TO: ALL MEMBERS, ELECTED MEMBERS AND OFFICER REPRESENTATIVES OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

(See Distribution List attached)

Clerk and Standards Officer:
Roger Mennie
Head of Democratic and Legal Services
Dundee City Council

Assistant to Clerk:
Willie Waddell
Committee Services Officer
Dundee City Council

City Chambers
DUNDEE
DD1 3BY

22nd February, 2019

Dear Sir or Madam

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

I refer to the agenda of business issued in relation to the meeting of the above Integration Joint Board which is to be on Tuesday, 26th February 2019 at 2.00 pm and now enclose the undernoted items of business which were not received at the time of issue.

Yours faithfully

DAVID W LYNCH

Chief Officer

4 PERFORMANCE AND AUDIT COMMITTEE (page no. 1)

(b) CHAIRS ASSURANCE REPORT

(Report No DIJB11-2019 by the Chairperson of the Performance and Audit Committee, copy attached).

10 FINANCIAL MONITORING POSITION AS AT DECEMBER 2018 (page no. 3)

(Report No DIJB7-2019 by the Chief Finance Officer, copy attached).

11 DELEGATED BUDGET 2019/2020 DEVELOPMENT – PROGRESS REPORT (page no. 15)

(Report No DIJB8-2019 by the Chief Finance Officer, copy attached).

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
DISTRIBUTION LIST

(a) DISTRIBUTION - INTEGRATION JOINT BOARD MEMBERS

(* - DENOTES VOTING MEMBER)

Role	Recipient
Non Executive Member (Chairperson)	Trudy McLeay *
Elected Member (Vice Chairperson)	Councillor Ken Lynn *
Elected Member	Councillor Roisin Smith *
Elected Member	Bailie Helen Wright *
Non Executive Member	Jenny Alexander *
Non Executive Member	Dr Norman Pratt *
Chief Social Work Officer	Jane Martin
Chief Officer	David W Lynch
Chief Finance Officer	Dave Berry
Registered medical practitioner (whose name is included in the list of primary medical services performers)	Dr Frank Weber
Registered nurse	Sarah Dickie
Registered medical practitioner (not providing primary medical services)	Dr Cesar Rodriguez
Staff Partnership Representative	Raymond Marshall
Trade Union Representative	Jim McFarlane
Third Sector Representative	Christine Lowden
Service User residing in the area of the local authority	Linda Gray
Person providing unpaid care in the area of the local authority	Martyn Sloan
Director of Public Health	Dr Drew Walker

(b) DISTRIBUTION – FOR INFORMATION ONLY

Organisation	Recipient
NHS Tayside (Chief Executive)	Chief Executive
Dundee City Council (Chief Executive)	David R Martin
Dundee City Council (Head of Democratic and Legal Services)	Roger Mennie
Dundee City Council (Members' Support)	Jayne McConnachie
Dundee City Council (Members' Support)	Dawn Clarke
Dundee City Council (Members' Support)	Fiona Barty
Dundee City Council (Communications rep)	Steven Bell
NHS Tayside (Communications rep)	Jane Duncan
NHS Tayside (PA to Director of Public Health)	Linda Rodger
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
Audit Scotland (Senior Audit Manager)	Bruce Crosbie

ITEM No …4(b)…….

Dundee Health & Social Care Partnership

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD - 26 FEBRUARY 2019**

REPORT ON: **PERFORMANCE AND AUDIT COMMITTEE CHAIR'S ASSURANCE REPORT**

REPORT BY: **CHAIR, PERFORMANCE AND AUDIT COMMITTEE**

REPORT NO: **DIJB11-2019**

Instructions Issued by the Committee

The committee issued the following instructions in relation to the business laid before it:

- Item V Dundee Health and Social Care Partnership Performance Report – 2018/19 Quarter 2: *instructed the Chief Finance Officer to amend the way in which performance reporting to the PAC is provided in that summary reports only for quarters 1 and 3 of each financial year are submitted with full performance reports provided for quarters 2 and 4*.

- Item VII Falls Performance and Action Plan – *requested further information on what was being done to reduce the 15 week waiting time from referral for Otago maintenance classes.*

- Item VIII Clinical, Care and Professional Governance Group Chair's Assurance Report – *requested details of what mandatory training had not been carried out.*

- Item IX Transformation and Service Redesign Internal Audit Report – *remitted the Chief Finance Officer to provide an action plan in response to the issues raised in the report.*

- Item X 2017/18 Annual Internal Audit Report – Action Plan Update – *remitted the Chief Finance Officer to report back to Committee prior to June 2019 to provide an update on outstanding actions.*

- Item XI Risk Management Action Plan – *instructed the Chief Finance Officer to provide an update on the action plan in September 2019.*

Issues to highlight to the Board

- I undertook the role of Chair for the meeting in Councillor Ken Lynn's absence and welcomed Jenny Alexander and Dr Norman Pratt to their first Performance and Audit Committee meeting.

- The Measuring Performance Under Integration 2019/20 Submission to the Ministerial Strategic Group (MSG) for Health and Community Care sets out challenging but realistic targets for which the partnership's performance will be measured over the coming year. Given the uncertainties around the financial position, while these will be submitted to the MSG by the end of February, they will remain in draft until the IJB sets its budget at the end of March.

- The PAC accepted a recommendation to change the performance reporting to the PAC from 2019/20 which would see a combination of summary data and more in depth information being presented at various meetings throughout the year.

- The Committee noted the mid-year performance summary which outlined areas of continued improved performance such as a reduction in emergency bed days and delayed discharge bed days, mixed performance in relation to emergency admissions with areas of declining performance being readmission rates and falls related admissions.

- In relation to the latter, the committee noted a more in-depth report around falls performance and associated action plan. The committee was pleased to see the action plan and will continue to monitor performance following implementation of the actions.

- The Committee noted the outcome of the Transformation and Service Redesign Internal Audit Report and raised concerns around the timing of a number of actions given the findings of the report were “inadequate”. Assurance was sought and given that the actions will be reviewed and brought forward if possible.

- The Committee noted the risk management action plan and invited Colin Carmichael, the Council’s Corporate Risk Management Coordinator to the table for additional comment. The Committee looks forward to an update in due course.

Bailie Helen Wright
Acting Chair **20 February 2019**

ITEM No …10…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 26 FEBRUARY 2019**

REPORT ON: **FINANCIAL MONITORING POSITION AS AT DECEMBER 2018**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB7-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board with an update of the projected financial monitoring position for delegated health and social care services for 2018/19.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report including the overall projected financial position for delegated services to the 2018/19 financial year end as at 31 December 2018 as outlined in Appendices 1 and 2 of this report.

2.2 Approves the use of historical legacy funding as a key element of the IJB's financial recovery plan as set out in section 4.1.5 of this report in order to deliver the net projected financial position reflected in the report

3.0 FINANCIAL IMPLICATIONS

3.1 The financial monitoring position for Dundee Health and Social Care Partnership based on expenditure to 31 Dec 2018 shows a net projected overspend position of £166k after implementing a financial recovery plan through the use of legacy funding and through effecting the planned draw down of reserves to support the 2018/19 financial position as agreed by the IJB as part of the budget setting process. This position is an improvement from the previously reported overspend of £1,681k. Despite the reduction in the net projected overspend, a number of financial pressure areas remain, primarily in relation to GP prescribing (+£504k) and the net impact of hosted services (+£714k).

4.0 MAIN TEXT

4.1 Background

4.1.1 As part of the IJB's financial governance arrangements, the Integration Scheme outlines that "The Chief Finance Officer will ensure routine financial reports are available to the Chief Officer and the Integration Joint Board on a timely basis and include, as a minimum, annual budget, full year outturn projection and commentary on material variances."

4.1.2 The IJB set out its final budget for delegated services at its meeting of the 28 August 2018 following receipt of confirmation of NHS Tayside's budget (Article XIII of the minute refers). Within this report, the risks around the prescribing budget were reiterated after being formally noted in the initial budget report presented to a special meeting of the IJB held on 30 March 2018 (Article V of the minute refers) in addition to Report DIJB41-2018 (Dundee Prescribing Management Position) considered by the IJB at its meeting held on 27 June 2018 (Article X of the minute refers).

4.1.3 The financial information presented has been provided by the finance functions of NHS Tayside and Dundee City Council as set out within the Integration Scheme.

4.1.4 Under the terms of the Integration Scheme, the risk sharing arrangements in relation to any residual overspends incurred by the end of the financial year will be met proportionately by the Council and NHS Tayside. . Both parties have been advised of the partnership's financial position throughout the financial year and given the scale of previous months projected overspends, the parties have requested a financial recovery plan.

4.1.5 In response to the request to the financial recovery plan, officers from the partnership have continued to exercise scrutiny over expenditure areas, including a risk based approach to vacancy management which has reduced particular pressure areas. In addition, NHS Tayside passed over a range of historical legacy funds during the financial year which had been held on behalf of the IJB. These included historic change funding streams and while some of this funding came with in-year commitments, including decisions the IJB had previously made, much of the funding remains uncommitted. It is recommended that the IJB agrees to the use of these remaining resources of £1,018k to contribute to the associated overspend areas within the 2018/19 revenue budget. The funding streams and commitments are set out below:

LEGACY FUNDING	**Funding Value £**	**Already Committed £**	**Residual Value £**
Change Funding	1,062,000	(462,000)	600,000
ADP Funding	378,000	(255,000)	123,000
Mental Health Innovation Funding	158,000	(124,000)	34,000
Primary Care Transformation Funding	395,000	(133,900)	261,100
Palliative Care Funding	44,000	(44,000)	0
Trauma Improvement Funding	111,000	(111,000)	0
Total	**2,148,000**	**(1,129,900)**	**1,018,100**

4.2 Projected Outturn Position – Key Areas

4.2.1 The following sets out the main areas of note from the financial information contained within Appendices 1 (Summary Position) and 2 (More Detailed Position) and provides commentary on the reasons for significant variances, actions being taken to manage these and outlines the key elements of risk which may remain.

4.3 Services Delegated from NHS Tayside

4.3.1 The financial projection for services delegated from NHS Tayside to the IJB indicates a projected overspend of around £166k by the end of the financial year after the applying the unspent legacy funding as set out in section 4.1.5 above. Of the overspend £714k relates to the net effect of hosted services risk sharing arrangements with a further £1k in relation to General Medical /Family Health services. GP prescribing is £504k overspent while community based health services managed directly by Dundee Health and Social Care Partnership is projected to be underspend by approximately £2k.

4.3.2 Service underspends are reported within Allied Health Professionals (£389k), Community Mental Health (£90k), Keep Well (£160k) and hosted services such as Psychology (£536k) and Dietetics (£215k) mainly as a result of staff vacancies.

4.3.3 Staff cost pressures continue to exist in a number of other services such as the Medicine for the Elderly (+£655k), Palliative Care (+£164k) and Community Nursing Services (+95k). Additional staffing pressures have contributed to the adverse position within these services through ensuring safe staffing levels in accordance with the National Nursing and Midwifery workload tools requirements.

4.3.4 The Family Health Services prescribing budget currently projects a shortfall totalling £504k based on the expenditure trends to date and the impact of a range of interventions as part of the Tayside wide Prescribing Management Group's action plan as noted in the Dundee Prescribing Management Position report presented to the June 2018 IJB meeting (Report DIJB41-2018). This is a significantly improved position from the previous financial monitoring report of October 2018 where an overspend of £914k was anticipated.

4.3.5 Members of the IJB will also be aware that Angus and Perth and Kinross IJBs host delegated services on behalf of Dundee IJB and a number of services are hosted by Dundee on behalf of Angus and Perth and Kinross. These are subject to a risk sharing agreement whereby any over or underspends are reallocated across the three Tayside IJBs at the end of the financial year. The financial monitoring position of these services in their totality are reflected in each of the IJB's financial monitoring reports and for information purposes the projected net impact of these services on each IJB's budgeted bottom line figure is noted. More detail of the recharges from Angus and Perth and Kinross IJBs to Dundee IJB are noted in Appendix 3. This shows net overspends to the value of £803k being recharged with the net impact of hosted services to Dundee being an overspend of £714k.

4.3.6 As with 2017/18, the financial position of Dundee City IJB continues to be impacted upon by the significant overspend in the Mental Health Inpatient service which is hosted by Perth & Kinross IJB. Perth and Kinross IJB has continued to utilise cost pressure funding and apply other interventions to reduce the overspend position in respect of this service provision. However the latest projection from Perth and Kinross shows Dundee's share of this overspend increased slightly from the £576k previously reported to £618k. This position is driven by undelivered savings carried forward from previous years, medical locum costs and nursing costs in General Adult Psychiatry. Plans to reduce and offset costs are not yet impacting on the financial position as anticipated. This includes savings anticipated from Mental Health, Learning Difficulties, Inpatient, Transformation Programme against which slippage is now anticipated. Furthermore, the Out of Hours service hosted by Angus IJB continues to present a financial risk with a projected overspend of £122k.

4.3.7 The Chief Finance Officer formally wrote to the Chief Finance Officers of Angus and Perth and Kinross IJB's in November 2018 on behalf of Dundee Integration Joint Board to request information on the reasons for the scale of the overspends and details of the recovery plan they are working to in order to deliver a reduction or removal of the overspend position. In relation to In Patient Mental Health Services, and in addition to the issues set out in section 4.3.6 above, a number of other pressures such as loss of assumed income from other areas due to changes in accommodation and availability of beds have been incurred. These have been partly offset by decreases in nursing and locum costs. A new leadership team is in place which is working through a significant programme of work to move the service towards financial balance, albeit this plan will cover a three year period. Discussions with NHS Tayside continue around temporary financial support. The Out of Hours Service has now undertaken a comprehensive financial analysis of its service. This does create challenges in terms of delivering the required level of care within historic budgets. Angus HSCP are considering options to remodel staffing in the longer term and may look at other funding options.

4.4 Services Delegated from Dundee City Council

4.4.1 The financial projection for services delegated from Dundee City Council to the IJB shows a balanced budget position at this stage of the financial year after application of £1,983k of reserve balances as agreed by the IJB as part of the 2018/19 budget setting process. This net position however consists of a range of overspending and underspending areas noted below.

4.4.2 A significant financial challenge facing the IJB's delegated budget continues to be the provision of home based social care with a projected overspend of £223k anticipated, mainly as a result of increased demand due to demographic factors with the underlying cost of service provision also increasing. In addition, expenditure on respite care is higher than budget by around £259k again mainly due to high levels of demand. In line with the IJB's strategic vision, the range of service developments around multi-disciplinary models of care primarily through the Enhanced Community Support Acute Model have started to impact positively through a reduction in care home placements with an underspend of around £707k anticipated in the current financial year for older people care home placements. The resultant underspend however will be required to support the Enhanced Community Support Acute Model on a permanent basis as set out within the Proposed Model of Care for Older People Report agreed by the IJB at its meeting of 31 October 2017 (Article VII of the minute refers).

4.4.3 A range of underspends within Substance Misuse and Management and Support functions mainly arising from staff turnover as well as slippage in the development of new services are currently projected to balance these budget pressure areas.

4.5 Primary Care Improvement Funding and Mental Health Action 15 Funding

4.5.1 The above funding streams have been provided by the Scottish Government from this financial year onwards and have been subject to separate reporting to the IJB with plans set out at the IJB's meeting of 28 August 2018 (Articles IX and XII of the minute refer). Given the timescales for developing, submitting and approving expenditure plans associated with these funding streams it was always anticipated that significant expenditure slippage would occur. Indeed the Scottish Government withheld 30% of funding to partnerships unless they could demonstrate full commitment of expenditure during the year, with this balance being released in the following financial year. Dundee's anticipated expenditure profile for this year is set out below. It should be noted that any underspends in relation to these funds have not been included in the delegated budgets overall financial position as the Scottish Government is clear they should be spent on primary care improvement and in relation to the Mental Health Action 15 priorities.

18/19 Financial Position	Primary Care £	Mental Health £	Total £
2018/19 Funding:			
2018/19 Allocation Received (70%)	789,777	228,135	1,017,912
2018/19 Allocation Retained by SG for use in future years (30%)*	338,476	97,772	436,248
Pharmacotherapy Initial Allocation	227,223		
Transfers from Angus and Perth	66,091		
Total Funding Available	**1,421,567**	**325,907**	**1,454,160**
Current Forecast Expenditure as at Jan 2019	**447,220**	**181,000**	**628,200**
Forecast Slippage to be Carried Forward to 2019/20	**974,347**	**144,907**	**1,119,254**

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a significant risk that the IJB is unable to deliver a balanced budget over the financial year.
Risk Category	Financial
Inherent Risk Level	Likelihood 4 x Impact 5 = Risk Scoring 20 (which is Extreme Risk Level)
Mitigating Actions (including timescales and resources)	The IJB has agreed a range of efficiency savings and other interventions including the use of reserves to balance expenditure. A range of service redesign options through the Transformation Programme will offer opportunities to further control expenditure. Regular financial monitoring reports to the IJB will highlight issues raised.
Residual Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is a High Risk Level)
Planned Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is a High Risk Level)
Approval recommendation	While the inherent risk levels are extreme, the impact of the planned actions reduce the risk and therefor the risk should be accepted.

7.0 CONSULTATIONS

The Chief Officer, Executive Director of Corporate Services (Dundee City Council), Director of Finance of NHS Tayside and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 8 February 2019

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Appendix 1

DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP - FINANCE REPORT 2018/19 **Dec-18**

	Dundee City Council Delegated Services		NHST Dundee Delegated		Partnership Total	
	Net Budget £,000	Projected Overspend / (Underspend) £,000	Net Budget £,000	Projected Overspend / (Underspend) £,000	Net Budget £,000	Projected Overspend / (Underspend) £,000
Older Peoples Services	38,530	(246)	15,982	219	54,512	(27)
Mental Health	4,358	(21)	3,345	(100)	7,703	(121)
Learning Disability	22,753	243	1,279	(30)	24,032	213
Physical Disabilities	6,485	79	0	0	6,485	79
Substance Misuse	959	(182)	2,671	40	3,630	(142)
Adult	351	198	11,296	(294)	11,647	(96)
Hosted Services	0	0	18,877	(451)	18,877	(451)
Other Dundee Services / Support / Mgmt	257	(72)	25,878	(340)	26,135	(412)
Centrally Managed Budgets	0	1,983	2,393	(64)	2,393	1,919
Total Health and Community Care Services	**73,694**	**1,983**	**81,721**	**(1,020)**	**155,415**	**963**
Prescribing (FHS)	0	0	32,738	504	32,738	504
Other FHS Prescribing	0	0	811	(33)	811	(33)
General Medical Services	0	0	25,036	34	25,036	34
FHS - Cash Limited & Non Cash Limited	0	0	18,072	(33)	18,072	(33)
Grand Total	**73,694**	**1,983**	**158,378**	**(548)**	**232,072**	**1,435**
Net Effect of Hosted Services*			5,481	714	5,481	714
Grand Total	73,694	1,983	163,859	166	237,553	2,149
Less: Planned Draw Down From Reserve Balances		(1,983)				(1,983)
Grand Total	**73,694**	**(0)**	**163,859**	**166**	**237,553**	**166**
***Hosted Services - Net Impact of Risk Sharing Adjustment**						

Appendix 2

Dundee City Integration Joint Board – Health and Social Care Partnership – Finance Report Dec 2018

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Psychiatry Of Old Age (POA) (In Patient)			4,594	66	4,594	66
Older People Serv. – Ecs			0	(500)	0	(500)
Older Peoples Services -Community			310	0	310	0
Continuing Care			1,338	0	1,338	0
Medicine for the Elderly			4,871	655	4,871	655
Medical (POA)			641	(5)	641	(5)
Psychiatry Of Old Age (POA) - Community			1,859	(125)	1,859	(125)
Intermediate Care			865	93	865	93
Dundee- Supp People At Home			0	0	0	0
Medical (MFE)			1,504	35	1,504	35
Older People Services	38,530	(246)			38,530	(246)
Older Peoples Services	38,530	(246)	15,982	219	54,512	(27)
General Adult Psychiatry			3,345	(100)	3,345	(100)
Mental Health Services	4,358	(21)			4,358	(21)
Mental Health	4,358	(21)	3,345	(100)	7,703	(121)
Learning Disability (Dundee)	22,753	243	1,279	(30)	24,032	213
Learning Disability	22,753	243	1,279	(30)	24,032	213

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Physical Disabilities	6,485	79			6,485	79
Physical Disabilities	6,485	79	0	0	6,485	79
Drug Problems Services			2,671	40	2,671	40
Substance Misuse	959	(182)			959	(182)
Substance Misuse	959	(182)	2,671	40	3,630	(142)
A.H.P. Admin			374	1	374	1
Physiotherapy			3,478	(260)	3,478	(260)
Occupational Therapy			1,309	(130)	1,309	(130)
Nursing Services (Adult)			5,606	150	5,606	150
Community Supplies - Adult			155	(25)	155	(25)
Anticoagulation			374	(30)	374	(30)
Joint Community Loan Store			0	0	0	0
Intake/Other Adult Services	351	198			351	198
Community Nurse Services / AHP / Intake / Other Adult Services	351	198	11,296	(294)	11,647	(96)

