required.

41. There was a lack of clarity over roles and responsibilities in relation to awarding the contract extension. The ITT states that the contract may be extended '*at the option of Argyll and Bute Council (on behalf of the ADP)'* and the ADP constitution does not make any reference to the Committee having the authority to award contracts. General discussions about the Addaction extension were held at Committee meetings in May 2017, August 2017, October 2017, and December 2017, however the decision to award the extension was primarily taken by the Chair on the basis of the performance reporting provided for Addaction. This decision was communicated to the ADP Coordinator by e-mail on 18 January 2018.

42. The Committee are presented with quarterly scorecard reports for Addaction which reflect trends across a number of key performance measures. The Committee considers the reports and can raise questions as deemed appropriate. As such the Committee is regularly updated on Addaction's performance and minute review does not highlight any material concern about their performance being raised by the Committee.

43. A contract review was carried out however, whilst it commenced prior to the Addaction contract expiring, it was not completed until mid-February 2018, a month after the extension was awarded. Its late completion was due to competing work commitments. It is recognised that the contract review did not highlight any reason why the contract should not be awarded.

Action Plan 1

44. **Conclusion:** The award of Addaction's contract extension was consistent with the terms of the original ITT in that the basis for extension was satisfactory performance which has been demonstrated through regular performance monitoring (refer to paragraphs 48-51). However there was a lack of clarity regarding responsibility for awarding the extension and the conclusion of the Addaction contract review post-dated rather than pre-dated the decision to award the extension. It is however recognised that the review, once complete, did not highlight any reason not to extend the contract.

Q7 – Confirm what quality indicators and/or recovery targets are in place for the Addaction contract. Specifically confirm whether there is a sole contractual target that 90% of clients wait no more than three weeks to receive drug or alcohol treatment.

45. **Findings:** The ITT sets out the performance management framework for the Addaction contract. It details the required outcomes, the actions to take to deliver them and how they are to be measured. There is a total of six overarching outcomes with each of these broken down into more detailed outcomes. As there are no performance targets established in the ITT it can be difficult to determine how the quality of service delivery can be assessed. However it is recognised that setting meaningful performance targets for the delivery of care services can be difficult as, for example, how do you determine what is a 'good' number of referrals or a 'poor' number of referrals? Consequently performance monitoring focuses more on trends over a period of time to identify areas of concern. This is considered to be a reasonable approach to take.

46. The performance management framework in the ITT does make reference to the 'HEAT standard – Waiting Time Target' as being a measurement. This is a national standard which, for alcohol and drug treatment, is that *'90 per cent of clients will wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery'*. Performance against this measure is monitored through the quarterly performance reporting carried out by the ADP as detailed in paragraphs 48-51.

47. **Conclusion:** It is correct that the sole contractual target established by the ITT is for 90% of clients to wait no longer than three weeks to receive drug or alcohol treatment however Addaction's performance is assessed against a wider range of factors than that one target.

Q8 – Confirm how performance against the quality indicators and/or recovery targets is monitored including consideration of whether performance monitoring allows comparison across the geographical areas of Argyll and Bute.

48. **Findings:** Addaction provide quarterly performance monitoring reports which are discussed in meetings attended by the ADP Coordinator, a Council Performance Improvement Officer (PIO) and an Addaction manager. The PIO uses this information to monitor Addaction on a quarterly basis against contractual criteria using a balanced scorecard approach which allocates scores across four component parts (quality, service, delivery and cost). The quarterly scorecard changes if the performance report provided by Addaction highlights a performance issue which would alter the overall risk rating for the contract. If the performance report does not highlight a material change in performance then the scorecard is not changed and it rolls forward into the next quarter. There is also a yearly scorecard which is a consolidation of all activity in year and the quarterly performance reports.

49. A review of Addaction performance reports confirmed they provide some of the information set out as 'measurement' in the ITT (for example service user feedback, a statement on referral numbers, a summary of care inspectorate reports and a sentence on meeting national waiting times and HEAT targets). However, as the format of the performance reports are not aligned to the ITT's performance management framework, it is difficult to assess and evidence whether the outcomes required by the ITT are being delivered.

50. The Committee are presented with quarterly scorecard reports for Addaction which reflect trends across a number of performance measures. These scorecards have not historically broken down performance across the four geographical areas of Argyll and Bute however in May 2018 the Committee were presented with alcohol and drug reports which were specific to each of the four localities. This was the first time these reports had been made available. It would be beneficial to engage with the ADP Committee to determine whether they are satisfied with the current performance reporting and obtain feedback on where it could potentially be strengthened.

Action Plan 3

51. **Conclusion:** There are sound arrangements in place for performance monitoring by the Council and the ADP with regular reporting to Committee. This could potentially be improved by better aligning performance reports to the performance management framework and further exploring the provision of performance information which facilitates the comparison of performance across the four geographical areas of Argyll and Bute to help identify any areas of specific concern. However the ADP Committee should be consulted before making any changes to the current levels of performance reporting to ascertain whether they are of the view that any proposed changes would be of benefit.

ABAT

52. Queries 9 and 10 are duplicates of queries 7 and 8 except they relate to the performance monitoring of services delivered by ABAT rather than the services delivered by Addaction. The process followed by the ADP Coordinator and the PIO for ABAT performance monitoring is identical to that followed for Addaction and the quarterly scorecards presented to the Committee consolidate the Addaction and ABAT information. Therefore the information, actions, conclusions and recommended actions documented in paragraphs 45-51 are equally applicable to ABAT. They have not been documented again to avoid repetition.

Q11 – Confirm whether there is transparency over the manner in which ABAT is funded, the operation of the ABAT SLA and arrangements for monitoring and evaluating performance against the SLA.

53. **Findings:** For the sake of clarity it should be noted there is no formal document in place called the ABAT SLA. However there is a document called the 'ABAT Submission' which acts as an SLA and describes itself as an SLA within its introduction. For ease of reference, in this report, it shall be referred to as the ABAT SLA.

54. The ABAT SLA is funded by ADP, NHS Highland and the Council. The base value of the SLA, based on 2014/15 costs, is £1,036,407 with the funding split as follows:

- ADP - £760,000
- NHS Highland - £134,500
- Argyll and Bute Council - £141,907

55. The ABAT SLA confirms that the funding would be reviewed annually by the three parties taking account of:

- availability of funding

- pay awards and other pay cost adjustments
- any savings requirements.

56. Funding reviews have taken place with, for example, there being a reduction in funding in the 2016/17 ABAT budget.

57. The 'award' of the ABAT SLA was not subject to competitive tendering as ABAT are a combination of NHS Highland and council officers providing a clinical service. These sorts of service are not subject to competitive tendering as there would be no alternative provider for the ADP to consider. Hence it is unusual for an SLA to be in place to manage the delivery of these type of services. This does not present a material audit concern so no action plan point has been raised however, in future, consideration should be given to whether it is an efficient use of scarce time and resource to establish an SLA for the delivery of services of this nature.

58. ABAT performance monitoring and report has been addressed through the responses to queries 7 and 8 as explained at paragraph 52.

59. **Conclusion:** The manner in which ABAT services are funded is clearly detailed in the ABAT SLA. It is recognised that the SLA is not a public document which may lead to a perception that ABAT funding is not transparent however it would not be normal practice for an SLA to be a public document. It was also noted that the ADP contribution to ABAT is detailed in the minutes for the Committee meeting held on 28 February 2017. This minute is available to the public via the ADP website. Conclusions on performance monitoring and reporting are detailed at paragraph 51.

5. Children 1st - Procurement / Extension

Q12 – Determine the nature of all contracts awarded to Children 1st totalling £847,357 in the period 2008-2018. Confirm, whether the contracts were awarded after competitive tendering and, if not, whether this was justifiable and appropriate.

60. **Findings:** From 2008 to 2018, including extensions, there were a total of ten agreements with Children 1st for the delivery of advocacy and abuse & trauma recovery services. These total £847,357.

61. Under council policy, when procuring services, if only one supplier can undertake the work required the purchasing officer can seek approval for a non-competitive action from the Procurement Team Leader and the relevant department personnel. The Council's procurement manuals (various versions between 2008 and 2018) state that *'Non Competitive Action is an exceptional procedure and should be strictly limited to certain situations and should be documented for audit purposes.'*

62. A review of the available documentation for each of the ten agreements highlighted that:

- There is no documentation for the original award for £60k covering the three year period 01/04/2008 – 31/03/2011. Confirmation has been received by verbal evidence that Children 1st were on the approved providers list when the contract was awarded and that the relevant procurement process at that time meant this was sufficient to award the contract.
- The first two extensions (01/04/11 – 31/03/12 and 01/04/12 to 31/03/13) were instructed by the relevant service to the commissioning team. There is no documentary evidence to

support this decision as the documents are outwith the period for retention as per the Procurement Reform Act (Scotland) 2014 (refer to paragraph 64).

- The other seven extensions (dated between 01/04/13 and 31/03/2017) for both advocacy and abuse & trauma recovery services were awarded following the non-competitive action process. Documentation was in place to support this approach which had been approved by the appropriate officers in compliance with the relevant procurement manuals at the time the extensions were awarded.

63. The review of the seven extensions where there was approval of the non-competitive action highlighted that the approval was often provided a number of months after the commencement of the extended award. This means that, for those months, the service was being delivered without formal approval.

Action Plan 2

64. **Conclusion:** As the original award was ten years ago and the first two extensions for 2011/12 and 2012/13 are approximately seven and six years ago respectively it is considered acceptable that no supporting documentation was available for audit purposes. The Procurement Reform Act (Scotland) 2014 requires the Council to keep and maintain a contract register and includes provision for deletion of an entry after the contract expires or has been terminated. The current data retention policy for procurement documentation requires retention for a period of five years after the contract terminates. The appropriate approval was in place for each extension since 2013/14 however approval of non-competitive action should be provided prior to the contract extension being awarded rather than retrospectively

Q13 – Confirm whether Children 1st led an ADP external bid for external funding from which Children 1st would then benefit by £285k over a three year period.

65. **Findings:** In 2016 and 2017, Children 1st led on an external funding bid to Lloyds PDI (now Corra Foundation) with the support of the ADP to help finance the delivery of work with young people across Argyll & Bute. If successful the intention was to match fund the Lloyds PDI funding with ADP funds that the ADP had allocated to that area of work. Children 1st were bidding to undertake a coordination, monitoring and developmental role. Verbal evidence was provided that none of the ADP funds were due to go to Children 1st as their element was to be paid from the Lloyds PDI funding. In addition, the Lloyds monies would have provided a small amount of additional funds to local service providers. Progress made on this bid was reported to the Committee as evidenced by committee meeting minutes between October 2016 and August 2017. The August 2017 minute confirms that the bid was not proceeding at that stage.

66. The legality of the application was challenged by a member of one ADP local forum and the ADP Coordinator contacted NHS Highland regarding this matter. The NHS Highland officer confirmed verbally that there was no legal issue with the process adopted however to get this confirmation formally in writing from the Central Legal Office (who provide the public sector with legal advice and assistance) would have incurred a fee and this route was therefore not adopted.

67. **Conclusion:** Children 1st were the lead body in an external bid for funding. The bid was not progressed to the final stage and therefore no award was made. Consequently neither Children 1st, nor any other body, benefited.

Q14 - Confirm whether the contract award associated with the £285k funding was subject to a formal tender process and, if not, whether this was justifiable and appropriate. If the award was not subject to tendering then confirm whether this approach was discussed and cleared with other ADP partners.

68. **Findings/Conclusion:** As per paragraph 67 the Children 1st led bid for external funding was not progressed meaning there was no contract to be subject to formal tendering.

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Appendix 1 – Action Plan

	No.	Finding	Risk	Agreed Action	Responsibility / Due Date
Medium	1	**Addaction Contract Extension** There was a lack of clarity over who was responsible for awarding the Addaction contract extension. The wording of the ITT suggests it should be a Council decision and the ADP constitution does not make any reference to the Committee having the authority to award contracts. The actual decision was primarily taken by the independent ADP Chair on the basis of Addaction's performance as evidenced by quarterly performance reports presented to the Committee. This decision was taken prior to the completion of the Addaction contract review. Clarity should be provided regarding authority to award contracts, and contract extensions, for services commissioned by the ADP with the text of relevant procurement and/or ADP governance documentation amended accordingly. This decision should be informed by the completion of a contract review as required by the terms of the ITT.	The award of contracts and/or contract extensions may be subject to legal challenge if they were not awarded by a person with the appropriate delegated authority.	Procurement and Commissioning Team Manager to liaise with ADP Co-ordinator to identify the appropriate authorised person in the ADP to award contracts. This authorised signatory will then be incorporated within our contract award recommendation report template. ADP governance structures will provide clarity on the responsibility for all decisions regarding contracts.	Argyll and Bute Council Procurement And Commissioning Manager 31 March 2019 ADP Co-ordinator 31 March 2019

Medium	2	**Approval of Non-Competitive Action** Approval to commission services using a non-competitive action procurement approach is often provided retrospectively.	Services may be commissioned which do not represent value for money.	Procurement and Commissioning Team Manager to instruct PCT at team meeting to ensure all non-competitive action procurement approaches are completed in advance of contract award date.	Argyll and Bute Council Procurement And Commissioning Manager 31 October 2018
Low	3	**Performance Reporting** Addaction and ABAT provide performance monitoring reports which are reviewed by the ADP Coordinator and a Council Performance Improvement Officer and used to inform the quarterly performance scorecards reported to Committee. The performance reports provide some of the information set out as 'measurement' in the Addaction ITT and ABAT SLA however the formats of the reports are not aligned to the performance management frameworks in the ITT and SLA which can make it difficult to assess and evidence whether the outcomes required by the ITT are being delivered. In May 2018 the Committee were presented with alcohol and drug reports which were specific to each of the four localities. This was the first time these reports had been made available. It would be beneficial to engage with the ADP Committee to determine whether they are satisfied with the current performance reporting and obtain feedback on where it could potentially be strengthened.	Failure to deliver against the outcomes established in the ITT and SLA may not be identified by performance monitoring.	ADP Committee will be consulted on the level of performance reporting they require from ABAT and Addaction.	ADP Co-ordinator 31 March 2019

Low	4	**Annual Review of Chair** Annual reviews of the Chair, as required by the job specification, were not carried out over the three year period of his appointment.	Failure to conduct an annual review may lead to ineffective decision making.	The appointment process for the Chair is to be considered by the IJB in September 2018 as part of a wider review of the ADP's governance arrangements. Once agreement is reached on the process to be adopted consideration will be given to the need for annual reviews.	ADP Co-ordinator 31 December 2018
Low	5	**ADP Constitution** The Chair has introduced material changes to the structure of the ADP which are not reflected in the ADP's constitution. It also names a number of sub-groups which no longer exist. The constitution would benefit from a review to reflect these specific issues but also more widely to ensure it reflects current working practices.	There may be a lack of clear guidance for Committee members on the operation and internal management of the ADP.	Constitution will be reviewed, amended and agreed by the ADP.	ADP Co-ordinator 31 March 2019

In order to assist management in using our reports a system of grading audit findings has been adopted to allow the significance of findings to be ascertained. The definitions of each classification are as follows:

Grading	Definition
High	A major observation on high level controls and other important internal controls or a significant matter relating to the critical success of the objectives of the system. The weakness may therefore give rise to loss or error.
Medium	Observations on less significant internal controls and/or improvements to the efficiency and effectiveness of controls which will assist in meeting the objectives of the system. The weakness is not necessarily substantial however the risk of error would be significantly reduced if corrective action was taken.
Low	Minor recommendations to improve the efficiency and effectiveness of controls or an isolated issue subsequently corrected. The weakness does not appear to significantly affect the ability of the system to meet its objectives.

Appendix 2 – Audit Opinion

Level of Assurance	Definition
High	Internal control, governance and the management of risk are at a high standard. Only marginal elements of residual risk have been identified with these either being accepted or dealt with. A sound system of control designed to achieve the system objectives is in place and being applied consistently.
Substantial	Internal control, governance and the management of risk is sound. However, there are areas of weakness which put some system objectives at risk and specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Reasonable	Internal control, governance and the management of risk are broadly reliable. However, whilst not displaying a general trend, there are a number of areas of concern which have been identified where elements of residual risk or weakness may put some of the system objectives at risk.
Limited	Internal control, governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and placing system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.
No Assurance	Internal control, governance and the management of risk is poor. Significant residual risk and/or significant non-compliance with basic controls exists leaving the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources to the issues.

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Integration Joint Board **Agenda item: 5.5b**

Date of Meeting: **28 November 2018**

Title of Report: **Alcohol & Drugs Partnership Annual Report 2017/18**

Presented by: **Sandra Cairney, Associate Director of Public Health**
Craig McNally, ADP Coordinator

The Integration Joint Board is asked to:

- Note the attached Alcohol & Drug Partnership (ADP) 2017/18 annual report which was submitted to Scottish Government in September 2018

1. EXECUTIVE SUMMARY

The attached Alcohol & Drugs Partnership Annual Report 2017/18 details (1) the funding allocated to reducing alcohol and drug related harm within Argyll & Bute; (2) reports Argyll & Bute's position against the Scottish Government Ministerial Priorities; and (3) describes the formal arrangement for working with local partners.

2. INTRODUCTION

Scottish Government require each ADP to submit an annual report detailing work delivered in line with the delivery plans shared in 2015.

The Scottish Government revised this year's template in order to focus on key priorities within the current national strategy.

3. DETAIL OF REPORT

3.1 Section 1 indicates that Argyll & Bute ADP received £972,27 earmarked funding from Scottish Government through NHS Board Baseline. The IJB provided an additional £1,051,10 funding plus £40,000 from the NHS resulting in a **total budget allocation of £2,063,380** split across the priority areas of Prevention (£192,155); Treatment & Support Services (£1,436,425); Recovery(£281,354); and Dealing with problem alcohol and drug use (£153,446).

3.2 Section 2 Outlines work undertaken towards established improvement goals across the Scottish Government's Ministerial priorities:

PRIORITY	BRIEF SUMMERY OF ACTION
1. Preparing for new Information System (DAISy)	Working closely with service providers to ensure staff, service users and systems are ready for DAISy implementation.
2. Tackling drug and	In 2017 there were 8 Drug Related Deaths

alcohol related deaths (DRD & ARD)/risks in your local ADP area.	where the deceased was either resident in or where the death occurred within Argyll & Bute. DRD meetings are now taking place regularly and actions have been taken back to the wider ADP.
3. Respond to the needs of prisoners affected by problem drug and alcohol use	ADP Coordinator has met with Community Justice Lead with a view to increasing partnership approaches.
4. Implement recommendations within the Care Inspectorate Report	ADP has worked in partnership with Scottish Drugs Forum to develop and pilot a ROSC (Recovery Oriented System of Care) tool. ADP re-ran a Self Assessment exercise with service deliverers in Argyll & Bute.

3.3 The Scottish Government requested details of the formal arrangement for working with local partners. The return is based on the current position as the IJB had just agreed the updated arrangements.

4. RELEVANT DATA AND INDICATORS

As presented in Section 2 (Ministerial Priorities) of the Annual Report.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The ADP contributes to several strategic priorities including:

- Promoting healthy lifestyle choices and increase self-management of long term conditions
- Reducing the number of avoidable emergency admissions to hospital.
- Minimising the time that people are delayed in hospital.
- Reducing the adverse events for children and young people, and provide the best start in life for them.)

The ADP Annual Report focuses specifically on the Scottish Government's Ministerial priorities.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

Section 1 of the report outlines the financial impact on the IJB of the delivery of services aimed at reducing the harms associated with alcohol and drug use in Argyll & Bute.

6.2 Staff Governance

There are no implications identified in this report

6.3 Clinical Governance

There are no implications identified in the report.

7. EQUALITY & DIVERSITY IMPLICATIONS

The revised ADP Strategic Plan will be subject to an Equality Impact Assessment.

8. RISK ASSESSMENT

There are no identifiable risks identified at this point in time.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Argyll & Bute ADP is in the process of developing its public and user involvement & engagement. As such, the ADP has contracted Scottish Drugs Forum to implement the ADP's involvement strategy over the next three years.

10. CONCLUSIONS

This paper provides a snapshot of the wider partnership work directed through the A&B ADP on behalf of the IJB. The ADP plays a key role in targeting resources and services from a range of partners to reduce the negative impact of alcohol and drugs on individuals, families and communities across Argyll & Bute.

This report represents a small proportion of the work undertaken by ADP partners, specifically aimed at meeting the Scottish Government's Ministerial priorities. It also gives an overview of funding allocated by the IJB to help meet these and other priorities set out by the ADP.

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ADP ANNUAL REPORT 2017-18 (ARGYLL & BUTE ADP)

Document uses the Scottish Government template and Details:

ADP Reporting Requirements 2017-18

1. Financial framework

2. Ministerial priorities

3. Formal arrangements for working with local partners

Appendix 1 Feedback on this reporting template.

In submitting this completed Annual Report we are confirming the this has been signed off by both the ADP Chair and Integrated Authority Chief Officer.

The Scottish Government copy should be sent by **26 September 2018** for the attention of Amanda Adams to: alcoholanddrugdelivery@gov.scot

June 2018

1. FINANCIAL FRAMEWORK - 2017-18

Your report should identify all sources of income that the ADP has received (via your local NHS Board and Integration Authority), alongside the monies that you have spent to deliver the priorities set out in your local plan. It would be helpful to distinguish appropriately between your own core income and other expenditure on alcohol and drug prevention, treatment and support, or recovery services which each ADP partner has provided a contribution towards. You should also highlight any underspend and proposals on future use of any such monies.
Income and Expenditure through the Programme for Government should only be recorded in ANNEX A – Programme for Government Investment Plans and Reporting Template

a) Total Income from all sources

	Problem Substance Use (Alcohol and Drugs)
Earmarked funding from Scottish Government through NHS Board Baseline *	972,277
Funding from Integrated Authorities	1,051,103
Funding from Local Authority – if appropriate	
Funding from NHS (excluding funding earmarked from Scottish Government) – if appropriate	40,000
Total Funding from other sources – as appropriate	
Carry forwards	
Total (A)	**2,063,380**

b) Total Expenditure from sources

	Problem Substance Use (Alcohol and Drugs)
Prevention (include community focussed, early years, educational inputs/media, young people, licensing objectives, ABIs)	192,155
Treatment & Support Services (include interventions focussed around treatment for alcohol and drug dependence)	1,436,425
Recovery	281,354
Dealing with consequences of problem alcohol and drug use in ADP locality	153,446
Total (B)	**2,063,380**

c) 2017-18 Total Underspend from all sources: (A-B)

Income (A)	Expenditure (B)	Under/Overspend
2,063,380	**2,063,380**	**0**

d) 2017-18 End Year Balance from Scottish Government earmarked allocations (through NHS Board Baseline)

	Income £	Expenditure £	End Year Balance £
Problem Substance Use *	**972,277**	**972,277**	**0**
Carry-forward of Scottish Government investment from previous year (s)			

Note: * The income figure for Scottish Government should match the figure given in table (a), unless there is a carry forward element of Scottish Government investment from the previous year.

2. MINISTERIAL PRIORITIES

ADP funding allocation letters 2017-18 outlined a range of Ministerial priorities. Please describe in this ADP Report your local Improvement goals and measures for delivery in the following areas during 2017-18 below.

PRIORITY	*IMPROVEMENT GOAL 2017-18	PROGRESS UPDATE	ADDITIONAL INFORMATION
1. Preparing Local Systems to Comply with the new Drug & Alcohol Information System (DAISy)	• Ensure compliance with SMR25 • Increase the level of identifiable records in DATWT database.	• Continued to raise awareness of DAISy and RO Tool locally • Support and advise given to all providers	Continuing to work as part of the national process to implement DAISy. Working closely with service providers to ensure staff, service users and systems

			are ready for DAISy implementation.
2. Tackling drug and alcohol related deaths (DRD & ARD)/risks in your local ADP area. Which includes - Increasing the reach and coverage of the national naloxone programme for people at risk of opiate overdose, including those on release from prison and continued development of a whole population approach which targets harder to reach groups and focuses on communities where deprivation is greatest.	• Reduce numbers of Drug Related Deaths across Argyll & Bute • Target support & resources to areas most in need	• Further established and maintained links between key partners. • All DRD meetings are well informed with all relevant parties invited and encouraged to engage with the process. • Ensured the ADP is represented at all DRD national coordinators meetings held by ISD and act upon learning gained through this forum. • Ensured all deaths are recorded in the National DRD database.	In 2017 there were 8 Drug Related Deaths where the deceased was either resident in or where the death occurred within Argyll & Bute. Drug related deaths in Argyll and Bute more than doubled from 2013 (5) to 2015 (11), they reduced slightly in 2016 to 10. They have reduced in 2017. DRD meetings are now taking place regularly and actions have been taken back to the wider ADP.
3. Ensuring a proactive and planned approach to responding to the needs of prisoners affected by problem drug and alcohol use and their associated through care arrangements, including women	• Ensure pre/post release care arrangements consider relevant prisoners needs.	• Developed links between community based services and services within prisons serving Argyll & Bute. • Worked with partners to plan a review of the extent of Argyll & Bute women in prison and look at their needs. • Developed stronger links with Community Justice and Criminal Justice teams.	ADP Coordinator has met with Community Justice Lead with a view to increasing partnership approaches. Attended Community Justice Committee, Criminal Justice Planning Event and The joint Argyll, Bute and Dunbartonshire's Criminal Justice meeting before it was disbanded in March 2017.
4. Continued implementation of improvement activity at a local level, based on the individualised	Areas for improvement identified through the 2016 Care Inspectorate Report on local implementation of the Quality	• Work has been done with partners to increase partnership working and access to services in some communities.	ADP has worked in partnership with SDF to establish two ROSC pilot areas. A ROSC tool has

recommendations within the Care Inspectorate Report, which examined local implementation of the *Quality Principles.*	Principles as follows: • Improved access to services • Reduce waiting times • Shared outcome tools across services • Data sharing (consent, assessment, plans) • Develop a ROSC • Service user involvement • Training • Development of Recovery Communities (recovery capital) • Whole population approaches • Advocacy • Prevention and early intervention • Repeat Quality Principles exercise with Adult drug & alcohol services to ascertain any change in recommendations.	• Developed a joint working protocol to increase collaborative working • Data sharing agreements have been put in place between two major service providers • ROSC piloted and rolled out (Partnership Pathways or PaPa- led by TSI) incorporates a wide range of services • Training programme managed and delivered by SDF developed and disseminated to target a number of identified training needs. • Quality Principles exercise repeated with SDF as lead agency. • Involvement strategy developed and contract awarded to SDF. Looking at engaging service users, families, young people, people with lived experience, hard to reach and remote populations. • Work ongoing in partnership with existing Recovery Cafe's and partner agencies (SRC, SDF, Addaction, ABAT) to develop Recovery Communities across Argyll & Bute. • PaPa developed a whole population approach which covers a wide range services. • Work ongoing to develop a Virtual Law Centre with Peer Advocacy element. • School based support work providing prevention and early intervention. PaPa also aimed at increasing access	been developed in one of the localities with a view to cascading across Argyll & Bute. Work has been done in partnership with Highland ADP to look at re-running a Self Assessment exercise with all service deliverers in Argyll & Bute.

		to services at an early stage. • Quality Principles exercise repeated and undertaken by two ADP funded services.	

* SMART *(Specific, Measurable, Ambitious, Relevant, Time Bound)* measures where appropriate

3. FORMAL ARRANGEMENT FOR WORKING WITH LOCAL PARTNERS

What is the formal arrangement within your ADP for working with local partners including Integrated Authorities to report on the delivery of local outcomes.	ADP is accountable to the IJB for all strategic planning and funding decisions. ADP has responsibilities to the CPP for determining joint priorities and performance measures required for the Local Outcome Improvement Plan.

In submitting this completed Investment Plan, we are confirming the this has been signed off by both the ADP Chair and Integrated Authority Chief Officer.

APPENDIX 1:

1. **Please provide any feedback you have on this reporting template.**

The reporting template is significantly reduced from previous years while still providing details of the required priorities. However, the level of detail requested does not give a true reflection of the range and depth of work being undertaken within the ADP. I anticipate changes based on the new strategy.

Integration Joint Board **Agenda item: 5.5c**

Date of Meeting: **28 November 2018**

Title of Report: **Allocation of Scottish Government "Programme for Government" funding**

Presented by: **Sandra Cairney, Associate Director of Public Health**

Craig McNally, ADP Coordinator

The Integration Joint Board is asked to:

- Note the high level proposal submitted to the Scottish Government (October 2018) for allocation of £315,000 additional resource to meet national priorities.

1. EXECUTIVE SUMMARY

The attached report (appendix 1) provides details of the Argyll & Bute Integration Joint Board and Alcohol & Drug Partnership response to the Scottish Government's "Programme for Government" letter of August 2018 which sets out a series of priorities against an additional £315,000 funding.

The Report sets out the background to this allocation, details the Scottish Government priorities and sets out a range of service delivery proposals to meet these priorities.

2. INTRODUCTION

In August 2018 the Scottish Government issued a letter, detailing an additional £17 million "Programme for Government" funding to be allocated to NHS Boards in September 2018 for onward delegation to Integration Authorities.

Argyll & Bute IJB were awarded an additional £315,091. The letter indicated that IAs, working with ADPs, should agree local arrangements for improvements. It stated that IAs hold responsibility for the effective investment of this budget to meet the needs of the affected population in the local area against the purposes set out in the August letter.

3. DETAIL OF REPORT

3.1 August 2018 Letter areas for investment:

- Increased involvement of those with lived experience of addiction and recovery in the evaluation, design and delivery of services;
- Reduce waiting times for treatment and support services. Particularly waits for opioid substitution therapy (OST) including where these are reported as secondary waits under the LDP Standard;

- Improved retention in treatment particularly those detoxed from alcohol and those accessing OST;
- Development of advocacy services;
- Improved access to drug/alcohol treatment services amongst those accessing inpatient hospital services;
- Whole family approaches to supporting those affected by problem drug/alcohol use;
- Continued development of recovery communities.

4. RELEVANT DATA AND INDICATORS

A performance framework will be developed to track progress against priorities.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The work of the ADP will be reflected in the IJB strategic priorities and performance target.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

This paper presents proposed allocation of addition funding provided by Scottish Government for the specific purposes set out in the letters of May and August 2018. Non-allocation of funds for these purposes would risk recall of funds within this financial year and reduction/removal of allocation across the next two years.

6.2 Staff Governance

There are no implications identified in the report.

6.3 Clinical Governance

There are no implications identified in the report.

7. EQUALITY & DIVERSITY IMPLICATIONS

An equality impact assessment will be undertaken as part of the ADP Strategic Plan development.

8. RISK ASSESSMENT

There are no identifiable risks identified at this point in time.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Argyll & Bute ADP is in the process of developing its public and service user involvement & engagement plan. As such, the ADP has contracted Scottish Drugs Forum to implement the ADP's involvement strategy over the next three years. This paper proposes an increase in funding to support the development of this work.

10. CONCLUSIONS

The Argyll & Bute IJB and the Alcohol & Drugs Partnership are required by the Scottish Government to present a Plan which ensures the development and delivery of services to meet the national priorities set out in the funding letters of May and August. This paper sets out a series of proposals that allow the IJB and ADP to meet those priorities and allocate appropriate funding against them.

Appendix 1

PROGRAMME FOR GOVERNMENT 2018-19: ADDITIONAL INVESTMENT IN SERVICES TO REDUCE PROBLEM DRUG AND ALCOHOL USE

2018-19 INVESTMENT PLANS AND REPORTING TEMPLATE

ADP: ARGYLL & BUTE HEALTH & SOCIAL CARE PARTNERSHIP

Investment Area *	Key Challenge	Proposal & Intended Outcome	Anticipated Investment £	Anticipated Investment Measure - Progress
Continued development of recovery communities	Support the development of strong and sustainable recovery communities across Argyll & Bute	▪ Establish a fund to support the development of recovery communities across A&B ▪ Work with ABAT & Addaction and other local partners ▪ Work with SRC, SDF, SFAD and other national partners to ensure the work is lead by trained and supported individuals with lived and living experience.	Year 1: 50,000 Year 2: 50,000 Year 3: 50,000	Quantitative – number of recovery activities developed and sustained. Numbers participating. Qualitative –feedback from individuals engaged in the community and from those choosing not to engage
Reduce waiting times for treatment and support services.	Reduce waiting times for appropriate treatment	Clinical Psychologist with a responsibility for: ▪ delivering clinical psychology services in line with the recommendations of "The delivery of psychological interventions in substance misuse services in Scotland" ▪ freeing up ABAT staff time to strengthen links with inpatient hospital services	Year 1: 60,000 Year 2: 60,000 Year 3: 60,000	Quantitative – number of people attending sessions with clinical psychologist. Number of additional people seen by staff. Qualitative – measured by Recovery Outcome Tool
Development of advocacy services	Develop a peer advocacy programme in Argyll & Bute	In conjunction with specialist peer advocacy service: ▪ develop peer advocacy programme in Argyll & Bute ▪ link with Virtual Law Centre ▪ link with Partnership Pathways programme ▪ ensure that there is a link into service for people in Scottish Prison Service ▪ support development of recovery communities ▪ link with Scottish Drugs Forum to support service users to engage with the ADP	Year 1: 30,000 Year 2: 30,000 Year 3: 30,000	Quantitative – number of people trained as peer advocates. Number of people accessing service. Qualitative – success of service (measured in conjunction with Virtual Law Service and through feedback from people accessing the service).
Whole family	Develop an	Development of Young People's	Year 1:	Quantitative – number of

approaches to supporting those affected by problem drug/alcohol use	equitable support service for young people across Argyll & Bute	Support Services in partnership with the Education Department and key delivery services - in line with the recommendations of the evaluation of services and the Joint Inspection of Children's Services: Early intervention aimed at building resilience and providing support to reduce both the prevalence of, and long term impact of, Adverse Childhood Experiences.	95,000 Year 2: 95,000 Year 3: 95,000	young people accessing the service, number of sessions, length of engagement, issues covered by support. Qualitative – success of service, behaviour change measured using appropriate tool, feedback from Schools, individuals and families. Qualitative –independent evaluation of the quality of the services and experience of those individuals involved.
Improved retention in treatment particularly those detoxed from alcohol and those accessing OST	Support access to a wide range of wider recovery networks and opportunities for people in services	Hosted service with responsibility for: ▪ coordinating pathways and partnership for people in services ▪ ensuring that there is a link into service for people in Scottish Prison Service & Drug Related Death ▪ linking with peer advocacy and PaPa ▪ supporting recovery communities ▪ developing Naloxone programme and activities aimed at reducing Alcohol	Year 1: 30,000 Year 2: 30,000 Year 3: 30,000	Quantitative – number of people accessing services as a direct result of support from this service. Increased number of naloxone kits handed out. Increase in activities aimed at reducing A/DRD. Qualitative - measured through Recovery Outcome Tool
Improved retention in treatment particularly those detoxed from alcohol and those accessing OST	Coordinate pathways and partnership for people in services, families, carers and wide community	Develop a Recovery Oriented System of Care tool (PaPa) aimed at increasing knowledge of available services/supports, increasing partnership between services, increasing quality of partnership agreements between services. Presented in an easy to use and easy to understand format which can be shared and accessed by partner agencies and members of the public.	Year 1: 11,000 Year 2: 11,000 Year 3: 11,000	Quantitative – Number of agencies signed up to PaPa. Number of partnership agreements between agencies signed. Number of people indicating they are using PaPa. Qualitative – level of partnership agreements. Feedback from service and public regarding quality, effectiveness and use of PaPa
Increased involvement of those with lived experience of addiction and recovery in the evaluation, design and	Develop a structured process and programme of involvement for people with lived and living experience,	▪ Develop appropriate opportunities for service users and families to have their voice within the services. Support service users to ensure their voice is independent of service providers. ▪ Ensure that families and	Year 1: 20,000 Year 2: 20,000 Year 3:	Quantitative – number of organisations who have actively engaged people with lived experience in the design and delivery of their services. Qualitative –independent evaluation of the quality

delivery of services	their families and carers.	carers have an independent voice and an opportunity to help develop service. ▪ Deliver a mechanism for the development of local ideas at a community level	20,000	of the process and experience of those individuals involved.
Improved access to drug/alcohol treatment services amongst those accessing inpatient hospital services	Manage pathways from hospital into treatment provision	▪ Develop a protocol for identifying need and supporting people into treatment. ▪ Provide leadership in building pathways. ▪ Ensure that all key partners are trained/offered training.	Year 1: 19,000 Year 2: 19,000 Year 3: 19,000	Quantitative – number of patients identified as requiring input from specialist drug & alcohol treatment services Qualitative – measured by Recovery Outcome Tool
TOTAL ANTICIPATED INVESTMENT PER YEAR			**£315,000**	

Notes:

* As detailed in paragraph 10 of 2018-19 Programme for Government additional investment in services to reduce problem drug and alcohol use dated 23 August 2018

In submitting this completed Investment Plan, we are confirming that this has been signed off by both the ADP Chair and Integration Authority Chief Officer(s).

Integration Joint Board **Agenda item: 5.6a**

Date of Meeting: **28 November 2018**

Title of Report: **Strategic Plan Consultation Feedback Report**

Presented by: **Sandra Cairney, Associate Director of Public Health**

The Integration Joint Board is asked to:

- consider the contents of this report.

1. EXECUTIVE SUMMARY

The attached report present the findings of the feedback from citizens, service user and carer representatives, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022).

2. INTRODUCTION

The Health & Social Care Partnership (HSCP) invited and received feedback from citizens, service user and carer representatives, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022).

3. DETAIL OF REPORT

3.1 The purpose of the consultation was fourfold:

- To inform people about the HSCP proposed strategic areas of change;
- Invite comments on eight specific service change areas;
- Invite suggestions around what the HSCP needs to do to make sure people are involved in the process of change; and
- Use the information gathered in the consultation to inform strategic priorities.

3.2 The consultation process took place between July and October 2018, people took part in worshops, presentation and/or were asked to complete a questionnaire (hard copy or SurveyMonkey).

3.3 Responses were grouped in terms of general comments, proposed key areas of change and feedback relating to engagement.

4. RELEVANT DATA AND INDICATORS

Not applicable

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The feedback from the Strategic Plan consultation will inform the development of the next HSCP Strategic Plan.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

There are no financial implications identified in the report.

6.2 Staff Governance

A wide range of staff delivered and responded to the consultation.

6.3 Clinical Governance

There are no clinical governance implications identified in the report.

7. EQUALITY & DIVERSITY IMPLICATIONS

The consultation process was designed to listen to the views of a wide range of stakeholders including those who are impacted by health and social care services.

8. RISK ASSESSMENT

There are no identifiable risks identified at this point in time.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The consultation process was designed to take account of feedback from a wide range of stakeholder including staff, partners, community members, service users and carer representatives.

10. CONCLUSIONS

The HSCP engagement process involves three stages and the attached report represents the process and findings of stage 1 which took place between July and October 2018. The purpose of this stage was to:

- Inform people about what the HSCP is going to do;
- Invite people to comment on the key service change areas; and
- Invite suggestions from people about what the HSCP needs to do to make sure people are involved as changes are designed and implemented.

This feedback obtained as a result of this consultation will inform the next the Strategic Plan (April 2019- March 2022).

A&B HSCP | Transforming Together

Argyll & Bute Health & Social Care Partnership

STRATEGIC PLAN CONSULTATION

OCTOBER 2018

1. Introduction

The Health & Social Care Partnership (HSCP) invited feedback from citizens, service user and carer representatives, partners and staff [Appendix 1] on the development of the 2nd Strategic Plan (April 2019- March 2022).

2. Consultation Process

The purpose of the consultation was fourfold:

- To inform people about the HSCP proposed strategic areas of change.
- Invite comments on eight specific service change areas.
- Invite suggestions around what the HSCP needs to do to make sure people are involved in the process of change.
- Use the information gathered in the consultation to inform strategic priorities

The consultation process (July-Oct 2018) involved:

- presentations to service user and carer representatives and partner organisations through a range of groups/forums [Appendix 2];
- cascade presentations to a wide range of health and social care staff; and
- Survey Monkey questionnaire via website, social media and hard copy [Appendix 3 - 78 responses].

This report presents a précis of the findings from all these processes.

3. General Feedback

The feedback suggests there was broad agreement with the 8 key areas of service change, *"All very relevant, good coverage to address challenges and clear messages". Others felt they were "aspirational, ambitious but needed out-of-the-box thinking to succeed".*

> *"The 8 areas should not be considered in isolation as their cross cutting themes, their impact on each other and the potential gains are inter-related".*

There were strong views that 'transformational change' should not just about savings but should also be about maintaining and improving the quality.

Views were expressed about the need to manage public expectations of health and social care services within the current financial climate. There was an understanding of the need to balance expectations and resources within the available budget.

> *"Need to be much clearer about the inevitable service cuts that are going to result from the next plan".*

It was suggested that for years public services created an 'open door' system whereby service users have become dependent on things 'being done to them' by professionals. People perceive recent policy changes as 'rationing' due to financial savings rather than positive changes associated with quality. There was support for shifting people from being dependent to becoming more self-reliant but recognition that "this won't happen overnight and requires a cultural shift and an evolving journey".

There was a suggested that people can have an emotional attachment to bricks and mortar, presenting challenges in persuading the public and staff to accept alternative service models. There was support for moving away from office hours to a more 24/7 model to better meet need. Successful service delivery was thought to hinge on effective recruitment and retention of health and social care staff.

> *"Sounds good but can [the HSCP] recruit and maintain staff to ensure provision of services"?*

4. Priority Areas Feedback

4.1 Children's Services

There were very few comments regarding the proposed priorities for children's services. There were suggestions that supporting children and families as earlier as possible was important and promoting health and well being should be integral to the work of the HSCP. Many respondents strongly believed that children being looked after away from their home and community would be detrimental to positive outcomes including, social, emotional, education and ultimately their life circumstances.

> *"It is a nice idea to keep children in their area when fostered but does that not bring potential challenges* ……[in relation to] *parental issues?"*

Continuity of midwifery care was important to respondents and there were concerns about differences between urban and rural services in relation to routine check-ups throughout pregnancy but also the trend toward……..

> *"fewer mothers have the option of giving birth in Argyll & Bute and more are being sent to Paisley….this means that, when they are in need of seeing a familiar face, they are instead faced with a midwife they have never met before and who may not know their birth plan."*

There was some concern about the HSCP's ability to balance 'new funding' with the need for savings, for example……..

> *"a requirement to increase Health Visitors, but this has to be reconciled with* [£XXk] *savings, so how is this possible?*

A number of respondents believed there was an opportunity to bring planning for services together where there were obvious overlaps.

> *"The [HSCP] could identifying key themes around* [Adverse Childhood Events]*(ACEs) and what needs to be done by families, schools, health visitors, social workers, the police to reduce ACEs and create a culture where children are valued and value themselves - this is the holy grail".*

4.2 Care Homes and Housing

Respondents felt it was vital to work with housing services, including registered social landlords, to effectively identify future housing needs and models such as 'step up and step down', 'extra care' homes and 'transition' housing to enable people to remain in their home as their needs change. There was a perception that the cost of adapting individual service users' homes was costing more than care homes, however the overwhelming view was there is a strong case for adaptations, assistive technology and the various forms of supported living.

> "[The HSCP needs to] *clearly articulate the rurality challenges e.g. you cannot have a nursing home in every community."*

4.3 Learning Disability Services

Respondents advised of the need to develop new models of care that were modern, flexible and more able to support people with a learning disability into an older age. There were however concerns about the growing cohort of older carers who are likely to require support in order that they can continue in their caring role for as long as possible.

There was a view that developing a service strategy, such as an Autism Strategy, that is not supported by the required resource creates unrealistic expectations.

> *"learning disabilities population is dispersed - need to work hard to engage people* [in designing new models]*."*

4.4 Community Models of Care

Respondents believed there is a need to look at how responsive the current equipment service is and if there is room for improvement to better align with multi-disciplinary teams. Telecare was cited as an important contribution to enabling people to remain independent for longer and that the pace of change for introducing new technologies needs to significantly increase. Respondents reflected that consideration is required with regard to the needs of carers, particularly in light of the new Carers Act.

The Third Sector was believed to be an invaluable asset, providing a wide range of services spanning preventative approaches to direct support. The 'non bureaucratic' nature of the third sector meant it has the potential to be creative, innovative and able respond at a faster pace that public sector organisations. Social connectivity was felt to be a key strength of the sector that should be exploited to its full potential in order to address social isolation in particular.

> *"I think that the Core Cluster needs to be fully investigated and rolled-out properly*.....[to better meet the needs of individuals]*."*

> *"sounds good but can you recruit and maintain provision of services? more carers will be needed especially in rural areas."*

Respondents highlighted the ageing population and the potential that almost everyone will be a carer or caree at some stage and almost definitely in the latter stages of their lives. Given this population profile, there were questions raised about the HSCP's capacity to support caring at home within the context of a multi agency approach involving public, private and third sector arrangements and particularly in rural settings.

Respondents reflected the need to "encouraging social enterprise in health and care", break down barriers, encourage NHS staff to refer to and utilise more preventative social prescribing approaches, recognising the value of what is being offered in the third sector.

4.5 Mental Health Services

It was felt by some that Mental Health Service needs the biggest change with some commenting that the pace of change in mental health services was too slow and that a focus on resilience building would achieve improved outcomes for service users.

> *"I think the Mental Health Service needs the biggest change"*

"more safe places for mentally ill people are needed."

One respondent felt that waiting lists for community mental health services are too long and there needs to be more rapid access to talking therapies. This was cited as a particular issue for children, where it was stated that the lack of Child Psychiatrists or Child Psychiatric Services based in Argyll & Bute was a cause of long waiting list. Journeys to services based in Glasgow were felt to be unacceptable for children and young people in particular experiencing distress. Respondents felt there should be more provision within Argyll and Bute.

Respondents cited self-management as an essential approach to supporting those experiencing mental ill health. This should include the wider determinants of wellbeing such as mitigating the impact of debt and loneliness. There was also a perception that there was limited access to psychology services in some communities and that this could be the single biggest change that could be made.

There was a suggestion that in-patient services could be improved if there was better access to interview rooms, physiotherapy and other activities such as gardening.

It was felt that new technologies were emerging but further improvements and funding is required to the IT infrastructure which would better enable electronic notes and case management systems.

Respondents were keen to highlight the need to focus on mental health and wellbeing and not just mental illness.

"Mental illness [priorities] feel very illness heavy and needs more on prevention and wellbeing - this is also a community responsibility."

4.6 Primary Care Services

There was limited understanding of the implications of a new primary care contract but may respondents believed that GPs need to work collegiately to meet the very different needs of the populations. There was some concern about the changing nature of GP services and the move to delivery through a range of different professionals and services and there were comments about the new contract not taking account of rural communities. Respondents also posed questions about the ability to creatively attract permanent GPS and other health professionals to this area?

"Value local GP services but have worries about new contract."

"There is ongoing concern about the new GP contracts not taking account of the rural nature of our practices and it is hoped this will be recognised."

"Very unhappy about Primary Care [contract]. There is a SLWG looking at rural and remote issues with the new contract so it should not be implemented in a manner which cause change to these areas."

"I have some awareness of primary care changes - these seem positive. However some changes already in place, e.g. take phone triage in Lochgilphead."

"This requires staffing resource input: GP Workload - free up time and support the changing role of GPs so they can concentrate on patients with more complex health

and care conditions. All models tested so far have required significant resource input, without this, pressure will be put already stretched services. A&B already have staff recruitment problems. The GPs expectations around this need to be realistic without more staff this won't be possible."

Respondents also suggested that promoting wellbeing for the whole population should be a focus for primary care and cited opportunities to deliver or signpost to preventative services. Activities such as social and recreational activities and befriending services were believed to be important in combat loneliness. However, there was a belief that preventative activities are a 'soft option' when facing savings.

4.7 Hospital Services

Very few responses were provided in relation to hospital services However, the consensus from those who did comment was that hospital services need to be retained within Argyll and Bute and out of area provision to Glasgow should specialist services and not routine.

"People value local hospital services. In some areas like Oban the population is growing so there is a need to retain local services."

There was a clear consensus that people wanted to stay in their homes rather than being in hospital where they are likely to become more dependent. A few respondents cited difficulties patients have in getting an appointment with their own GP, or being unable to get a response from, NHS24, as a reason for inappropriate attendance at Accident & Emergency. Respondents emphasized the need to develop sufficient community services in order to prevent patients inappropriately remaining in hospital long after their clinical needs require.

4.8 Corporate Services

Respondents believed that looking to make corporate services more efficient was eminently sensible and could reduce unnecessary saving being taken from frontline services.

"Mostly seem sensible, especially integrating admin , finance jobs, hopefully more training for care workers to cope with the situations they have to deal with."

"These are the main areas that require focused change due to population changes and recruitment difficulties. They appear all inclusive and not just focused on services to communities but back room services also."

Some concerns were raised about reducing and centralizing administrative services which was thought to place a greater burden of administrative tasks on professionals which was considered an inefficient use of money.