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Palliative Care – Dundee			2,587	78	2,587	78
Palliative Care – Medical			1,105	(6)	1,105	(6)
Palliative Care – Angus			324	12	324	12
Palliative Care – Perth			1,609	80	1,609	80
Brain Injury			1,613	105	1,613	105
Dietetics (Tayside)			2,766	(215)	2,766	(215)
Sexual and Reproductive Health			2,065	(20)	2,065	(20)
Medical Advisory Service			154	(48)	154	(48)
Homeopathy			27	4	27	4
Tayside Health Arts Trust			58	0	58	0
Psychology			4,906	(536)	4,906	(536)
Eating Disorders			0	0	0	0
Psychotherapy (Tayside)			894	170	894	170
Learning Disability (Tayside AHP)			769	(75)	769	(75)
Hosted Services	0	0	18,877	(451)	18,877	(451)
Working Health Services			0	0	0	0
The Corner			407	25	407	25
Resource Transfer			0	0	0	0
Grants Voluntary Bodies Dundee			46	0	46	0
IJB Management			804	(65)	804	(65)
Partnership Funding			23,068	0	23,068	0
Carers Strategy			0	0	0	0
Public Health			450	(80)	450	(80)
Keep Well			590	(160)	590	(160)
Primary Care			514	(60)	514	(60)
Support Services/Management Costs	257	(72)			257	(72)
Other Dundee Services / Support / Mgmt	257	(72)	25,878	(340)	26,135	(412)

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Centrally Managed Budgets	0	1,983	2,383	(64)	2,393	1,919
Total Health and Community Care Services	**73,694**	**1,983**	**81,721**	**(1,020)**	**155,415**	**963**
Other Contractors						
Prescribing (FHS)			32,738	504	32,738	504
Other FHS Prescribing			811	(33)	811	(33)
General Medical Services			25,036	34	25,036	34
FHS - Cash Limited and Non Cash Limited			18,072	(33)	18,072	(33)
Grand Total HSCP	**73,694**	**1,983**	**158,378**	**(548)**	**232,072**	**1,435**
Hosted Recharges Out			(11,077)	(89)	(11,077)	(89)
Hosted Recharges In			16,558	803	16,558	803
Hosted Services - Net Impact of Risk Sharing Adjustment			**5,481**	**714**	**5,481**	**714**
Less: Planned Draw Down from Reserves		(1,983)				(1,983)
NET POSITION	**73,694**	**0**	**163,859**	**166**	**237,553**	**166**

Appendix 3

NHS Tayside - Services Hosted by Integrated Joint Boards - Charge to Dundee IJB
Risk Sharing Agreement - Dec 2018

Services Hosted in Angus	Annual Budget	Forecast Over (Underspend)	Dundee Allocation
Forensic Service	914,533	(35,000)	(13,790)
Out of Hours	7,431,950	310,000	122,140
Tayside Continence Service	1,430,626	(90,000)	(35,460)
Ang-loc Pharmacy	1,200,000	0	0
Speech Therapy (Tayside)	982,650	(1,500)	(591)
Hosted Services	**11,959,759**	**183,500**	**72,299**
Balance of Savings Target	(122,365)	122,400	48,226
Grand Total Hosted Services	**11,837,394**	**305,900**	**120,525**

Services Hosted in Perth			
Angus Gap Inpatients	2,204,370	340,000	133,960
Dundee Gap Inpatients	5,486,710	425,000	167,450
Dundee Gap Snr Medical	1,950,746	412,500	162,525
P+K Gap Inpatients	5,417,211	265,000	104,410
Learning Disability (Tayside)	6,009,500	125,000	49,250
T.A.P.S.	653,265	(45,000)	(17,730)
Tayside Drug Problem Services	823,652	(135,000)	(53,190)
Prison Health Services	3,239,317	0	0
Public Dental Service	2,006,586	10,000	3,940
Podiatry (Tayside)	2,833,180	(103,000)	(40,582)
Hosted Services	**30,624,537**	**1,294,500**	**510,033**
Balance of Savings Target	(99,507)	99,507	39,206
Balance of Savings Target - IPMH	(337,546)	337,546	132,993
Grand Total Hosted Services	**30,187,484**	**1,731,553**	**682,232**

Total Hosted Services	**42,024,878**	**2,037,453**	**802,756**

ITEM No …11…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 26 FEBRUARY 2019**

REPORT ON: **DELEGATED BUDGET 2019/20 DEVELOPMENT – PROGRESS REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB8-2019**

1.0 PURPOSE OF REPORT

1.1 The purpose of this paper is to provide the Integration Joint Board (IJB) with an updated overview of the delegated budget 2019/20. This paper forms phase two of a set of three budget development reports to be presented to each IJB meeting leading up to the meeting of 29 March 2019 when the delegated budget will be laid before the IJB for approval.

2.0 RECOMMENDATIONS

It is recommended that the IJB:

2.1 Notes the content of this report including the potential implications to the delegated budget of the impact of the Scottish Government's Budget on Dundee City Council and NHS Tayside's financial settlements as set out in sections 4.3, 4.4, 4.5 and Appendix 1 of this report;

2.2 Remits to the Chief Finance Officer to bring forward a proposed budget for 2019/20 in relation to delegated services as the final phase of the development of the budget for consideration by the IJB at its meeting on 29 March 2019.

3.0 FINANCIAL IMPLICATIONS

3.1 The revised cost pressure estimate will be set against the confirmed available resources within the delegated budget once these have been agreed by Dundee City Council and NHS Tayside at their respective budget setting meetings. The resultant funding gap and transformation and efficiency savings plan will be presented to the IJB at its meeting of 29 March 2019 for approval.

4.0 BACKGROUND

4.1 Report DIJB72-2018 (Delegated Budget 2019/20 – Initial Outlook) presented to the December meeting of the IJB set out an initial overview of the projected financial pressures likely to be faced within the delegated budget during 2019/20 as phase one of a set of three budget reports leading to the planned finalisation of the IJB's budget at the end of March 2019. This report focussed on the totality of the potential pressures but did not at that stage identify the funding solutions which would offset these given the relative stages of the budget process within NHS Tayside and Dundee City Council and the overall Scottish Government's Budget. The identified cost pressures totalled around £14.2m.

4.2 Since then, officers within Dundee Health and Social Care Partnership have undertaken a further review of these cost pressures using the most up to date intelligence and assumptions and have continued to dialogue with Dundee City Council and NHS Tayside in relation to their own cost pressure assumptions and funding position including developments around the Scottish Government's Budget. This includes consideration of current and future pay award negotiations. This report provides an updated position to the IJB on these issues however it should be noted that due to the budget setting timescales for Dundee City Council and NHS Tayside, the delegated budget's position cannot be finalised until both of these have been concluded.

4.3 **Scottish Government Budget Position**

4.3.1 The Scottish Government's Draft Scottish Budget had just been issued at the time of the December IJB meeting therefore the content of the draft budget including its intentions to invest in health and social care had not been formally laid before the IJB for noting at that stage. However in the subsequent period, discussions have been held at a national level through COSLA and the Scottish Government in relation to the Local Government Settlement which has resulted in more clarity around the financial flexibility that local government can exercise over its resources and in particular in relation to delegated budgets to integration authorities.

4.3.2 Within the draft budget issued in December 2018 the Cabinet Secretary set out proposals for further investment to support health and social care. This consists of an additional £40m to be included in the core local government settlement to support the continued implementation of the Carers (Scotland) Act 2016 and extending free personal care to under 65s. A further £120m will be transferred from the Health portfolio to local government for investment in integration including delivery of the Living Wage, uprating free personal care and school counselling services (the latter national amount of £12m is not a delegated function to Dundee IJB). This funding is to be additional to each council's recurrent 2018/19 spend on social care. While the distribution of free personal care for under 65's funding has not as yet been confirmed, Dundee's share of this funding is set out as follows:

Funding	**National Value** **£m**	**Dundee Share** **£m**
Share of £108m (£120m less School Counselling £12m)	108	3.252
Carers Act	10.5	0.301
Free Personal Care for Under 65s	29.5	0.888*
Total Additional Investment	148	4.441

**Estimated figure – National Distribution of funding not yet confirmed*

4.3.3 At the end of January 2019, the Cabinet Secretary for Finance, Economy and Fair Work set out in his Budget Bill Part 1 a range of further measures to be made available to local authorities to support their financial position including the core local government settlement. This includes a range of additional local tax raising powers such as the "tourist tax", workplace parking levy, the ability to increase council tax by up to 4.79% and an increase to the core local government settlement of £90m.

4.3.4 In relation to funding to integration authorities, the Cabinet Secretary has agreed to allow local authorities the flexibility to offset their adult social care allocations by up to 2.2% compared to 2018/19 i.e. up to £50m across all local authorities to help them manage their own budgets. It is therefore within this revised financial context that Dundee City Council's financial planning framework has been developed.

4.4 Dundee City Council Budget Position

4.4.1 Dundee City Council's budget was set on 21 February 2019 which is after this report has been issued therefore the final delegated budget offer is not confirmed at the time of writing. A verbal update will be provided at the IJB's meeting however it is anticipated that through a combination of inflationary uplifts, allocation of Scottish Government additional funding offset by a share of the council's savings required to balance the council budget, the delegated budget will be subject to a net uplift of approximately £3.5m (inclusive of indicative allocation for free personal care for under 65s the distribution of which is still to be agreed nationally). The confirmed value of this and therefore the impact on the delegated budget and subsequent level of IJB savings required will be formally laid before the IJB at its meeting on 29 March 2019.

4.5 NHS Tayside Budget Position

4.5.1 The Scottish Government's Draft Budget set out that all Health Boards would receive a minimum funding uplift of 2.5% to their baseline budgets with some boards also receiving a further share of £23m to ensure NRAC (national resource allocation committee funding formula) parity. NHS Tayside will receive a 2.6% uplift and will also receive a share of the additional NRAC resource by £2.1m giving a total uplift of 2.8%.

4.5.2 The Scottish Government has stated that NHS payments to Integration Authorities for delegated health functions must deliver a real terms uplift in baseline funding, before provision of funding for pay awards, over 2018-19 cash levels. The NHS Tayside Director of Finance has indicated that subject to the NHS Board approving its Financial Plan on 28 February 2019, the delegated budgets for the three Tayside IJB's will receive a 2.6% uplift in line with NHS Tayside core uplift. This is likely to result in a funding uplift of approximately £2.8m. Discussions continue regarding potential share of the additional £2.1m NRAC funding.

4.5.3 The 2.6% overall uplift to the delegated budget is likely to fund the majority of the inflationary pressures within the health expenditure element of the budget. Any resultant funding shortfall will be as a result of existing funding pressures and the replacement of non-recurring savings from previous years. This is anticipated to be around £2m.

4.6 Large Hospital Set aside

4.6.1 A key component of the overall funding of health and social care is in relation to progressing the arrangements to release resources through the Large Hospital Set Aside mechanism. The system reform assumptions in the Scottish Government's Health and Social Care Medium Term Financial Framework include material savings to be achieved from reducing variation in hospital utilisation across partnerships. Planning across the whole unplanned care pathway is key to delivering this objective and the Scottish Government has set out that partnerships must ensure that by the start of 2019-20, the set aside arrangements are fit for purpose and enable this approach. The Scottish Government will work with Integration Authorities, Health Boards and Local Authorities to ensure the legislation and statutory guidance on hospital specialties delegated to Integration Authorities, particularly in relation to set aside budgets, is put into practice. This will continue to be a focus of financial planning in conjunction with NHS Tayside.

4.7 Primary Care and Mental Health Action 15 Funding

4.7.1 The Scottish Government's Draft Scottish Budget sets out the continued additional planned funding for Primary Care transformation and Mental Health Action 15 Funding. Primary Care funding will increase from £120m to £155m in 2019/20 while Mental Health and CAMHS funding will increase from £47m to £61m.

4.7.2 Dundee core share of the Primary Care Funding for 2019/20 is £1,630k which will be enhanced through a transfer from Angus and Perth and Kinross to recognise GP practice boundaries and patient flow. The share of Mental Health funding is £504k. Both of these funding streams are subject to strong governance arrangements through the Scottish Government and come with high expectations of delivering increased capacity and improvement within the respective areas.

4.8 Dundee IJB Revised Financial Planning Assumptions 2019/20

4.8.1 The revised estimated financial impact of the range of factors likely to affect the level of delegated budget, including current year's pressures and moving from non-recurring savings for 2018/19 to recurring savings (given the high usage of reserves in 2018/19), inflationary pressures, the cost of new legislation and national policies is set out in Appendix 1.

4.8.2 While the projected additional costs to the delegated budget in total of £14.317m are similar in value to the previous December Budget Outlook report (£14.237m), the make up of these costs are different as the latest report includes commitments for Primary Care and Mental Health for which funding is provided, additional funding for posts for Protecting People Transformation and changes to assumptions such as pay awards, third sector funding, the cost of the national care home contract, legislation and national policies, current year budget pressures and anticipated demographic pressures.

4.9 Savings and Transformation Programme

4.9.1 While significant levels of additional funding are anticipated to be provided by both NHS Tayside and Dundee City Council as part of their respective delegated budget offers, these will not be sufficient to balance the cost pressures set out above. Therefore a range of service savings and Transformation Programme savings are currently being developed to be presented to the IJB at its meeting in March in order to set a balanced budget. Given the potential scale of savings required, there will be a number of challenging decisions for the IJB to make.

4.9.2 The IJB will be provided with comprehensive reports of the implications of any savings proposal put forward to ensure members are fully informed when making budget decisions at the IJB's meeting on 29 March.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that the IJB will not be able to balance its resources and achieve its strategic objectives should the combination of the level of funding provided through the delegated budget and the impact of the IJB's Transformation Efficiency Programme be insufficient.
Risk Category	Financial
Inherent Risk Level	Likelihood 4 x Impact 4 = 16 (Extreme)
Mitigating Actions (including timescales and resources)	Developing a robust and deliverable Transformation Programme Negotiations with Dundee City Council and NHS Tayside to agree the most advantageous funding package as part of the development of the IJB's delegated budget.
Residual Risk Level	Likelihood 3 x Impact 4 = 12 (High)
Planned Risk Level	Likelihood 3 x Impact 4 = 12 (High)
Approval recommendation	Despite the high level of risk, it is recommended that this should be accepted at this stage of the budget process with a reviewed position set out as the proposed budget is set out to the IJB in March 2019.

7.0 CONSULTATION

The Chief Officer, the Director of Finance - NHS Tayside, Executive Director - Corporate Services, Dundee City Council and the Clerk have been consulted on the content of this paper.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 19 February 2019

Appendix 1

DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP		
REVENUE BUDGET 2019/20		
Anticipated Cost Pressures:		**Total Delegated Budget Cost Pressures**
		£000
Current Year Non-Recurring Savings / Budget Pressures		
2018/19 Legacy Savings Gap		**2,837**
Current Year Budget Pressures		**1,100**
Total Current Years Funding Requirements		**3,937**
New Pressures 2019/20 - Inflationary Pressures/Demographic Growth		
Staff Pay Increases (includes impact of 18/19 additional 0.5%)		**3,179**
Increased Costs of Externally Provided Services (including living wage)		**1,527**
Anticipated Demographic Demand Growth		**1,500**
Prescribing Growth		**667**
Total Inflationary / Demographic Pressures		**6,872**
National Policy / Legislative Costs:		
Carers Act Implementation - Year 2		**301**
Free Personal Care for Under 65s*		**888**
Free Personal & Nursing Care Rate Increases		**65**
Primary Care Improvement Plan		**1,630**
Mental Health Action 15		**504**
Total National Policy / Legislative Costs		**3,389**
Dundee City Council Additional Commitments (Additional Public Protection Posts)		**119**

Total Anticipated Cost Pressures 2019/20		**14,317**
Anticipated Net Funding Increase:**		
Dundee City Council (including share of £160m for social care)*		**3,519**
NHS Tayside		**2,786**
Scottish Government Funding - Primary Care / Mental Health		**2,134**
Total Anticipated Additional Funding		**8,439**
Net Anticipated Residual Funding Shortfall		**5,878**
* Distribution of Scottish Government national funding for Free Personal Care for Under 65s has not yet been announced		
** Final Figures to be confirmed		

TO: ALL MEMBERS, ELECTED MEMBERS AND OFFICER REPRESENTATIVES OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

(See Distribution List attached)

Clerk and Standards Officer:
Roger Mennie
Head of Democratic and Legal Services
Dundee City Council

Assistant to Clerk:
Willie Waddell
Committee Services Officer
Dundee City Council

City Chambers
DUNDEE
DD1 3BY

19th February, 2019

Dear Sir or Madam

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

I would like to invite you to attend a meeting of the above Integration Joint Board which is to be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 26th February 2019 at 2.00 pm.

Apologies for absence should be intimated to Willie Waddell, Committee Services Officer, on telephone 01382 434228 or by e-mail willie.waddell@dundeecity.gov.uk

Yours faithfully

DAVID W LYNCH

Chief Officer

A G E N D A

1 APOLOGIES FOR ABSENCE

2 DECLARATION OF INTEREST

Members are reminded that, in terms of the Integration Joint Board's Code of Conduct, it is their responsibility to make decisions about whether to declare an interest in any item on this Agenda and whether to take part in any discussions or voting.

3 MINUTE OF PREVIOUS MEETING - Page 1

The minute of previous meeting of the Integration Joint Board held on 18th December, 2018 is attached for approval.

4 PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF PREVIOUS MEETING OF 12TH FEBRUARY, 2019 - Page 9

(Copy attached for information and record purposes).

(b) CHAIRS ASSURANCE REPORT

(Report No DIJB11-2019 by the Chairperson of the Performance and Audit Committee, copy to follow).

5 DUNDEE CHILD PROTECTION COMMITTEE ANNUAL REPORT 2017/2018 - Page 13

(Report No DIJB3-2019 by the Chief Social Work Officer, copy attached).

6 AUDIT SCOTLAND REPORT – HEALTH AND SOCIAL CARE INTEGRATION - UPDATE ON PROGRESS - Page 71

(Report No DIJB9-2019, by the Chief Finance Officer, copy attached).

7 STRATEGIC COMMISSIONING PLAN 2019/2022 – PROGRESS UPDATE - Page 131

(Report No DIJB5-2019, by the Chief Officer, copy attached).

8 MEASURING PERFORMANCE UNDER INTEGRATION 2019/2020 SUBMISSION - Page 197

(Report No DIJB6-2019 by the Chief Officer, copy attached).

9 NATIONAL SUICIDE PREVENTION ACTION PLAN: EVERY LIFE MATTERS - Page 227

(Report No DIJB2-2019 by the Chief Officer, copy attached).

10 FINANCIAL MONITORING POSITION AS AT DECEMBER 2018

(Report No DIJB7-2019 by the Chief Finance Officer, copy to follow).

11 DELEGATED BUDGET 2019/2020 DEVELOPMENT – PROGRESS REPORT

(Report No DIJB8-2019 by the Chief Finance Officer, copy to follow).

12 PROPOSED NEW "PAUSE" SERVICE FOR DUNDEE - Page 277

(Report No DIJB1-2019 by the Chief Social Work Officer, copy attached).

13 ARRANGEMENTS FOR MANAGING HIGH RISK OFFENDERS - Page 283

(Report No DIJB4-2019 by the Chief Social Work Officer, copy attached).

14 MEETINGS OF THE INTEGRATION JOINT BOARD 2018 – ATTENDANCES - Page 307

A copy of the attendance return for meetings of the Integration Joint Board held to date over 2018 is attached for information.

15 DATE OF NEXT MEETING

The next meeting of the Integration Joint Board Budget will be held in Committee Room 1, 14 City Square, Dundee, on Friday, 29th March, 2019 at 2.00 pm. (This meeting is primarily to agree the Budget for 2019/2020).

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
DISTRIBUTION LIST

(a) DISTRIBUTION - INTEGRATION JOINT BOARD MEMBERS

(* - DENOTES VOTING MEMBER)

Role	Recipient
Non Executive Member (Chairperson)	Trudy McLeay *
Elected Member (Vice Chairperson)	Councillor Ken Lynn *
Elected Member	Councillor Roisin Smith *
Elected Member	Bailie Helen Wright *
Non Executive Member	Jenny Alexander *
Non Executive Member	Dr Norman Pratt *
Chief Social Work Officer	Jane Martin
Chief Officer	David W Lynch
Chief Finance Officer	Dave Berry
Registered medical practitioner (whose name is included in the list of primary medical services performers)	Dr Frank Weber
Registered nurse	Sarah Dickie
Registered medical practitioner (not providing primary medical services)	Dr Cesar Rodriguez
Staff Partnership Representative	Raymond Marshall
Trade Union Representative	Jim McFarlane
Third Sector Representative	Christine Lowden
Service User residing in the area of the local authority	Linda Gray
Person providing unpaid care in the area of the local authority	Martyn Sloan
Director of Public Health	Dr Drew Walker

(b) DISTRIBUTION – FOR INFORMATION ONLY

Organisation	Recipient
NHS Tayside (Chief Executive)	Chief Executive
Dundee City Council (Chief Executive)	David R Martin
Dundee City Council (Head of Democratic and Legal Services)	Roger Mennie
Dundee City Council (Members' Support)	Jayne McConnachie
Dundee City Council (Members' Support)	Dawn Clarke
Dundee City Council (Members' Support)	Fiona Barty
Dundee City Council (Communications rep)	Steven Bell
NHS Tayside (Communications rep)	Jane Duncan
NHS Tayside (PA to Director of Public Health)	Linda Rodger
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
Audit Scotland (Senior Audit Manager)	Bruce Crosbie

Dundee Health & Social Care Partnership

ITEM No …3……..

At a MEETING of the **DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 18th December, 2018.

Present:-

Members	**Role**
Trudy McLEAY *(Chairperso*n)	Nominated by Health Board (Non-Executive Member)
Ken LYNN (*Vice Chairperson*)	Nominated by Dundee City Council (Elected Member)
Roisin SMITH	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
Norman PRATT	Nominated by Health Board (Non-Executve Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
Sarah DICKIE	Registered Nurse
Jane MARTIN	Chief Social Work Officer
Drew WALKER	Director of Public Health
Raymond MARSHALL	Staff Partnership Representative
Jim McFARLANE	Trade Union Representative
Christine LOWDEN	Third Sector Representative
Martyn SLOAN	Person providing unpaid care in the area of the local authority

Non members in attendance at the request of the Chief Officer:-

Diane McCULLOCH, Dundee Health and Social Care Partnership
Dr David SHAW, Dundee Health and Social Care Partnership
Kathryn SHARP, Dundee Health and Social Care Partnership
Alexis CHAPPELL, Dundee Health and Social Care Partnership
Arlene MITCHELL, Dundee Health and Social Care Partnership
Sheila ALLAN, Dundee Health and Social Care Partnership
Ruth BROWN, Dundee Health and Social Care Partnership
Elaine TORRANCE, Dundee Adult Support and Protection Committee (Independent Convenor)
Lucinda GODFREY, Dundee Carers' Centre

Trudy McLEAY, Chairperson, in the Chair.

Prior to the commencement of the business the Chairperson, Trudy McLeay, introduced herself and gave information to her background and advised that she welcomed her appointment to the position of Chairperson of Dundee Integration Joint Board and looked forward to working with the Integration Joint Board in progressing the Dundee Health and Social Care Partnership for the benefit of the people of Dundee.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of:-

Members	**Role**
Cesar RODRIGUEZ	Registered Medical Practitioner (not providing primary medical services)
Jenny ALEXANDER	Nominated by Health Board (Non-Executive Member)
Frank WEBER	Registered Medical Practitioner (whose name is included in the list of primary medical performers)

II DECLARATION OF INTEREST

Christine Lowden declared a non-financial interest in relation to the item of business at Article XIII of this minute by virtue of her work with the Alcohol and Drug Partnership.

III MEMBERSHIP OF DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – SERVICE USER REPRESENTATIVE

Reference was made to Article III(c) of the minute of meeting of this Integration Joint Board held on 30th October, 2018, wherein it was noted that the service user position on the Integration Joint Board was vacant and that a report would be submitted to a future meeting of this Integration Joint Board on proposed appointment to this position.

It was reported that Andrew Jack who had been appointed as a member of Dundee Integration Joint Board in the capacity of service user representative had submitted his resignation from the Integration Joint Board resulting in the vacancy and that a new member in respect of service users residing in the area had been sought from NHS Tayside Public Partners to fill the vacant position of office.

The Integration Joint Board agreed:-

(i) to note that the new service user representative on Dundee City Health and Social Care Integration Joint Board had been identified as Linda Gray; and

(ii) that Linda Gray be appointed as a member of Dundee City Health and Social Care Integration Joint Board in the capacity of Service User Representative.

IV MINUTE OF PREVIOUS MEETING

The minute of previous meeting of the Integration Joint Board held on 30th October, 2018 was submitted and approved.

V PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF PREVIOUS MEETING OF 27TH NOVEMBER, 2018

The minute of previous meeting of the Performance and Audit Committee held on 27th November, 2018 was submitted and noted for information and record purposes.

(b) CHAIR'S ASSURANCE REPORT

There was submitted Report No DIJB74-2018 by Ken Lynn, Chairperson of the Performance and Audit Committee providing an assurance report to the Integration Joint Board on the work of the Performance and Audit Committee.

The Integration Joint Board agreed to note the content of the report.

VI STANDING ORDERS INCLUDING TERMS OF REFERENCE FOR THE PERFORMANCE AND AUDIT COMMITTEE

Reference was made to Article X of the minute of meeting of this Integtration Joing Board held on 27th October, 2015 wherein the Integration Joint Board agreed to adopt the Standing Orders of the Integration Joint Board.

Refrence was also made to Article IX of the minute of meeting of this Integration Joint Board held on 30th August, 2016 wherein the Integrationn Joint Board agreed to the establishment of the Performance and Audit Committee as a Standing Committee of the Integration Board and also agreed the Terms of Reference for the Committee.

There was submitted Report No DIJB73-2018 by the Clerk and Standards Officer seeking approval to the proposed amendments to the Integration Joint Board's Standing Orders including the proposed Terms of Reference for the Performance and Audit Committee which were attached to the Standing Orders as detailed in the Appendix to the report.

The Integration Joint Board agreed:-

(i) to approve the proposed amendments to the Standing Orders including the proposed Terms of Reference for the Performance and Audit Committee which were attached to the Standing Orders as detailed in the appendix to the report;

(ii) to remit the Clerk and Standards Officer to the Integration Joint Board to amend the Standing Orders including the proposed Terms of Reference for the Performance and Audit Committee which were attached to the Standing Orders accordingly and that these be distributed to the membership and placed on the website for Dundee Health and Social Care Partnership; and

(iii) that, the amended Standing Orders including the proposed Terms of Reference for the Performance and Audit Committee which were attached to the Standing Orders be effective from the next meeting of the Integration Joint Board which would be held on 26th February, 2019.

VII DUNDEE MENTAL HEALTH AND WELLBEING STRATEGIC PLAN 2019-2024

There was submitted Report No DIJB64-2018 by the Chief Officer providing a briefing on the intended strategic direction for mental health and wellbeing developments in Dundee and seeking authority to progress the finalisation of a Strategic Plan in collaboration with key stakeholders.

Arlene Mitchell, Service Manager, Dundee Health and Social Care Partnership, Ruth Brown and Sheila Allan, gave a joint presentation in supplement to the report.

The Integration Joint Board agreed:-

(i) to note the contents of the presentation and that a copy of the presentation and electronic link to film footage be issued to the Integration Joint Board for their information;

(ii) to endorse the strategic direction outlined within the draft Dundee Mental Health and Wellbeing Strategic Plan 2019-2024 which was attached to the report as Appendix 1;

(iii) to instruct the Mental Health and Wellbeing Strategic and Commissioning Group to engage further with key stakeholders and existing networks in order to finalise the Plan and to note the extensive consultation undertaken to date as outlined in the report;

(iv) to instruct the Chief Officer to present a final Plan to a meeting of the Integration Joint Board early in 2019;

(v) to instruct the Chief Officer to present a Commissioning and Financial Framework with the final Strategic Plan to a meeting of the Integration Joint Board in early 2019;

(vi) to instruct the Mental Health and Wellbeing Strategic and Commissioning Group to continue to develop a reporting framework to ensure that performance in relation to the priorities outlined in the Strategic Plan was managed effectively;

(vii) that this performance measure be indicative of what the Group perceived as being what they wished to achieve so that assurance may be provided to the Integration Joint Board; and

(viii) to remit to the Chief Officer of the Integration Joint Board in consultation with the Mental Health and Wellbeing Strategic and Commissioning Group the authority to make commissioning decisions throughout the life of the Plan, once this was formalised and published.

VIII CHIEF SOCIAL WORK OFFICER GOVERNANCE FRAMEWORK

There was submitted Report No DIJB62-2018 by the Chief Social Work Officer providing information on a new Chief Social Work Officer Governance Framework, which outlined the statutory duties and functions of the Chief Social Work Officer and the arrangements to provide assurances about the quality of Social Work Services. The Framework was approved by the Policy and Resources Committee of Dundee City Council on 24 September 2018.

The Integration Joint Board agreed:-

(i) to note the statutory duties and functions of the Chief Social Work Officer and requirements to have a Governance Framework to assist them in carrying out their role;

(ii) to note the contents of the Governance Framework which outlined the arrangements in place to provide assurances on each requirement relating to the Chief Social Work Officer role, a copy of which was attached to the report as Appendix 1;

(iii) to note the arrangements described in section 4.8 of the report would meet recommendations of the Audit Scotland Report on Social Work as summarised in Appendix 2 of the report which emphasised the importance of having effective governance arrangements in place;

(iv) to note the commitment from the Chief Social Work Officer to provide advice and leadership to the Integration Joint Board, including thematic reports and briefings as required as indicated in section 4.9 of the report of the report; and

(v) to note the continued requirement for the Chief Social Work Officer to provide Annual reports which were considered by both Dundee City Council and the Integration Joint Board.

IX CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2017/2018

There was submitted Report No DIJB61-2018 by the Chief Social Work Officer providing details of the Chief Social Work Officer's Annual Report for 2017/18, which was attached to the report as Appendix 1. The report was approved by the Policy and Resources Committee of Dundee City Council on 19th November 2018.

The Integration Joint Board agreed to note the content of the report and the Chief Social Work Officer's Annual Report for 2017-18 which was attached to the report as Appendix 1.

X DUNDEE ADULT SUPPORT AND PROTECTION COMMITTEE, INDEPENDENT CONVENOR'S BIENNIAL REPORT 2016-2018

There was submitted Report No DIJB63-2018 by the Independent Convenor of the Dundee Adult Support and Protection Committee's Biennial Report for the period April 2016 – March 2018, which included a summary of the work undertaken and priorities identified for 2018 – 2020.

Thereafter, having heard the Independent Convenor in supplement to the report the Integration Joint Board agreed:-

(i) to note the content of the Independent Convenor's Report which was attached to the report as Appendix 1;

(ii) to note the progress achieved in relation to the previous Independent Convenor's recommendations for 2016 – 2018 as outlined in section 4.5 of the report; and

(iii) to note the priorities identified by the current Independent Convenor for 2018 – 2020 as outlined in section 4.6 of the report.

XI FINANCIAL MONITORING REPORT AS AT OCTOBER 2018

Reference was made to Article XIII of the minute of meeting of this Integration Joint Board held on 28th August, 2018 wherein the final budget for delegated services was set.

There was submitted Report No DIJB65-2018 by the Chief Finance Officer providing an update of the projected financial monitoring position for delegated health and social care services for 2018/19.

The Integration Joint Board agreed:-

(i) to note the content of the report including the overall projected financial position for delegated services to the 2018/19 financial year end as at 31st October, 2018 as set out in the appendices which were attached to the report; and

(ii) to instruct the Chief Finance Officer to report back to the next meeting of the Integration Joint Board with the outcome of the responses from Chief Finance Officer of Perth and Kinross Integration Joint Board and the Chief Finance Officer of Angus Integration Joint Board in relation to recovery plans for hosted services as noted in section 4.3.7 of the report.

The Integration Joint Board further agreed:-

(iii) to note that the reference to Nursing Services in section 4.3.3 of the report was in relation to Community Nursing Services; and

(iv) to note that the reference to additional staffing pressures within the services referred to in section 4.3.3 of the report was through ensuring safe staffing levels in accordance with the National Nursing & Midwifery workload tools requirements.

XII DELEGATED BUDGET 2019/20 – INITIAL OUTLOOK

There was submitted Report No DIJB72-2018 by the Chief Finance Officer providing an initial overview of the delegated budget 2019/20 following publication of Dundee City Council's Financial Outlook 2019/2022 and the Scottish Government's Medium Term Health and Social Care Financial Framework. The report formed phase one of a set of three budget development reports to be presented to each Integration Joint Board meeting leading up to the meeting of the 29th March, 2019 when the delegated budget would be laid before the Integration Joint Board for approval.

The Integration Joint Board agreed:-

(i) to note the content of the report including the potential implications to the delegated budget of the impact of the Scottish Government's Budget on Dundee City Council and NHS Tayside's financial settlements as set out in sections 4.2 and 4.3 of the report;

(ii) to note the potential implications of these and the range of increased costs and cost pressures to Dundee Integration Joint Board's delegated budget and subsequent indicative level of budget requisition to Dundee City Council and NHS Tayside as set out in section 4.4 of the report and Appendix 1 of Integration Joint Board report to enable the Integration Joint Board to deliver the priorities as set out within its Strategic and Commissioning Plan;

(iii) to remit to the Chief Finance Officer to bring an updated report as phase two of the development of the budget to the Integration Joint Board meeting to be held on 26th February 2019 to further inform the budget setting process; and

(iv) to remit to the Chief Finance Officer to bring forward a proposed budget for 2019/20 in relation to delegated services as phase three of the development of the budget for consideration by the Integration Joint Board at its meeting on the 29th March, 2019.

XIII SUBSTANCE MISUSE REDESIGN UPDATE

Reference was made to Article XI of the minute of meeting of this Integration Joint Board held on 30th October, 2018 wherein a Local Investment Plan for use of Scottish Government funding in relation to the redesign of substance misuse services was approved.

There was submitted Report No DIJB66-2018 by the Chief Officer providing information about the redesign of substance misuse services and seeking approval to release Dundee Alcohol and Drug Partnership resources carried forward from previous financial years held by Dundee Integration Joint Board to progress the proposed Dundee Alcohol and Drug Partnership Investment Plan.

The Integration Joint Board agreed:-

(i) to note the content of the report and approve the Substance Misuse Redesign Programme Implementation Plan which was attached to the report as Appendix 1;

(ii) to note that the intentions within the Substance Misuse Redesign Programme and the proposed Alcohol and Drug Partnership Investment Plan supported the delivery of the Dundee Health and Social Care Strategic and Commissioning Plan 2016 – 2021 as described in section 4.1.6 of the report and the Substance Misuse Strategic Commissioning Plan 2018 – 2021;

(iii) to approve the release of Alcohol and Drug Partnership resources carried forward from previous years and held by the Integration Joint Board in order to implement the proposed Alcohol and Drug Partnership Investment Plan agreed by the Dundee Alcohol and Drug Partnership on 22nd November, 2018 which was attached to the report as Appendix 2;

(iv) to request a report on progress with the Redesign Programme to be submitted to a meeting of the Integration Joint Board in six months; and

(v) that the Chief Officer be remitted to issue directions to Dundee City Council and NHS Tayside as outlined in the report.

XIV CARERS (SCOTLAND) ACT 2016 IMPLEMENTATION UPDATE

There was submitted Report No DIJB67-2018 by the Chief Officer providing information about progress with implementation of the Carers (Scotland) Act 2016 and seeking approval for the Carers (Scotland) Act Investment Plan.

The Integration Joint Board agreed:-

(i) to note the progress made in implementing the Carer's (Scotland) Act 2016 as outlined at section 5 of the report;

(ii) to remit the Chief Officer to issue the directions set out in section 9.0 of the report;

(iii) to approve the Carers (Scotland) Act funding investment plan which was attached to the report as Appendix 1; and

(iv) to note that a Dundee Carers Partnership Bi Annual Report would be published by May 2019 and would include self-evaluation against first full year of Carers (Scotland) Act 2016 implementation.

XV CARERS (SCOTLAND) ACT 2016 – SHORT BREAKS STATEMENT

There was submitted Report No DIJB69-2018 by the Chief Officer seeking approval of the Dundee Short Breaks Statement.

The Integration Joint Board agreed:-

(i) to note the duties and powers placed on Local Authorities through the Carers (Scotland) Act 2016 regarding the duty to prepare a Short Break Statement as outlined in the report;

(ii) to approve the Dundee Short Break Service Statement which was attached to the report as Appendix 1; and

(iii) to instruct the Chief Officer to publish the Short Break Statement on Dundee Health and Social Care Partnership, Carers of Dundee and the Dundee Mylife Webpages.

XVI AWARD OF CONTRACT FOR THE SUPPLY OF COMMUNITY EQUIPMENT FOR THE DUNDEE AND ANGUS EQUIPMENT LOAN SERVICES

There was submitted Report No DIJB68-2018 by the Chief Officer providing information regarding a Framework Agreement for the supply of equipment to the Dundee and Angus Equipment Loan Service. The Service was hosted by the Dundee Health and Social Care Partnership and was required to tender for the provision of equipment to ensure best value for money.

The Integration Joint Board agreed:-

(i) to approve the tendering of equipment by the Dundee and Angus Equipment Loan Service; and

(ii) to note that approval would be sought from Dundee City Council Policy and Resources Committee on 7th January, 2019 regarding the Equipment Framework Agreement.

XVII COMMUNITY CUSTODY UNIT IN DUNDEE

There was submitted Report No DIJB70-2018 reporting that on 22nd October, 2018 the Planning Committee of Dundee City Council approved the application by the Scottish Prison Service (SPS) to build a Community Custody Unit for 16 females in Dundee, on the site of the former Our Lady's Primary School in Coldside. The intention was that the facility would open in 2020 and would build on the well-established approach to women delivered through the Justice centre based at Friarfield.

The rationale behind a small local Community Custody Unit embedded within a community, as opposed to a large institutional conventional prison, flowed from the 2011 Commission on Women Offenders (Angiolini Report) which emphasised that women in prison often had clusters of support and vulnerability issues, such as being victims of domestic abuse, childhood sexual abuse, mental health and substance misuse issues. Women in prison were assessed as being lower risk to others than males. Women in prison could also lose contact with their own children and their family networks when separated by geographical distance. The Community Custody Unit would prioritise admission to women from the Tayside and North Fife area, as well as prioritising admission to women who were assessed to be heading toward a transition phase, most commonly toward the end of a sentence. Women in the "Community Custody Unit" should be able to maintain stronger links to family supports and stronger links to community support, including increasing contact with community services, as and when they met the criteria for community access.

Initial discussion had begun about how the health and social care services should be delivered to support the women in the Community Custody Unit. There would require to be some in-unit provision, as not all women would qualify for community access, yet alongside this the ethos of the Community Custody Unit would be to encourage links to local services, as women prepared to re-enter the community. The negotiations around support provision also needed to factor-in that not all the women would be normally resident in Dundee and also look at social work provision.

The Integration Joint Board agreed to note the contents of the document and that a further report to Integration Joint Board would be submitted when these discussions, involving Prison Healthcare (hosted by NHS Perth) and Dundee Health and Social Care partnership, were further advanced.

XVIII DEVELOPMENT OF TAYSIDE PUBLIC HEALTH STRATEGY

There was submitted Report No DIJB71-2018 by the Chief Officer reporting that the NHS Tayside Directorate of Public Health was in the process of developing a Tayside Public Health Strategy. The strategy would set out the vision and key priority areas for action to protect and improve health across Tayside and would be centred on values of equity, empowerment and inclusivity and based on the principle of partnership and co-production.

The Integration Joint Board agreed:-

(i) to note the content of the report and welcomed the contribution of our partner organisations and associated networks in the development of the Tayside Public Health Strategy; and

(ii) to note the invitation to the ongoing involvement of partner organisations with the strategy, including commenting on the final draft, participation in development and implementation of an action plan and assistance in evaluation of impact of the strategy.

XIX MEETINGS OF THE INTEGRATION JOINT BOARD 2018 – ATTENDANCES

There was submitted a copy of the attendance return for meetings of the Integration Joint Board held to date over 2018.

The Integration Joint Board agreed to note the position as outlined.

XX DATE OF NEXT MEETING

The Integration Joint Board agreed to note that the next meeting of the Integration Joint Board would be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 26th February, 2019 at 2.00 pm.

Trudy McLEAY, Chairperson.

ITEM No …4(a)……

At a MEETING of the **PERFORMANCE AND AUDIT COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 12th February, 2019.

Present:-

Members	**Role**
Helen WRIGHT (*Chairperson)*	Nominated by Dundee City Council (Elected Member)
Jenny ALEXANDER	Nominated by Health Board (Non Executive Member)
Dave BERRY	Chief Finance Officer
David W LYNCH	Chief Officer
Norman PRATT	Nominated by Health Board (Non Executive Member)

Non-members in attendance at the request of the Chief Finance Officer:-

Colin CARMICHAEL	Corporate Services, Dundee City Council
Stephen HALCROW	Dundee Health and Social Care Partnership
Clare HARPER	Dundee Health and Social Care Partnership
Kathryn SHARP	Dundee Health and Social Care Partnership
David VERNON	Corporate Services, Dundee City Council

Helen WRIGHT, in the Chair.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of:-

Ken LYNN	Nominated by Dundee City Council (Elected Member)
Raymond MARSHALL	Staff Partnership Representative
Jane MARTIN	Chief Social Work Officer
Cesar RODRIGUEZ	Registered Medical Practitioner (not providing primary medical services)

II DECLARATION OF INTEREST

No declarations of interest were made.

III MINUTE OF PREVIOUS MEETING

The minute of meeting of the Committee held on 27th November, 2018 was submitted and approved.

IV MEASURING PERFORMANCE UNDER INTEGRATION 2019/20 SUBMISSION

There was submitted Report No PAC1-2019 by the Chief Finance Officer seeking approval of the 2019/20 submission made by the Partnership to the Ministerial Strategic Group for Health and Community Care (MSG) as part of the Measuring Performance Under Integration Workstream.

The Committee agreed:-

(i) to endorse the 2019/20 submission to the MSG as outlined in Appendix 3 of the report;

(ii) to note the methodology used to develop proposed targets for submission to the MSG as outlined in section 4.2.1, Appendix 1 and Appendix 2 of the report; and

(iii) to note that 2019/20 targets will remain in draft until such times as the Integration Joint Board budget for 2019/20 has been confirmed as outlined in section 4.2.2 of the report.

V DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2018/19 QUARTER 2

There was submitted Report No PAC2-2019 by the Chief Finance Officer updating Committee on 2018/19 Quarter 2 performance against the National Health and Wellbeing Indicators and 'Measuring Performance Under Integration' interim targets.

The Committee agreed:-

(i) to note the content of the report;

(ii) to note the performance of Dundee Health and Social Care Partnership, at both Dundee and locality levels, against the National Health and Wellbeing Indicators as summarised in section 6 and Appendix 1 of the report;

(iii) to note the performance of Dundee Health and Social Care Partnership against the 'Measuring Performance Under Integration' interim targets as summarised in section 6 and Appendix 1 of the report; and

(iv) to instruct the Chief Finance Officer to submit to Committee summary reports only for Quarters 1 and 3 of each financial year and full performance reports for Quarters 2 and 4 of each financial year, as described in section 7 of the report.

A number of queries arose around re-admission rates and the Committee noted that a report on re-admissions would be presented to the next meeting of the Committee.