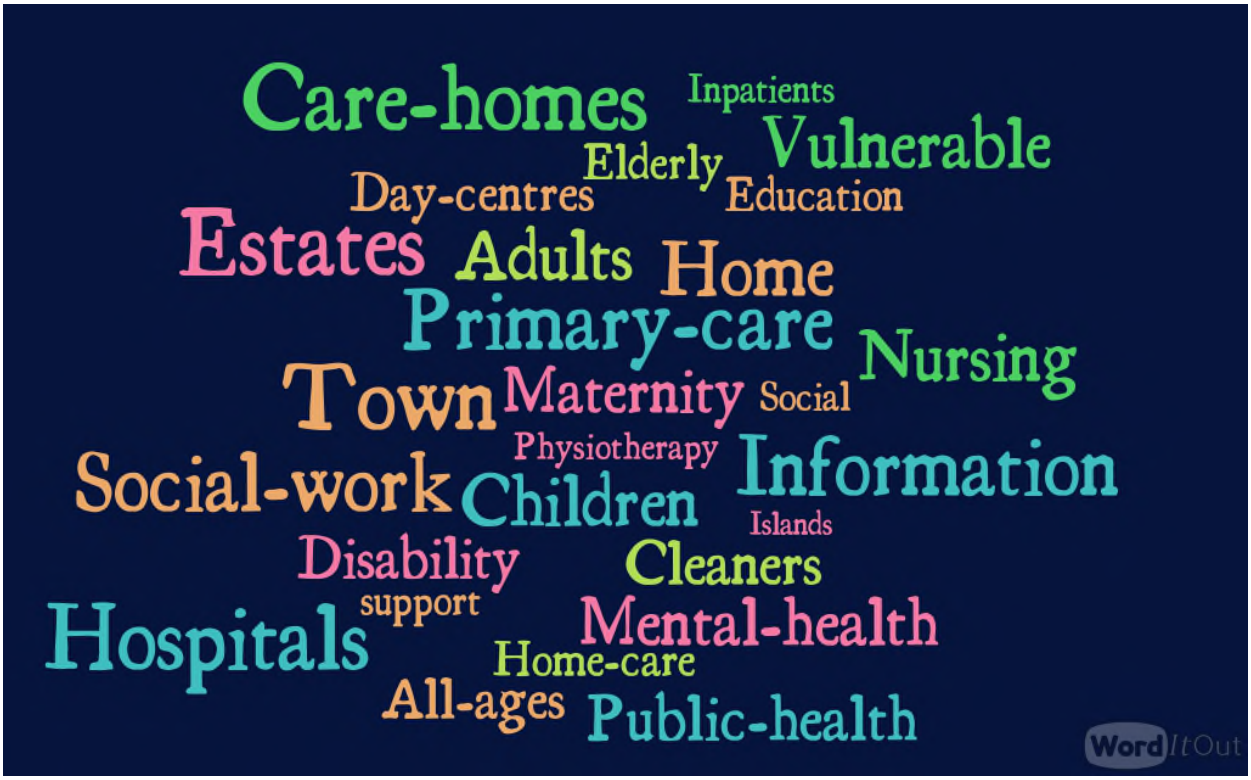
"In addition, many services benefit from the expertise that builds up within their admin teams and there is huge concern about the quality of service being reduced if admin teams become more dispersed from the services/areas they support."

Respondents felt the HSCP should focus on modernising the IT infrastructure in order to improve access and sharing a wide range of information and better supporting performance management.

"We are still using internet version which is no longer seen as secure and no longer used by NES, the NHS education for Scotland. IT needs to be funded and staffed appropriately."

5. Respondents' understanding of the types of services that are provided by the Health & Social Care Partnership

Many responses said they had good understanding of the wide range of services devolved to the HSCP. Others went further, describing what they considered to be integration arrangements *"encompass the needs of the community" [*particularly for people with] "*complex and varied needs"* [and for those] "*who are the most vulnerable people in the community"*. A range of services was articulated for example:



6. How can individuals and our partners work with us to help people stay healthy and well?

Respondents made reference to reducing poverty as a means of improving overall health outcomes. There was some support for government to legislate for more regulation relating to tobacco, alcohol and food sales and availability and specific age related interventions, for example reduce numbers of alcohol off-sales and outlets; reduce and regulate unhealthy foods and fast food outlets.

Respondents also suggested there were actions that could be taking locally (Argyll & Bute) including access to free healthy school meals and affordable leisure facilities, as well as maximising school playing fields for community use. Others emphasised the need to create safe communities that promote "*social and recreational opportunities, as well as activities such as walking and cycling".* Many responses highlighted the need for communities that generate a sense of people looking after each other.

"Helping neighbours and looking after their own health"

"Support exercise and social inclusion. Encourage a more community spirit."

A number of respondents acknowledged that people should take responsibility for their own health.

"People need to take ownership of their health and rely less on services."

"People can try to live a healthy lifestyle and not depend on being treated when they get to crisis point"

It was suggested that for people to be more independent, there was a need for service user education to enable self-management and to enable people to take more ownership and responsibility for their own health. Increasing opportunities that enable people to remain or improve levels of physical activity was important to respondents including:

"Walking groups……promote benefits of these groups."

"Structured exercise programmes for chronic diseases."

There was recognition that *"everyone has a part to play in helping people to remain healthier for longer including public sector and voluntary organization, volunteers, communities, patients and carers".*

Respondents commented that third sector organisations and volunteers provide a wide range of valued services for example home safety services; volunteer sitters preventing conveyance to hospital; home from hospital service enabling faster/safer discharge; buddying service; and spiritual support in a variety of settings, and involvement of faith-based groups in service provision.

However, reference was made to the fact that.....

" we are running out of volunteers in Argyll and Bute.....[and not to rely on] volunteers and community solutions instead of funded services with paid staff."

7. Supporting Engagement

Responses reflected different aspects of engagement including who should be engaged with, the level of engagement that is undertaken and included suggestions for how engagement should take place i.e. the tools used and the way the message is delivered.

The need for an engagement strategy was specifically highlighted in order to effectively plan for engagement, not including it as an 'add on' and providing sufficient time to ensure service changes are not implemented overnight, "avoiding a clifftop approach". There was thought to be a need to develop strong 'building blocks' for engagement but there was acknowledge this could take time and would require being clear about the difference between planning and engagement.

"clearer [engagement] entry points for influencing instead of multiple different

meetings for example, health and wellbeing meetings, locality planning groups, health and care fora etc."

"Being really clear what service redesigns are taking place and building in co-production from the start of the process".

It was suggested that ample time and budget allocated to do this effectively, utilise some of the engagement matrix`s that are available to plan this and be able to show transparency. An effective approach was also perceived to be a "*cycle of engagement and that information is not just collected, or people consulted but are part of the process*".

There was acknowledgement that for engagement to be meaningful it should primarily involve those who are experiencing services and who will be directly impacted by service change. Engagement should be part of the journey towards change.

Respondents suggested the need for honest debate, particularly with the community about what we can and can't do regarding their expectations. Being honest means....

"making it very clear that the financial envelope is fixed.....the only choices are within that spending cap. This questionnaire is a good start".

"Engage with the people making the changes before decision are made."

"Speak to front line services, listen to their concerns and reflect back to those working at the grass roots."

"Provide regular communication to staff and the public on progress of the various workstreams."

Many respondents felt strongly about the need to engage directly with service user, carers and families and not just focus on 'representatives.

"Need a consistent approach…….not engaging with the same people all the time…….important to engage with people actually using services…….. be flexible about how best to involve different people."

"Broaden your range of ways to engage so you don't get the same folk attending groups, modernise your engagement methods"

"Talk to the service users. Too many working groups made up of representatives and professionals who only see one side of things. Invite service users to forums such as 'Our Voices' and encourage more connected communities."

Responses highlighted additional support or effort that is needed to engage effectively with particular groups.

"Older adults, people with learning difficulties and mental health issues will need support to be involved. If the primary worker……. is given the opportunity to spend time and gather information this would be valuable."

"Need to reach out to inequalities groups eg learning disabled; mental health service users and families on low incomes in particular"

"You need to involve the carers, guardians, social workers and other health professionals e.g. Occupational Health, on what are the main needs of the people with Learning Disabilities."

How the message is delivered was important for respondents who indicated the need for clear, easy to understand material used in engagement.

"Present the information in simple language…….ask simple straight forward questions using plain English that is understandable."

"Communicate frequently and offer updates regularly."

Respondents highlighted that the knowledge of the person delivering the message is crucial.

"The people delivering the message need to be honest, approachable and have relevant knowledge"

"Ensure all [staff] in sectors understand plan and communicate clear and consistent messages in their local communities"

Responses included comments on the methods used to engage with people, highlighting the need to reach communities through a variety of methods. This including having an effective feedback system.

"Find out how [people] like to receive information- may be different in each area, may be a combination. Look at how other businesses etc have been able to successfully reach people and learn from them in each area. It may be the local paper, local FB site or it may be as simple as notices/flyers in local shops."

"keeping [people] informed, publicising to inform everyone what is happening……..need to publish information in a variety of formats, roadshows, leaflets, radio, newspapers and not just rely on social media."

"Convening specific public meetings less successful unless [the public can be involved in] vital decision to be made"

"Need to go to people (not public meetings) recognising that people don't always attend community events….. therefore have to target people or [attend] events that are already where people will be."

"Younger people use social media - should have questionnaires there for them."

Responses suggested specific engagement methods including;

- Informing community councils; general public meetings; people available in GP

practices and health clinics; community hubs ie each locality Co-op

- roadshows; service user forums
- Posters /leaflets – buildings and public transport; newsletters in print in surgeries
- Mail drops – using volunteers if expensive
- Websites; Social media; Email updates
- Local papers/press/radio
- Third sector evaluation tools
- Surveys

8. Appendices

A. List of Consultees

B. Survey Monkey Questionnaire

C. Consultation Presentation

Appendix 8a

HSCP STRATEGIC PLAN ENGAGEMENT

1. Survey Monkey questionnaire running from August, September to mid October 2018. https://www.surveymonkey.co.uk/r/AB-HSCP2019-23
2. HSCP Locality Manager, Local Area Managers and Team Leads delivered presentations to staff across Argyll and Bute to **inform** and **consult** on the Strategic Plan.
3. The Public Health Team have delivered presentations to a number of multi-agency groups across Argyll and Bute to **inform** and **consult** service user and carer representatives and partners organisations on the Strategic Plan.

1. Survey Monkey questionnaire

The survey monkey questionnaire was widely available on the HSCP website and social media channels, as well as promoted through the face to face staff and multi-agency presentations. A total of **78** responses were received. These responses have been summarised and incorporated into the range of other responses received via the presentation sessions with staff and multi-agency groups. A more full write up of the survey monkey responses is available on request.

2. HSCP Staff Consultation

DATE	TEAM
July 2018	▪ A&B Council Finance Team (who support the HSCP)
	▪ Income Maximisation Team (who support admissions and contracting for residential care and carefirst financial support)
	▪ Succoth ward staff
	▪ Campbeltown local staff sessions
	▪ Kintyre and Islay local staff sessions
	▪ Islay Heads of Department
	▪ Mental health Heads of Department
	▪ Helensburgh Adult Services Management meeting and Team Leader Community Nursing, Adult Services, Social Care and Learning Disabilities Service staff
	▪ Adult Services Management Team
August 2018	▪ Cowal and Bute Team Leaders, Unit Managers, Heads of Department
	▪ Campbeltown hospital staff staff session 1
	▪ Campbeltown hospital staff staff sessions 2
	▪ Woodlands staff session
	▪ Greenwood staff session
	▪ Maternity staff session

	▪ Helensburgh Community Nursing Team, Mental Health/Discharge Team, OTs, Social Work, Admin staff, Dietetics Team
	▪ Islay Maternity and Social Work services
	▪ ABAT Team (Addictions)
	▪ OLI Joint Heads of Department Meeting
September 2018	▪ Helensburgh Physiotherapy staff
	▪ Mental Health OTs
	▪ Radiography staff
	▪ Mid Argyll Community Care Team
	▪ Speech and Language Therapist - Mid Argyll, Kintyre and Islay
	▪ Learning Disability Team
October 2018	▪ Children & Families Operational Management Group

3. Multi-Agency Groups Consultation

DATE	GROUP
July 2018	▪ Strategic Planning Group
	▪ Kintyre Comms and Engagement Group
	▪ Kintyre Health and Wellbeing Network
August 2018	▪ TSI disseminated to 225 third sector organisations
	▪ MAKI Community Planning Group
	▪ OLI Community Planning Group
	▪ Cowal/Bute Community Planning Group
	▪ Helensburgh Community Planning Group
	▪ Elected Member Seminar
	▪ Kintyre Locality Planning Group
	▪ Oban, Lorn & Isles Locality Planning Group
	▪ Oban, Lorn & Isles Health and Wellbeing Network
	▪ Bute Health and Wellbeing Network
	▪ Information sent to Community Councils
	▪ Argyll and Bute CPP Bulletin
September 2018	▪ Coll/Colonsay & Tiree Locality Planning Group
	▪ Helensburgh and Lomond Locality Planning Group

	▪ Islay & Jura Locality Planning Group
	▪ Mull & Iona Locality Planning Group
	▪ Cowal Health and Wellbeing Network
	▪ Argyll and Bute CPP Bulletin
	▪ OLI Communications & Engagement Group
October 2018	▪ Cowal Locality Planning Group
	▪ Bute Locality Planning Group
	▪ Mid Argyll Locality Planning Group
	▪ OLI Health Forum
	▪ Argyll and Bute CPP Bulletin

Appendix 8b

Survey Monkey Questionnaire

STRATEGIC PLAN (2019/22)

The Health & Social Care Partnership (HSCP) is seeking feedback from service user and carer representatives, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022), specifically on eight strategic areas of service change required to deliver the ambitions of the Partnership over the life of the Plan.

The Challenging financial position means the Health & Social Care Partnership cannot do everything to meet the public's expectations of care. The ageing population and increasing health and care demands mean it is not possible to continue to provide services in the same way. Simply we need to utilize our staff, buildings and money differently to achieve the best impact.

Delivering services within a balanced budget will require a shift of focus to delivering high quality and effective services for people with a complex range of needs and investing in communities, enabling and supporting people to enjoy the best quality of life possible, informed by choices they make for themselves.

The HSCP engagement process involves three stages, with stage 1 taking place from summer 2018 to early autumn 2018:

- **Stage 1 – Informing and Consulting on the Strategic Plan**
  - Informing people about what the HSCP is going to do
  - Inviting comments on the key service change areas that are required
  - Inviting suggestions around what we need to do to make sure we involve people as we make these changes
  - Use the information gathered in this stage to inform what we do next
- **Stage 2 – Involving and Collaborating on service redesign**
  - Developing the areas of work around the 8 key areas for service change
  - Involve staff, citizens and partners as we take forward this work
  - Publicise what we have found out and how this information will be used to make service changes
- **Stage 3 – Involving and Collaborating on implementing service change**
  - Involve people who use services, carers, staff and partners in how we implement service change

The key service change areas are outlined below. We welcome and value your feedback to better inform the Strategic Plan and the transformational service changes required over the next three years and beyond.

Please could you complete your response to the following five questions online via https://www.surveymonkey.co.uk/r/AB-HSCP2019-23
Alternatively, you can post your response to:

Caroline Champion - Public Involvement Manager
Argyll & Bute Health & Social Care Partnership FREEPOST RRYT-TKEE-RHBZ
Blarbuie Road, LOCHGILPHEAD, Argyll, PA31 8LD.

1. CHILDREN'S SERVICES

What do we Know?

Data for 2017 shows 13,163 children aged 0-15 years live in Argyll& Bute (6705-males and 6458 females). The children and young people population is declining. The number of children with complex needs is increasing. The single biggest challenge is the recruitment and retention of midwives, health visitors and social workers. £844K of savings will need to be delivered over the next year.

Being exposed to adverse and stressful experiences (ACEs) can have a negative impact on children and young people throughout their lives. Trauma-informed and resilience-building practices should be embedded within services.

What do we plan to do?

- Provide continuity of midwifery care.
- Increase visits by health visitors.
- Prevent children and young people coming into care.
- Increase the number of fostering and kinship placements.
- Place children close to their families and communities.
- Reduce youth and adult reoffending rates.
- Preventing problems through early intervention such as breastfeeding support and reducing poverty.

2. CARE HOMES AND HOUSING

What do we Know?

The number of older people is set to rise significantly in the coming years with the steepest rises being in the over 75 year age group. 10.7% of the current population is aged 75 and over. There is an increasing demand for adapted properties as more older people are enabled to stay at home.

The challenge is to provide suitable housing and sustainable 24 hour care and care at home services for people with high levels of need in the context of workforce recruitment difficulties. As service demand rises there is a requirement to make £0.1 million of saving over the next year from this service.

A Health and care housing needs assessment has been undertaken to inform need and a Care & Nursing Home Modelling Tool is being developed to better assess future needs.

What do we plan to do?

- Understanding current scale and profile of nursing, residential care & supported accommodation for older people.
- Working across health, social care, housing and independent sector to determine future demand.
- Plan future provision around 24 hour care and housing.

3. LEARNING DISABILITY SERVICES

What do we Know?

Argyll & Bute has a growing number of people living with learning disabilities who are living healthier for longer. There is an increasing demand for Learning Disability services, both internal and external, with this trend not predicted to slow given the population profile. The challenge will be to deliver community based supported living services with a reducing resource, increasing need while meeting quality standards.

Other models of care will be required which will involve moving away from individual tenancies which are unsustainable. Engaging with Third Sector providers will enable the development of new opportunities for supported living with a view towards delivering alternative models of care and support.

What do we plan to do?

- Further develop service and resources that will support individuals to return from out of area placements.
- Review and evaluate current 'sleepover' services and increase usage of Telecare whilst maintaining service user safety and wellbeing.
- Work with housing services to develop 'Core and Cluster' models of care.
- Develop HSCP internal services that are able to support individuals with complex needs.
- Sustain and further improve on the positive feedback from external regulators regarding the quality of service provision.
- Increase the uptake of Self Directed Support.
- Support the co-production of community based services for families living with learning disabilities.

4. COMMUNITY MODEL OF CARE

What do we Know?

There are more elderly people living in Argyll and Bute and it is anticipated this will increase significantly in future years. There will be more people living with care needs in our communities and some of these care needs will be complex. It is also predicted that more people will be living with dementia requiring support and care in our communities. There are a number of challenges to meeting service demand including recruiting care workers; high public expectation of care provision; the availability of appropriate homes/housing for people with care needs; and the delivery of care across a large geographical area.

Evidence suggests that a multi disciplinary team provides more efficient and effective community care, reducing hospital admissions and supporting discharges. Focussed re-ablement following a period of ill health can improve health and wellbeing outcomes for people and reduce the demand on homecare. A team approach to falls prevention and frailty supports people to continue to stay at home.

What do we plan to do?

- Develop and implement multi-disciplinary community care teams
- Develop a multi skilled care worker role to work within the multi-disciplinary community care teams.

- Ensure anticipatory care planning is adopted to reduce the incidence of emergency hospital admissions.
- Prioritise the prevention e.g. empower people to self manage long term health conditions and connect people with sources of support in their community such as opportunities to be more physically active.
- Further develop the use of technology to support people living at home who have health and care needs.

5. MENTAL HEALTH SERVICES

What do we Know?

There are increasing numbers of people living with mental health problems in our communities. Demand for support and care services centre around in-patient beds for people with severe and acute episodes of mental ill health and community services to support people living at home. There continues to be an increasing demand for services and recruitment to specialist mental health professionals and care support workers remains challenging. The nature of the large geographical area presents difficulties in delivering care and support, particularly responding to acute episodes of care out with normal working hours.

It is well recognised that anticipatory and crisis care planning reduces admission to a hospital bed and a positive therapeutic environment supports recovery. A multi disciplinary team approach provides more efficient and effective care in the community and new technologies can support care delivery.

What do we plan to do?

- Establishment of the in-patient beds within Mid Argyll Community Hospital.
- Review of the community mental health teams.
- Explore new technological ways of delivering therapy.
- Implement the Locality Based consultant model of care.
- Further develop the WRAP approach to enable people to self manage their mental wellbeing (Wellness Recovery Action Planning).
- Mitigate the impact of problems such as debt and loneliness on mental health through connecting people to community based support.

6. PRIMARY CARE SERVICES

What do we Know?

There are 33 GP practices in Argyll and Bute, with a registered patient population of 88,657 as at 1 April 2018. The national priority is to reduce the future workload on GPs and practices and to transfer work to HSCP to deliver services through other clinicians such as Pharmacy, Physiotherapy, Advanced Nurse Practitioners.

The new GP Contract was implemented in April 2018. Sustainable services delivered by wider teams are being planned within the context of Primary Care Service Redesign. This will see extra funding over the next 3 years in Argyll and Bute - £848,000 in the first year expected to rise to £2.9 Million.

What do we plan to do?

- Musculoskeletal (MSK) Services - More physiotherapists employed so that patients can benefit from quicker access and treatment reducing unnecessary referrals to GPs.
- Community Mental Health - Increasing the number of community mental health nurses better placed to support up to 25% of patients who currently see GPs.
- GP Workload - Free up time and support the changing role of GPs so they can concentrate on patients with more complex health and care conditions. Make the role more attractive to recruit to.

7. HOSPITAL SERVICES

What do we Know?

There is one Rural General Hospital in Oban and six Community Hospitals all with Accident & Emergency departments.

As more people live longer there is more demand on services. The number of A&E attendances continues to increase; more care is now being delivered in the community and hospitals are being used for more day care services. A challenge is that the general population decline in Argyll and Bute is also mirrored in the workforce impacting on the ability to recruit a sustainable workforce.

International and national evidence advises that people have better outcomes when they receive care as close to home when it is safe and possible to do so; hospital care should be used when needed for acute care; and A&E departments should only be for urgent care.

What do we plan to do?

- Standardise role and function of each community hospitals.
- Bed model each in-patient area to ensure we make best use of all resources.
- Workforce review to ensure we are utilsing the full potential of all individuals.

8. CORPORATE SERVICES

What do we Know?

HSCP corporate services include finance, planning, IT, HR, pharmacy management, medical management and estates, as well as all IT and corporate asset infrastructure. Demands are increasing alongside new corporate demands of health and social care integration. There is a requirement to make corporate services more efficient and integrated for front line managers.

There are a number of challenges in improving the effectiveness and efficiency of these services. These include less people and buildings; not all corporate support services from Council are delegated to the partnership; the balance between efficiencies and reduced level of service; and more efficient use of technology and systems requires significant investment. The recurring budget is expected to reduce, requiring savings of £1.3m over the next year. However, if efficiency and effectiveness are to be achieved non-recurring investment may be required.

The National health and wellbeing outcome indicators require HSCPs to use resources effectively and efficiently and to integrate support services to provide efficiencies. The HSCP will model corporate efficiencies on those already realised by the Council.

What do we plan to do?

- Health and social care corporate staff (eg finance, planning, IT, HR, estates) are co-located to work together in the same locations and in the same teams.
- Integrate health and social work administration and implement digital technology.
- Efficiencies in catering and cleaning services through shared services.
- Rationalise estates and properties by co-location of staff.
- Efficiencies in travel and subsistence costs.

Your views are important and we welcome your feedback.

Q1:	**What is your understanding of the types of services that are provided by the Health & Social Care Partnership?**

Q2:	**What are your thoughts about the 8 key areas of service change?**

Q3:	**What do we need to do to make sure we involve people as we go about making these changes (effective engagement)?**

Q4:	**How can individuals, communities and our partners work with us to help people stay healthy and well?**

Q5:	**What would help communities to work with us and play an active role in developing and delivering future services?**

Consultation Presentation

A&B HSCP Transforming Together

STRATEGIC PLAN (April 2019- March 2022)

STAKEHOLDER ENGAGEMENT

Healthy Together Argyll & Bute

Health & Social Care Partnership

- The Integrated Joint Board was established as a new public body on the 1st April 2016.
- First Strategic Plan (2016/19) identified key areas of focus to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and require support from both health and social care.
- There have been some notable successes in the first two years.

Successes in the first 2 years

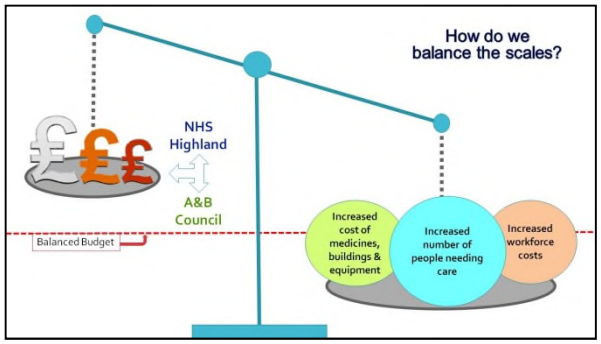
- Developed Community Care Teams with a single point of access in Kintyre and Mid-Argyll.
- Developed a single point of access for health community referrals in Dunoon.
- Development of an extra care housing unit in Lorn Campbell Court Campbeltown.
- Relocation of in patient mental health facility in Mid Argyll.
- Embedding a re-ablement approach to care that enable a people to reach their highest level of independence, reduce the need for continued care at home.
- Developing process to improve referral into a community team, how referrals are triaged and allocated, to reduce the time and simplify the process.
- Working with the carer centres and respite providers to implement the Carers Act which gives carer rights to be assessed and supported in their caring role.
- Graded VERY GOOD for children's residential and fostering services.
- More Looked After Children placed in family type placements.
- Implemented 'Attend Anywhere' within Maternity Services.