VI 2018/19 MID-YEAR PERFORMANCE SUMMARY

On a reference to Article VIII of the minute of this Committee of 13th February, 2018 there was submitted Report No PAC3-2019 by the Chief Finance Officer providing Committee with a summary of performance against key areas of service delivery reflected in the National Health and Wellbeing Outcomes and Indicators and 'Measuring Performance Under Integration Targets' in the first six months of 2018/19.

The Committee agreed:-

(i) to note the performance in each service delivery area from 1st April, 2018 to 30th September, 2018 as outlined in Appendix 1 of the report;

(ii) to note the areas of improving performance achieved by the Partnership in comparison to the pre-integration position (2015/16) as outlined in section 4.2 of the report;

(iii) to note the areas in which variation in performance between LCPPs had narrowed in comparison to the pre-integration position as outlined in section 4.3 and Appendix 1 of the report; and

(iv) to note planned improvement actions and timescales and planned investment in relation to areas of service delivery where performance has not been improving as outlined in setions 4.6 and 4.7 of the report.

The Committee also noted that future mid-year Performance Summary reports would be more in line with the format of the Annual Performance Report.

VII FALLS PERFORMANCE AND ACTION PLAN

On a reference to Article IX of the minute of this Committee of 29th May, 2018 there was submitted Report No PAC6-2019 providing assurance that issues in relation to falls related hospital admissions in Dundee had been identified and that an associated action plan had been developed to address the identified issues.

The Committee agreed:-

(i) to note the content of the report; and

(ii) to note the current activity to reduce falls related hospital admissions, prevent incidences of falls and support people who had fallen or who were at risk of a fall.

Jenny Alexander asked for information on what was being done to reduce the 15 week waiting time from referral for Otago maintenance classes and it was agreed that Diane McCulloch would get information and feedback.

VIII CLINICAL, CARE AND PROFESSIONAL GOVERNANCE (CCPG) GROUP CHAIR'S ASSURANCE REPORT

There was submitted Report No PAC4-2019 by the Clinical Director, Dundee Health and Social Care Partnership providing the Committee with an update on the most recent Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Committee.

The Committee noted the content of the assurance report.

The Committee also noted that meetings were taking place to review the Tayside Clinical, Care and Professional Governance Framework.

Jenny Alexander asked to be provided with details of what mandatory training had not been carried out and it was agreed that this would be provided following the next meeting of the CCPG Group.

IX TRANSFORMATION AND SERVICE REDESIGN INTERNAL AUDIT REPORT

There was submitted Report No PAC9-2019 by the Chief Finance Officer advising Committee of the outcome of the Internal Audit assessment of the Integration Joint Board Transformation and Service Redesign Programme.

The Committee agreed:-

(i) to note the content of the Internal Audit assessment of the Integration Joint Board's Transformation and Service Redesign Programme as set out in Appendix 1 of the report; and

(ii) to remit the Chief Finance Officer to provide an action plan to respond to the issues raised within the report at the Committee that would be held on 28th May, 2019.

X 2017/2018 ANNUAL INTERNAL AUDIT REPORT – ACTION PLAN UPDATE

On a reference to Article XII of the minute of meeting of this Committee of 25th September, 2018 there was submitted Report No PAC7-2019 by the Chief Finance Officer providing an update in relation to the agreed actions to deliver areas for improvement arising from the 2017/18 Annual Internal Audit Report.

The Committee agreed:-

(i) to note the progress of the action plan developed to respond to the range of areas for improvement contained within the Integration Joint Board's 2017/18 Annual Internal Audit Plan as set out in Appendix 1 of the report; and

(ii) to remit the Chief Finance Officer to report back to Committee by June, 2019 outlining the status of the outstanding actions.

XI RISK MANAGEMENT ACTION PLAN

On a reference to Article IX of the minute of meeting of this Committee of 25th September, 2018 there was submitted Report No PAC8-2019 by the Chief Finance Officer seeking approval of Committee to implement the Risk Management Action Plan which had been developed in response to the outcome of the Internal Audit assessment of the Risk Maturity of the Integration Joint Board.

The Committee agreed:-

(i) to approve the Action Plan, which was presented as Appendix 1 of the report, in response to the Internal Audit assessment of the Risk Maturity of the Integration Joint Board that was presented to this Committee on 25th September, 2018; and

(ii) to instruct the Chief Finance Officer to provide an update on the Action Plan to Committee in September, 2019.

XII DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT

On a reference to Article VII of the minute of meeting of this Committee of 28th November, 2017 and Article XII of the minute of meeting of 31st July, 2018 there was submitted Report No PAC5-2019 by the Chief Finance Officer providing Committee with a progress update in relation to the current Internal Audit Plan.

The Committee agreed to note the substantial completion of the 2017/18 Internal Audit Plan, with the one remaining review at draft stage, as well as the continuing delivery of the 2018/19 plan as outlined in the report.

XIII MEETING OF PERFORMANCE AND AUDIT COMMITTEE 2018 – ATTENDANCES

There was submitted Agenda Note PAC11-2019 providing a copy of the attendance return for meetings of the Performance and Audit Committee held over 2018.

The Committee noted the position as outlined.

XIV DATE OF NEXT MEETING

The Committee noted that the next meeting would be held in Committee Room 1, 14 City Square, Dundee on Monday, 25th March, 2019 at 2.00 pm.

Helen WRIGHT, Chairperson.

ITEM No …5……..

Dundee Health & Social Care Partnership

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 26 FEBRUARY 2019**

REPORT ON: **DUNDEE CHILD PROTECTION COMMITTEE ANNUAL REPORT 2017-18**

REPORT BY: **CHIEF SOCIAL WORK OFFICER**

REPORT NO: **DIJB3-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to present the Integration Joint Board with the Independent Chair of the Child Protection Committee's annual report for the period April 2017-March 2018. This includes a summary of the work undertaken and identifies future priorities.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Note the content of the annual report (Appendix 1).

2.2 Note the key achievements as detailed in section 4.4 and the recommendations and future plans identified for 2018-19 as summarised in section 4.5 of this report.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 All agencies, professional bodies and services that deliver child and/or adult services and work with children and their families have a responsibility to recognise and actively consider potential risk to a child, irrespective of whether the child is the focus of their involvement.

Child Protection Committees have overall strategic responsibility for the continuous improvement of child protection policy and practice in their local areas. There are 31 child protection committees across Scotland and they consist of representatives from a range of backgrounds including the health and social care, police, health services, local authorities, children services and community planning structures and relevant voluntary sector fora.

4.2 Although not a statutory requirement, most Child Protection Committees publish an annual report. The first such report for Dundee City was published last year. This report outlines Child Protection in the wider Protecting People context before examining the progress made in strengthening arrangements for the protection of children in Dundee. It also details management information relating to key child protection processes across the partnership.

4.3 Last year saw the development of the Dundee Child Protection Delivery Plan and the report offers a summary of the Key Achievements and Areas Identified for Further Development. Progress is also detailed in respect of the Tayside Plan for Children, Young People and Families as well as activity relating to information, engagement and communication. The report concludes by outlining recommendations and future plans.

The report includes a focus on identified priorities and showcases examples of work being undertaken to provide support to specific risk groups. This includes work in relation to substance misuse, domestic abuse, child sexual exploitation and neglect where interfaces and joint working between children's and adult services are critical to reducing risk and improving outcomes for children, young people and adults.

4.4 Key Achievements detailed in the report include.

- The revision of Dundee Integrated Children's Services System staged intervention process and guidance;
- Review of the multi-agency child protection procedures. "Dundee Child Protection Committee's Interagency Child Protection Operational Instructions";
- The Getting It Right for Every Child (GIRFEC) Improvement Programme has continued to be developed across Dundee;
- Further development of the Reducing the Impact of Sexual Exploitation (RISE) project in partnership with Barnardo's, Police Scotland and Comic Relief;
- Dundee is one of three Community Planning Partnerships, to take forward the ANEW strand of the National Child Protection Improvement Programme which has a specific focus on neglect and wellbeing;
- Further development of the Safe and Together Approach to address the number of children and young people affected by domestic abuse and support positive engagement with adult victims and perpetrators;
- Child Protection training has been refreshed and more clearly set in the context of GIRFEC and has now been delivered to 550 staff across the partnership, including staff from adult services;
- An increase in the number of staff designated to operate as Child Protection Buddies supported by Children 1st to promote more meaningful family engagement in child protection processes;
- The development of public facing materials to support the identification and reporting of Child Protection concerns; and,
- An expansion of both the Child Protection Forum and Chief Officer Engagement Activity.

4.5 Dundee Child Protection Committee has identified six priority areas recommended for further development over the next year. Specifically:

Recommendation One: We will improve the integrity, collation and presentation of data to Dundee Child Protection Committee and Chief Officers Group to better inform decision making and the monitoring of progress.

Recommendation Two: We will undertake a review of roles, core functions and membership of Dundee Child Protection Committee.

Recommendation Three: We will consider the recommendations from the Joint Thematic Inspection of Adult Support and Protection through the Public Protection Improvement Programme, monitor and evaluate progress with regular reports to the Committee and identify specific areas for development in respect of Child Protection.

Recommendation Four: We will develop a working culture across the partnership whereby multi-agency self-evaluation activity is planned, supported and quality assured. The Child Protection Committee will seek to bring together single and multi-agency self-evaluation activity into an integrated picture, including supporting preparation for inspections as and when appropriate.

Recommendation Five: We will work with our partners across Tayside to deliver on the priorities identified by the Tayside Plan for Children, Young People and Families.

Recommendation Six: We will ensure that learning from Initial and Significant Case Reviews are applied in the context of Child Protection across Dundee.

Work has already begun to address a number of these recommendations, including through collaboration with the other Child Protection Committees across Tayside. The full participation of the Health and Social Care Partnership in multi-agency working is critical to the full implementation of the recommendations over the coming year. Officers from the Partnership are active participants in multi-agency child protection governance and strategic planning structures and the Chief Social Work Officers provide professional oversight and advice regarding the protection of children and young people at risk.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Integrated Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it is for information and does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

The Chief Officer, Chief Finance Officer, Head of Service, Health and Community Care, the Chief Officers Group (Protecting People), members of the Dundee Child Protection Committee and the Clerk have been consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Directions Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

None.

Jane Martin
Chief Social Work Officer

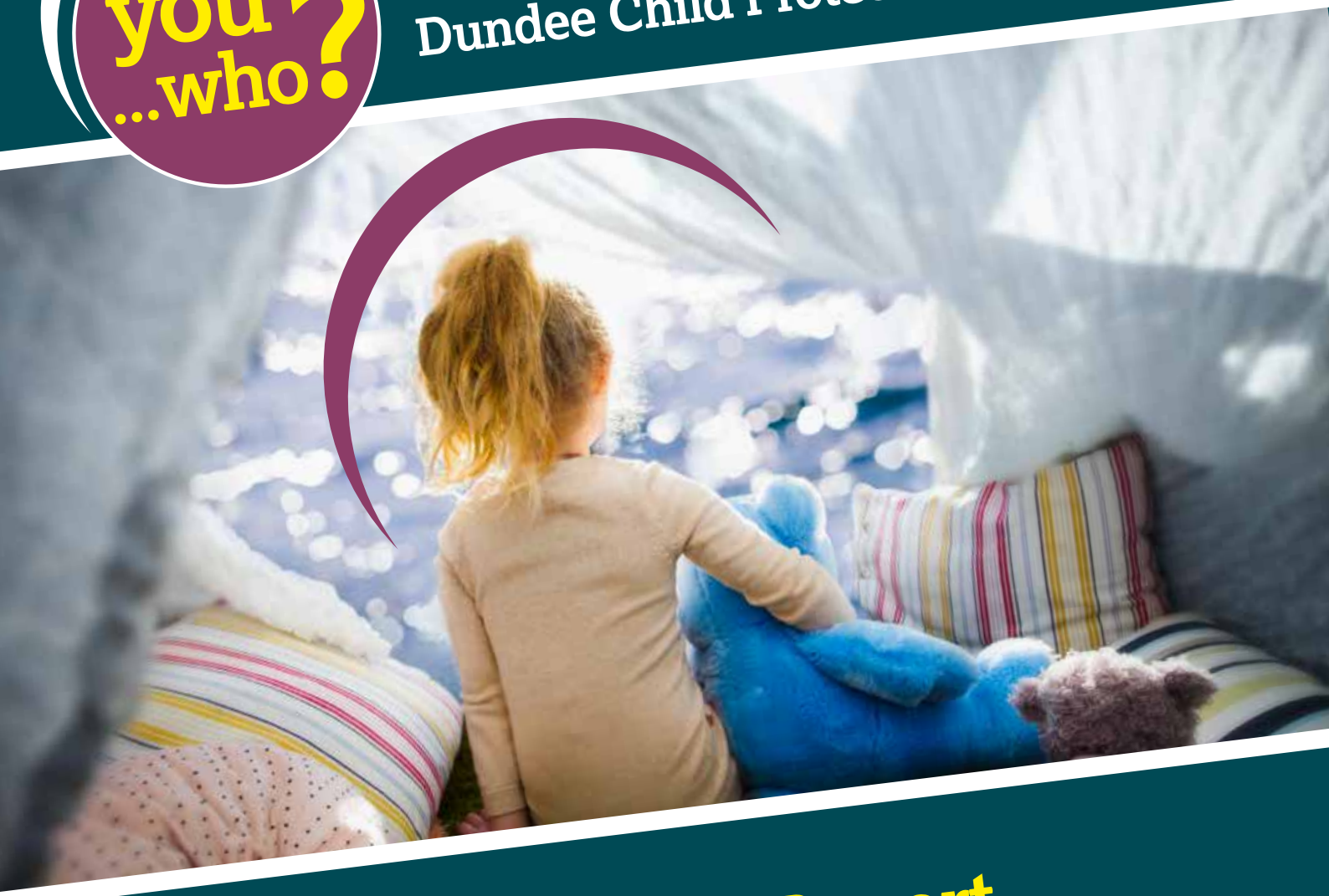
DATE: 11 February 2019

Andrew Beckett
Lead Officer, Protecting People

Kathryn Sharp
Senior Manager, Strategy and Performance

If not you ...who?

Dundee Child Protection Committee



Annual Report

April 2017 - March 2018

www.dundeeprotectschildren.co.uk

Dundee Child Protection Committee

Contents

Introduction

Independent Chair of Dundee Child Protection Committee

Welcome to our Dundee Child Protection Annual Report 2017-18: this report covers the period 01 April 2017 to 31 March 2018.

For the second consecutive year I am very pleased to present this overview report of our multi-agency activity for the past year. This report identifies our achievements; both key strengths and areas for further improvement. It also describes our capacity for improvement and our ambitious improvement programme and work plan for the next year. It is certainly our aim to have in place a refreshed and updated website and to publish updated multi-agency child protection instructions by the end of 2018; each of these will reflect the significant changes in child protection legislation, policy and practice which have taken, and continue to take place.

In order to ensure that Dundee has an effective child protection committee we have, in partnership with the Scottish Government Improvement Service, undertaken a Dundee Child Protection Committee Self-Assessment exercise in order to identify our high level priorities for the upcoming year. Identified priorities include the need to ensure that the committee is provided with relevant, good quality data to better inform decision making and to support the committee in its role as a multi-agency scrutiny body. It is also our intention to further develop a working culture across the partnership whereby multi-agency self-evaluation activity is planned, supported and quality assured.

We are also keen to ensure that we work in partnership with the public and continue with our **"If Not You, Who?"** campaign to raise awareness of their role in the protection of children and young people in Dundee. The campaign, together with the publication of the booklet "Protecting People of All Ages" (which provides information for people who have concerns about harm and ensures that they are directed to the right public protection agency) and our refreshed website, will, it is hoped further our ambition of a city which provides *"…the protection children and young people need, when they need it, to protect them from harm"*.

Finally, I wish to acknowledge the hard work, commitment and dedication of staff, who, working in partnership, continue to realise the city's ambition of "…**creating a community which is healthy, safe, confident, educated and empowered**". (City Plan for Dundee 2017 – 2026).

Norma Ritchie
Independent Chair
Dundee Child Protection Committee


If not
you
...who?

Protecting People

Dundee's future lies with its people. They deserve the best this city can give them. We will provide the protection they need, when they need it, to keep them safe from harm.

Key Principles of Protecting People

The protection of people in Dundee is part of the overall provision of services that will deliver positive outcomes for people in Dundee.

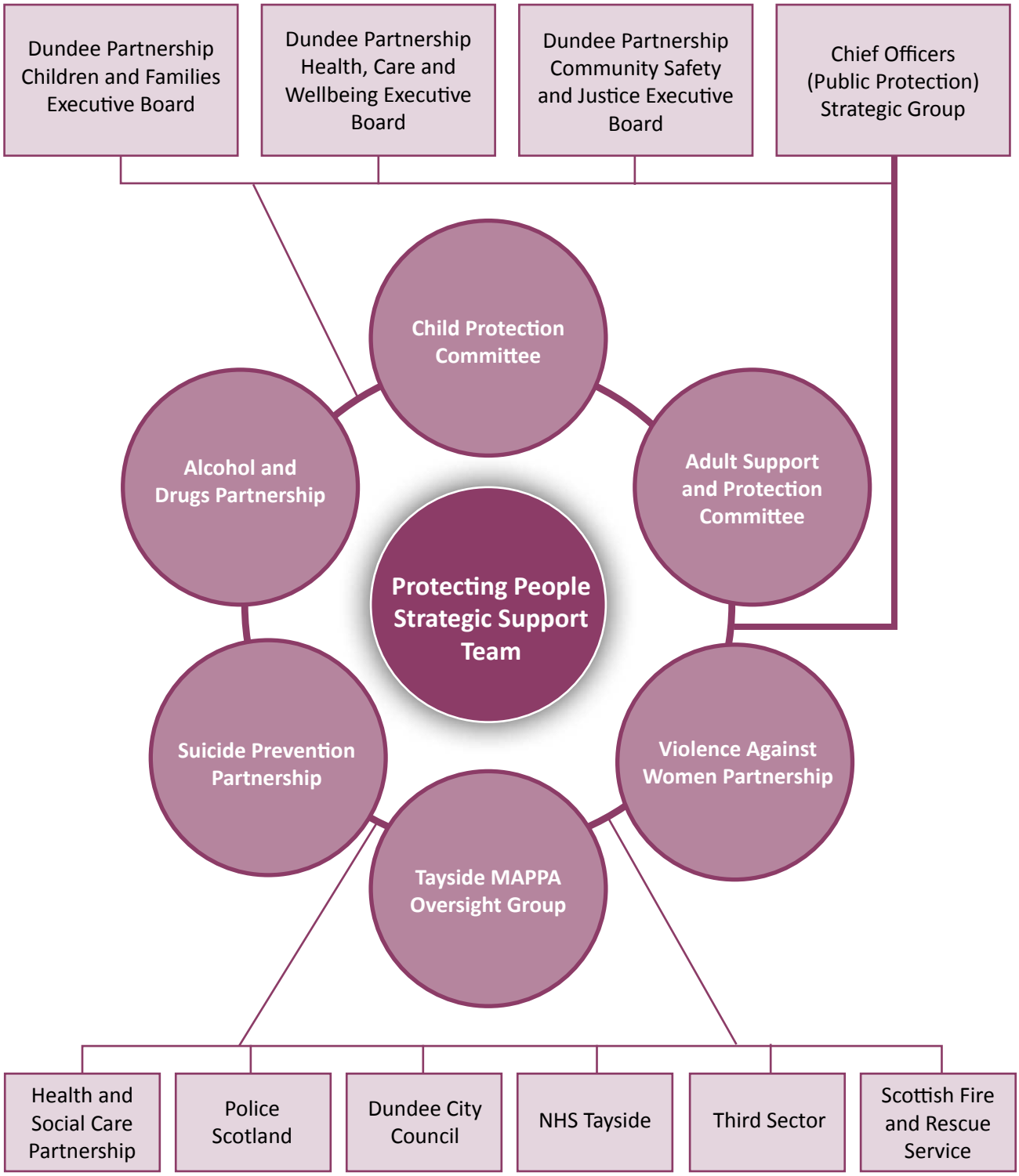
The people delivering those services will have the knowledge, skills and experience to deliver quality services.

We will deliver our vision by working in partnership across the statutory (Dundee City Council, NHS Tayside, Police Scotland and Scottish Fire and Rescue Service) and voluntary sector.

We will work with our partners in other local authority areas, both in Tayside and throughout Scotland, to improve services to protect people and work towards a consistent approach.

The wider Protecting People strategic agenda in Dundee City is led by a number of key public protection partnerships - these include the Adult Support and Protection Committee, the Child Protection Committee, the Violence Against Women Partnership and the MAPPA Strategic Oversight Group, all reporting to the Chief Officers Group (COG). Over the last year, the Protecting People Strategic Support Team has broadened its responsibility to include suicide prevention and displaced persons.

The Chief Officers Group is the strategic forum for public protection in Dundee with responsibility for shaping the operational development of the public protection arrangement. As such it will work through public safety and partnership committees statutory and otherwise to assess risk and to work to reduce it. The image below illustrates the relationship between the various bodies and groups to protect the people of Dundee.



Child Protection

All agencies, professional bodies and services that deliver child and/ or adult services and work with children and their families have a responsibility to recognise and actively consider potential risk to a child, irrespective of whether the child is the focus of their involvement. Child Protection Committees have overall strategic responsibility for the continuous improvement of child protection policy and practice in their local areas. There are 31 child protection committees across Scotland and they consist of representatives from a range of backgrounds including the police, health services, local authorities, children services and community planning structures and relevant voluntary sector fora amongst others.

Child Protection in Dundee

Dundee is home to 23,889 children and young people under the age of 16 (General Records of Scotland), most of whom live in safe and nurturing home environments where they are supported to develop and reach their full potential.

It is widely recognised that children and young people living in poverty often have poorer outcomes than their more affluent peers. Deprivation is a significant issue for Dundee with almost half of its children and young people, **11, 665 (43.4%)**, living in communities identified as the most deprived in Scotland.

Deprivation also contributes to the prevalence of other health and social inequalities such as alcohol and substance misuse, physical and mental health and domestic violence and these in turn and recognised as contributory factors to the abuse and neglect of children.

However, any child, from any background, living in any community can be at risk of abuse or neglect and we all share a responsibility to protect children from harm.

All local authority areas have a responsibility to provide supports and services to minimise risk and protect children and young people. This includes raising awareness amongst the public, supporting the development of our community as well as the provision of a structure by which risks can be identified, responded to and, where necessary, appropriate proportionate action taken.

Child Protection Committees

Child Protection Committees were first established in each local authority area across Scotland in 1991. Since then, they have been subject to many reforms and reviews, in particular in 2005 when they were strengthened as part of the then Scottish Executive's Child Protection Reform Programme.

Child Protection Committees are locally based, inter-agency strategic partnerships responsible for the design, development, publication, distribution, dissemination, implementation and evaluation of child protection policy and practice across the public, private and wider third sectors in their locality and in partnership across Scotland. Their role, through their respective local structures and memberships, is to provide individual and collective leadership and direction for the management of child protection services across Scotland. They work in partnership with their respective Chief Officers' Groups and the Scottish Government to take forward child protection policy and practice across Scotland.

Dundee Child Protection Committee

The Dundee Child Protection Committee core membership consists of representatives of key stakeholder agencies, namely…

The committee is chaired by an independent chairperson contracted to fulfil this role by Dundee City Council on behalf of Dundee Child Protection Committee. The Vice Chair role is undertaken by the Service Manager, Strategy and Performance Team, Children and Families Service, Dundee City Council.

There may be more than one representative of a partnership agency, for example, The Chief Social Work Officer for Dundee City attends together with a Learning and Organisation Development Officer. The committee also has a number of minuted members who are not required to attend every meeting. In addition, the Lead officer is neither a core nor minuted member but provides the necessary support for the committee. Full details of the membership of Dundee Child Protection Committee can be found in **Appendix 1**.

The work of the Dundee Child Protection Committee takes place within a framework on both a local and national level. The committee is represented in a Tayside collaborative as well as the Central and North Scotland Child Protection Committee Consortium and Scottish National Chairs and Lead Officers group. Over the past 12 months this has provided an opportunity to share learning and experiences and develop areas for joint working in an effort to further develop continuous improvement of child protection policy and practice.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The Child Protection Process

The following summarises key management information relating to the formal Child Protection process.

The Child Protection process is one end of a spectrum of staged interventions applied across the partnership in Dundee to address concerns in respect of children and young people. Social Work come into contact with a very small number of families, with the majority not requiring any additional support at all. All children will, however, at various stages have ongoing input from health or education professionals and it is these services that are often the first point of contact to recognise and respond to issues of concern. When a child or young person is identified as having significant additional support or wellbeing needs, a written plan describing these needs and how they might be met is prepared. This involves a "Team around the Child" (TAtC) meeting which includes parents, the child or young person and any other professional agencies who may provide support.

Most Team around the Child meetings will not result in statutory child protection procedures, the presenting issues being adequately addressed by the appropriate agencies at the appropriate stage.

Similarly, Police Scotland operate a "Risk and Concern Hub" ensuring that all concerns raised are assessed appropriately and where wellbeing concerns are identified, relevant and proportionate information is shared with partners in a timely manner to enable the necessary additional support from all partner services.

Last year police in Dundee were involved in over child concern incidents. **800**

The chart below details the prevalence of concerns as identified by the Police Scotland response to child concern incidents.

Percentage of reported concerns as identified by Police Scotland

Domestic abuse is by far the largest concern resulting in police involvement. However it should be noted that there may be a number of concerns identified from a single incident.

For a small number of children and young people it may be necessary to address the identified risk by way of statutory child protection procedures. This involves a referral to Local Authority for assessment / investigation.

510 **new referrals made to the Local Authority relating to child protection concerns in 2017/18, an increase of 100.**

Referrals have increased 25% over the past year. This may be reflective of a greater awareness of child risk issues with the public and across the partnership and relates, in part, to the awareness raising activity carried out across the city. It is also demonstrative of the changing nature of the risk and concerns being reported, for example, young people sharing inappropriate digital images may result in multiple referrals depending upon the number of young people involved. Our screening and intake services report an increased awareness of risk and protection issues amongst young people themselves which has led to increased episodes of disclosure to named persons and child protection officers.

Some of these referrals may not relate to risk that requires a statutory response, however where it is suspected that a child or young person has suffered, is suffering or maybe at risk of harm or abuse then a joint assessment of this risk is undertaken.

398 **Interagency Referral Discussions took place across Dundee in 2017/18 in relation to 367 children. This is a slight increase on previous years of 20 (6%).**

An Interagency Referral Discussion (IRD) is the first stage in the process of a joint child protection investigation and assessment. The purpose of an IRD is to discuss the concerns raised and to further consider them in the context of what is known about the child, their family, including siblings and children connected through adult relationships and the particular circumstances in which they live.

410 **Child Protection Investigations recorded in 2017/18. An increase of 179 (77%) on the same period last year. Accounting for changes in recording processes over the last year this equates to a comparable increase of 90 (39%).**

Although this year's figures seem to indicate a startling (77%) increase in investigations recorded this can be explained, in part, by a change in the process by which investigations are identified and recorded. Once this is taken into account a comparable increase of 39% (321) investigations is calculated.

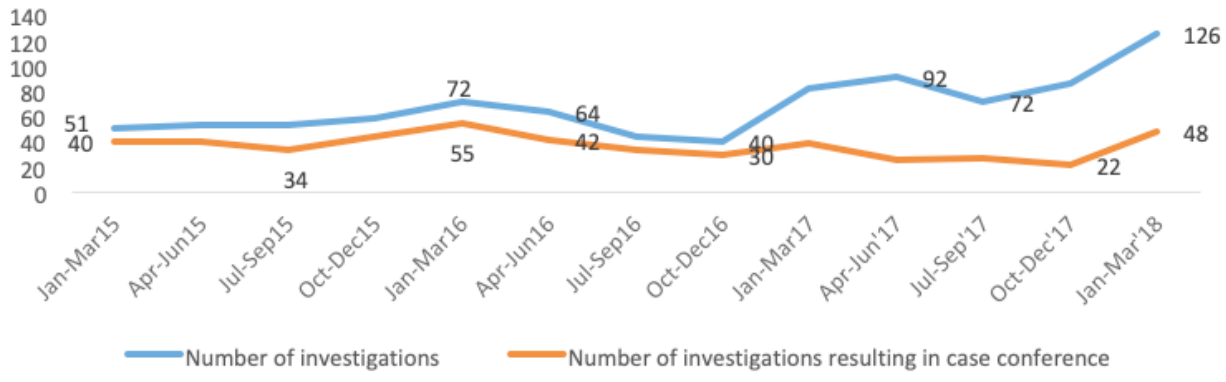
Nevertheless this is indicative of a significant increase in investigative activity.

An initial child protection case conference (ICPCC) is held if the child is assessed as being at risk of significant harm, so that all of the relevant professionals can share information, identify risks and outline what needs to be done to protect the child.

Any agency may request a Case Conference and Social Work Services are responsible for responding to the request. A significant part of the function of the case conference is to determine if a child's name should be entered onto the Child Protection Register.

140 **initial case conferences held in 2017/18, all but two resulted in registration.**

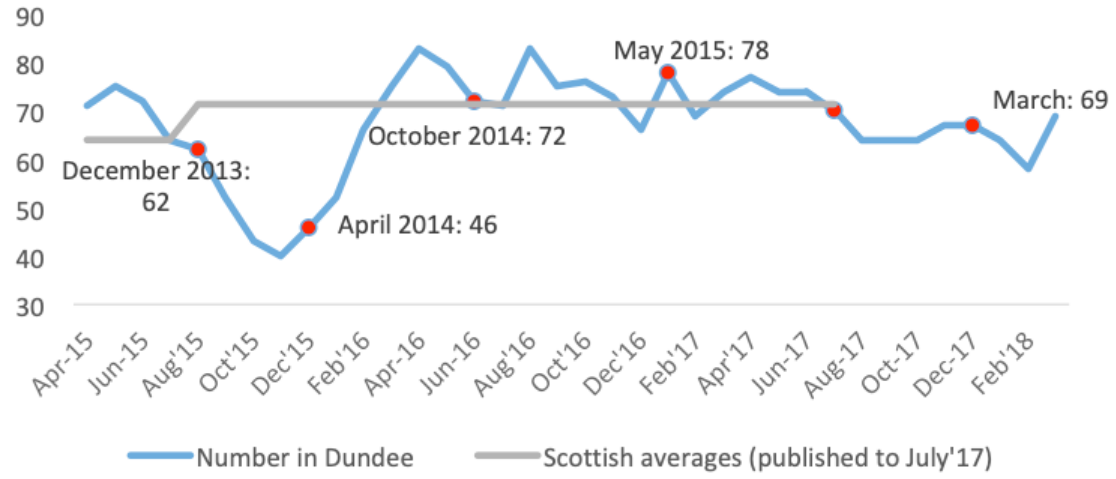
Number of investigations per quarter and number progressing to case conference



Every local authority area in Scotland has a child protection register, which is a list of children who may be at risk of current or future harm. A child's name (including unborn babies) will be entered onto the register when they are believed to be at actual or potential risk of significant harm. The number of children whose names are on the register at any given time will vary.

69 **children and young people were on the Child Protection register for Dundee on 31st March 2018**

Number of children on the Child Protection Register since April 2015



Children's names can be entered onto the register for a variety of reasons relating to identified risk.

A child's name will remain on the register until it has been agreed by a Child Protection Review Case Conference that they are no longer at risk of significant harm. This may be because the issues identified as placing them at risk have been addressed and no longer warrant registration, the child has been made subject to a supervision order by way of a Children's Hearing or the child is being cared for by someone else in a living environment other than the one in which they were considered to be at risk. This may be with relatives or family friends (kinship care) or in a foster placement or residential establishment.

95% **Between April 2017 and March 2018 95% of children deregistered had their names removed from the CP register within 12 months of the original registration date with 49% having their names removed from the CP register within 6 months of the original registration date.**

If, at any point during the child protection process, a child is considered to be in immediate danger, an order can be made through the sheriff court. A child protection order (CPO) can be issued to immediately remove a child from circumstances that put them at risk, or to keep a child in a place of safety (e.g. a hospital). Anyone can apply to the sheriff for a CPO although in practice this is normally undertaken by the local authority. These emergency measures allow time to decide the best way to protect a child. This may involve a case conference and possibly care proceedings.

31 CPO's granted in Dundee during 2017-18, a significant reduction on the previous year's figures. (42)

Indicator	2016-17	2017-18	Trend Analysis
New referrals to Local Authority	410	510	Increase 25%
Child Protection Investigations	231	410	Increase 77%
Child Protection Investigations (allowing for changes in recording)	231	321	Increase 39%
Initial Case Conferences Held	145	140	Stable
Registrations as of 31st March	77	69	Stable
Child Protection Orders Granted	47	32	Decrease 32%

In summary

Although there has been a significant increase in the reporting and investigation of Child Protection concerns this has not been converted into an increase in Case Conferences convened or registrations.

This is indicative of both an increased awareness of Child Protection and risk issues across Dundee and the development of the named person across Dundee. Hence more concerns being reported and requiring investigation.

Case Conferences remained relatively stable over the past 12months with a significant increase in the last quarter. Similarly, registrations were consistent with a slight decrease during the third quarter of the year.

The 32% decrease in the number of Child Protection Orders granted is illustrative of the joint work undertaken between Dundee City Council Children and Families Service and the Scottish Children's Reporters Administration to address this issue. There has been a consistent decrease in the use of Child Protection Orders since a peak of 79 in the year 2013-14.

Dundee Child Protection Delivery Plan 2017-18 Key Achievements and Areas for Further Development

Dundee Child Protection Committee Annual Report April 2016 – March 2017 detailed the Delivery Plan for 2017 -2018. This set out our long term goals detailing not what we could measure but rather what we needed to do.

It also introduced the Child Protection Delivery Group as a means by which identified actions would be progressed and Key Performance Indicators reported and analysed.

The committee reviewed this arrangement early in 2018 and concluded that it was more practicable to transfer the format of the delivery group from a physical meeting to a digital environment with progress reports being provided to the CPC on a quarterly basis.

The following summarises the progress achieved over the time covered by this report and identifies further areas for development.

Long Term Outcome

Improve outcomes for children and young people identified as being at risk of significant harm, including those at risk from domestic abuse, substance misuse sexual abuse, child sexual exploitation (CSE) and neglect.

We will reduce risk of significant harm and ensure appropriate support is provided where early concerns are identified.

Dundee Integrated Children's Services System staged intervention process and guidance has been reviewed and revised.

This includes clear definitions of each stage of the process as well as an agreed hierarchy of need. The role of the named person and lead professional is clearly defined within the context of Dundee and operational guidance including procedural instruction is now available to all partners.

Work has continued throughout the year on reviewing the multi-agency child protection procedures. "Dundee Child Protection Committees Interagency Child Protection Operational Instructions" will be formally launched in the Autumn of 2018 supported by a programme of engagement and awareness raising activity as well as a review of single and multi-agency guidance relating to specific areas of Child Protection and Protecting People.

The new operational instructions can be found at:
www.dundeeprotectschildren.co.uk/sites/default/files/docs/Inter-AgencyCPInstructions.pdf

The Getting It right for Every Child (GIRFEC) Improvement Programme has continued to be developed across Dundee. This includes the Addressing Neglect and Enhancing Wellbeing (ANEW) Programme, as well as the development of shared priorities across the Children and Families Service and Health and Social Care Partnership.

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We will reduce the number of children and young people affected by sexual abuse and child sexual exploitation

The past year has seen the further development of the Reducing the Impact of Sexual Exploitation (RISE) project in partnership with Barnardo's, Police Scotland, and Comic Relief.

A Child Sexual Exploitation (CSE) Advisor from Barnardo's is embedded within the Risk and Concern Hub. The Advisor role takes a proactive, multiagency approach, aiming to ensure effective systems and supports are in place to identify and robustly respond to CSE. The Advisor works in partnership with Police Scotland and other key agencies – by sharing skills, specialist knowledge, and intelligence – in order to provide a coordinated response to CSE.

The CSE advisor in Dundee has made a considerable contribution to the development and delivery of Dundee's Child Sexual Exploitation Plan.

An evaluation of the project is currently being undertaken by Stirling University and will report early in 2019.

We will reduce the number of children and young people affected by substance misuse

The period covered by this report has seen significant developments in the role of the Dundee Alcohol and Drug Partnership. One of the key priorities for the ADP includes: " ensuring that children who are at risk of early initiation into alcohol and drug use, and / or are at risk of exposure to harm in family settings where substances are misused - have improved life chances and are safe." An example of this is detailed in the next section of this report.

We will reduce the number of children and young people affected by neglect

Dundee is one of three Community Planning Partnerships, to take forward the ANEW strand of the national Child Protection Improvement Programme. This is focusing upon addressing neglect and enhancing wellbeing across the city. This activity draws together a comprehensive and diverse range of developments that reflect national, regional and local priorities with the shared, collective aim to improve outcomes for children and families in Dundee.

A summary of this activity is detailed in the next section of this report.

We will reduce the number of children and young people affected by domestic abuse.

Dundee began introducing Safe and Together in 2016 with the first cohort of training taking place in conjunction with Fife Council. This was followed with another program of training in 2017. This compliments the work already underway with a Domestic Abuse Resource Worker now located within Intake Services at Seymour House. In addition to operating in an advisory capacity for domestic abuse cases direct work is now undertaken with perpetrators of domestic abuse.

We will promote a multi-agency learning culture in respect of Child Protection.

Over the last year a training programme was designed and a schedule of workshops delivered with 550 places available.

An open education learning resource was launched in February 2018. The Protecting People Learning and Development Framework and the Dundee open educational resource signposts to a full range of additional learning resources and options across the workforce groups. Practitioner Forums / CP Forum / COG events / locality events all provide additional focussed learning and development opportunities.

The full range of multi-agency training is updated and is being promoted on the Protecting People website, where the current multi-agency guidance is also now located.

Full details of the Learning and Organisational opportunities available can be found at:
www.dundeeprotectschildren.co.uk/professionals/learning-and-development

We will provide children and young people with opportunities to be listened to and heard at all stages of the child protection process

The Tayside Regional Improvement Collaborative (Priority Group 5) has undertaken a comparison of opportunities for children and young people to be heard throughout the Child Protection process. This will help inform future developments across Dundee and the wider Tayside area. In addition, there has been an increase in the training of Child Protection Buddies supported by Children 1st to promote more meaningful family engagement.

We will promote public identification and reporting of Child Protection concerns

Dundee CPC has led on the development of public facing materials promoting the identification and reporting of Child Protection concerns. This is detailed in the Information, Engagement & Communication section of this report.

We will ensure that learning and outcomes from above is communicated in the right way at the right time to the right audience

Similarly, the past year has seen a focus upon workforce engagement with an expansion of both the Child Protection forum and Chief Officer Engagement Activity.

NHS Tayside: Continuous Improvement

A wide range of work has been undertaken throughout 2017/2018 to strengthen and develop services to protect children and young people in NHS Tayside. Significant achievements include developments in how information is shared across partner agencies and measures to support staff across the organisation to ensure they confidently engage with others when concerned about a child.

Generic Email Boxes

Sharing relevant information at the right time between partner agencies is fundamental to the protection of unborn babies, children and young people who are at risk of harm. An important development in September 2017 was the establishment of two centralised generic email boxes, hosted in NHS Tayside, which support information flow and partnership working. The boxes receive and distribute information relating to practitioner concerns about children and young people. Standardised processes and monitoring arrangements ensure any delays in information flow are minimised enabling timely and appropriate partnership responses to protect vulnerable children and young people.

Child Protection Advice Line

NHS Tayside's centralised telephone child protection staff advice line provides advice on child protection matters and signposts staff to other agencies when needed, Mon - Fri 9.00am - 4.30pm (excluding Public Holidays). In addition to the support given to those working in children and young people's services contacts from services including Sexual Health, Mental Health, General Practitioners and Social Work accounted for 61% of all contacts in 2017/2018 indicating increased staff child protection awareness across the wider organisation.

Child Protection Training & Case Supervision Programmes

NHS Tayside has a responsibility to ensure that all staff have the appropriate skill level for the role that they undertake. A refreshed programme of training reflecting learning from both national and local child protection reviews was developed and a comprehensive training programme that included mandatory Child Protection e-learning for all staff, core child protection training and training on specific areas including Neglect, Working with Hostile and Non Engaging Families, Assessment & Decision Making Skills and Child Sexual Exploitation was available to all staff.

885 **staff attended NHS Tayside Child protection training sessions appropriate to their role over the last year.**

For staff involved in the day-to-day work with children, young people and families, effective supervision is important to promote good standards of practice and to supporting individual staff members to understand their roles, responsibilities and identify their training and developmental needs. An enhanced model of robust child protection supervision targeting key front line practitioners i.e. Health Visitors, Family Nurses, Community Midwives, School Nurses and Looked after Children (LAC) Nurses and other key staff groups i.e. Medical, Nursing or Allied Health Professionals who come into direct contact with children and young people was implemented across NHS Tayside in 2017/2018. This process ensures practitioner access to appropriate and timely specialist support when there are emerging risks and concerns about children and young people. Implementation of this programme was supported by the delivery of a bespoke training programme for supervisors and managers.

Focus on Priorities

The Dundee Child Protection Committee Annual report 2016-2017 identified four priority areas for the focus of Child Protection activity - domestic abuse, substance misuse, child sexual abuse/exploitation and neglect.

Across the city there a number of organizations and services providing support, advice and guidance in respect of the identified priorities.

The following section gives examples of one such provision for each of the identified areas.

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Focus on Alcohol and Substance Use

Key to Change

Key to Change is a Young Persons Drug & Alcohol Service delivered by Gowrie Care to provide support to young people aged 12 – 17 affected by their own drug and alcohol use.

The service provides one to one support as well as individual and group outreach work. Specific input (including prevention work) is also delivered in collaboration with secondary schools in Dundee.

A tiered model of intervention is applied as follows;

Tier 1 - generically raising awareness

Tier 2 - provides drug & alcohol prevention work to groups and on a 1-2-1 basis

Tier 3 - provides prevention and therapeutic support to individuals affected by drug and alcohol issues

During 2017-18 the service received 53 referrals for young people.

The following table illustrates the age and gender breakdown of these referrals.

Referral Breakdown of Referrals by Age and Gender

	12	13	14	15	16	17	18	TOTAL
Male	2	5	8	16	5	5	1	**42**
Female	1	0	2	6	2	0	0	**11**

The above table illustrates that males outnumber females by a ratio of almost 4:1 in respect of the referrals made to the service. It is also the case that fifteen year olds make up 41% (n. 24) of the total referrals.

The majority of the referrals (24) 45% are made from schools, with the The Helm (Career and Supportive Learning) accounting for a further 17% of the referrals.

The table below outlines the specific substances used by the young people referred to the service, and illustrates the primary, secondary and tertiary substances used by the young people.