2nd Strategic Plan (April 2019 - March 2022)

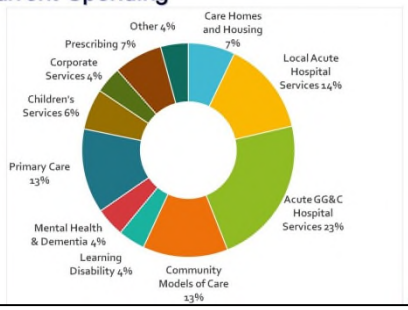
- The Challenging financial position means the Health & Social Care Partnership cannot do everything to meet the public's expectations of care.
- The ageing population and increasing health and care demands mean it is not possible to continue to provide services in the same way. Simply we need to utilise our staff, buildings and money differently to achieve the best impact.
- Delivering services within a balanced budget will require a shift of focus to:
  - delivering high quality and effective services for people with a complex range of needs, and
  - investing in communities, enabling and supporting people to enjoy the best quality of life possible, informed by choices they make for themselves.

Engagement Process

- Stage 1 – Informing and Consulting on the Strategic plan
  - Informing people about what the HSCP is going to do
  - Inviting comments on the key service change areas that are required
  - Inviting suggestions around what we need to do to make sure we involve people as we make these changes
  - Use the information gathered in this stage to inform what we do next
- Stage 2 – Involving and Collaborating on service redesign
  - Developing the areas of work around the 8 key areas for service change
  - Involve staff, citizens and partners as we take forward this work
  - Publicise what we have found out and how this information will be used to make service changes
- Stage 3 – Involving and Collaborating on implementing service change
  - Involve people who use services, carers, staff and partners in how we implement service change.



Current Spending



Spending Shortfall

NHS Highland — A&B Council

2017/18	Income	£258.9m	£6.4m shortfall
	Spending	£265.3m	
2018/19	Income	£263.1m	£5.2m shortfall
	Spending	£268.3m	
2019/20 (estimated)	Income	£265.7m	£6.2m shortfall
	Spending	£271.9m	

High Level Service Changes

1. Children's Services
2. Care Homes and Housing
3. Learning Disability Services
4. Community Model of Care
5. Mental Health Services
6. Primary Care Services
7. Hospital Services
8. Corporate Services

Each of the high level Service Changes will involve a major area of work, needing their own improvement plan and engagement process.

1. Children's Services

Population Profile

Data for 2017 shows 13,163 children aged 0-15 years live in Argyll& Bute (6705-males and 6458 females). The children and young people population is declining.

Service Demand

The number of children with complex needs is increasing.

Challenges

The single biggest challenge is the recruitment and retention of midwives, health visitors and social workers.

Evidence Base

Being exposed to adverse and stressful experiences (ACEs) can have a negative impact on children and young people throughout their lives.
Trauma-informed and resilience-building practices should be embedded within services.

Current Service Cost

£19.1 million

Estimated Savings

Required to make **£0.8 million** savings over the next year.

Service change

1.1	Provide continuity of midwifery care.
1.2	Increase visits by health visitors.
1.3	Prevent children and young people coming into care.
1.4	Increase the number of fostering and kinship placements.
1,5	Place children close to their families and communities.
1.6	Reduce youth and adult reoffending rates.
1.7	Preventing problems through early intervention such as breastfeeding support and reducing poverty.

2. Care Homes & Housing Services

Population Profile

The number of older people is set to rise significantly in the coming years; with the steepest rises being in the over 75 year age group. 10.7% of the current population is aged 75 and over.

Service Demand

Increasing demand for adapted properties as more older people are enabled to stay at home.
Long-term sustainable solutions for high level needs (24 hour care).

Challenges

Our challenges are providing suitable housing and sustainable 24 hour care and care at home due to our workforce difficulties.

Evidence Base

A Health and care housing needs assessment has been undertaken to inform need.
A Care & Nursing Home Modelling Tool is being developed to better assess future needs.

Current Service Cost

£18.8 million

Estimated Savings

Required to make **£0.1 million** savings over the next year.

Service change

2.1	Understanding current scale and profile of nursing, residential care & supported accommodation for older people.
2.2	Working across health, social care, housing and independent sector to determine future demand.
2.3	Plan future provision around 24 hour care and housing.

3. Learning Disability Services

Population Profile

Argyll & Bute has a growing number of people living with learning disabilities who are living healthier for longer.

Service Demand

There is an increasing demand for Learning Disability services, both internal and external, with this trend not predicted to slow given the population profile.

Challenges

The challenge will be to deliver community based supported living services with a reducing resource, increasing need while meeting quality standards.

Evidence Base

Engaging with Third Sector providers will enable the development of new opportunities for supported living with a view towards delivering alternative models of care and support.

Current Service Cost

£10.8 million

Estimated Savings

Required to make **£1.4 million** savings over the next year

Service change

3.1	Further develop service and resources that will support individuals to return from out of area placements.
3.2	Review and evaluate current 'sleepover' services and increase usage of Telecare whilst maintaining service user safety and wellbeing.
3.3	Work with housing services to develop 'Core and Cluster' models of care.
3.4	Develop HSCP internal services that are able to support individuals with complex needs.
3.5	Sustain and further improve on the positive feedback from external regulators about quality of service provision.
3.6	Increase the uptake of Self Directed Support.
3.7	Support the co-production of community based services for families living with learning disabilities.

4. Community Model of Care

Population Profile

There are more elderly people living in Argyll and Bute and it is anticipated this will increase significantly in future years.

Service Demand

There will be more people living with care needs in our communities and some of these care needs will be complex.
There will be more people living with dementia requiring support and care in our communities.

Challenges

Recruiting care workers.
High public expectation of care provision.
The availability of appropriate homes/housing for people with care needs.
The delivery of care across a large geographical area.

Evidence Base

A multi disciplinary team provides more efficient and effective community care, reducing hospital admissions and supporting discharges.
Focussed re-ablement can improve outcomes for people and reduce demand on homecare.
A team approach to falls and frailty supports people to continue to stay at home.

Current Service Cost

£34.2 million

Estimated Savings

Required to make **£1.7 million** savings over the next year

Service change

4.1	Develop and Implement Multi-disciplinary Community Care Teams.
4.2	Develop a multi skilled care worker role to work within the Multi-disciplinary Community Care Teams.
4.3	Ensure anticipatory care planning is adopted to reduce the incidence of emergency hospital admissions.
4.4	Prioritise the prevention e.g. empower people to self manage long term health conditions and connect people with sources of support in their community such as opportunities to be more physically active.
4.5	Further develop the use of technology to support people living at home who have health and care needs.

5. Mental Health Services

Population Profile

There are increasing numbers of people living with mental health problems in our communities.

Service Demand

In patient beds for people with severe and acute episodes of illness.
Community services to support people living at home.

Challenges

Increasing demand for services.
Recruitment to specialist mental health professionals.
Recruitment to care /support workers.
Delivery of care in a large geographical area.
Ability to provide a response to acute episodes of care out with normal working hours.

Evidence Base

Anticipatory and crisis care planning reduces admission to a hospital bed.
A positive therapeutic environment supports recovery.
A multi disciplinary team approach provides more efficient and effective care in the community.
New technologies can support care delivery.

Current Service Cost

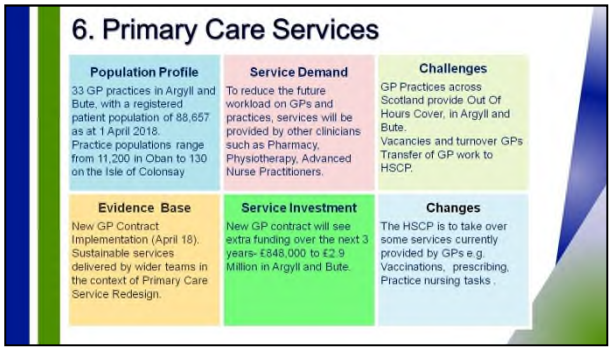
£11.6 million

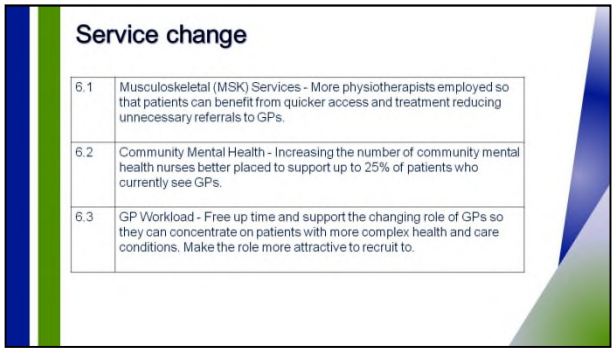
Estimated Savings

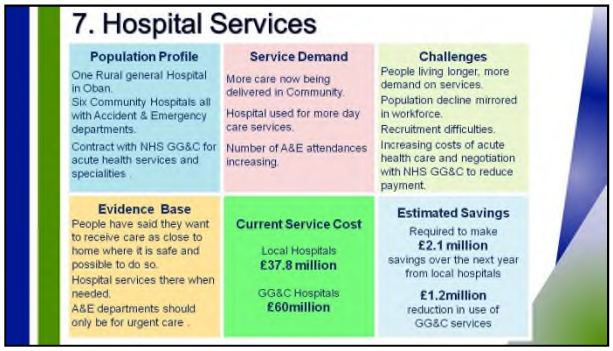
Required to make **£0.6 million** savings over the next year

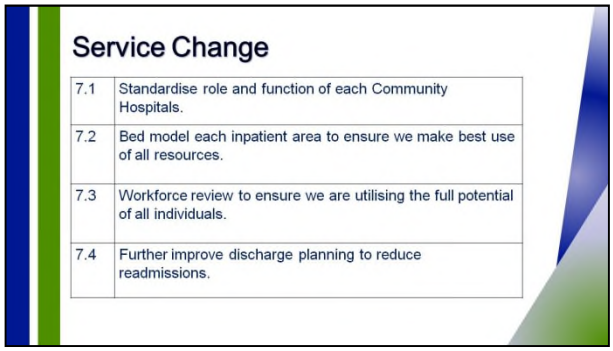
Service change

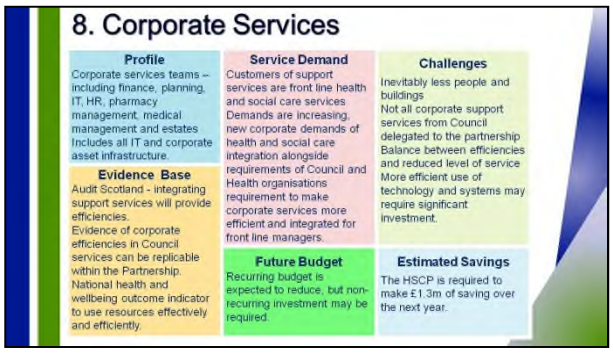
5.1	Establishment of the in patient beds within Mid Argyll Community Hospital.
5.2	Review of the Community Mental Health Teams.
5.3	Explore new technological ways of delivering therapy.
5.4	Implement the Locality Based consultant model of care.
5.5	Further develop the WRAP approach to enable people to self manage their mental wellbeing (Wellness Recovery Action Planning).
5.6	Mitigate the impact of problems such as debt and loneliness on mental health through connecting people to community based support.

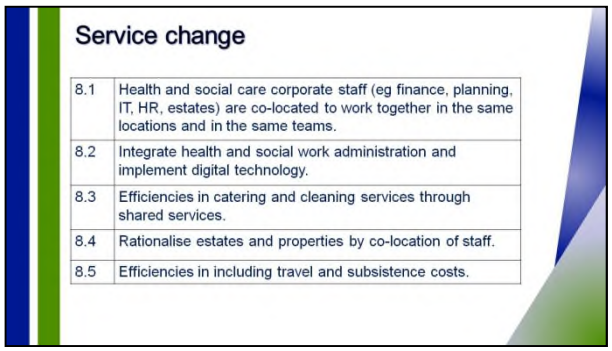

6. Primary Care Services
Population Profile
33 GP practices in Argyll and Bute, with a registered patient population of 88,657 as at 1 April 2018.
Practice populations range from 11,200 in Oban to 130 on the Isle of Colonsay
Service Demand
To reduce the future workload on GPs and practices, services will be provided by other clinicians such as Pharmacy, Physiotherapy, Advanced Nurse Practitioners.
Challenges
GP Practices across Scotland provide Out Of Hours Cover, in Argyll and Bute.
Vacancies and turnover GPs
Transfer of GP work to HSCP.
Evidence Base
New GP Contract Implementation (April 18).
Sustainable services delivered by wider teams in the context of Primary Care Service Redesign.
Service Investment
New GP contract will see extra funding over the next 3 years- £848,000 to £2.9 Million in Argyll and Bute.
Changes
The HSCP is to take over some services currently provided by GPs e.g. Vaccinations, prescribing, Practice nursing tasks .

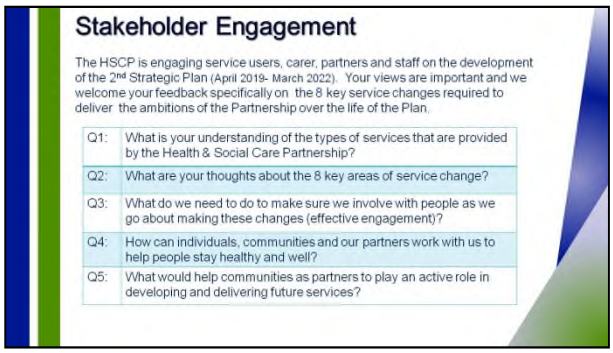

Service change
6.1 Musculoskeletal (MSK) Services - More physiotherapists employed so that patients can benefit from quicker access and treatment reducing unnecessary referrals to GPs.
6.2 Community Mental Health - Increasing the number of community mental health nurses better placed to support up to 25% of patients who currently see GPs.
6.3 GP Workload - Free up time and support the changing role of GPs so they can concentrate on patients with more complex health and care conditions. Make the role more attractive to recruit to.


7. Hospital Services
Population Profile
One Rural general Hospital in Oban.
Six Community Hospitals all with Accident & Emergency departments.
Contract with NHS GG&C for acute health services and specialities .
Service Demand
More care now being delivered in Community.
Hospital used for more day care services.
Number of A&E attendances increasing.
Challenges
People living longer, more demand on services.
Population decline mirrored in workforce.
Recruitment difficulties.
Increasing costs of acute health care and negotiation with NHS GG&C to reduce payment.
Evidence Base
People have said they want to receive care as close to home where it is safe and possible to do so.
Hospital services there when needed.
A&E departments should only be for urgent care .
Current Service Cost
Local Hospitals
£37.8 million
GG&C Hospitals
£60million
Estimated Savings
Required to make
£2.1 million
savings over the next year from local hospitals
£1.2million
reduction in use of GG&C services


Service Change
7.1 Standardise role and function of each Community Hospitals.
7.2 Bed model each inpatient area to ensure we make best use of all resources.
7.3 Workforce review to ensure we are utilising the full potential of all individuals.
7.4 Further improve discharge planning to reduce readmissions.


8. Corporate Services
Profile
Corporate services teams – including finance, planning, IT, HR, pharmacy management, medical management and estates
Includes all IT and corporate asset infrastructure.
Service Demand
Customers of support services are front line health and social care services
Demands are increasing, new corporate demands of health and social care integration alongside requirements of Council and Health organisations
requirement to make corporate services more efficient and integrated for front line managers.
Challenges
Inevitably less people and buildings
Not all corporate support services from Council delegated to the partnership
Balance between efficiencies and reduced level of service
More efficient use of technology and systems may require significant investment.
Evidence Base
Audit Scotland - integrating support services will provide efficiencies.
Evidence of corporate efficiencies in Council services can be replicable within the Partnership.
National health and wellbeing outcome indicator to use resources effectively and efficiently.
Future Budget
Recurring budget is expected to reduce, but non-recurring investment may be required.
Estimated Savings
The HSCP is required to make £1.3m of saving over the next year.


Service change
8.1 Health and social care corporate staff (eg finance, planning, IT, HR, estates) are co-located to work together in the same locations and in the same teams.
8.2 Integrate health and social work administration and implement digital technology.
8.3 Efficiencies in catering and cleaning services through shared services.
8.4 Rationalise estates and properties by co-location of staff.
8.5 Efficiencies in including travel and subsistence costs.


Stakeholder Engagement
The HSCP is engaging service users, carer, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022). Your views are important and we welcome your feedback specifically on the 8 key service changes required to deliver the ambitions of the Partnership over the life of the Plan.
Q1: What is your understanding of the types of services that are provided by the Health & Social Care Partnership?
Q2: What are your thoughts about the 8 key areas of service change?
Q3: What do we need to do to make sure we involve with people as we go about making these changes (effective engagement)?
Q4: How can individuals, communities and our partners work with us to help people stay healthy and well?
Q5: What would help communities as partners to play an active role in developing and delivering future services?

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Integration Joint Board **Agenda item: 5.6b**

Date of Meeting: **28 November 2018**

Title of Report: **Locality Planning Group Evaluation - Outcome of Option Appraisal**

Presented by: **Sandra Cairney, Associate Director of Public Health**

The Integration Joint Board is asked to:

- note the contents of this report;
- note that success of the preferred model hinges on the development of effective engagement mechanisms at a community level;
- note the Strategic Planning Group's endorsement of Option 2; and
- approve **Option 2 : 'Four Locality Planning Group Model'** as the preferred model for locality planning arrangements for Argyll & Bute HSCP.

1. EXECUTIVE SUMMARY

The attached report presents the conclusions of the Locality Planning Group (LPG) Option Appraisal exercise. The Option 2: 'Four Locality Planning Group Model' overwhelmingly emerged as the preferred model for future locality planning arrangements. This conclusions and the participatory process were endorsed by the Strategic Planning Group on the 25th October 2018.

2. INTRODUCTION

The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislative framework which directs the integration of health and social care services in Scotland. It requires Health and Social & Care Partnerships (HSCPs) to establish at least two localities within its area. The current 'nine locality planning group model' has been operational within Argyll and Bute HSCP for around two years.

This evaluation offered the opportunity to adopt a participatory approach to evaluating the efficiency and effectiveness of three structural models to inform a sustainable model for the future.

3. DETAIL OF REPORT

3.1 Thirty-three individuals participated in a workshop held in October 2018.

3.2 Participants were supported in facilitator led groups to evaluate three LPG models using SWOT analysis, systematically identifying strengths, weaknesses, opportunities and threats as they related to each of the three models.

3.3 Option 2 overwhelmingly emerged as the preferred model in all aspects of the SWAT analysis.

4. RELEVANT DATA AND INDICATORS

Not applicable

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The conclusions arising from the Option Appraisal will inform the development of a sustainable LPG model and consequently the opportunity to shape the delivery of Strategic Plan priorities at a locality level.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

The preferred model will have an impact on the level of resource required to administer and support locality planning groups.

6.2 Staff Governance

Staff who are currently members of LPGs were able to participate and express their views in the Option Appraisal process.

6.3 Clinical Governance

There are no clinical governance implications identified in the report.

7. EQUALITY & DIVERSITY IMPLICATIONS

There are no equality and diversity implications identified in the report.

8. RISK ASSESSMENT

Success of the preferred model hinges on the development of effective engagement mechanisms at a community level.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The participatory approach meant that stakeholders that will be impacted by the change were able to participate and express their view to inform the future model.

10. CONCLUSIONS

The Option 2: ‘Four Locality Planning Group Model’ overwhelmingly emerged as the preferred model for future locality planning arrangements.

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Argyll & Bute Health & Social Care Partnership

Locality Planning Group Option Appraisal

OCTOBER 2018

1. Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislative framework which directs the integration of health and social care services in Scotland. It requires Health and Social & Care Partnerships (HSCPs) to establish at least two localities within its area.

A 'nine locality planning group model' has been operational within Argyll and Bute for around two years and is arranged into the following geographical groupings: Bute; Cowal; Helensburgh and Lomond; Islay and Jura; The Isles; Kintyre; Mid Argyll; Mull and Iona; and Oban and Lorn.

Locality planning group (LPG) members were invited to attend a half day Option Appraisal Workshop in October 2018 with a view to evaluating the current model against other models in order to influence an improved and sustainable model for the future.

2. Option Appraisal

Thirty-three individuals participated in the workshop [Appendix 2] and were divided into three groups. Participants were provided with background information pertaining to the legislative context for LPGs and the strategic planning constructs within Argyll and Bute HSCP benchmarked against other locality planning arrangements across Scotland [Appendix 3].

Participants were also presented with other local partnership planning arrangements such as the Council and Community Planning Partnership.

Participants were supported in facilitator led groups to evaluate three options using a SWOT analysis to systematically, identify the strengths, weaknesses, opportunities and threats as they related to each of the three models.

Option 1:	Nine Locality Planning Group Model
The current LPG construct in Argyll and Bute	

Option 2:	Four Locality Planning Group Model
A model used within the Community Planning Partnership	

Option 3:	Thematic Locality Planning Group Model
A planning model used in other areas for a range of purposes	

3. Conclusions

The Option 2: 'Four Locality Planning Group Model' overwhelmingly emerged as the preferred model for future locality planning arrangements [Appendix 1].

The optional appraisal clearly drew out participants' views that the current model of locality planning groups was not universally working and required urgent revision to achieve a more efficient and effective shared planning across Argyll & Bute.

Whilst all three options had some merit, there was consensus that Option 2 offers the best opportunity to plan at scale and align with partners' organisational level. Participants advised that success of this model hinges on the development of effective engagement mechanisms at a community level.

Appendix 1: SWAT Analysis – Option 2.

Strengths	The primary strengths of this model was recognised as being its alignment to wider HSCP and partners planning structures, including A&B Council and the Community Planning Partnership. Participants felt implementing this model would allow planning to be undertaken on the scale as other partners. Furthermore, it was perceived to be representative, more equitable, reduce duplication and improve productivity. Ultimately participants described this model as potentially the most effective and efficient utilisation of resources. Improved communication was also cited as a clear strength of this model, more specifically the facilitation of shared learning across localities and the authority as a whole. Another strength is the ability to achieve robust linkage to the Strategic Planning Group and establishing wider engagement with local communities obtaining a wider perspective on issues. There was a clear aspiration from all participants that four LPG groups should be revitalised in accordance with the spirit of the original legislation.
Weaknesses	Option 2 demonstrated the least number of weaknesses of all the models. Participants however, cautioned that success of this model would rest on the ability of the model to sustain representation of the smaller areas and links to robust engagement mechanisms at a community level.
Opportunities	Participants felt there was an opportunity to re-establish a clear sense of purpose and clarity about the role, structure and membership. This model will enable smaller communities to be equally heard alongside larger populated areas rather than in isolation. There were strong perceptions that more effective, strengthening links with locality planning and community planning groups. The opportunity to create more supportive collective arrangements for service user and carer representatives in order that they have robust induction, clarity of their role in planning and share learning among the representatives. Inclusive engagement methods and structures could be developed constructing a 'basket' of engagement approaches with staff, partners, communities, service users and carers.
Threats	The remote and disparate geography of the HSCP area was identified as a threat to Option 2 in relation to attendance at meetings and efforts would be required to reduce this potential barrier. Information technology was cited as an opportunity to support and sustain active participation at meetings. Robust mechanisms would be vital if the needs of smaller and remote communities are to be visible in the construct of larger scale planning.

Appendix 2: Workshop Participants

Table 1: LPG Workshop - Group Membership		
Group 1	**Group 2**	**Group 3**
Duncan Martin, Community Representative - Oban, Lorn and Isles.	**Nicola Gillespie,** Local Area Manager Mental Health.	**Alison Pugh** Senior Occupational Therapist, MAKI.
Anne Horn, Councillor, Kintyre and Islands.	**Susan Paterson,** Community Representative, Kintyre.	**Tina Watt**, Local Area Manager,
Jason Woods, Care Home Manager, Kintyre Care Home.	**Donald Watt,** Locality Manager, MAKI.	**PJ McGrann**, Community Representative, Islay.
Wendy Dix, Senior Charge Nurse, Islay and Jura.	**Jim Littlejohn,** Local Area Manager, Helensburgh and Lomond.	**Isobel Strong**, Councillor, Bute.
Mark Lines, Local Area Manager Children and Families, A&BHSCP.	**Kirsteen Murray,** Chief Executive, Argyll and Bute Third Sector.	**Jayne Lawrence-Winch**, Local Area Manager, Cowal,
Heather Grier, Independent Co-chair A&B Integration Joint Board, (Cowal).	**Alison Hardman,** Health Improvement Lead	**Robin Creelman** Chair of A&B Integration Joint Board.
Kate Stephens, Public representative, Cowal.	**Lesley McColl,** Staff representative, NHS Highland.	**Alison McCrossan** Local Officer, Scottish Health Council.
Fiona Broderick, Staff representative, NHS Highland.	**Jay Wilkinson,** Public Involvement Officer, A&BHSCP.	**Mary Anne Douglas** Senior Charge Nurse, A&BHSCP.
		Morven Gemmell Locality Manager, Oban. Lorn and Isles.

Table 2: Speakers, Facilitators and others in attendance		
Sandra Cairney, Associate Director of Public Health, Argyll and Bute HSCP		
Facilitators: LPG Option 1 (9LPG)	**Facilitators: LPG Option 2 (4 LPG)**	**Facilitators: LPG Option 3 (Thematic LPG)**
Kristin Gillies Senior Planning Manager, A&BHSCP	**Maggi Clark** Health Improvement Lead	**Alison McGrory** Health Improvement Principal, A&BHSCP
Kirsten Robertson Planning Manager, A&BHSCP	**Laureen McElroy** Planning Manager, A&BHSCP	**Fiona Sharples** OD Lead, A&BHSCP
In attendance:		
Stephen Whiston, Director Planning and Performance, Argyll and Bute HSCP		

Appendix 3: LPG Options for LPG Model

LPG Option 1 – Nine Local Planning Group Model

LPG Option 2 - Four Local Planning Group Model

LPG Option 3 - Thematic Local Planning Group Model

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Integration Joint Board **Agenda item: 5.6c**

Date of Meeting: **28 November 2018**

Title of Report: **Engagement Quality Assurance Framework**

Presented by: **Sandra Cairney, Associate Director of Public Health**

The Integration Joint Board is asked to:

- Consider the outcomes and standards; and
- Approve the Engagement Quality Assurance Framework.

1. EXECUTIVE SUMMARY

The attached Engagement Quality Assurance Framework supports the *HSCP Engagement Framework (2018)* and provides greater transparency to processes and activity by which quality is assured and evaluated against a set of standards.

2. INTRODUCTION

The Engagement Quality Assurance Framework provides a means of benchmarking and evidencing engagement activity against well documents good practice. Quality Assurance is focused on planning, documenting and agreeing a set of standards from the outset in order to provide greater transparency to processes and activity by which quality is assured and evaluated against these standards.

3. DETAIL OF REPORT

3.1 Quality assurance focuses on four key engagement standards.

- Engagement is planned, proportionate, meaningful and effective
- IJB representatives are supported in their role.
- There is supported engagement of people in service planning.
- There is a positive culture where staff feel valued and engaged.

3.2 Each engagement standard sets out a number of quality dimensions that are able to be evidenced.

3.3 The Framework also sets out an engagement matrix which describes the levels of organisational engagement that can be expected by stakeholders. Specifically **who** is being engaged; **what** method is utilised; **why** they are being engaged; and **how** their contribution informs decisions.

4. RELEVANT DATA AND INDICATORS

The Engagement Quality Assurance Framework outlines a range of benchmarking dimensions to evidence achievement against agreed standards.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

Effective engagement is fundamental to all strategic and service planning.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

There are no financial implications identified in the report.

6.2 Staff Governance

The Engagement Quality Assurance Framework will form part of staff governance activity.

6.3 Clinical Governance

There are no clinical governance implications identified in the report.

7. EQUALITY & DIVERSITY IMPLICATIONS

Equality and diversity will be evaluated in terms of the reach of engagement activity.

8. RISK ASSESSMENT

The Engagement Quality Assurance Framework mitigates the risk of the IJB not meeting the requirements of the Community Empowerment (Scotland) Act 2015 which places a duty on public bodies to support people to have more say in decisions that affect them.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The Engagement Quality Assurance Framework enables the IJB to be clear with stakeholders about the expected standards for engagement.

10. CONCLUSIONS

Better stakeholder engagement and participation leads to the delivery of better, more responsive services and better outcomes for people. The Engagement Quality Assurance Framework provides greater transparency to processes and activity by which quality is assured and evaluated against a set of standards.

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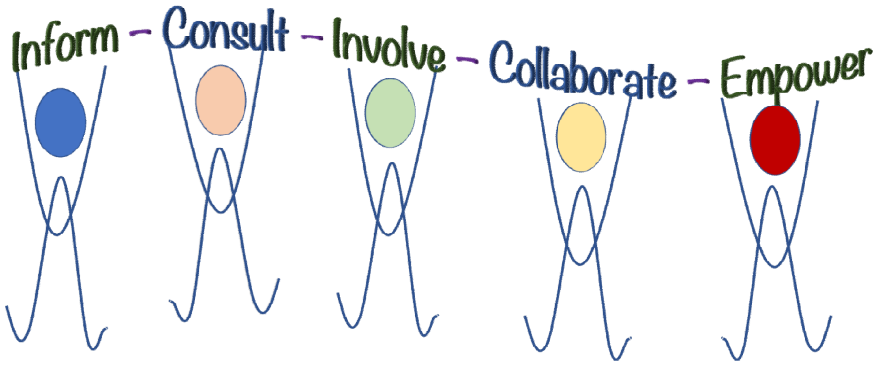
Argyll & Bute Health & Social Care Partnership

DRAFT Engagement Quality Assurance Framework

OCTOBER 2018



INTRODUCTION

The Integrated Joint Board approved the *HSCP Engagement Framework* in May 2018. The document articulated the Health & Social Care Partnership's approach to engagement, providing a foundation for all future engagement approaches relating to service transformation.

The Engagement Framework draws on the International Association for Public Participation's *IAP2 Spectrum for Public Participation*[2] and the Scottish Health Council's *Participation Toolkit*[3], both of which outline incremental levels of engagement.

QUALITY ASSURANCE

This Engagement Quality Assurance Framework supports the *HSCP Engagement Framework (2018)* and provides a means of benchmarking and evidencing engagement activity and achievement against well documents good practice.

Quality Assurance is focused on planning, documenting and agreeing a set of standards from the outset in order to provide greater transparency to processes and activity by which quality is assured and evaluated against these standards. It reflects a strong commitment to demonstrable approaches to engagement with service users, carers, partners and staff (stakeholders) and aims to achieve excellence in all aspects of engagement, embedding a culture of continuous improvement and meeting a range of regulatory and legislative requirements.

Quality assurance focuses on four key standards and a number of quality dimensions (Fig 1.).

Fig 1. Engagement Standards

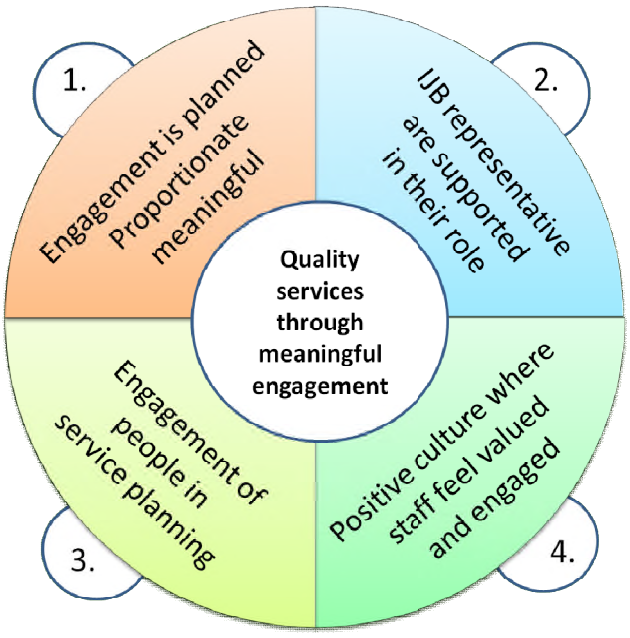


Fig 2 sets out an engagement matrix which describes the levels of organisational engagement that can be expected by stakeholders. The matrix is designed to be explicit about the:

a) different degrees of engagement;
b) the nature of engagement;
c) theoretical basis, essentially distinguishing between normative and/or pragmatic; and
d) objectives for which engagement is used.

The purpose is to ensure stakeholders clearly understand:

- **who** is being engaged;
- **what** method is utilised;
- **why** they are being engaged; and
- **how** their contribution informs decisions.

Fig 2. Engagement Matrix

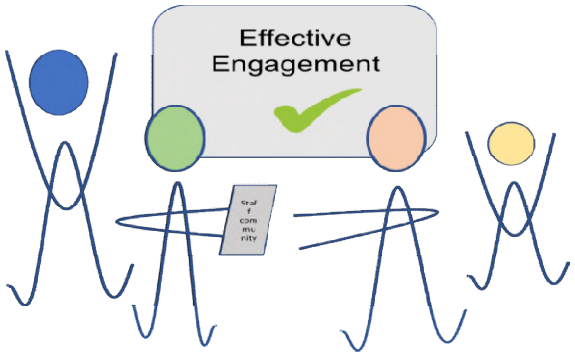
HSCP Level includes Service Users, Carers, Partners and Workforce				
Participation Level	**Functional Level**	**Structural Level**	**HSCP Level**	**Operating Level**
Empower	Shared decision making about strategic priorities and service developments, delivery and monitoring progress.	Strategic	Integrated Joint Board	▪ Planned meetings ▪ Prescribed membership ▪ Planned induction ▪ Organisational priorities ▪ Working Agreement ▪ Code of Conduct ▪ Confidentiality Agreement ▪ Learning & Development
Collaborate	Partnership working, seeking perspectives, ideas and solutions to inform priorities	Strategic	Strategic Planning Group	
Involve	Collectively expressing concerns and aspirations to influence decision making	Locality	Locality Planning Groups	
		Community	Collective staff and/or communities of interest	▪ Participatory workshops, focus groups ▪ Service feedback through surveys; online questionnaires; Viewpoint ▪ Website; newsletter; social media; press article; briefings; letters
Consult	Providing feedback to inform development and/or improvement	Community	Staff, communities & individual service users and carers	
Inform	Requesting and/or receiving information	Population	General public and universal staff	

STANDARD 1.

Stakeholder engagement is planned, proportionate, meaningful and effective

Outcomes

- The IJB is recognised as an organisation that is committed to engaging citizens, partners and staff (stakeholders) in strategic planning and decision-making.
- IJB strategies, plans and policies are informed by the views of stakeholders through effective engagement



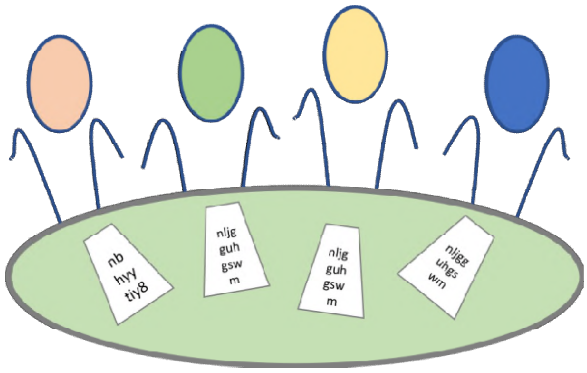
Quality dimension		Review Date	Evidence
a.	Board members and senior managers are able to articulate the organisation's approach to stakeholder engagement.		
b.	Clear organisational governance structures are in place to meet the statutory duties in relation to participation/engagement.		
c.	The IJB has robust mechanisms in place that provide assurance that a culture of engagement is encouraged throughout the organisation.		
d.	The IJB is able to access and benefit from independent strategic engagement expert advice and support.		
e.			
f.			

STANDARD 2.

Service user, carer and third sector representatives on strategic planning groups are supported to effectively undertake their role

Outcomes

- Service user, carer and third sector representatives are clear about and feel confident in undertaking the responsibilities of their role.
- Service user, carer and third sector representatives are able to evidence their contribution to the work of the IJB, Strategic Planning Group and locality planning groups.



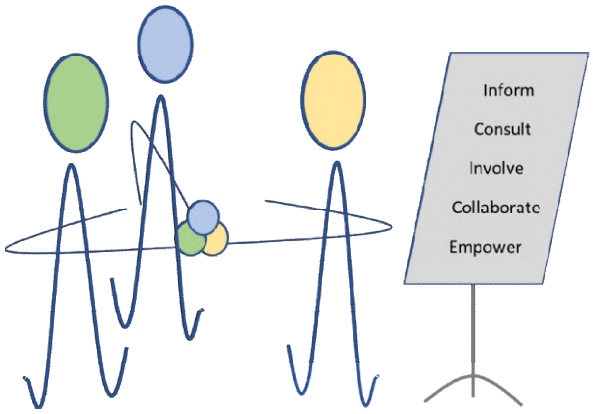
Quality dimension		Review Date	Evidence
a.	Processes for the recruitment and induction of service user, carer and third sector **representatives** are clear, proportionate and fair.		
b.	Mechanisms are in place to enable service user, carer and third sector **representatives** to have their development needs met through shared learning, exchanging ideas and generating actions.		
c.	Mechanisms are in place to enable service user, carer and third sector **representatives** to be involved in service planning and development.		
d.	Service user and carer **representatives** will have their expenses reimbursed including the costs of any 'substitutionery' care that might be required.		
e.			
f.			

STANDARD 3.

There is supported and effective engagement of service users and carers in service planning and improvement.

Outcomes

- Engaging service users and carers in the planning and delivery of their care makes a positive contribution to responding to needs, as well as improving outcomes and service experience.
- Positive experience of engagement helps to generate greater public confidence in health and social care services.
- Health and social care staff feel confident about engaging service users and carers and this forms part of the day-to-day planning, delivery and monitoring of services.



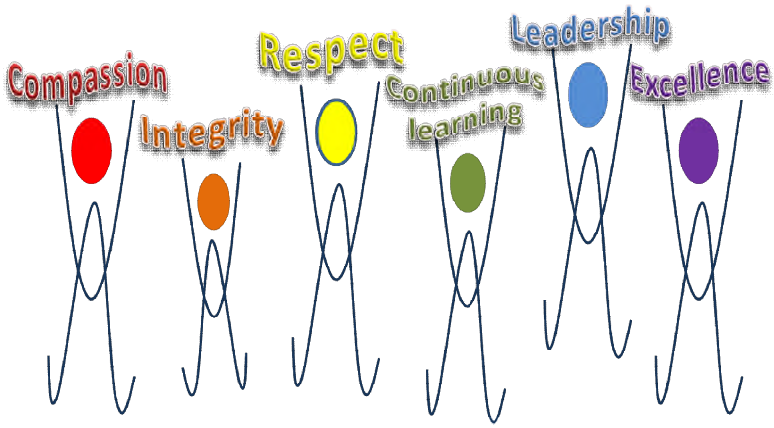
Quality dimension		Review Date	Evidence
a.	Supportive policies, protocols, tools and learning opportunities are available to assist staff in undertaking effective engagement.		
b.	Systems are in place to routinely obtain service user feedback about their experience of services.		
c.	The people who are affected by proposed service change are identified and supported to be appropriately engaged in the process.		
d.	Feedback is provided to service users and carers about how their contribution was taken into account and influenced outcomes.		
e.	Staff, service users and carers have the opportunity to learn from their own and others' experiences of engagement.		

STANDARD 4.

The organisation creates a positive workplace culture that enables staff to feel valued and engaged.

Outcomes

- Health and social care staff are committed to the organisation's vision and values
- Health and social care staff are motivated to contribute to the success of the organisation.
- Health and social care staff feel their voice is heard in the organisation's decision making processes.



Quality dimension		Review Date	Evidence
a.	Staff communications channels are in place to efficiently and effectively receive and transmit information.		
b.	Staff are able to articulate the organisational values and practice and reflect them in everyday behaviours.		
c.	Mechanisms are in place to enable staff to be involved, contribute their experience, expertise and ideas .		
d.	Staff are well-led, given feedback on their contribution and developed to meet the needs of future roles.		
e.			
f.			

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A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item: 5.7**

Date of Meeting: **28 November 2018**

Title of Report: **West of Scotland Regional Health and Social Care Delivery Plan – Discussion Document**

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

The Integration Joint Board is asked to:

- Note the West of Scotland Regional Delivery Plan discussion document.
- Consider the draft response on behalf of the HSCP which has been developed through, management, staff and stakeholder feedback.
- Remit final submission subject to inclusion of feedback from the stakeholder workshop on the 23rd November 2018 to Head of Strategic Planning and Performance for the 3rd December 2018 deadline.
- Note the next steps.

1. Introduction

This paper sets out the draft response from the HSCP to feedback on the West of Scotland Regional Health and Social Care Delivery plan discussion document.

The *Health and Social Care Delivery Plan* and the *National Clinical Strategy* set out the expectations for a modern health and care system for Scotland. This includes a requirement for organisations to come together and focus on regional planning of services where appropriate.

The *West of Scotland (WoS) regional Design and Discussion Document (attached)* describes the collective ambition of the West of Scotland Boards to improve the health and care of the 2.7 million people who live within our communities. The intention is to do this by providing care for and with individuals and their carers that foster independence; are sustainable; and are safe, effective, equitable and proportionate to their needs.

The National Health and Social Care Delivery Plan sets out a significant list of objectives, including a focus on regional and national planning of services where appropriate. It draws on earlier strategies and sets out the direction of travel and expectations of a modern health and care system. Strategic aspirations include:

- A vision for 2020 where people live longer, healthier lives at home or in a homely setting.
- Integrated health and social care which promotes prevention, anticipation and supported self-management.
- Day case treatment as the norm.

- Highest standards of quality and safety.
- Person centred care.
- An integrated 'Health and Social Care Workforce Plan' for workforce planning and development.
- Investment that is matched to reform and transform.
- Digital Strategy promoting technology and information that supports both patients and care professionals with modern models of care.

The National Clinical Strategy set out areas for change including:

- Planning and delivery of primary care services around individuals and their communities.
- Planning hospital networks at a national, regional or local level based on population size and the availability of an appropriately skilled workforce
- Providing high value, proportionate, effective and sustainable healthcare (linked with *Realistic Medicine*).
- Transformational change supported by investment in eHealth and technological advances.

The WoS has been directed by the Scottish government to produce a Regional Delivery Plan to implement the National Health and Social Care Delivery plan. The discussion document attached provides the "Case for Change" including an assessment of health needs and a forecast of service use for the 2.7 million people who live in the West of Scotland. It also details the guiding principles, vision aims and direction of travel which will inform the redesign and development of regional services. It therefore takes account of the following drivers:

- Increasing demand for health and care services as our population ages
- Higher prevalence of illness in the West of Scotland
- Availability of health and care workforce to meet demand, there is projected to be not the expected do not have the workforce
- The cost of providing health and social care is exceeding budgets with an increasing deficit forecast over the next 5 years.

2 West of Scotland Regional Health and Social Care Delivery plan - Service Models.

The discussion document details what work has been undertaken to date to develop a regional health and care service model for the West of Scotland

It details who has been involved and how service models across these three care settings (Hospital, Community and Home) have been developed.

It also outlines how the work to produce and deliver the implementation deliver the Model of Care across will be taken forward at the most appropriate level – national, regional, Health Board, IJB/Community Planning Partnership and indeed locality/neighbourhood.

The National Clinical Strategy provides evidence for the specialties that should be planned and delivered on a regional basis such as vascular surgery, ophthalmology, urology, neurology and stroke care. This was primarily on the basis

that there is very strong evidence that low volume, complex interventions are better undertaken in specialist centres.

The Regional Design and Discussion Document has majored on that element of the proposed Model of Care (specifically with respect to Networked Clinical Services) and factoring in the importance of patient pathway integrated delivery across the health and care sector**.**

In planning for the future, the WoS regional planning approach stresses that the success of any future care models will be heavily determined by how effective the approach to prevention and early intervention is; and, importantly, the degree to which individuals and families can be more responsible for their own wellbeing and managing their own health. Achieving this and aligning health care services to maximise local diagnostic and appropriate treatment, underpinned by rapid and easy access into specialist services delivered in a consistent and standard "one stop shop" with follow up and step down delivered locally.

3 Assessment

The aim of the discussion document is to obtain feedback on the principles, aims and vision as well as the shape of the emerging models of health and care delivery in the West of Scotland to allow it to be refined.

Its purpose is to inform stakeholders and the population of the approach to be used and outline the next steps in this work. As such the feedback requested is at a high level looking to confirm agreement of the case for change, the approach and the framework for the model of regional health and care service design and delivery:

1. When thinking about the future of health and social care in the West of Scotland, what matters most to you?
2. What do you think of the aims and ambitions that we have set out for transforming health and care in the West of Scotland?
3. What do you think are the top three challenges for transforming health and social care in the West of Scotland?
4. What do you think needs to be done in order to meet those challenges?
5. What do you think should be the top three priorities for delivering improvements in health and social care in the West of Scotland?
6. How would you like to be kept informed and engaged going forward?
7. Do you have any other comments or - and if so, what are they?

This feedback will then support shaping the next piece of work setting out a road map of how and services will change, how they will operate, and where health and social care will be provided and resourced (workforce, buildings and funding). This requires developing a transformational and "whole systems" proposition to improving health and care with and for the WoS population which will:

- Design care around the specific needs of individuals and different segments of our population rather than around existing organisations and services.
- Proactively engage and support people to have better lifestyles, develop independence and self-care.
- Organise care services around population segments that are closer to home, particularly those services that require joined-up care.

- Design future hospital services around the new and expanded services in the community and within people's homes, with different levels of service provided in a networked hospital system.
- Design networked clinical services across hospitals to make best use of specialist staff and enhance quality of care.
- Develop competency-based roles within and across services that optimise and value the expertise of our multi-disciplinary workforce.
- Make best use of our estates to support out-of-hospital and hospital care models.
- Make better use of the technology that allows us to improve care and make best use of the "public pound

With regard to resources, the discussion document flags but does not provide any detail or timescale at this stage relating to:

- Funding implications –
    - The need to tackle the current WoS deficit of £141 million 2017/18
    - Completing a West of Scotland Strategic Resource Framework aligning with other regions and the national position
- Workforce – With the significant number of current vacancies across health and social care and the expectation/forecast will see this increase and to address this:
    - Detail on how staff will be supported to work more efficiently and effectively
    - Developing human resource approaches to support regional recruitment
- Assets/Building – many are not fit for purpose but funding to improve is restricted. Therefore there is an implicit expectation of the need to make best use of the existing estate and target investment:
    - Developing a regional capital investment strategy based on agreed service models
- Impact assessments, there is again an implicit understanding that the developing service models will require formal impact assessments to be undertaken as part of their benefits assessment process. This will require full involvement of stakeholders and the public/communities who will be affected by this.

Informed from the feedback received, the revised delivery plan will then be submitted to the WoS Health Boards and IJB for formal governance approval in January/February 2019 prior to submission to the Cabinet Secretary for Health in March 2019.

4 HSCP Draft response to Discussion Document

The HSCP response to the specific questions is detailed in appendix 1. This has been informed from discussion and debate within Argyll and Bute health and care partners, staff and public that the impact of the hospital delivery models could

potentially worsen equity of access to specialist services for our population.

It remains draft as an Argyll and Bute stakeholder event is being held on the 23rd November in Lochgilphead and the outcomes of this will be incorporated into Appendix 1

5 Conclusion

The HSCP and other IJBS are important stakeholder in this work to ensure the developing care models are influenced by and take account of urban and rural health and care needs of both mainland and Island communities.

Representatives from Argyll and Bute HSCP senior management and clinical leadership are members of the regional programme board and various work streams and members of the IJB have been attending a variety of development workshops etc.

The Governance and approval processes of the developing regional plan requires the consideration and consultation of the Argyll and Bute HSCP IJB as it proceeds through to March 2019.

To inform the IJB sign off there is an expectation that the HSCP will capture and facilitate the feedback on the discussion document as stated to inform its formal response. Appendix 1 details the current draft of the response. The response is to be submitted by the 3rd December 2018.

The IJB is asked to remit the final response to the Head of Strategic Planning and Performance.

6 Governance Implications

6.1 Contribution to IJB Objectives

The Regional Health and Social Care Delivery plans aligns with the IJB objectives as detailed in its strategic plan.

6.2 Financial

There will be a number of significant capital and revenue implications in producing and subsequently implementing the plan which will require the IJB to factor into its financial planning and management going forward

6.3 Staff Governance

The workforce requirements will require extensive and ongoing staff partnership involvement in shaping the plan for the future workforce and subsequent implementation.

6.4 Planning for Fairness:

A fundamental approach to planning at regional level is ensuring health inequalities are identified and addressed and assessment and impacts will be on-going for each service model which is to be provided at a regional level.

6.5 Risk

Actions to mitigate any risk with regards to services, safety and finance will be incorporated in the programme but will also require IJB risk identification for mitigation and action.

6.6 Clinical and Care Governance

Clinical and care safety is seen to be at the core of the Regional planning taking account of service demand, sustainability, capability, infrastructure and resources.

6.7 Public Engagement and Communication

An extensive public engagement and involvement programme will require to be conducted over the next few months across the West of Scotland and the HSCP has been asked to support.