Substances Used (reported at Initial Assessment)

Substance at time of Referral	Primary Substance used	Secondary Substance used	Tertiary Substance used
Alcohol	5	12	4
Cannabis	32	4	1
Cocaine	2	1	2
Ecstasy	2	5	4
Heroin			
Ketamine			
Solvents			
Valium			
Speed		1	
Synthetic Cannabinoids			
NPS			
Prescribed Medication			
Other			

Cannabis use features as the highest substance, with alcohol identified as the next most prevalent.

Of the active service users accessing the service on 31st March 2017, 25 (50%) completed their involvement with the service and were discharged on a planned basis.

In addition to the one to one support, 220 young people were provided with substance misuse prevention support and advice; 175 young people attended awareness sessions at drop-ins; and 540 young people accessed the drama & dance tours focussing on the impact of substance use.

Key to Change is one example of support being offered to young people identified as at risk from substance use and compliments the work already undertaken by organisations such as Tayside Counsel on Alcohol, Addaction and services offered by The Corner health, information and peer led services for young people.

Focus on Domestic Abuse

Dundee Women's Aid Children and Young Persons Service

Dundee Women's Aid has been supporting women, children and young people who are experiencing Domestic Abuse for almost 40 years.

The service works individually with a child or young person who is allocated their own keyworker. The keyworker uses issue based resources to work through feelings and records this in the child or young person's individual journey (Support Plan) and offers a safe and consistent place to discuss/ work through feelings. Individual work takes place with children and young people who are living in refuge accommodation or on an outreach basis and any supporting documentation is collated in a "My Journey" book at the end of support.

The book contains the child or young person's safety plan, support plan, evidence of sessions (outcomes covered) photographs, evaluations and art work. The book is theirs to keep and look back on in times of need. It also gives their mother/care giver a chance to look through and discuss the issues that have been covered. There is a clear start, middle and end to support by using the journey and children and young people are very proud of their journey books.

The service also delivers age appropriate focused group programs lasting 8 weeks. This covers topics considered to be most prevalent in young people's lives in Dundee; bullying, domestic abuse, healthy relationships, friendships, conflict, equality and gender roles feature regularly. This approach encourages children and young people to realise that they are not alone and are able to seek support, strength and understanding from their peers contributing to the building of strong positive relationships.

The team also deliver family work which highlights the effects of domestic abuse and provides a therapeutic support system for the family to recover and develop more positive relationships. The CYP support workers support information sessions for parents to consider the effects on children and young people when they have experienced domestic abuse and the effect this can have on their behaviour.

Using the Solihull approach support workers will share this information in a supportive and contained way to help the mums understand why their children may be behaving in a certain way. The CYP team have a presence in schools across the city, through providing outreach support sessions to children, assisting with health drop-ins and also by way of a prevention worker who delivers awareness raising and training to children, young people and professionals.

During 2017/18, 118 children and young people accessed the service. The following case study outlines the experience of two such children.

Case study:

"A referral was made from social work to Dundee Women's Aid Children and Young Peoples Service regarding a family with two children who had recently been exposed to a violent assault on their mother by her then partner who was in prison. As the perpetrator was released earlier than first thought the support for the children took this into account.

The children's names were placed on the child protection register due to the severity of the incident and the significant risk of another happening. The children were subsequently referred to the children's reporter in order to put measures in place to keep them safe.

Concerns were raised regarding the effect the incident had had on the children and the risk further exposure to the perpetrator may have for them when he was to be released. Although initially wary of engaging with services Mum agreed to support for the children first and then for herself.

The children, during the support sessions were given time to share their account of what had happened and address their feelings surrounding it. Safety plans were discussed with the children including what they would do in an emergency, what they would do if mum's ex-partner approached them and who they felt their safe people were to go to for help if they needed to.

Due to the eldest having ADHD she required additional support in recognising and managing her feelings. Support sessions were adapted to ensure that she could cope with the issues being addressed and to give her the best chance of understanding what had happened in her family. The younger child, due to his emotional needs, required a gentle, calming approach towards the difficult issues and addressing the assault on his mother. The children, throughout support, presented with mixed feelings regarding any future contact with mum's ex-partner and due to their age and needs appeared to be unaware of the level of risk to them. The children's views were sought during the support sessions and shared at the relevant child protection meetings to ensure their views and opinions were taken into account.

The children, after being placed on interim compulsory supervision orders were placed on a twelve month compulsory supervision order after grounds of domestic abuse were established. The order included a no contact order with mum's ex-partner due to the level of risk to the children's well-being.

During the course of support, Social Work colleagues felt that mum was not able to accept that she was experiencing domestic abuse and they were concerned that this presented

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safety issues for both her and the children. The Women's Aid Children's Services Manager visited mum together with the children's support worker to see if applying the safe and together approach would help. With this approach the aim is to partner with the non-abusing parent, keep the child/children safe and together with the non-abusing parent and hold the perpetrator fully accountable as the source of risk to the family.

The workers talked through the woman's life so far and how these experiences had impacted on her as an adult in an attempt to build a relationship with her to enable mum to have honest discussions. By partnering in this way it meant mum was able open up about her experiences because she did not feel judged or blamed for the situation she was currently in. This gave workers the ability to gain a greater understanding of the situation and therefore of the risks the family were facing. The Safe and Together approach advocates that this is the only way to truly assess risk as the non-abusing partner is the person who knows the full extent of the coercive control and the full range of specific tactics used by the perpetrator. In this situation mum had previously felt that she was being held accountable rather than the perpetrator and this had contributed to hostile relationships with agencies.

As it was felt to be a significant factor the workers attempted to understand why she would not name her experience as domestic abuse. The woman was able to explain that her life with her partner was better than her early childhood experiences and this helped workers understand that to her, even being with a violent partner was an improvement on what had happened to her in the past and therefore, she didn't recognise it as abusive in a way that someone else might. Over time mum showed emotion and acknowledged that the fighting between herself and her partner was not ok and it was not ok for her children to witness it.

It was discussed with mum what she did to keep her children safe, mum recognised that, even though she loved her partner she knew she could not be with him because the fighting was not good for the children so she had separated from him. She also called the police when he approached her. Mum was engaging with the children's service from Women's Aid and during discussion it was clear that mum might benefit from speaking with someone about her past. This was progress, mum had opened up and had shown a vulnerable side. Mum was not yet able to name her experience with her partner as domestic abuse but was able to see that it was not healthy or safe for the children to be exposed to it.

Mum engaged with a women's aid support worker and latterly a counsellor to address the abuse that she had been subjected to.

The family are currently supported by the Children and Families Service and the Team Around the Child process."

Focus on Child Sexual Exploitation

Funded by Barnardo's, Police Scotland, and Comic Relief, (Reducing the Impact of Sexual Exploitation) RISE is a partnership between Barnardo's and Police Scotland. The project was launched, as a two year pilot, in December 2016. The pilot operates in Aberdeen and Dundee.

Within the context of the pilot, the Scottish Government's National Action Plan to Prevent and Tackle Child Sexual Exploitation (2014, and Update March 2016) is highly relevant. In line with the Action Plan, the pilot project recognises that preventing and tackling child sexual exploitation (CSE) requires a co-ordinated, multi-agency response, in which effective work with children, young people, parents, and carers, requires skilled practitioners, and "must be accompanied by work to detect, disrupt and prosecute perpetrators and reduce re-offending".

The pilot relates to achieving a number of the Scottish Government's National Outcomes, and is designed to contribute to achieving progress towards the Scottish Government's aim of eliminating CSE in Scotland, which in turn contributes to the Scottish Government's vision of making Scotland the best place in the world to grow up in.

CSE Advisors from Barnardo's are embedded within local child protection arrangements, and are co-located within Police Scotland Divisions in the two pilot sites. The Advisor roles take a proactive, multiagency approach, aiming to ensure effective systems and supports are in place to identify and robustly respond to CSE. Advisors work in partnership with Police Scotland and other key agencies – by sharing skills, specialist knowledge, and intelligence – in order to provide a coordinated response to CSE.

Within Dundee the CSE Advisor role has, to date, focused primarily on:

- Enabling culture and systems change, in order to embed effective responses to CSE into existing arrangements
- Capacity building, through awareness raising and training across a wide range of professionals (and others) involved in supporting children and young people – this has involved, for example, work with police, schools, housing, social work, local Multi-Agency Screening Hub (MASH), sexual health clinics, residential care workers, and community safety wardens, as well as work with foster carers, and parents/carers
- Working in consultation with Police Scotland, to coordinate intelligence information, to assist in improving identification and disruption of perpetrators and perpetrator networks, in order to protect current victims and prevent potential victims of CSE.

The CSE advisor in Dundee has made a considerable contribution to the development and delivery of Dundee's Child Sexual Exploitation Plan.

An evaluation of RISE is currently being undertaken by Stirling University and will report early in 2019.

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Focus on Neglect

Addressing Neglect and Enhancing Wellbeing (ANEW)

In 2016 The Scottish Government and the Centre for Excellence for Looked After Children in Scotland (CELCIS) selected Dundee City to take forward the ANEW strand of the national Child Protection Improvement Programme.

The past year has seen a significant amount of progress, specifically;

- Robust exploration of how neglect manifests itself and is currently addressed across sectors, resulting in identification and clear definition of three strands of work, namely;
    - Co-ordinated and quicker access to resources to address unmet need
    - Support for Named Persons
    - More meaningful family engagement
- Careful selection of first 'target group' for testing and installing changes i.e. pupils at three primary schools and their younger siblings
- Forming and supporting implementation teams within each of the 3 schools, as well as within the Dundee Health Visiting Service, to build capacity for sustainable change
- Testing of several changes in each site designed to promote improved family engagement with services and better joint working, including:
    - Team Around the Child (TAtC) meetings without minutes
    - TAtC environment changes
    - The 'Meetings Buddy' approach
    - Health Visitor Named Person's chairing pre-school TATC meetings
- Significant progress towards a suite of tools to ensure that changes are implemented with fidelity and have the desired outcomes/impact, including: a Named Person practice profile, a Meetings Buddy practice profile, feedback tools on TAtC process for children and parents, TAtC meeting observation tools and last a (SHANARRI based) Dundee wellbeing tool.
- Strong and effective collaborative relationships with key partners such as Children 1st and Dundee Educational Psychology Service (DEPS), as well as collaboration with a wide range of colleagues and stakeholders across the partnership, to support long term sustainability and alignment with other key strategies and interventions.
- Specific developments related to three strands to date:
    - Co-ordinated and quicker access to resources to address unmet need.
    - Support for Named Persons – Named Person practice profile in development, increased support from, and alignment with DEPS and Education Officers for the 3 primary school sites, guidance and mentoring for chairs of TAtC (and other meetings), and early progress relating to more efficient and effective recording of concerns, assessments and plans.
    - More meaningful family engagement – additional numbers of Meeting Buddies trained and supported by Children 1st.

Developments in respect of ANEW are just one part of the wider GIRFEC Improvement Programme drawing together a comprehensive and diverse range of developments that reflect national, regional and local priorities with the shared, collective aim of improving outcomes for children and families in Dundee.

The overarching improvement programme is ambitious in its intent with an increasing range of partners directly involved, together with ongoing support and leadership from Chief Officers Group Children and Families Services and Dundee Community Planning Partnership.


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Tayside Plan for Children, Young People and Families

The **Tayside Plan for Children, Young People and Families 2017 - 2020** is the first joint plan to be produced by the three Community Planning areas of Angus, Dundee and Perth and Kinross. It reflects shared leadership towards multi-agency cross-border collaboration in the planning, management, commissioning, delivery, evaluation and improvement of services to children, young people and families. It also reflects a shared and longstanding commitment to implementing Getting It Right for Every Child (GIRFEC).

The plan has been developed by the three Councils, NHS Tayside, Police Scotland, Health and Social Care Partnerships, the third sector and other organizations. It supercedes the Integrated Children's Services Plan.

The Tayside Plan for Children, Young People and Families identified five priorities underpinned by key policies, such as GIRFEC and the consistent implementation of the Named Person and providing the right help at the right time; the Curriculum Excellence; and Developing the Young Workforce.

Priority 5 states…

Our children and young people will be safe and protected from harm at home, school and in the community.

Our approaches to protecting vulnerable children and young people will be integrated and focused on early identification, and immediate and effective intervention to remove and reduce the risk of significant harm.

In addition, the Tayside plan outlines what we will do to keep children safe:

- Continue to build a confident, competent and supported workforce in order to protect children and young people from abuse, exploitation and neglect.
- Continue to promote highly effective practices in the sharing of information in order to protect and safeguard children, young people and vulnerable adults
- In partnership with the Centre for Excellence for Looked After Children in Scotland (CELCIS), strengthen our approaches to tackling and mitigating the effects of childhood neglect
- Improve children and young people's capacity for personal safety and the avoidance of abuse and exploitation, including from their use of the internet
- Develop a shared Tayside communication strategy in support of consistent messages to promote the protection and welfare of children and young people
- Involve children, young people, parents and wider families in decision-making and planning processes that affect them

In order to deliver on the identified priorities and commitments a multi-agency group representing Angus, Dundee and Perth & Kinross Child Protection Committees Priority Group 5 has convened to address the following;

- Develop, implement and quality assure a standardized approach to key child protection processes across Tayside, in particular Inter-Agency Referral Discussions (IRDs) and Medical Examinations to improve practice consistency and to provide better outcomes for children and young people.
- Raise practitioner awareness and understanding on tackling neglect and enhancing wellbeing by holding a Practitioner Shared Learning / Showcase Event in Tayside.
- Develop creative approaches to helping children and young people to stay safe online.
- Develop and implement best practice for the involvement and participation of children, young people and families in key child protection processes and in the work of the CPCs.
- Develop and pilot qualitative measures in relation to the impact of child protection interventions on the safety and wellbeing of children and young people.
- Review and implement a consistent approach to chronologies (single agency and multi-agency) to improve practice consistency and to provide better outcomes for children and young people.

Dundee Child Protection Committee is contributing to and leading on these identified priority actions.

Information, Engagement & Communication

One of the core functions of Dundee Child Protection Committee is communication.

Over the past year there have been three primary areas of focus in respect of Information, Engagement and Communication.

Public Awareness and Engagement.

In January 2018 Dundee Child Protection Committee launched a new appeal to the public – If Not You, Who? – initiating an ongoing campaign informing people how they can raise concerns should they be worried about a child or young person in Dundee.

Posters have been widely distributed around public buildings with plans to expand this to schools and local businesses over the coming months.

The Child Protection content of the Protecting People website has been revised with a launch set for late 2018.

Dundee Child Protection Committee contributed to the development of **Protecting People of All Ages** in Dundee which is a booklet providing information for people who have concerns about harm and ensures they are directed to the right public protection agency. The booklet was put together with the involvement of community representatives of the 8 Local Community Planning Partnerships (LCPP's) in Dundee.

It is supported by 4 key protecting people forums: Dundee Child Protection Committee (CPC), Dundee Adult Support & Protection Committee, Dundee Violence Against Women Partnership and Tayside Multi-Agency Public Protection Arrangements (MAPPA).

These bodies are involved with children in need of care and protection, adults in need of support and protection, adults and children affected by domestic abuse and sexual violence and protecting the general public from people who could be dangerous.

The Protecting People Team have promoted the public protection agenda at a number of local events including the Dundee Farmers Market and Flower and Food Festival.

Together with colleagues working within the Community Safety partnership, a Facebook page has been run throughout the year highlighting areas of local and national importance and publicising development and events relating to community safety and Protecting People.

Engaging with the workforce

Practitioners Forum
2017-18 saw the further development of the Child Protection Practitioner Forum in Dundee. Supported directly by a Service Manager from Children and Families service and the Lead Officer Protecting People this has continued to provide a means by which practitioners can share knowledge, skills and experience as well as communicate directly with the Child Protection Committee and Chief Officers Group. The forums have focused on particular areas for discussion and development including domestic violence and statutory intervention processes and Child Sexual Exploitation.

Chief Officers Engagement
Since 2014 the Chief Officers' (Public Protection) Group (COG) has held events focusing on different Protecting People (PP) issues. In recent years, the aim of these events has been to upskill those working in Dundee about different PP issues and to provide an opportunity to explore, discuss and consider solutions for such issues. In addition, the events provided the opportunity for a 'two-way' communications between the Chief Officers and the wider multi-agency workforce.

These engagement events had previously taken the form of two large events per year. In August 2017 the COG agreed that there is a need to consider the correct balance between engagement and learning at future events, and to seek practitioner feedback regarding their expectations of COG events planned for the future. Consultation was undertaken with practitioners attending the Child Protection Practitioners Forum, Adult Support and Protection Practitioners Forum and Adult Support and Protection Stakeholder Group regarding the purpose and format of COG events and a revised programme of smaller, more frequent events was initiated from the start of 2018.

On January 24th, the Public Protection Chief Officers Group held an event titled 'Transitions' – 'Protecting People of all Ages'. The event was attended by 60 stakeholders representing a cross section of statutory and voluntary organisations concerned with protecting the citizens of Dundee. This included Children and Families, Neighbourhood Services, Health and Social Care Partnership, NHS Tayside, Police Scotland, Community Justice, Scottish Prison Service and a variety of 3rd Sector Providers.

COG Transitions Conference January 2018

Throughout March the engagement events took the form of a series of breakfast meetings. Chief Officers led a focus group style discussion focused on the issue of communication and engagement in relation to public protection. These were hosted by the Executive Director of Children and Families Services, Independent Chair of the Child Protection Committee and the Chief Executive of Dundee City Council.

In February - March 2018 Chief Officers hosted a number of Breakfast sessions where a variety of Protecting People issues were discussed.

Engaging with Young People subject to Child Protection Procedures

Children 1st Dundee Child and Family Engagement Service supports the Child Protection "Buddy" programme. Buddies support children in the child protection process before, during and after decision-making meetings, helping them to express and share their views either in person or by expressing them on their behalf with their consent.

The buddy approach makes the most of the positive relationships already existing within the child's network as an alternative to introducing another unknown adult into the child's life. As such, the Buddy is usually a person already known to the child who, with the child's agreement, helps them to choose how they want to participate and share their views in their child protection case conference. So far, Buddies have come from a range of roles within education, social work, health services and voluntary organisations.

Recommendations and Future Plans

The Key Achievements and Areas for Further Development identified in relation to Dundee Child Protection Delivery Plan 2017-18 are detailed elsewhere in this report.

Dundee Child Protection Committee has identified the following as priority areas recommended for further development throughout 2018-2019.

Recommendation 1

We will improve the integrity, collation and presentation of data to Dundee Child Protection Committee and Chief Officers Group to better inform decision making and the monitoring progress.
Work across the partnership to;

a) Revise Balanced Scorecard content for Chief Officers Group. (February 2018)

b) Revise Dataset to be tabled at each CPC meeting. (Commencing December 2018)

Recommendation 2

We will undertake a review of roles, core functions and membership of Dundee Child Protection Committee.

In partnership with the Improvement Service, Transformation, Performance and Improvement Team we will undertake self-evaluation activity of the core business of the Child Protection Committee and incorporate the Committee Improvement Plan into the Child Protection Delivery Plan. (Commencing June 2018, reporting December 2018)

Recommendation 3

We will consider the Recommendations from The Thematic Joint Inspection of Adult Support and Protection through the Public Protection Improvement Programme, monitor and evaluate progress with regular reports to the Committee and identify specific areas for development in respect of Child Protection.

Primarily:
The partnership should make sure that full implementation of its Information and Communication Technology (ICT) system is achieved in order to meet the user needs of council officers and other users to record all information clearly and effectively.

The partnership should make sure that its key processes follow a clearly defined path, which council officers and other staff fully understand and implement.

The partnership should make sure that it prepares valid chronologies, risk assessments and risk management plans in respect of children and young people at risk of harm

Recommendation 4

We will develop a working culture across the partnership whereby multi-agency self-evaluation activity is planned, supported and quality assured. The Child Protection Committee will seek to bring together single and multi-agency self-evaluation activity into an integrated picture, including supporting preparation for inspections as and when appropriate.

Recommendation 5

We will work with our partners across Tayside to deliver on the priorities identified by the Tayside Plan for Children, Young People and Families.

Recommendation 6

We will ensure that learning from Initial and Significant Case Reviews are applied in the context of Child Protection across Dundee.

Appendices

Appendix 1

Appendix One Dundee Child protection Committee Membership As of March 2017	
Position	**Organisation**
The following are core members. Dundee CPC also has a number of minuted members who are not required to attend every meeting. In addition, the Lead officer is neither a core nor minuted member but provides the necessary support for the committee.	
Independent Chairperson	Dundee Child Protection Committee
Lecturer Social Work	Dundee University
Chief Executive Officer (Cair Scotland) (Alcohol and Drug Partnership Representative)	Alcohol and Drug Partnership
Chair of the Vulnerable Adolescent Partnership	Dundee City Council
Chief Social Work Officer	Dundee City Council
Learning and Organisational Adviser	Dundee City Council, Learning and Organisational Development Service
Strategy and Performance Manager (IJB)	Dundee Health and Social Care Partnership
Principal Officer / Chief Social Work Officer	Dundee City Council, Children and Families Service, Strategy and Performance
Service Manager (Vice Chair)	Strategy and Performance Team, Children and families Service, Dundee City Council
Locality Manager	Scottish Children's Reporters Administration
Assistant Director (Third Sector Rep)	Barnardo's Scotland
Independent Chair	Violence Against Women Partnership
Protecting People Team Leader	Dundee City Council, Neighbourhood Services
Lead Paediatrician Child Protection	NHS Tayside
Lead Nurse Child Protection	NHS Tayside
Lead Nurse Children and Young People	NHS Tayside
Detective Chief Inspector PPU & CID Partnerships and Support	Police Scotland

Appendix 2 Glossary

This is an explanation of some Child Protection terms.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

A

Assessment of need - Evaluation of the child and family identifying areas of need, which may require additional support.

Assessment of Risk - Evaluation of possibility of child abuse has taken place or that it is likely to occur in the future.

B

Buddy Scheme - is aimed at supporting children to express their views in any child protection meeting. Each child will be ask to choose someone they trust who can act as their Buddy, their voice in meetings. The scheme is supported by Children 1st

C

Child - For the purpose of child protection instructions a child is defined as a young person under the age of 16 years or between 16-18 if he/she is the subject of a supervision requirement imposed by a Children's Panel or who is believed to be at risk of significant harm and there is no adult protection plan in place.

Child Abuse - Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent, significant harm to the child. Children may be abused in a family or in an institutional setting, by those known to them or, more rarely, by a stranger. Assessments will need to consider whether abuse has occurred or is likely to occur. To define an act of omission as abusive and/or presenting future risk a number of elements can be taken into account. These include demonstrable or predictable harm to the child that would have been avoidable except for the action or inaction by the parent(s) or other carers.

Chief Officers Group – the COG comprises of the chief officers for each of the key partner agencies in Child Protection and Protecting People. This includes members from Health and Social Care, Children and Families, Health, Neighbourhood Services Police and Third (voluntary) Sector.

Child Assessment Order - A Child Assessment Order allows for a child to undergo a medical examination or assessment where this has been deemed necessary. This does not supersede the child's rights under the Age of Legal Capacity (Scotland) Act 1991. At all times the child's welfare is paramount.

Child Protection Committee – Every Local Authority must have a Child Protection Committee. Child Protection Committees are locally based, inter-agency strategic partnerships responsible for the design, development, publication, distribution, dissemination, implementation and evaluation of child protection policy and practice across the public, private and wider third sectors in their locality

Child Protection Order - A Child Protection Order may be granted on application to a Sheriff if conditions for making such an order exist. A Child Protection Order can allow for the removal of a child to a place of safety or prevent removal of a child from their home or any other safe place. A Child Protection Order can last up to six days and is granted to secure the safety and wellbeing of a child.

Child Protection Plan - Agreed inter-agency plan outlining in detail the arrangements to ensure the protection of the child and supports to the family.

Child Protection Register - A formal list of named children where there are concerns about the possibility of future abuse and where a child protection plan has been agreed.

Child Trafficking - This is the term given to the movement of children into and within the country with the intent to exploit them.

Core Group Meeting - Meeting of small group of inter-agency staff with key involvement with the child and family who meet (with child and family) to review progress and make arrangements for implementing the child protection plan.

E

Emergency Police Powers - The Police have the power to remove a child to a place of safety for up to 24 hours where the conditions for making an application for a Child Protection Order exist.

Emotional Abuse - Emotional abuse is persistent emotional neglect or ill treatment that has severe and persistent adverse effects on a child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate or valued only in so far as they meet the needs of another person. It may involve the imposition of age or developmentally inappropriate expectations on a child. It may involve causing children to fee frightened or in danger, or exploiting or corrupting children. Some level of emotional abuse is present in all types of ill treatment of a child; it can also occur independently of other forms of abuse.

Exclusion Order - An Exclusion Order allows for a named person to be ejected or prevented from entering the child's home. Conditions can also be attached to secure the child's safety and wellbeing.

I

Initial Child Protection Conference - An inter-agency meeting to consider the safety and welfare of children who have been the subject of a child protection investigation. The meeting will consider whether the child is a risk of significant harm, and place their name on the child protection register. It will also create a child's protection plan. The parents and sometimes the child will also attend this meeting.

Inter- Agency Child Protection Discussion - An IRD is an inter-agency meeting to share information where there are child protection concerns which need further clarification. Strengths within the family and the family's capacity to co-operate with agencies should be discussed. Any support required should also be identified and a plan of intervention should be agreed which could include organising a Initial Child Protection Conference.

J

Joint Investigative Interview - A Joint Investigative Interview is a formal planned interview with a child. It is carried out by staff, usually a social worker and a police officer trained specifically to conduct this type of interview. The purpose is to obtain the child's account of any events, which require investigation.

N

Non-organic Failure to Thrive - Children who significantly fail to reach normal growth and development milestones (i.e. physical growth, weight, motor, social and intellectual development) where physical and genetic reasons have been medically eliminated and a diagnosis of non-organic failure to thrive has been established.

P

Physical Abuse- Physical abuse is causing physical harm to a child or a young person. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child they are looking after.

Physical Neglect - Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or failure to respond to, a child's basic emotional needs. Neglect may also result in the child being diagnosed as suffering from 'no organic failure to thrive', where they have significantly failed to reach normal weight and growth or development milestones and where physical and genetic reasons have been medically eliminated. In its extreme form children can be at risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young people in particular, the consequences may be life-threatening within a relatively short period of time.

Planning Meeting - A Planning meeting (usually between social work and police) is usually held to plan a joint investigation - who does what and when is agreed.

Pre-Birth Child Protection Conference - An inter-agency meeting which considers the risk of harm to an unborn child and future risk upon the child's birth.

R

Review Child Protection Conference - An inter-agency meeting which reviews the circumstances of a child whose name is on the Child Protection Register.

S

Safe and Together – Is a programme for working with families where there are concerns about domestic abuse. It is a strengths bases approach working in partnership with the victim of abuse to reduce risk to themselves and any children. It is an approach that strives to help the perpetrator of the violence responsible for their behaviour.

Sexual Abuse - is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities such as involving children in looking at, or in the production of, pornographic material or in watching sexual activities, using sexual language towards a child or encouraging children to behave in a sexually inappropriate way.

Significant Harm - Physical or mental injury or neglect, which seriously affects the welfare or development of the child.

T

Team Around the Child – Is a meeting involving parents and children with key professionals where some concerns or the need for additional supports are identified. There are usually three levels meeting. A level one meeting will be a meeting between the names person and the parent, level 2 will involve other professionals – sometimes a specialist such as speech and language, a specialist nurse or similar. If there are increased concerns a level 3 team around the child will involve a social worker. A TATC meeting at levels 2 and 3 will agree a Childs Plan to support the child and their family to ensure needs are met and risks reduced.

Transfer Child Protection Conference - An inter-agency meeting which considers arrangements to transfer cases of a child whose name is on the Child Protection Register where the family moves to another area.

If not you ...who?

Dundee Child Protection Committee
c/o Andrew Beckett, Lead Officer
Protecting People Team
Dundee House
North Lindsay Street
Dundee, DD1 1NF
t: 01382 433343

www.**dundeeprotectschildren**.co.uk

Dundee Child Protection Committee

ITEM No …6……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 26 FEBRUARY 2019**

REPORT ON: **AUDIT SCOTLAND REPORT – HEALTH AND SOCIAL CARE INTEGRATION UPDATE ON PROGRESS**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB9-2019**

1.0 PURPOSE OF REPORT

The purpose of this paper is to provide the Integration Joint Board (IJB) with an overview of Audit Scotland's most recent national report on the progress of Health and Social Care Integration.

2.0 RECOMMENDATIONS

It is recommended that the IJB:

2.1 Notes the content of the Audit Scotland Health and Social Care Integration Update on Progress report as attached as Appendix 1, including the key messages and recommendations contained within the report and highlighted in section 4.3 and 4.4 below.

2.2 Instructs the Chief Officer to work with partner agencies to consider the report recommendations and ensure arrangements are in place to respond to these through appropriate IJB governance processes as set out in section 4.5 of this report.

3.0 FINANCIAL IMPLICATIONS

There are no direct financial implications arising from this report.

4.0 MAIN TEXT

4.1 In November 2018, Audit Scotland published its' most recent national report on the progress of Health and Social Care Integration as part two of a planned three series of audits around the development of integrated Health and Social Care following the introduction of the Public Bodies (Joint Working) (Scotland) Act 2014. The aim of the audit is to examine the impact public bodies are having as they integrate health and social care services. The report sets out six areas which need to be addressed if integration is to make a meaningful difference to the people of Scotland.

4.2 As part of the development of the report, Audit Scotland visited a number of partnership areas in Scotland as case study sites, including Dundee where they held a range of discussions with IJB members and key officers of the Health and Social Care Partnership, Dundee City Council and NHS Tayside. Indeed the examples of the impact of integration set out on page 20 of the report include Dundee's Sources of Support Social Prescribing initiative.

4.3 The key messages from the report are summarised below:

4.3.1. Integration Authorities (IAs) have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital. People at the end of their lives are also spending more time at home or in a homely setting, rather than in hospital. These improvements are welcome and show that integration can work within the current legislative framework, but IAs are operating in an extremely challenging environment and there is much more to be done.

4.3.2 Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support. This is a fundamental issue which will limit the ability of IAs to improve the health and social care system. Financial pressures across health and care services make it difficult for IAs to achieve meaningful change. IAs were designed to control some services provided by acute hospitals and their related budgets. This key part of the legislation has not been enacted in most areas.

4.3.3 Strategic planning needs to improve and several significant barriers must be overcome to speed up change. These include: a lack of collaborative leadership and strategic capacity; a high turnover in IA leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public. Local areas that are effectively tackling these issues are making better progress.

4.3.4 Significant changes are required in the way that health and care services are delivered. Appropriate leadership capacity must be in place and all partners need to be signed up to, and engaged with, the reforms. Partners also need to improve how they share learning from successful integration approaches across Scotland. Change cannot happen without meaningful engagement with staff, communities and politicians. At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland.

4.4 The report also sets out a number of recommendations drawn from the conclusions of the report. These are set out in pages 6 and 7 of the report and cover the areas summarised below. These recommendations are for Integration Authorities, Local Authorities, NHS Boards and the Scottish Government to consider collectively and to work through in partnership in order to enhance the arrangements for Health and Social Care Integration and to ensure the objectives of integration are achieved.

Key recommendations:

1) Commitment to collaborative leadership and building relationships.
2) Effective strategic planning for improvement.
3) Integrated finances and financial planning.
4) Agreed governance and accountability arrangements.
5) Ability and willingness to share information.
6) Meaningful and sustained engagement.

4.5 The Chief Officer will work with the partner agencies to consider what may be required locally to strengthen governance arrangements and working relationships to meet the recommendations as set out by Audit Scotland. These will be developed through the IJB's various finance and governance arrangements.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it relates to the sharing of a national report for which the IJB is not being asked to make a policy decision on.

7.0 CONSULTATION

The Chief Officer and the Clerk have been consulted on the content of this paper.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Directions Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 11 February 2019

Health and social care series

Health and social care integration

Update on progress

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
November 2018

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about-us/accounts-commission

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

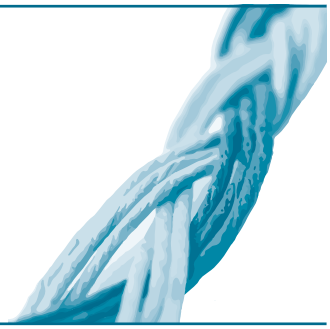
The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about-us/auditor-general

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

Contents



Links

PDF download

Web link

Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Audit team

The core audit team consisted of Leigh Johnston, Neil Cartlidge, Christopher Lewis and Lucy Jones, under the direction of Claire Sweeney.

Key facts

Savings Integration Authorities needed to achieve in 2017/18

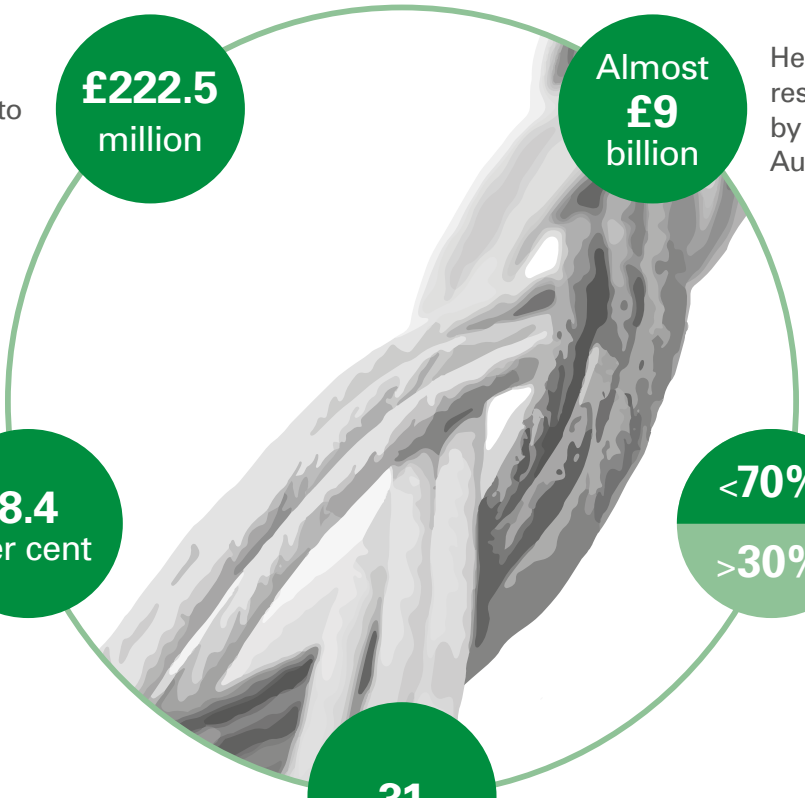
£222.5 million

Almost **£9 billion**

Health and social care resources directed by Integration Authorities

Increase in required savings from 2016/17

8.4 per cent



<70%

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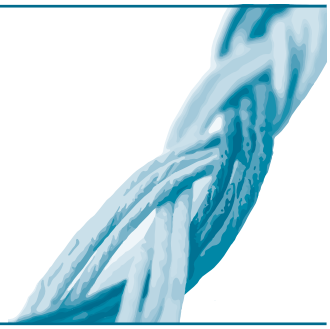
Integration Authority funding comes from the NHS

Funding comes from local authorities

31

Integration Authorities established through partnerships between the 14 NHS boards and 32 councils in Scotland

Summary



Key messages

1 Integration Authorities (IAs) have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital. People at the end of their lives are also spending more time at home or in a homely setting, rather than in hospital. These improvements are welcome and show that integration can work within the current legislative framework, but IAs are operating in an extremely challenging environment and there is much more to be done.

2 Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support. This is a fundamental issue which will limit the ability of IAs to improve the health and social care system. Financial pressures across health and care services make it difficult for IAs to achieve meaningful change. IAs were designed to control some services provided by acute hospitals and their related budgets. This key part of the legislation has not been enacted in most areas.

3 Strategic planning needs to improve and several significant barriers must be overcome to speed up change. These include: a lack of collaborative leadership and strategic capacity; a high turnover in IA leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public. Local areas that are effectively tackling these issues are making better progress.

4 Significant changes are required in the way that health and care services are delivered. Appropriate leadership capacity must be in place and all partners need to be signed up to, and engaged with, the reforms. Partners also need to improve how they share learning from successful integration approaches across Scotland. Change cannot happen without meaningful engagement with staff, communities and politicians. At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland.

several significant barriers must be overcome to speed up change

Recommendations

It is not possible for one organisation to address all the issues raised in this report. If integration is to make a meaningful difference to the people of Scotland, IAs, councils, NHS boards, the Scottish Government and COSLA need to work together to address six areas outlined below.

Commitment to collaborative leadership and building relationships

The Scottish Government and COSLA should:

- ensure that there is appropriate leadership capacity in place to support integration
- increase opportunities for joint leadership development across the health and care system to help leaders to work more collaboratively.

Effective strategic planning for improvement

Integration Authorities, councils and NHS boards should work together to:

- ensure operational plans, including workforce, IT and organisational change plans across the system, are clearly aligned to the strategic priorities of the IA
- monitor and report on Best Value in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

The Scottish Government should:

- ensure that there is a consistent commitment to integration across government departments and in policy affecting health and social care integration.

Integrated finances and financial planning

The Scottish Government should:

- commit to continued additional pump-priming funds to facilitate local priorities and new ways of working which progress integration.

The Scottish Government and COSLA should:

- urgently resolve difficulties with the 'set-aside' aspect of the Act.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- support integrated financial management by developing a longer-term and more integrated approach to financial planning at both a national and local level. All partners should have greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care.

Integration Authorities, councils and NHS boards should work together to:

- view their finances as a collective resource for health and social care to provide the best possible outcomes for people who need support.

Agreed governance and accountability arrangements

The Scottish Government and COSLA should:

- support councillors and NHS board members who are also Integration Joint Board members to understand, manage and reduce potential conflicts with other roles.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- agree local responsibility and accountability arrangements where there is disagreement over interpretation of the Public Bodies (Joint Working) (Scotland) Act 2014 and its underpinning principles. Scenarios or examples of how the Act should be implemented should be used which are specific to local concerns. There is sufficient scope within existing legislation to allow this to happen.

Ability and willingness to share information

The Scottish Government and COSLA should:

- monitor how effectively resources provided are being used and share data and performance information widely to promote new ways of working across Scotland.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

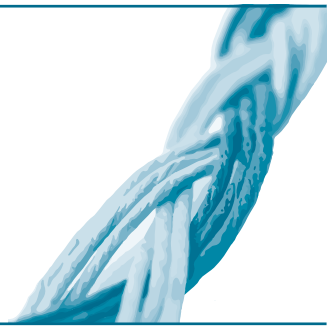
- share learning from successful integration approaches across Scotland
- address data and information sharing issues, recognising that in some cases national solutions may be needed
- review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in the future. They should also ensure mechanisms are in place to collect and report on this data publicly.

Meaningful and sustained engagement

Integration Authorities, councils and NHS boards should work together to:

- continue to improve the way that local communities are involved in planning and implementing any changes to how health and care services are accessed and delivered.

Introduction



Policy background

1. The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act) is intended to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care. The reforms affect everyone who receives, delivers and plans health and care services in Scotland. The Act requires councils and NHS boards to work together to form new partnerships, known as Integration Authorities (IAs). There are 31 IAs, established through partnerships between the 14 NHS boards and 32 councils in Scotland.

2. As part of the Act, new bodies were created – Integration Joint Boards (IJBs) (Exhibit 1, page 9). The IJB is a separate legal entity, responsible for the strategic planning and commissioning of the wide range of health and social care services across a partnership area. Of the 31 IAs in Scotland, 30 are IJBs and one area, Highland, continues with a Lead Agency model which has operated for several years. In Highland, the NHS board and council each lead integrated services. Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley. You can find more information about integration arrangements in our short guide.

3. Each IA differs in terms of the services they are responsible for and local needs and pressures. At a minimum, IAs need to include governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. In some areas, partners have also integrated children's services and social work criminal justice services. Highland Lead Agency, Dumfries and Galloway IJB, and Argyll and Bute IJB have also integrated planned acute health services. IAs became operational at different times but were all established by April 2016. The policy context for IAs is continually changing, and many policies have an impact on IAs, such as the new GP contract and changes to payments for social care services.

About this audit

4. This is the second of three national performance audits of health and social care integration following the introduction of the Act. The aim of this audit is to examine the impact public bodies are having as they integrate health and social care services. The report sets out six areas which need to be addressed if integration is to make a meaningful difference to the people of Scotland. This audit does not focus in detail on local processes or arrangements and it complements the programme of strategic inspections by the Care Inspectorate and Healthcare Improvement Scotland.[1] Appendix 1 (page 41) has more details about our audit approach and Appendix 2 (page 42) lists the members of our advisory group who provided help and advice throughout the audit.

What is integration? A short guide to the integration of health and social care services in Scotland

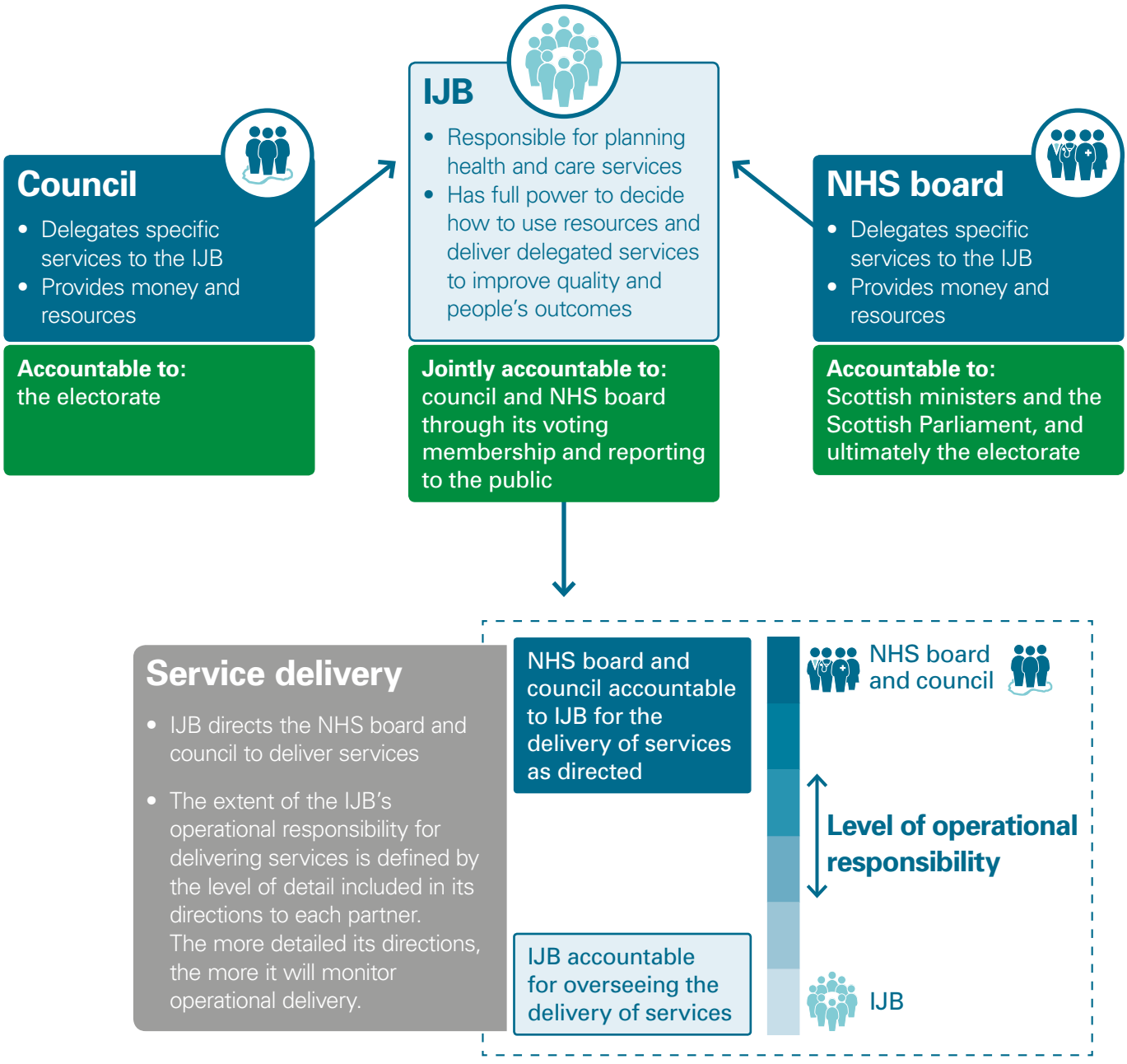
the reforms affect everyone who receives, delivers and plans health and social care services in Scotland

5. Appendix 3 (page 43) summarises progress against the recommendations in our first audit, which looked at transitional arrangements and highlighted several risks that needed to be addressed.[2] We will carry out a third audit in this series later in our work programme, which will report on the impact that integration has had and how health and social care resources are used.