Appendix 1- WoS Regional Health and Social Care Discussion document – Draft HSCP Response

1. **When thinking about the future of health and social care in the West of Scotland, what matters most to you?**
    - Maintaining my health and independence across the age spectrum from cradle to grave
    - Ensuring any urgent or emergency health and care needs are met quickly, with fast access to specialist services and a swift and seamless return to my community
    - If I need planned health care, the majority of "my work up" should be done locally with specialist support. It should be delivered as part of a "1-Stop Shop" encompassing all of my health conditions and follow up on my treatment should be provided locally via use of modern IT links, with support from local health and care teams
    - Ensuring mental health services are available 24/7 with a community focus on anticipating intervention and access to specialist services

2. **What do you think of the aims and ambitions that we have set out for transforming health and care in the West of Scotland?**

    The Argyll and Bute are also committed to and our shared aims of:
    - Improving the health of the population.
    - Improving patient's experience of care.
    - Achieving the best possible value in all activities (both financial value, and value to the patient).
    - Supporting and valuing staff.

3. **What do you think are the top three challenges for transforming health and social care in the West of Scotland?**
    - Workforce, both recruitment, but also cultural change and OD development to ensure delivery of joined up health and social care system for the 2.7m population.
    - Regionally planned and delivered health care services requires a move away from Board boundaries within a context of assuring equity of access for the 2.7m population. These services should exhibit the following characteristics
        - Locally assessment and diagnostic work up
        - Initial consultation in your community (by VC, telephone etc.) not only taking account of treatment plan but physical access intelligence – (key for rural communities)
    - Financial challenge - rebalancing of resources from Acute to community health and care services, including transitional investment.
    - Political buy in with regard to the profile of services in current council and MSP constituency areas

- Infrastructure including, digital, transport and SAS and third sector in supporting seamless patient and carer access to services

4. What do you think needs to be done in order to meet those challenges?

- Clear plan including governance and accountability arrangements of how the shared collaborative approach will be developed and formalised.

  This will inform the development of the regional and local integrated network of specialist and local services, shaped by local patient and public experience of health care and

- Radical review and overhaul of the existing cross boundary health board financial contracting model to support the transformational pace and scale of change required. This will facilitate the shift of resource to community and care services and drive the elective delivery models described supporting the reconfiguration of services

  This must be supported by the "once for region" infrastructure including IT and Digital delivery and access to services reducing the burden of work on staff and supporting fast access to service.

- Achieving a cross party political and public consensus that the outcome and process will meet policy and service need objectives. This needs to be informed by a strong communication and engagement process, but ultimately will require a new "governance landscape" between Health Boards, IJBs and the Region.

5. What do you think should be the top three priorities for delivering improvements in health and social care in the West of Scotland?

- The regional plan and prioritising investment in health and well-being through integrated health and social care
- Delivering transformational change in elective pathways to free up resource and capacity to facilitate the change

6. How would you like to be kept informed and engaged going forward?

The Argyll and Bute HSCP will continue to participate in and support the developing regional planning agenda

7. Do you have any other comments or - and if so, what are they?

The Argyll and Bute HSCP welcomes the approach undertaken to develop the West of Scotland Regional Health and Social Care Delivery plan. Its explicit focus and recognition of the integrated health and care pathway is a major strength of its approach and the HSCP has been pleased to participate in the formal planning and stakeholder events to date.

There are however a number of other areas and points the HSCP would like the

regional plan to take into account and respond to.

There is limited mention of children services and no direct reference to paediatric/sustainability/workforce or CAMHS:

There is limited acknowledgement of families/adverse childhood experiences implicated in mental health need/distress and obesity and Type 2 diabetes. This is a critical anticipatory and preventative area that should be focused on to support the future planning and rebalancing of health resource into community services, and our population's health and well-being.

A significant and developing children's service need and resulting financial pressures on the horizon is the increase in children and young people with life limiting conditions: living longer: with more complexity: requiring home based support and nursing/community based care.

The discussion document points out that the resource implications of continuing the existing service model is unaffordable and undeliverable, with a £141 million deficit on a £6,554 million budget for health services across the West of Scotland region.

There is however, limited indication of the financial modelling of the future service options and scale of service investment required. The HSCP would request that there is greater transparency on the financial modelling for the service models outlined together with the detail on the rebalancing of resource from Acute to community services across the West of Scotland.

The HSCP also notes the workforce planning assumptions and the national evidence that the reconfiguration of Urgent and Emergency care medical workforce will not result in a saving. The converse of this is a reduction in elective activity and workforce needed as a result of the impact of integration of health and social care and the rebalancing of this resource accordingly.

Whilst the discussion document acknowledges this is work in progress, there is a significant gap in the detail of the current gaps in medical and other workforce to inform the "where are we now" position.

The HSCP supports the process to address this as detailed in figure 13 & 24 below, however, the absence of information covering steps 6 to 8 in figure 13 at this point is deemed of some concern to allow the IJB to make an informed decision. This could also be compounded by the different planning cycles being followed by HSCPs- 3 years as opposed to the 5 year cycle identified in the regional plan. This could compromise the pace of change required.

Figure 13: Developing Our Model of Care

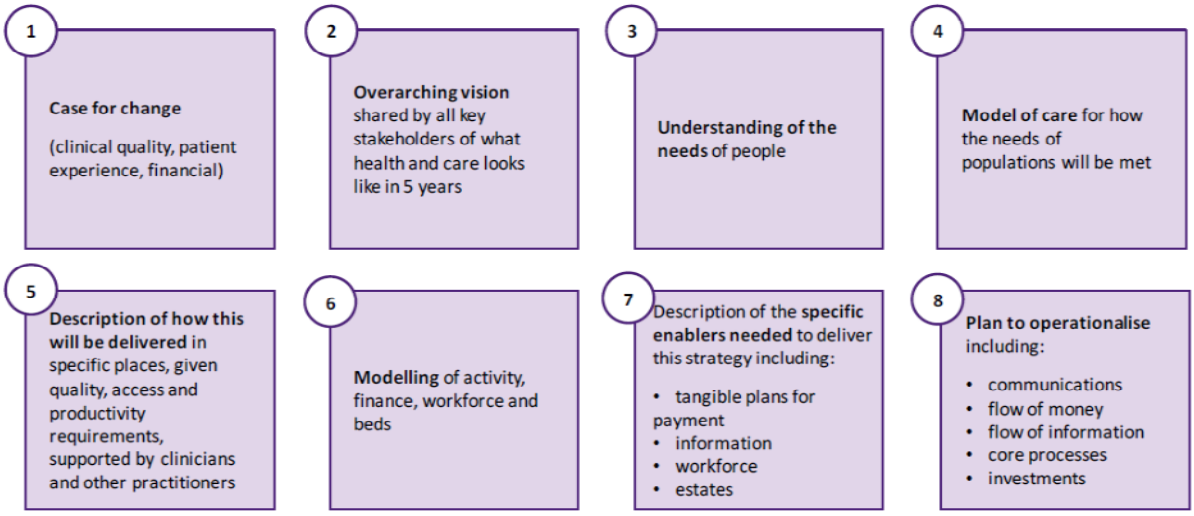
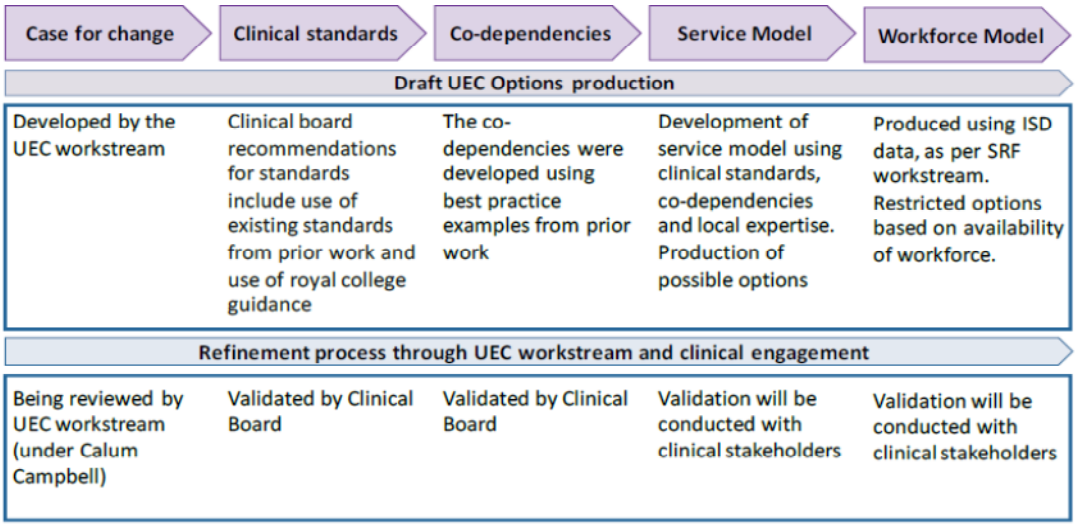
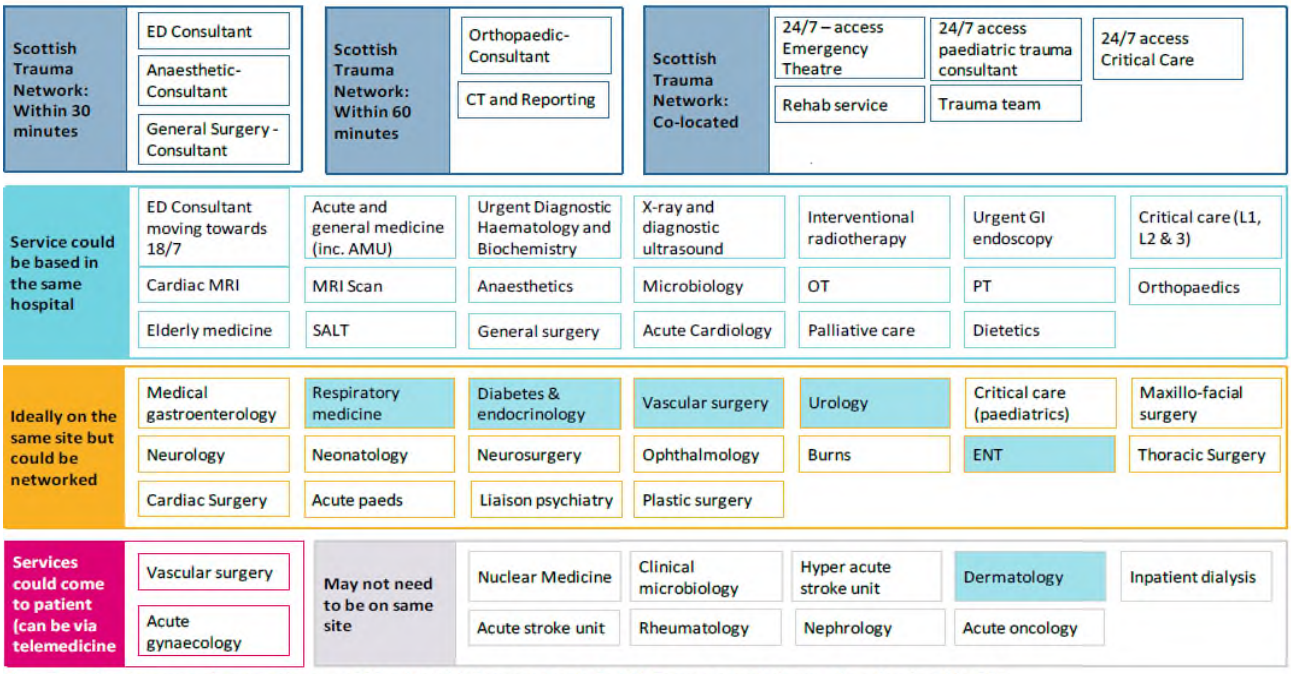


Figure 24: Our Approach to Modeling Hospital Options for Urgent and Emergency Care



This is particularly relevant to understand the practicalities of considering the service delivery options as detailed within figures 26 and 28 within the rural context and the importance of clinical networked obligate services.

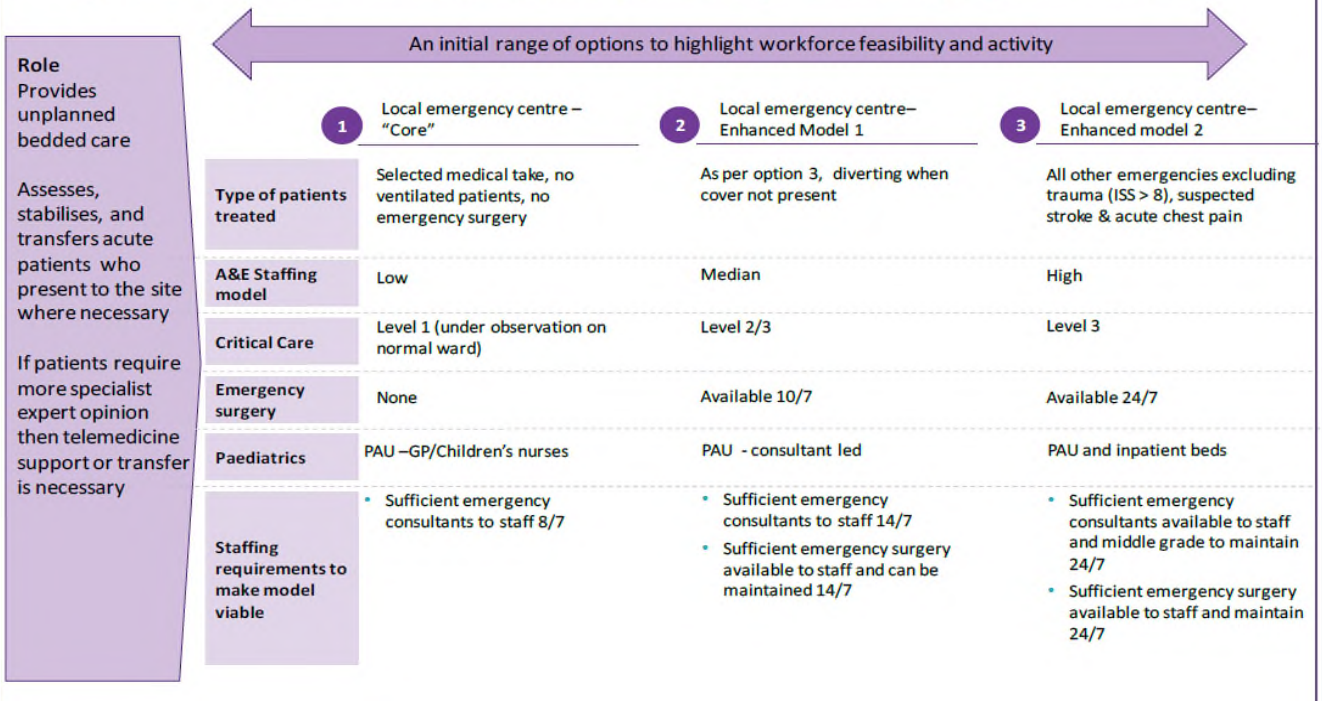
Figure 26: Potential Co-Location of Services (Acute Hospital with Trauma Unit)



Note: Two colour represents divergence between GGC and Scottish Trauma network, Scottish Trauma network shown, coloured reviewed by GGC

Source: The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014, Scottish Trauma Network,

Figure 28: Range of Potential Local Hospital Options for Urgent and Emergency Care services



This point is particularly relevant regarding the proposal that there could be an increase in transfer of patients in and out of hours to sites providing the best outcomes for care.

Whilst referencing the impact on the SAS resource is not defined and this is of

particular concern within Argyll and Bute where there is already evidence that the service is not meeting demand. Equally this is very pertinent to the alignment with the HSCPs “Transforming Together” work on the role, function and configuration of its acute community hospital, the Rural General hospital in Oban and its acute mental health service in Lochgilphead.

It is within this context the HSCP supports the principle of Collaborative Advantage and would wish to see this fomalised in due course via obligate networks and formal Health board and IJB agreements.

Integration Joint Board **Agenda item: 5.8**

Date of Meeting: **28 November 2018**

Title of Report: **Clinical & Care Governance - Biannual Infection Control Report**

Presented by: **Liz Higgins, Lead Nurse**

The Integration Joint Board is asked to:

- **Note** the biannual summary of Healthcare Associated Infection (HAI) surveillance and Infection Control activity.
- **Note** the recent HEI inspection report and associated action plan

1. EXECUTIVE SUMMARY

Infection Surveillance

The Infection Prevention and Control Team undertake continuous, real-time surveillance on a range of 'ALERT' organisms defined by Health Protection Scotland. These organisms are those which have either the ability to cause severe disease or can be easily transmitted and result in infection outbreaks. Some are the subject of HEAT targets which require enhanced surveillance and investigation by the multidisciplinary team.

HEAT Targets are set out by NHS Scotland and the Scottish Government's Health Directorates, to ensure services are constantly monitored and improved. There are four groups of Targets, collectively known as HEAT targets; these are:

- **H** - Health Improvement
- **E** - Efficiency
- **A** - Access to treatment
- **T** - Treatment

Achievements

The use of Infection Control Management software (ICNet) is now embedded within the Argyll & Bute team. The data upload from both Raigmore and NHSGGC labs is functioning well and maximizes communication and surveillance among the Infection Control Team (ICT) members in different sites.

The ICNs continue to collaborate nationally with the Infection Control Teams in other Health Boards and in Health Protection Scotland (HPS) by means of informal visits, attendance at Conferences and attendance at HPS educational events.

Introduction of the National Catheter Passport is now underway in collaboration with the NHSH Continence Nurse Specialist. It is hoped that one of the outcomes of this will be to reduce the number of catheter associated bloodstream infections.

Challenges

Staff attendance at face-to-face education sessions facilitated by the Infection Control Nurses (ICNs) continues to pose a challenge due to the difficulty of releasing staff from their teams during working hours. The ICNs attempt to augment formal sessions by, where possible, working with staff in their clinical areas and providing opportunistic advice and education.

2. INTRODUCTION

The purpose of this paper is to present the infection surveillance data gathered by the Infection Prevention and Control Team in Argyll & Bute HSCP from April 2018-September 2018. The report also provides detail as to the source, location and trends in infections and summarises any lessons highlighted by enhanced surveillance and root cause analysis.

3. DETAIL OF REPORT

3.1 Infection Surveillance Report

3.1.1 *Staphylococcus aureus* bacteraemia (SAB)

Staphylococcus aureus is a bacterium normally found on the skin surface or nasal passages in about 30% of healthy adults. Confined to these sites, it is not harmful and is considered part of the normal bacterial flora. Bloodstream infection caused by this bacterium can, however, be extremely serious, carrying a mortality rate up to 50%.

S. aureus bacteraemia (SAB) is the subject of a HEAT target and each one is subject to detailed investigation and reported to Health Protection Scotland. SAB can develop in community settings if a wound, respiratory or other infection spreads to the bloodstream before it is recognised and treated. Healthcare interventions, either in hospital or in the community can also lead to SAB. Procedures such as intravenous cannulation, surgery and invasive investigations can result in SAB if bacteria are inadvertently introduced to the bloodstream. Healthcare associated SAB (as opposed to community acquired) is considered preventable until found otherwise, and all are subject to detailed surveillance to assess the root cause and learn lessons. Information on the national surveillance programme for Staphylococcus aureus bacteraemias can be found at:

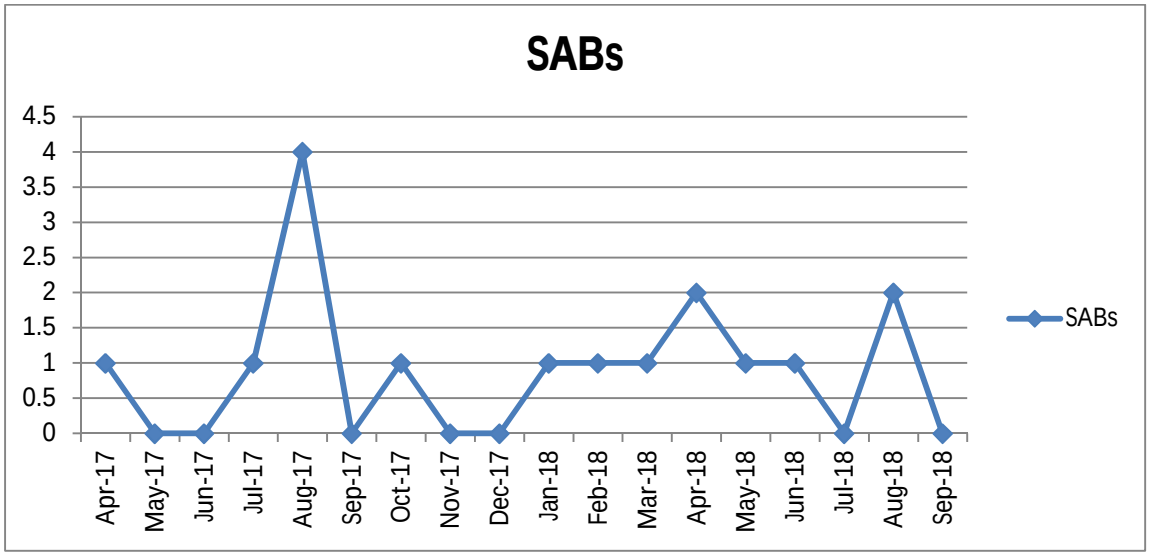
http://www.hps.scot.nhs.uk/haiic/sshaip/publicationsdetail.aspx?id=30248

The NHSH HEAT target for 2018/2019 is 24 SABs or less per 100,000 acute occupied bed days (AOBD). For NHSH, this translated to no more than 60 SABs during the last surveillance year. NHSH's performance for the current surveillance year currently exceeds this target.

In Argyll & Bute, during the period April-September 2018, SAB was diagnosed in 6 patients. This is equivalent to the same period last year. In detail:

SABs 1st Apr-30th Sep	**Lorn & Islands – 3** **Community Hospitals – 3** **Total SABSs = 6**	Hospital Acquired Cases = 0 Healthcare Associated Cases = 6 Community Acquired Cases = 0 ***No lessons identified from review***

SAB cases Apr 2017- Sept 2018



3.1.2 *Clostridium difficile* infection (CDI)

Clostridium difficile is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. Recurrent infection is common (up to 30%) especially in elderly females), More information can be found at:
http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx

NHS Boards carry out surveillance of *Clostridium difficile* infections (CDI), and there is a national target to reduce these. Information on the national surveillance programme for *Clostridium difficile* infections can be found at:
http://www.hps.scot.nhs.uk/haiic/sshaip/ssdetail.aspx?id=277

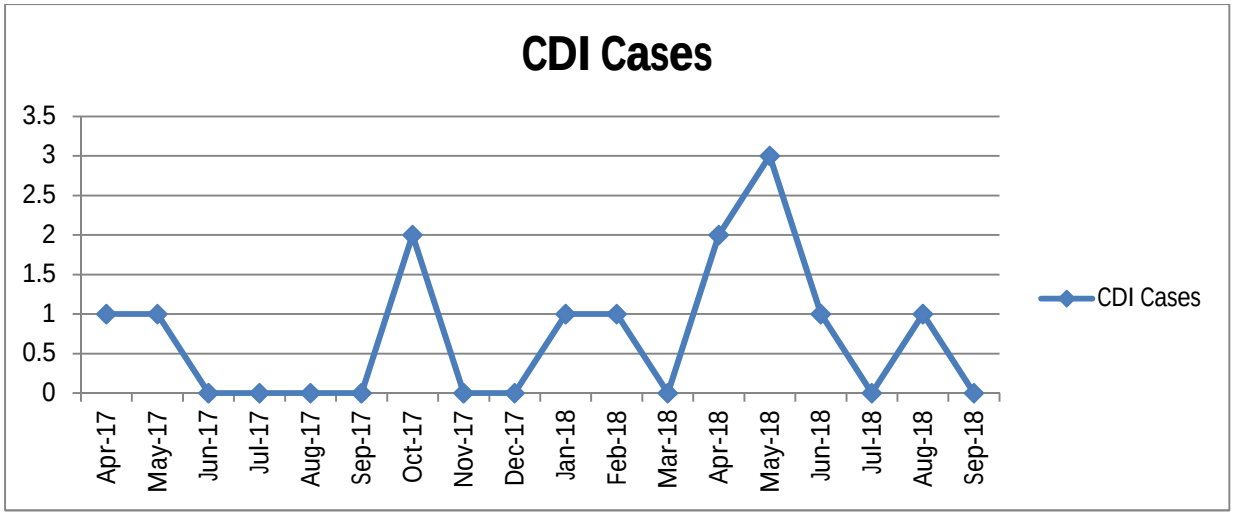
4. RELEVANT DATA AND INDICATORS

The NHSH HEAT target for 2018/2019 is 32 cases or less of CDI in patients aged 15 and over per 100,000 total occupied bed days (OBD). For NHS Highland, this translated to no more than 78 cases in the last surveillance year. NHSH's performance for the current surveillance year currently exceeds this target.

In Argyll & Bute, during the period Apr-Sep 2018, 7 cases of CDI were diagnosed in 6 patients. 2 cases were diagnosed in the same period last year. Due to the higher than expected number of cases throughout NHSH, a review of all CDI cases is in progress in conjunction with Health Protection Scotland (HPS). Any conclusion will be shared in a later report.

1st Apr-30th Sep 2018	**Total CDI Cases aged 15 and over = 7**	**Aged 15-64 = 0** **Aged 65+ = 7**
	Healthcare Associated = 6 (1 of these was an infection recurrence) Community Acquired = 1 ***No lessons identified from review***	

CDI Cases Apr 2017- Sept 2018



As of 1st April 2016 the surveillance of *Escherichia coli (E. Coli)* Bacteraemia became a mandatory requirement for all NHS Boards to undertake. Data is collected by the Infection Prevention and Control Team in conjunction with the relevant clinical teams, and cases discussed to identify learning. The data collected and presented below highlights the local case numbers.

In Argyll & Bute, during the period Apr-Sep 2018, 14 patients with ECB were admitted to hospital. This compares to 17 in the same period last year.

4.1 Infection Outbreak Surveillance

In the period 1st Apr – 30th Sep 2018, 3 infection outbreaks were managed in A&B HSCP, 2 in Care Home settings and 1 hospital based.

The outbreaks affected a number of patients and staff and resulted in the care homes and the hospital being closed to admissions for several days.

Causes of outbreaks were Norovirus, and vomiting and diarrhea symptoms.

4.2 Audits

Hand Hygiene Reporting, Cleaning and Estates Audit and Standard Infection Control audits are monitored at Argyll & Bute Infection Control meeting and compliance remains high. A full year's figure will be reported within the year-end report to IJB.

4.3 Healthcare Environment Inspection (HEI)

The Healthcare Environment Inspectorate (HEI) report on the recent cluster inspection in Argyll and Bute was published on 26th September 2018. Three hospital sites, Campbeltown Hospital, Mid Argyll Community Hospital and Cowal Community Hospital were inspected in July this year.

The purpose of the inspection was to assess the hospitals against the Healthcare Improvement Scotland *Healthcare Associated Infection (HAI) Standards* (February 2015).

Following the visits the feedback from the inspection teams recognised that across all three sites:

- The standard of environmental cleanliness was very good
- The majority of patient equipment was clean
- Staff hand hygiene compliance was good

The inspection teams also highlighted a number of requirements that needed to be implemented and an action plan is in place to address all the recommendations within the timescales in the report.

http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hei_highland_reports/ch_cch_mach_sep_18.aspx

5. CONTRIBUTION TO STRATEGIC PRIORITIES

Robust infection control arrangements and practice are key in ensuring people are safe and appropriately cared for in both hospital and community settings.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

Inadequate infection control governance has a potential financial impact if it results in avoidable treatments and increased lengths of stay in hospitals

6.2 Staff Governance

Staff require to be supported to achieve safe patient and staff experience by implementing best practice in infection control standards. This will be achieved through compliance with training requirements and the availability of appropriate equipment, supporting policies and procedures and audit and feedback programmes.

6.3 Clinical Governance

Infection Control is a key Clinical Governance work stream and is essential for safe and quality care.

7. EQUALITY & DIVERSITY IMPLICATIONS

None.

8. RISK ASSESSMENT

Full ICNet implementation has greatly reduced the risks within the infection control service and the risk register amended appropriately.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Public and user involvements at a number of audits and meetings regarding infection control issues. HEI report and action plan are public documents

10. CONCLUSIONS

The Infection Prevention and Control team continue to work hard to ensure that there is a robust system in place for infection surveillance and support within Argyll & Bute.

The HEI visit and report should give some assurance regarding the standards in relation to infection control and cleanliness within our hospitals. Despite a disappointingly large number of requirements within the report, the feedback to staff from the inspectors was very positive and, patients who were being cared for at the time of inspection, also spoke very positively about the standards they were experiencing. It is clear that staff work very hard to maintain the high standards commented on during the inspection and they are to be commended for their dedication and hard work in ensuring patients are safe – as demonstrated by low infection rates and timely containment of outbreaks when they occur.

Integration Joint Board **Agenda item: 5.9a**

Date of Meeting: **28 November 2018**

Title of Report: **Month 7 Budget Monitoring Report**

Presented by: **Lesley Macleod, Interim Chief Finance Officer**

The Integration Joint Board is asked to consider the contents of the report and accept the recommendations included as section 10 of this report:

- Funding offers from NHS Highland and Argyll & Bute Council have yet to be formally accepted for 2018/19.
- Budgets have been set based on the funding offers made.
- Planned expenditure exceeded the funding available by £12.2m.
- A savings plan of £10.6m has been in place to close the funding gap and a Financial Recovery Plan exists for the balance.
- Slow progress has been recorded with regard to delivery of recurring savings.
- The year-end forecast outturn is currently for a £4.0m overspend. This is an improvement from the month 6 position of a forecast overspend of £4.6m.

1. EXECUTIVE SUMMARY

The Argyll & Bute HSCP budget for 2018/19 is currently £266.6m. This is based on funding offers from Argyll & Bute Council and NHS Highland plus several in-year allocations from Scottish Government that have been passed through by NHS Highland.

Planned expenditure exceeds the available budget by £12.2m. There is therefore a requirement to achieve recurring savings of £12.2m to achieve a balanced budget. Savings plans identified to date total £10.6m. There is a remaining budget gap of £1.6m with currently only informal plans in place to address it.

This is an unacceptable financial risk to the IJB, and Council and Health Board partners. The scale of savings planned to be delivered and the shortfall in identified savings presents a high level of risk in delivering financial balance for the partnership in 2018/19 and jeopardises the efficiency and effectiveness of partnership working. This is in the sharp focus of the Partnership's Senior Leadership Team and key stakeholders.

2. INTRODUCTION

This report provides information on financial performance up to October (Month 7) for 2018/19, progress on implementing measures to achieve savings, and a projected forecast outturn position for the financial year

3. DETAIL OF REPORT

3.1 Argyll & Bute HSCP Funding 2018/19

Funding offers from NHS Highland and Argyll & Bute Council have yet to be formally accepted. However, to ensure effective financial monitoring is in place, budgets have been set reflecting funding offers made.

In addition, beyond the base funding offers, a number of health in-year allocations have been provided. It is common practice for large numbers of in-year allocations to be provided by the Scottish Government Health Department. These are initially allocated to NHS Boards and then shares of the allocations are passed through to HSCPs and operating units.

Table 1 below summarises the funding position of Argyll & Bute HSCP as at 31st October 2018.

Table 1: Argyll & Bute HSCP Funding 2018/19

	£ '000	£ '000
Funding offer from Argyll & Bute Council		**56,389**
Funding offer from NHS Highland		**206,689**
		263,078
SGHD In-year allocations passed through by NHS Highland		
Waiting Times	930	
Primary Medical Services (GP services)	899	
New Medicines	821	
Additional Pay Award funding	787	
18/19 Primary Care Improvement Fund (70% : 30% c/f)	494	
Additional Alcohol and Drug Partnership (ADP) funding	315	
PFI funding	296	
Winter Pressures	175	
18/19 Mental Health Strategy (70% : 30% c/f)	143	
CAMHS & Psychological Therapies (pending)	128	
GP Out Of Hours	93	
Other miscellaneous allocations/adjustments (net)	(3)	
Dentists, Chemists, Opticians funding adjustment	(54)	
Contribution to CHAS	(112)	
Salaried Dental Service funding reduction	(165)	
Prescribing adjustment for pharmacy global sums	(332)	
E-health funding adjustments (retained central charges)	(867)	**3,548**
Total Funding as at 31 October 2018		**266,626**

As at 31st October 2018, operating budgets for Argyll & Bute HSCP total £266.626m.

3.1 Year to Date Position

For the seven months ended 31st October 2018, Argyll & Bute HSCP recorded an overspend of £570k. This is summarised in table 2 below.

Table 2: Argyll & Bute HSCP Year to Date Position

	Annual	Year to Date		
	Budget	Budget	Actual	Variance
Budget	£'000	£'000	£'000	£'000
Adult Services	132,254	75,958	77,222	(1,264)
Childrens Services	19,971	11,347	11,005	342
Primary Care Services	28,925	17,051	16,886	166
NHS commissioned services	64,845	37,747	39,175	(1,428)
All other budgets	20,631	7,958	6,344	1,614
	266,626	150,061	150,631	(570)

The main pressure on budgets is from savings not being achieved. There are also ongoing cost pressures which are commented on further in section 3.5 below.

It should be noted that NHS Highland and Argyll & Bute Council use different financial systems and their accounting practices differ. As a result, the consolidated year to date position is skewed by various factors including the profiling of budgets and the timing of payments for commissioned social care services. This makes the reported year to date position an unreliable indicator of the forecast year-end outturn position. Work is being carried out to better understand and align these forecasts including consistency of assumption and trend analysis.

3.2 Forecast Outturn Projection

The year-end forecast outturn position for 2018/19 is a **projected overspend of £4.0m.**

This forecast is produced by analysing and projecting trends, taking account of expected progress on achieving savings and other factors including receipt of in-year allocations and predicted slippage on spending plans. There are a considerable number of variables to consider when assessing the year-end forecast outturn.

The forecast of a £4.0m overspend therefore takes account of emerging cost pressures and savings not being achieved, offset to an extent by non-recurring benefits from vacancies and slippage on expenditure plans. The forecast needs to continue to take account of the in-year review being led by the Chief Officer and Chief Finance Officer with a renewed focus on the savings and investment plans.

By far the biggest factor affecting the forecast overspend is confidence in the level of recurring savings likely to be achieved. As noted earlier, there is a savings plan of £10.6m in place. However it is likely that there will be a significant shortfall against the savings plan. Beyond this there is a further £1.6m budget gap with currently no

formal plan in place to address it. This is also influencing the forecast year-end outturn.

It is believed that the forecast year-end overspend will reduce in the months ahead in response to action taken by managers around discretionary spend, contractual arrangements and renewed focus on savings programmes. Certainly there is an expectation that newly appointed Service Improvement Officers will have an impact on this. However it does look extremely unlikely at this stage that sufficient improvement could be made to enable a year-end break even position to be achieved.

3.3 Savings Plan

The HSCP is currently pursuing delivery of a £10.6m savings plan. Limited progress has been achieved to date in terms of declaring recurring savings. In fact, only £3.364m has been declared to date. This is summarised in table 3 below and while it is an improved position on previous months, there is not yet sufficient traction and pace on the overall programme.

Table 3: Argyll & Bute HSCP Savings Requirement 2018/19

Savings targets identified	£ 10.60m
Savings declared to date	£ 3.364m
Savings still to be achieved	£ 7.236m

In addition, it must be remembered that there is a £1.6m budget gap in addition to this with currently few formal plans in place to address it.

To assist IJB's understanding of the current savings programme, the most significant initiatives are shown below :

Ref.	Savings Description	Target £' 000	Achieved to 31/10/18 £' 000	Full Year Forecast £' 000
1	NHS GG&C contract / services	1,266	174	174
2	Prescribing	700	424	700
3	Bed Reduction Schemes	1,751	-	-
4	Learning Disabilities	810	376	636
5	Unidentified gap	2,345	1,015	1,015
	Total	**6,872**	**1,989**	**2,525**

In terms of governance, progress on delivering savings will be monitored by both the Quality and Finance Plan Programme Board and the Service Transformation Board. There are certainly measures in place to oversee and monitor the progress of transforming services and delivering savings. However, increased and improved accountability is required to increase confidence in the delivery of savings. Robust

project management and governance is required to highlight progress, potential blockages and poor delivery of programmes.

To address the forecast 18/19 overspend, and underlying recurring deficit, there is a requirement to achieve faster delivery of recurring savings.

3.4 Financial Risks

As noted in section 3, the forecast year-end outturn is currently for a £4.0m overspend.

Various risks and pressures are contributing to this forecast and the main ones worth highlighting are;

- A remaining budget gap of £1.6m. A review of budgets has been carried out which identified a possible budget challenge opportunity of some £1.6m. This is an iterative process which will continue on a monthly basis by the finance teams in conjunction with budget managers
- An expectation that there will be a significant shortfall against the existing recurring savings plan of £10.6m.
- The savings plan contains a target saving of £1.2m against the SLA with NHS Greater Glasgow & Clyde for patients' services. However, NHS Greater Glasgow & Clyde has indicated an intention to *increase* the SLA charge by £768,000. This movement in charging is being challenged by the Partnership to understand the rationale and the associated timing of the change.
- Ongoing reliance on locum psychiatrists. Currently 4 posts are being covered by locums. This has caused a £446,000 overspend on the psychiatry medical staffing budget at month 7.
- Higher than expected demand for services across the whole client group supported by social work is likely to result in increased costs.
- Social care independent service provider failure requiring the HSCP to provide more expensive replacement services to ensure safe service continuity.
- Failure within social work to achieve expected income levels from clients due to changes in operational arrangements.
- Ongoing reliance on locum GPs on Mull.
- Ongoing use of agency nurses in Oban and Lochgilphead hospitals.
- Recruitment difficulties/staff absence in social work resulting in increased use of higher cost agency staffing.

This is not a comprehensive or prioritised list of all financial risks facing the HSCP but it does highlight those that are considered to be the highest risks affecting financial performance.

4. RELEVANT DATA AND INDICATORS

Information is derived from the financial systems of NHS Highland and Argyll and Bute Council.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure that financial decisions are in line with priorities and promote quality of service delivery. The Quality and Finance Plan 2018/19 has been developed in line with delivering these strategic objectives.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

The year-end forecast outturn position for 2018/19 is a **projected overspend of £4.0m.** This includes the budget gap of £1.6m, due to the shortfall in identified savings, and reflects the risk associated with the scale and pace of change required to deliver savings identified in the Quality and Finance Plan. This is a significant financial risk to the IJB, and Council and Health Board partners. The financial position is very challenging and will require to be closely monitored during the financial year.

6.2 Staff Governance

The appropriate HR processes will require to be followed where there is an impact on staff as a result of any service changes in the Quality and Finance Plan.

6.3 Clinical Governance

None

7. EQUALITY & DIVERSITY IMPLICATIONS

None

8. RISK ASSESSMENT

Risks are highlighted within the body of the report

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Where required as part of the development and delivery of the proposed Quality and Finance Plan local stakeholder and community engagement will be carried out as appropriate in line with the re-design of service provision.

10. CONCLUSIONS

The IJB approved the Quality and Finance Plan for 2018/19 in March 2018. At that point there was a budget gap of £2.4m. This position has subsequently improved to a remaining gap of £1.6m. This is due to agreement to delay repayment of 2017/18 overspends by NHS Highland and Argyll and Bute Council.

Governance arrangements are in place for the development and delivery of service changes. The delivery of approved savings requires to be the main focus. It is clear that if there continue to be delays with delivery of service changes planned to deliver £10.6m of savings during 2018/19, then financial balance will be unlikely to be achieved.

The Integration Joint Board and parent organisations will be kept fully informed of the financial position during the year, including progress with the delivery of the Quality and Finance Plan, the forecast year-end outturn position and plans being progressed to develop the budget for future years.

To minimise the level of in-year overspend and to give rigour to the financial control environment, the following recommendations are made for IJB consideration and approval –

- **Current budget offers to be accepted such that there is stability in budgetary control and clarity of funding for 2018/19**

- **Continued restriction of all non-essential discretionary spend , particularly around new investment and staff recruitment**

- **Meaningful engagement with Greater Glasgow and Clyde to be sought by senior management to ensure a fit for purpose service level agreement for services provided to the population of Argyll and Bute. This is the subject of supplementary IJB papers.**

- **The ongoing focus on service transformation which drives down costs to continue as the priority for the Partnership's Senior Leadership Team and enhanced clarity of the supporting governance**

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A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item: 5.10**

Date of Meeting: **28 November 2018**

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 Integration Joint Board |(IJB) is asked to:

- Endorse the work completed and the work in Pyramid (train) to review the current performance reporting in line with ongoing National Review of current Health & Wellbeing Outcome Indicators (NHWBOI's)
- Endorse the review and approach to scorecard rationalisation
- Consider and Note the HSCP performance against National Health and Well Being Outcome Indicators: 3 and 4 and the Ministerial Steering Group measures of integration for the HSCP
- Note the Head of Services Performance Commentary with regards to local actions to address exceptions against indicators 3 and 4

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 (NHWBOI's) and 23 sub-indicators and additional measures which form the foundation of the reporting requirement for the HSCP.

2. National Review of Health & Wellbeing Outcome Indicators (NHWBOI's)

In 2017 Professor Sir Harry Burns was tasked by the Scottish Government to review at a National level the NHWBOI's and reporting across all the HSCP's in Scotland (**Review of Targets & Indicators for Health & Social Care in Scotland (2017), (https://beta.gov.scot/publications/review-targets-indicators-health-social-care-scotland/pages/28/)**.

This review process identified a number of key issues which will be revisited in 2019 as part of a wider national data set and performance outcomes approach.

A summary of the key areas for change are:

- If the aim is to improve healthy life expectancy and wellbeing of individuals, then different indicators have impact on different aspects of the life course.

- If an effective group of indicators, which would assist continuing improvement, are to be developed, we need to see the drivers of wellbeing as part of a complex system.

- It is important that frontline staff, managers accountable for performance and the people who use services coproduce the activities which they can then use to drive improvement.

- Scottish public services are effective and efficient. A new approach to improving those services can deliver further success in comparison to many other systems.

3. IJB Scorecard Review - Next Steps

In response to this National review and feedback from the IJB and the SLT the Performance & Information Team has been leading on further development and review of the IJB performance scorecard through engagement with the Integrated Joint Board (IJB) and Senior Leadership Team (SLT).

A summary of key themes were:

- *Pyramid is clunky to use and can be complicated to navigate with regards to finding data*
- *The current measures noted within the IJB Scorecard do not fully represent the objective, challenges and performance that localities would want to focus on*
- *There was a degree of repetition of measures across the nine Health & Wellbeing Indicators, which is not logical and is confusing*
- *The removal of duplicate reported measures would be a good starting point in refining the current scorecard*
- *There was confusion across the Heads of Service with regards to what information details activity reporting and/or performance reporting within the Pyramid system*
- *The layout of some of the graphic and visual content of Pyramid is not consistent or overly complex across measures. For example the identification of trend arrows within the outputs was misleading.*

- *Pyramid was good in that it could report across the partnership and maintained a corporate link to the wider performance agenda of both the LA and NHS Highland*
- *It was recognized that the Child Protection Committee had extended their use of their scorecard within Pyramid and this group had moved from hard copy paper reporting to using Pyramid to report performance electronically and this was seen as good practice.*
- *There was a significant amount of historic commentary or activity data which was no longer relevant and should be updated, archived or removed.*
- *The pyramid system should house all performance data for the HSCP removing the need for two IT platforms i.e. NHS Intranet activity/performance information and Pyramid.*

A work plan to undertake the review was produced and the following summarises the programme and timetable to undertake this work:

- Engagement and user feedback sessions with Heads of Service-August- Sept 2018
- Initial rationalisation and removal of duplicated measures across the IJB Scorecard to October 2018 which will be reported covering quarter 1 2018/19
- Scope of redesign presented and agreed with Strategic Leadership Team - November 2018
- Project Initiation Document completed and project group established- November 2018
    - A&B Council corporate Pyramid build Team briefed
    - Drivers identified for inclusion i.e. new 3 year Strategic Plan. Carers act new indicators etc.
    - Legacy and expired pyramid performance information scoped and achieved/removed
- IJB briefed re initial review and plan as part of HSCP performance report- November 2018
- Draft revised scorecard build completed - December 2018
- IJB development session on revised performance scorecard Jan 2019
- SLT and IJB approval re new performance scorecard March/May 2019
- New score card build finalised on Pyramid June 2019- to report 4th quarter 2018/19 performance
- Switch over to new scorecard on Pyramid from June 2019

4. HSCP Performance for Financial Quarter 1 2018/19

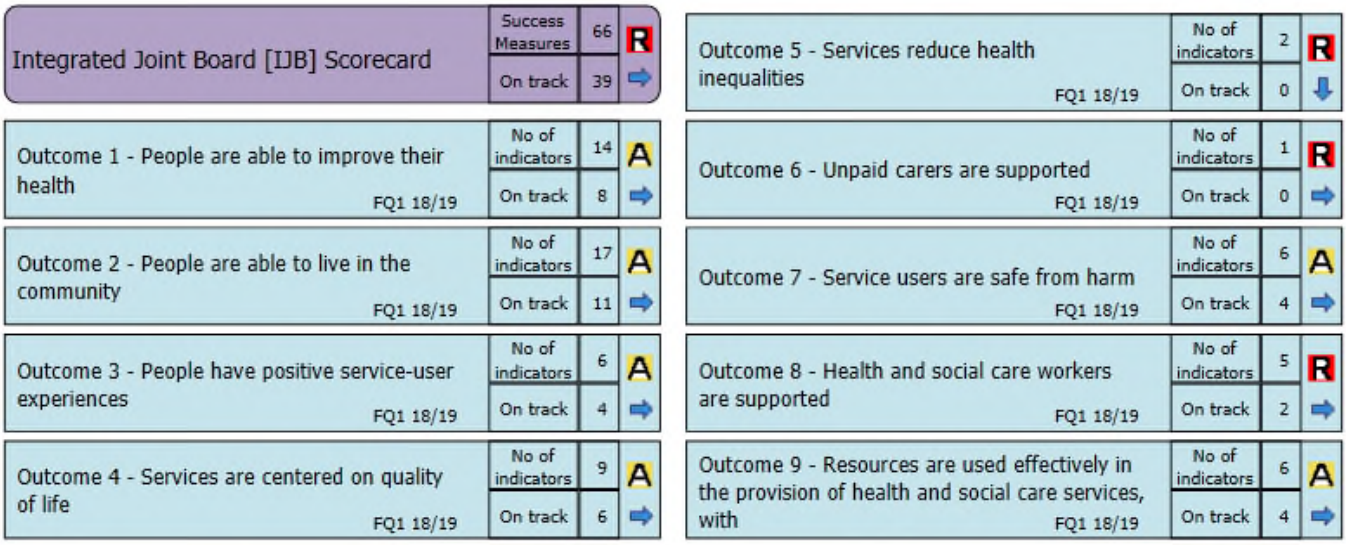
As outlined above taking account of the feedback from IJB members and the engagement sessions with Heads of Service and managers has identified the removal of duplicated measures across the scorecard. This has resulted in a reduction from the original 102 indicators to 66, **Appendix 1** details the duplicate indicators which have been removed from the relevant NHWBO indicator.

Taking account of this change the following summary scorecard report for the 66 measures to the IJB for quarter 1 2018/19 is detailed overleaf

The scorecard for FQ1 notes that from the 66 scorecard success measures that 39 are showing as ontrack against their individual targets.

The scorecard utilises , red, amber and green to highlight the performnace shift against each of the outcomes against the previous quarters performance. For example if the indicator for the outcome is showing red then the overall shift across the indicator is reduced from the previous quarter. If the indicator notes amber colour then there is no performance shift against the previous quarter and if it is showing green then there has been a improvement in perfromnace against the previous quarter.

FQ1 2018/19– IJB Performance Report Scorecard



Members should note that statistically the reduction in measures from FQ4 to FQ1 does not advantage the perfromance reporting for this quarter and should not be view as an attempt to massage the data or manipulate performance reporting.

In essence the HWBOI's continue to be reported alongside their respective sub-indicators and the duplication of these across the scorecard has been removed. In effect the perfromance remains the same for the HWBOI's as they are still reported but not duplicated across each of the outcome measures. The removal of duplicated performance reporting has also seen the removal of the Customer Service Reporting which is again duplicated within the report and reported outwith the scorecard.

The focus of this report is on Outcome Measures 3 and 4 :

- Outcome 3 – People have positive service – user experiences. 4 of the 6 indicators are on performance track

- Outcome 4 – Services are centered on quality of life. 6 of the 9 indicators are on performance track

Section 5 provides a summary exception report on the indicators which are off track.

For members reference, Appendix 2 provides the IJB with a benchmark assessment of the HSCPs performance compared to Scotland for its information. The report shows 12 out of the 19 indicators (with data) the HSCP is performing above the Scotland average.

Appendix 3 details the current HSCP Performance reporting timetable and frequency to the IJB and respective stakeholders. This will be reviewed as part of the process outlined above.

5. Exceptions Performance Report for Outcome Indicators 3 and 4

The table below summarises the exception report for the 5 performance measures across indicators 3 and 4 which are off track, including performance against the previous quarter and Head of Service Performance Narrative identifying actions to improve.

<table>
<tr><th colspan="2">Performance Indicator & Source Definitions</th><th>Target</th><th>Actual</th><th>Benchmark Performance Against Previous Quarter</th><th>Head of Service Actions to Improve Performance</th></tr>
<tr><td>3</td><td>Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated.

(Based on agreement with the statement (Q36e) in the biennial health and care experience survey: “My health and care services seemed to be well coordinated”. The number of people who agree or strongly agree divided by the total number answering.)</td><td>74%</td><td>72%</td><td>72%
(This is a 2 year national postal questionnaire)</td><td>Head of Service Adults (West)
Data trend over the last 6 financial years notes a reducing trend in satisfaction, however recognition need to be drawn to the fact that this is a 2 year GP Postal Questionnaire and as such the reported percentage of satisfaction is directly related to the response rate associated with the questionnaire. This is a nationally gathered and reported questionnaire.

<table>
<tr><th>Financial years</th><th>% Satisfaction</th></tr>
<tr><td>13/14</td><td>84%</td></tr>
<tr><td>14/15</td><td>84%</td></tr>
<tr><td>15/16</td><td>81%</td></tr>
<tr><td>16/17</td><td>81%</td></tr>
<tr><td>17/18</td><td>72%</td></tr>
<tr><td>18/19</td><td>72%</td></tr>
</table>

Implementation of single community IT system April 2019 for health community teams will significantly improve ability to coordinate and communicate more effectively.

Implementation of single points of access for community teams across Argyll and Bute is progressing with improvements in access to services, communication, and triage and</td></tr>
</table>

<table>
<tr><th colspan="2">Performance Indicator & Source Definitions</th><th>Target</th><th>Actual</th><th>Benchmark Performance Against Previous Quarter</th><th>Head of Service Actions to Improve Performance</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>planning of services to avoid duplication.-Local Area Managers responsible for community teams.
Application of a named lead professional for care co-ordination within teams-Community Team Leads.
Co-location of community teams.-SLT and local managers. Community Services Steering Group as part of the Adult Transforming Together programme will direct these initiatives to improve care co-ordination.

Local Short Life working groups to implement and drive change locally.
Further embedding of all Community Standards within the community teams.

This work is overseen by the Community Services Steering group.

Continued focus and support from the Council and Health IT departments to ensure new systems in place on time.
Timely education and training for staff in the new system.
Council and health estates department support for co-location, including IT and telecoms.</td></tr>
<tr><td>3</td><td>Number of patients with early diagnosis & management of dementia

(890 derived as prediction by Government as being the expected number of dementia diagnosis. Using Eurocode</td><td>890</td><td>791</td><td>806</td><td>Head of Service Adults (West)

Performance data for FQ4 and FQ1 notes a progressive reduction in the number of patients with an early diagnosis of dementia

<table>
<tr><th colspan="3">FQ4 17/18</th><th colspan="3">FQ1 18/19</th></tr>
<tr><th>Jan</th><th>Feb</th><th>Mar</th><th>April</th><th>May</th><th>June</th></tr>
<tr><td>833</td><td>824</td><td>806</td><td>800</td><td>795</td><td>791</td></tr>
</table>
</td></tr>
</table>

	Performance Indicator & Source Definitions	Target	Actual	Benchmark Performance Against Previous Quarter	Head of Service Actions to Improve Performance
	definition)				Dementia Registers are held by GP Practices. Locality Dementia Teams regularly liaise with GP Practices to ensure registers are up to date and that the diagnostic code is appropriately used in communications to ensure the recording of diagnosis. Statistics for diagnosis rates in Scotland show NHS Highland recording 2973 in April 2017 and 2946 in April 2018 with a variance of -0.19%. There is an apparent national trend in decreasing diagnosis rates. As part of the Transforming Together agenda a review of the dementia services to develop a dementia strategy and improved dementia care in Argyll & Bute for inpatient and community services is being progressed. This work includes a gap analysis and development of what the future pathways in the service will be. This will include diagnostic pathways and will inform these rates. Dementia Services Short Life Work Group is a sub group of the Mental Health & Dementia Steering Group which has been set up as part of the transforming of services to ensure future sustainability of services and delivery of the Quality & Finance plan. Data gathering and analysis, in particular relation to national data, with consideration given to rationale. E.g. Is prevention work starting to impact on the disease? (Lorraine Paterson)
4	Percentage of adults supported at home who agree their support had impact improving and maintaining	80%	74%	80% (This is a 2 year national postal questionnaire)	**Head of Service Adults (East)** Data trend over the last 6 financial years notes a reducing trend in reporting quality of life, however recognition need to be drawn to the fact that this is a 2 year GP Postal Questionnaire and as such the reported percentage improving quality of life is directly related to the response rate associated with the questionnaire. This is a nationally gathered and reported questionnaire.

<table>
<tr><th colspan="2">Performance Indicator & Source Definitions</th><th>Target</th><th>Actual</th><th>Benchmark Performance Against Previous Quarter</th><th>Head of Service Actions to Improve Performance</th></tr>
<tr><td></td><td>quality of life

(Based on agreement with the statement (Q36h) in the biennial health and care experience survey: “The help, care or support improved or maintained my quality of life”. The number of people who agree or strongly agree divided by the total number answering)</td><td></td><td></td><td></td><td>
<table>
<tr><th>Financial years</th><th>% Satisfaction</th></tr>
<tr><td>13/14</td><td>86%</td></tr>
<tr><td>14/15</td><td>86%</td></tr>
<tr><td>15/16</td><td>87%</td></tr>
<tr><td>16/17</td><td>87%</td></tr>
<tr><td>17/18</td><td>74%</td></tr>
<tr><td>18/19</td><td>74%</td></tr>
</table>

In Argyll and Bute there is difficulty achieving the target of 80%, this can be attributed to numbers waiting for care home placement and care at home. There is focused work on-going around reviewing existing care packages and incorporating reablement as core to care at home service delivery.

The work of the Community and Care Homes and Housing Transformation Steering groups is focused on delivery of services to ensure we can maintain quality of life and independence at home for as many of our community as possible. There is recognition that we need to focus attention of the outcomes we collect and report on that demonstrate the impact of this, we are looking at our Falls data and other outcome measures that will evidence work to increase levels of independence e.g. Indicator of Relative Need.

Establishment of the Community Services Steering Group to oversee implementation of the Community Standards across Argyll and Bute.

Implementation of the Carers Act.</td></tr>
</table>

<table>
<tr><th colspan="2">Performance Indicator & Source Definitions</th><th>Target</th><th>Actual</th><th>Benchmark Performance Against Previous Quarter</th><th>Head of Service Actions to Improve Performance</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Focus on prevention, reablement and self-management including use of TEC and engagement with third sector and local leisure services. Development of a self-management strategy.

Ongoing work to establish targeted input around those who are frail and fall.

Care at home commissioning process based on outcomes and not time and task.</td></tr>
<tr><td>4</td><td>Number of outpatient ongoing waits >12 weeks

(This is a data snapshot that records at month-end where a patient has not had an appointment booked Data is derived from a Zen OP report downloaded into spreadsheet and includes periods of unavailability as per New Ways rules. MMI Specialties only (Excludes Mental Health. Obstetrics and AHP) This is one element of the 18 week TTG standard (OP, Diagnostic & IP)</td><td>0</td><td>258</td><td>411</td><td>Head of Service Adults (West)

Data across FQ4 and FQ1 shows a reducing trend in the overall number of outpatient waits greater than 12 weeks.

<table>
<tr><th colspan="3">FQ4 17/18</th><th colspan="3">FQ1 18/19</th></tr>
<tr><th>Jan</th><th>Feb</th><th>Mar</th><th>April</th><th>May</th><th>June</th></tr>
<tr><td>506</td><td>529</td><td>411</td><td>276</td><td>251</td><td>258</td></tr>
</table>

• LIH: Ongoing issues with Dermatology, ENT, Ophthalmology, Gynaecology and Oral Surgery.
• Local action plan developed in conjunction with planning. Initiative clinics have taken place and further being negotiated with GG&C. AHP and triage to support ENT waits involving Audiology. Health Improvement support from Dermatology Nurse Consultants to support service. Increase in use of electronic photographic advice for GP's to Dermatology, which reduces referrals into the service locally.
• Kintyre: ENT - 20 weeks. November clinic full. January clinic full. Next available clinic March 2019. We receive 6 clinics per year
• Oban Gen Medicine - 31 weeks - Changes to service have created longer wait. 4 sessions a month (2 days) now 2 sessions (1 day) every alternate month</td></tr>
</table>

<table>
<tr><th colspan="2">Performance Indicator & Source Definitions</th><th>Target</th><th>Actual</th><th>Benchmark Performance Against Previous Quarter</th><th>Head of Service Actions to Improve Performance</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>

- Oban Gen Medicine - 15 weeks. Cardiology referrals to be submitted to Glasgow rather than Oban to allow waiting list to clear. Thereafter only general referrals to be submitted. We receive 4 sessions per month (2 days)
- Orthopaedics - 18 weeks - Changes to service have created longer wait. No longer monthly service. Changed to every alternate month
- Mid Argyll: We currently have higher than normal wait times in both orthopaedic and ophthalmology. Planning and performance have agreed funding and dates are being secured to hold 2 ophthalmology initiative clinics which should reduce our wait time.

</td></tr>
<tr><td>5</td><td>Number of treatment time guarantee completed waits >12 weeks

(TTG is enshrined in law NHS Highland is obliged to have commenced agreed treatment within 12 weeks of date of agreement
For admissions only)</td><td>0</td><td>3</td><td>0</td><td>Head of Service Adults (West)
<table>
<tr><th colspan="3">FQ4 17/18</th><th colspan="3">FQ1 18/19</th></tr>
<tr><th>Jan</th><th>Feb</th><th>Mar</th><th>April</th><th>May</th><th>June</th></tr>
<tr><td>3</td><td>0</td><td>0</td><td>0</td><td>2</td><td>3</td></tr>
</table>
This is a NHS Highland BS measures which is not reported locally -Data across FQ4 and FQ1 shows an erratic trend in performance against target (0)</td></tr>
<tr><td>5</td><td>Number of treatment time guarantee ongoing waits >12 weeks

As above. Reported</td><td>0</td><td>4</td><td>0</td><td>
<table>
<tr><th colspan="3">FQ4 17/18</th><th colspan="3">FQ1 18/19</th></tr>
<tr><th>Jan</th><th>Feb</th><th>Mar</th><th>April</th><th>May</th><th>June</th></tr>
<tr><td>0</td><td>0</td><td>0</td><td>1</td><td>1</td><td>4</td></tr>
</table>
</td></tr>
</table>

Performance Indicator & Source Definitions	Target	Actual	Benchmark Performance Against Previous Quarter	Head of Service Actions to Improve Performance
from Local data Warehouse Snapshot at month end)				• LIH: Oral Surgery – demand greater than clinic/theatre capacity. Discussion held with Dental lead to review current referral pathway

6 MSG Measures Performance Reporting FQ1 (18/19)

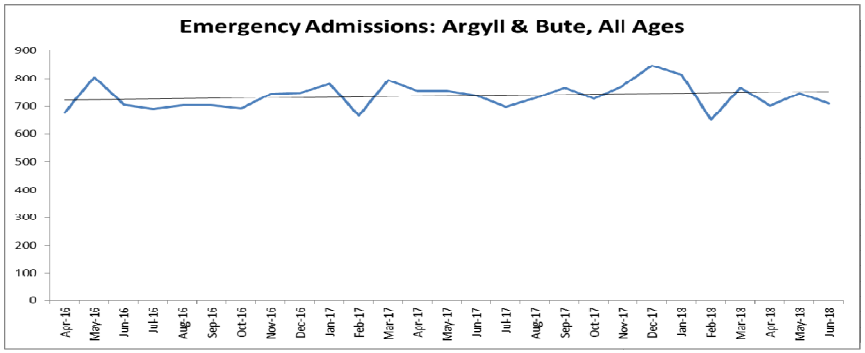
The Ministerial Steering Group (MSG) performance measures have been developed in addition to the National HWBOI's. The function of these performance measures is to examine macro performance activity trends relating to improved outcomes through the integration of service delivery across the HSCP. The data below notes the Argyll & Bute and Greater Glasgow & Clyde split with regards to the performance total against our agreed targets with MSG. These indicators are an overview of our performance and also contribute to our overall performance with regards to the commissioning of services within the GG&C hospitals.

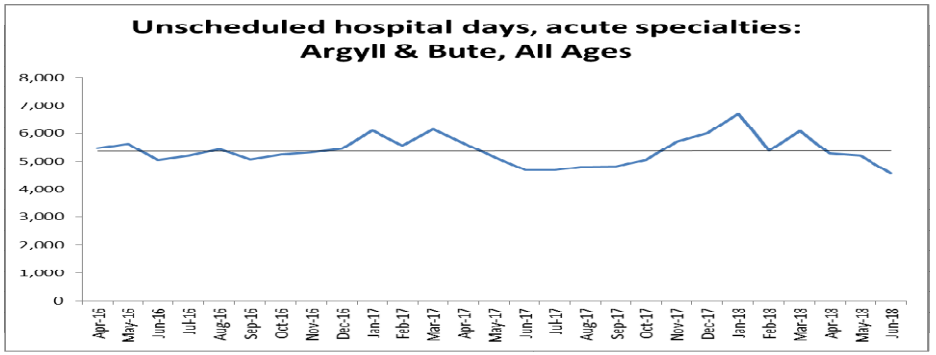
MSG Indicator	Objective	Target Q1 18/19	Actual Q1 18/19	A&B Actual	* A&B Target	GG&C Actual	*GG&C Target	Performance Variance Analysis for FQ4 & FQ1
Unplanned Admissions	Expected FY 2018/19 target 8332 - based on 5% reduction in overall total compared to FY17/18	2074	2119	998	*1003*	1121	*1071*	Quarterly performance is 2.2% off target 53% (1121) unplanned admissions reported in Greater Glasgow and Clyde health board hospitals
Unplanned Bed Days	Expected FY 2018/19 target 56687 - based on 0.6% reduction in overall total compared to FY17/18	14166	14877	7002	*7069*	7875	*7097*	Quarterly performance is 5.0% off target 53% (7875) unplanned bed days reported in Greater Glasgow and Clyde health board hospitals
A& E Attendance	Expected FY 2018/19 target 16194 - based on sustained levels in overall total compared to FY17/18 (Please note that ISD only count the attendances at Lorn & Islands Hospital for this data set as a consultant led unit)	4046	4190	1782	*1730*	2408	*2316*	Quarterly performance is 3.6% off target 57% (2408) A&E attendances reported in Greater Glasgow and Clyde health board hospitals
Delayed Discharge Bed Days Occupied	Expected FY 2018/19 target 7037 - based on 10% reduction in overall total compared to FY 17/18	1755	2194	1791	*1490*	403	*265*	Quarterly performance is 25.0% off target 81.6% (1791) Delayed Discharge bed days occupied reported in Argyll and Bute (NHS Highland) health board hospitals

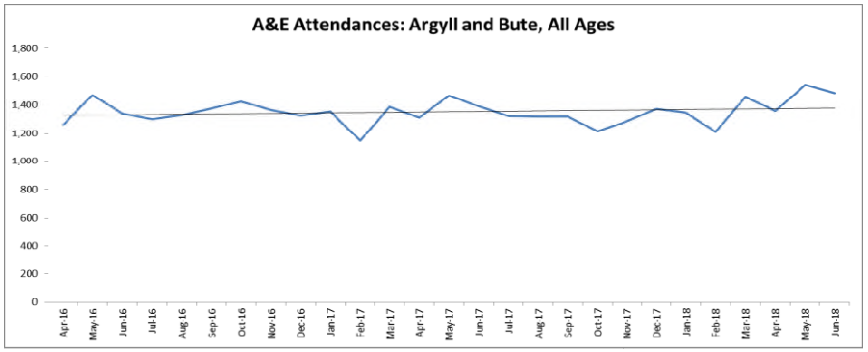
* Targets by Board of Activity are indicative based on expected % of activity applied to overall A&B HSCP target

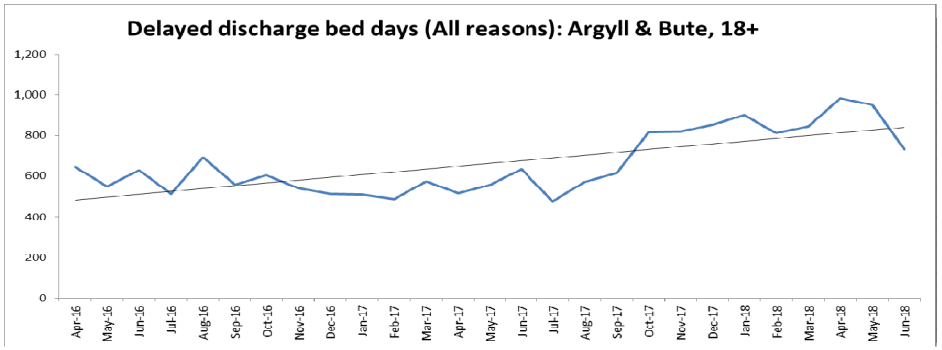
6.1 MSG Performance indicators Trends

The graphs below show the total monthly performance activity and include a trend line measure for the four MSG indicators April 2016 –to June 2018. Delayed discharges is showing a worsening trend whilst the other 3 are generally showing no improvement.









7. Governance Implications

7.1 Contribution to IJB Objectives

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

7.2 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.

7.3 Staff Governance

A number of indicators under outcomes 9 are pertinent for staff governance purposes

7.4 Planning for Fairness:

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

7.5 Risk

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

7.6 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

7.7 Public Engagement and Communication

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

Appendix 1- Duplicate Health & Wellbeing Outcome Measures

The table below details the duplicated measures which have been removed across the 9 Health & Wellbeing Outcome Indicators.

HWBOI's	1	2	3	4	5	7	9	Total
% of adults supported at home who agree that their health and care services seemed to be well co-ord			1				1	2
% of adults supported at home who agree they had a say in how their support was provided		1	1					2
% of health & care resource spend on hospital stays, patient admitted in an emergency		1		1		1	1	4
% of SW care services graded 'good' '4' or better in Care Inspectorate inspections			1	1		1		3
AC21 <=3 weeks wait between SM referral & 1st treatment		1			1			2
Emergency Admissions bed day rate		1		1		1		3
Falls rate per 1,000 population aged 65+		1		1		1	1	4
No of days people spend in hospital when ready to be discharged, per 1,000 population		1	1	1			1	4
Proportion of last 6 months of life spent at home or in a community setting		1	1				1	3
Rate of emergency admissions per 100,000 population for adults	1	1		1	1	1		5
Rate of premature mortality per 100,000 population	1				1			2
Readmission to hospital within 28 days per 1,000 admissions		1	1			1	1	4
Total	**2**	**9**	**6**	**6**	**3**	**6**	**6**	**38**

In addition duplicated measures were removed that were identified within the Customer Service, these already reported to the IJB in other reports

Appendix 2 - A&B HSCP Benchmark HWBOI Performance for FQ1 2018/19

The table below identifies the most recent SOURCE performance data with regards to Argyll & Bute HSCP and the Scotland wide performance against the 9 HWBOI's and their 23 sub-indicators.

Indicator	Title	Current score	Scotland
NI - 1	Percentage of adults able to look after their health very well or quite well	93%	93%
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	79%	81%
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	76%	76%
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	72%	74%
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	80%	80%
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	85%	83%
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	74%	80%
NI - 8	Total combined % carers who feel supported to continue in their caring role	33%	37%
NI - 9	Percentage of adults supported at home who agreed they felt safe	83%	83%
NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA
NI - 11	Premature mortality rate per 100,000 persons	380	425
NI - 12	Emergency admission rate (per 100,000 population)	12,617	12,256
NI - 13	Emergency bed day rate (per 100,000 population)	107,548	121,516
NI - 14	Readmission to hospital within 28 days (per 1,000 population)	87	101
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	90%	88%
NI - 16	Falls rate per 1,000 population aged 65+	26	22
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	77%	85%
NI - 18	Percentage of adults with intensive care needs receiving care at home	67%	61%
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	625	762
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22%	24%
NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA
NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA
NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA

Appendix 3 - HSCP Performance Reporting Timetable

The table below identifies key reporting dates and stages for current IJB and HSCP wide performance reporting. Note the outcome indicators to be reported on will change following the conclusion of the review and agreement of the IJB.

IJB Dates	Reporting Period	Draft Papers to HSP&P	Paper for SLT	Papers for Admin	Pre-Agenda Meeting	Reported Outcomes	Community Services Committee	NHS Board-Deadline
28th November 2018	FQ1 18/19 (Apr - Jun)	31st October	5th November	12th November	16th November	3 &4	11th December	15th Jan 2019
Wednesday 30th January 2019 No Report								
Wednesday 27th March 2019	FQ2 18/19 (Jul – Sep)	28th February 2019	Early Mar TBC	TBC	Mid-March TBC	5, 6,7 & 8	14th March 2019	14th May 2019
Wednesday 29th May 2019	FQ3 18/19 (Oct – Dec)	30th April 2019	Early May TBC	TBC	Mid May TBC	9	TBC	9th July 2019
Wednesday 7th August 2019	FQ4 18/19 (Jan – Mar)	28th June 2019	Early Jul TBC	TBC	Mid July TBC	1 & 2	TBC	10th Sept 2019
Wednesday 2nd October 2019 No Report								
Wednesday 27th November 2019	FQ1 19/20 (Apr - Jun)	31st October 2019	Early Nov TBC	TBC	Mid Nov TBC	3,4, & 5	TBC	No dates available

Integration Joint Board **Agenda item: 5.11**

Date of Meeting: **28 November 2018**

Title of Report: **Chief Officer Report**

Presented by: **Joanna Macdonald, Chief Officer**

The Integration Joint Board is asked to:

- Note the following report from the Chief Officer

Summary

As illustrated by the agenda, the Improvement and Quality & Finance plan are the key strategic direction with focus given to the delivery of quality and value services to the Argyll & Bute communities.

We are strengthening our partnership delivery through a strategic approach to planning and commissioning and supporting our front line staff with the necessary developments in their professional practice.

In line with developing our approach to Governance, we are concentrating the management resource to accelerate the process of transformation to the delivery of an integrated service.

The Health and Social Care Partnership has indicated some milestones in the development of Mental Health Services. This is demonstrative of the capability for an innovative approach across all of the service areas with the values at the heart of the delivery.

We inform through our public health work stream promoting health improvement and anticipatory care.

We are engaging with the challenges as we scope, consult and design services that are required of a rural health and social care service. We will seek that the board continues to support the HSCP in this area. Not least of these will be the forthcoming delivery of the new GP contract.

Campbeltown Hospital Celebrates its 25th Anniversary

Earlier this month staff from Campbeltown Hospital held an open day and invited the public to take a trip down memory lane to celebrate the 25th anniversary of the opening of the hospital.

Staff, former staff and members of the public came along on the day to mark the occasion, find out more about the history of the hospital and view a display of old photographs of the hospital over the last 25 years.

Helensburgh Childrens House Receives Positive Inspection

The Care Inspectorate recently published their report on their unannounced inspection to the Helensburgh Childrens House in September this year.

The inspection had no recommendations and graded the service as follows:

Quality of care and support	5 - Very good
Quality of management and leadership	5 - Very good

The report also outlined that the inspectors spoke to young people, their families and others involved in their care and support. Some of the young people they spoke to highlighted that they felt a strong sense of belonging and positive regard for their individual experience of living at the service.

There was also good evidence of young people being encouraged to maximise their opportunities and improve their wellbeing. The inspectors also found that the service listened to young people about what they wanted for the future and worked alongside other professionals to ensure seamless transitions to placements suited to their needs.

Dialysis Unit to be Developed on Bute

The HSCP, in partnership with the Bute Kidney Patients Support Group and the Dr J N Marshall (Island of Bute) Memorial Trust, is delighted that there has been agreement to build a Dialysis Unit in the Victoria Hospital in Rothesay.

The first meeting of the Island of Bute Hospital Dialysis Project Implementation Group was held on the 16th October 2018 where they were presented with plans from the HSCP's Project Architect and had a full discussion about formalising the project.

The HSCP will also be working very closely with NHS Greater Glasgow and Clyde to replicate the Hub and Spoke outreach model of Dialysis that is currently being delivered in Campbeltown Hospital and which has proven to be very successful.

Big Conversation Event

On the 7th November the Chief Officer and the Head of Service for Children and Families met with a number of young people in the Civic Centre in Helensburgh as part of the 'Big Conversation'.

This event was organised by the Council's Youth Services Team and provided a platform for young people to talk to senior representatives from the HSCP, the Council Leader, members of the Scottish Youth Parliament and a range of community planning representatives.

Scottish Health Awards 2018

A team of health and social care professionals from Oban, who operate under the Oban Living Well Initiative banner, were recently runners up for a Scottish Health Award.

These awards celebrate and recognise the work of the people on the frontline of health and social care services in Scotland and the team was nominated for the Integrated Care for Older People Award.