Exhibit 1

Integration Joint Boards

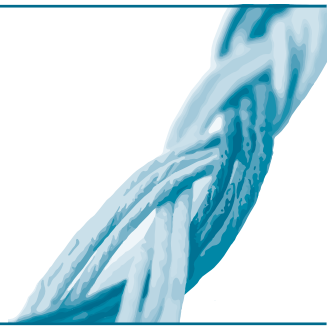
There are 30 Integration Joint Boards across Scotland.



Source: Audit Scotland

Part 1

The current position



Integration Authorities oversee almost £9 billion of health and social care resources

6. Our findings show that integration can work and that the Act can be used to advance change. Although some initiatives to integrate services pre-date the Act, there is evidence that integration is enabling joined up and collaborative working. This is leading to improvements in performance, such as a reduction in unplanned hospital activity and delays in hospital discharges. But there is much more to be done.

7. IAs are responsible for directing almost £9 billion of health and social care resources, money which was previously separately managed by NHS boards and councils (Exhibit 2, page 11). Over 70 per cent of this comes from the NHS, with the remainder coming from councils. As with councils and NHS boards, IAs are required to find efficiency savings from their annual budgets to maintain financial balance. Demands on services combined with financial pressures have led to many IJBs struggling to achieve this balance, with many needing additional financial contributions from partner organisations.

8. Each IA is underpinned by an integration scheme. This is the agreement between the council and the NHS board which shows how the IA will operate. For example, the scheme sets out arrangements for dealing with any budget overspends, which usually involves implementing a recovery plan. As local government bodies, IJBs can hold reserves if permitted by their integration schemes, although not all schemes allow this. Reserves are amounts of money that are built up from unspent budgets for use in future years. Generally, reserves are used for one of three purposes:

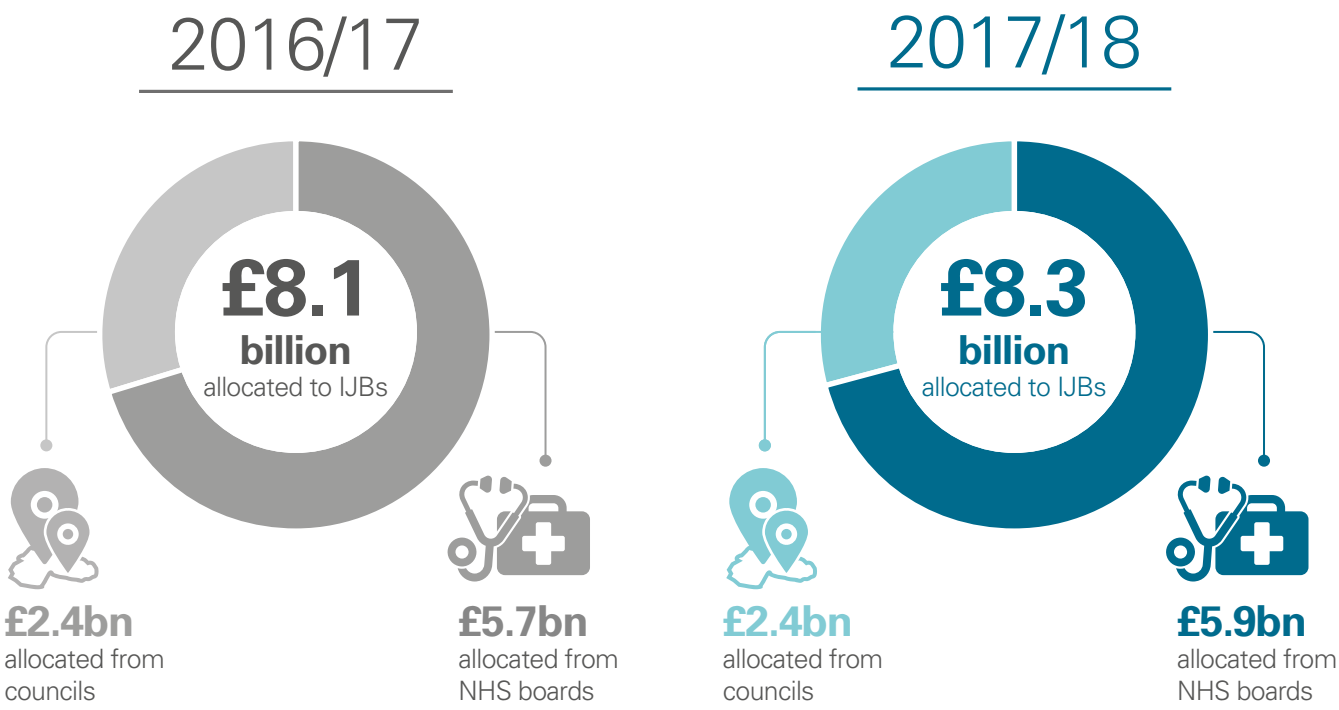
- as a working balance to help prevent the impact of uneven cash flows
- as a contingency to cushion the impact of unexpected events or emergencies
- held to fund known or predicted future requirements – often referred to as 'earmarked reserves'.[3]

there is evidence that integration is enabling joined up and collaborative working

Exhibit 2

Resources for integration

IAs are responsible for directing significant health and social care resources.



Lead Agency – the allocation for Highland Health and Social Care Services was:
£595 million in 2016/17 | £619 million in 2017/18

Note: Council allocations in 2016/17 and 2017/18 include criminal justice social work contribution.

Source: Audit Scotland, 2018

Financial pressures make it difficult for IAs to make sustainable changes to the way services are delivered

9. The Act was intended to help shift resources away from the acute hospital system towards preventative and community-based services. However, there is still a lack of agreement about whether this is achievable in practice – or whether rising demand for hospital care means that more resource is needed across the system. We have seen some examples of small-scale changes in the balance of care, which are explored further in Part 2 (page 23). These examples show that change can be achieved, but IAs now need to take the next steps to achieve wider-scale impact on outcomes over the coming years.

10. IAs needed to achieve savings of £222.5 million in 2017/18. This is an increase of 8.4 per cent on the previous year and is 2.5 per cent of the total allocation to IAs from NHS boards and councils. The level of savings, as a percentage of IA income, varied from 0.5 per cent in Moray, Orkney, Renfrewshire and South Lanarkshire, to 5.3 per cent in Shetland and 6.4 per cent in Highland Lead Agency. In several instances, budgets were agreed at the start of the financial year based on achieving savings which had yet to be identified.

Financial position

11. It is not easy to set out the overall financial position of IAs. This is due to several factors, including the use of additional money from partner organisations, planned and unplanned use of reserves, late allocations of money and delays in planned expenditure. This makes it difficult for the public and those working in the system to understand the underlying financial position.

12. In 2017/18, IJBs reported an overall underspend of £39.3 million. This represented 0.4 per cent of their total income allocation for the year.[4] However, this masks a much more complex picture of IJB finances. Appendix 4 (page 47) sets out more details about the financial position of IJBs in 2017/18. Many IAs have struggled to achieve financial balance at the year-end. The reasons for this vary but include rising demand for services, financial pressures and the quality of financial planning. In 2017/18, this resulted in several IJBs needing additional, unplanned allocations from their partners and adding to, or drawing on, reserves as follows:

- 17 needed additional money from NHS boards amounting to £33.3 million
- 11 needed additional money from councils amounting to £19.1 million
- eight drew on reserves amounting to £9.1 million
- 14 put money into reserves, amounting to £41.9 million.

13. Twenty-two IJBs are required by their integration schemes to produce a recovery plan if they forecast an overspend on their annual budget. Several IAs have had to produce recovery plans and are finding it harder to achieve the actions contained within them:

- In 2016/17, 11 IJBs needed to draw up a recovery plan. Of these, four IJBs achieved the actions set out in their recovery plans, but the remaining seven needed additional allocations from either their council or NHS board.
- In 2017/18, 12 IJBs needed to produce a recovery plan but only two achieved their recovery plans in full. In some cases, where additional allocations are required, the integration scheme allowed the NHS board or council to reduce the following year's allocation to the IJB by the same amount. In these circumstances there is a risk that IJBs will not have sufficient resources to deliver the services needed in future years.

14. An IA's integration scheme states how the IA will manage any year-end overspend and the responsibilities of the NHS board and council. For example, Fife IJB's integration scheme states that any overspend will be funded by partner bodies based on the proportion of their current year contributions to the IJB. In 2017/18, this meant that NHS Fife and Fife Council agreed to make additional contributions of 72 per cent and 28 per cent respectively.

15. The Highland Lead Agency model is also facing financial pressures. In 2017/18, NHS Highland overspent on adult social care services by £6 million. This was largely due to pressures on Highland Lead Agency adult social care services. This contributed to NHS Highland needing a loan of £15 million from the Scottish Government in 2017/18. Due to the way the Lead Agency model was established and the underlying agency agreement, the risks all rest with NHS Highland. Any increases in costs must be met by the NHS board.

16. Fourteen IJBs reported underspends in 2017/18 and these have arisen for a variety of reasons, for example: achieving savings earlier than expected; contingencies not being required; slippages in spending plans and projects; and staff vacancies.

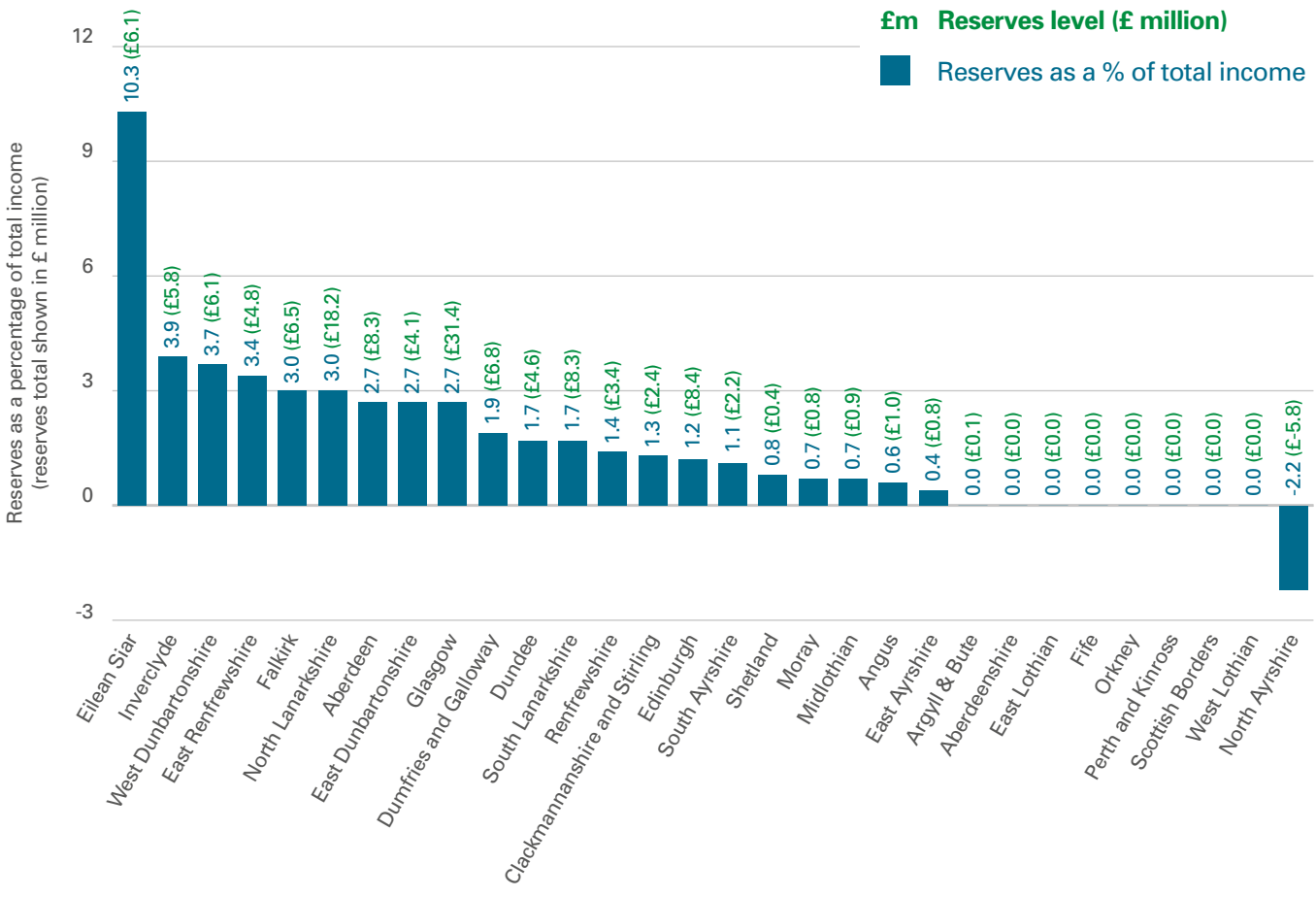
Reserves

17. The level of reserves held varies across IJBs, and not all integration schemes allow IJBs to hold reserves (Exhibit 3). In 2017/18, IJBs had built up reserves of £125.5 million, 1.5 per cent of their total income. This is not always a planned approach, and in some areas, reserves have arisen for several reasons including: the IJB receiving a late allocation of money; unspent strategic funding; staff vacancies; or year-end timing differences where money is received and allocated but unspent. Eilean Siar held the highest level of reserves as a percentage of its income at 10.3 per cent. The pressures on IJB budgets and the savings they need to achieve are significant, therefore the level of reserves in 2017/18 is not forecast to continue in future.

Exhibit 3

Reserves held by IJBs in 2017/18

There are significant differences in the levels of reserves held by IJBs.



Source: Integration Authority annual accounts, 2017/18

Hospital services have not been delegated to IAs in most areas

18. A key part of the reforms is that IJBs would direct some services provided directly within acute hospitals, to move care closer to people's homes and provide more joined-up care. Integration schemes, as approved by ministers, state that hospital services will be delegated to the IJB, as required under the Act. However, in practice, in most areas, the services have not been delegated. This has been a major source of debate and disagreement at a national and local level and is a fundamental issue which will hinder IJBs' ability to change the system.

19. The money for functions that are provided by large hospitals but are delegated to IJBs, such as unplanned care, is referred to as a 'set-aside' budget. Instead of paying this money to the IJBs along with payment for other delegated services, it is identified as a budget which should be directed by the IJB. The complexities around accurately preparing set-aside budgets has presented challenges to fulfilling this element of the Act. To date, the set-aside aspect of the Act is not being implemented. In line with Scottish Government guidance, NHS boards continue to manage the set-aside as part of their own resources.

20. In 2017/18, £809.3 million was included within IJBs' budgets for set-aside (where they were able to include a set-aside figure). This is 9.0 per cent of IJBs' income and is therefore a significant element of the health and social care budget that is not being directed by the IJBs. If IJBs are to use resources more strategically to prioritise prevention and care in a community setting, this issue needs to be resolved.

21. There are several reasons why all partners have struggled with this aspect of the Act, including fundamental issues in the data available to analyse set-aside-related activities. However, these technical issues do not appear to be the main issue. The main problem is a lack of common understanding and agreement on how to identify the set-aside budget and shared agreement on how to implement this aspect of the legislation.

Monitoring and public reporting on the impact of integration needs to improve

22. The context for integration is challenging, with many public bodies trying to work in partnership to achieve major changes while at the same time managing rising demand for services, financial pressures and continuing to deliver services and treat people. As we reported in *NHS in Scotland 2018*, the number of patients on waiting lists for treatment continues to rise while performance against targets is declining and an increasing number of NHS boards are struggling to deliver with the resources they have.[5] We have also reported that local government operates in an increasingly complex and changing environment with increasing levels of uncertainty.[6]

23. A significant number of measures are being used to monitor national and local progress which means IAs are reporting against a range of different measures to demonstrate progress (Exhibit 4, page 16). For the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way.

24. It is important that the Scottish Government can demonstrate that resources provided have led to improvements in outcomes, in line with its national health and wellbeing outcomes. These outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration. These national outcomes are not being routinely reported at a national level, although IAs refer to them as part of their annual performance reports.

25. The Scottish Government introduced the National Performance Framework (NPF) in 2007 and launched a new framework in 2018. The NPF is made up of 11 national outcomes, each with indicators and aligned to the United Nations' sustainable development goals. There is a clear alignment between the aims of integration and several of the outcomes and indicators.[7]

26. The Ministerial Strategic Group for Health and Community Care brings together representatives from the Scottish Government, NHS, local government and IAs to monitor a set of six national indicators. These are used as indicators of the impact of IAs (Exhibit 5, page 18). These measures focus on the aim of integration helping to care for more people in the community or their own homes and reducing unnecessary stays in hospital. While these measures focus on health, performance can only improve with input from health and social care services. One of the six national indicators is supported by two measures: A&E attendances and achievement of the four-hour A&E waiting time target (3a and 3b at Exhibit 5, page 18).

27. Four of the indicators show improved performance, but there is significant local variation in performance between IAs. The performance measures do not themselves provide a direct indication of whether people's outcomes have improved, although they do represent key aspects of care which should ultimately improve people's lives.

Exhibit 4

Health and wellbeing outcomes and indicators

A significant number of measures are being used to monitor local and national progress.

National Performance Framework

Purpose

To focus on creating a more successful country, with opportunities for all of Scotland to flourish, through sustainable and inclusive economic growth

Values

We are a society which treats all our people with kindness, dignity and compassion, respects the rule of law, and acts in an open and transparent way

11 outcomes and 81 national indicators, for example:

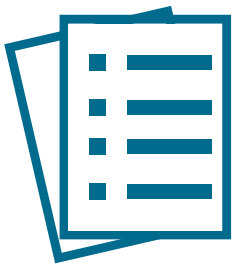
- **Outcome:** We are healthy and active
- **Indicators:** Healthy life expectancy, mental wellbeing, healthy weight, health risk behaviours, physical activity, journeys by active travel, quality of care experience, work-related ill health, premature mortality
- **Sustainable development goals:** gender equality, reduced inequalities, responsible consumption and production, good health and wellbeing

9 national health and wellbeing outcomes

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Health and social care services contribute to reducing health inequalities
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- People using health and social care services are safe from harm
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Resources are used effectively and efficiently in the provision of health and social care services

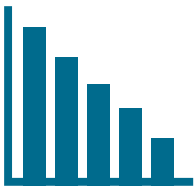
Cont.

Exhibit 4 (continued)



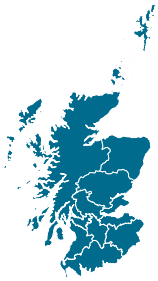
12 principles within the Act

- Be integrated from the point of view of the people who use services
- Take account of the particular needs of service users in different parts of the area in which the service is being provided
- Respect rights of service users
- Protect and improve the safety of service users
- Improve the quality of the service
- Best anticipate needs and prevent them arising
- Take account of the particular needs of different service users
- Take account of the particular characteristics and circumstances of different service users
- Take account of the dignity of service users
- Take account of the participation by service users in the community in which service users live
- Is planned and led locally in a way which is engaged with the community
- Make best use of the available facilities, people and other resources



6 national indicators

- Acute unplanned bed days
- Emergency admissions
- A&E performance (including four-hour A&E waiting time and A&E attendances)
- Delayed discharge bed days
- End of life spent at home or in the community
- Proportion of over-75s who are living in a community setting



Various local priorities, performance indicators and outcomes

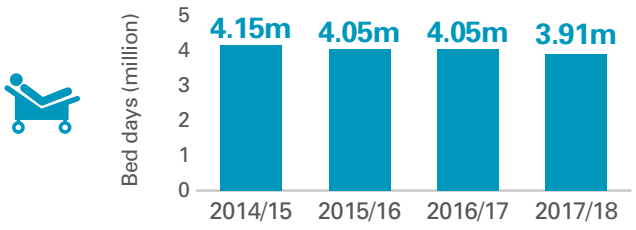
Source: Audit Scotland

Exhibit 5

National performance against six priority areas

National performance shows signs of improvement in some of the six key national indicators.

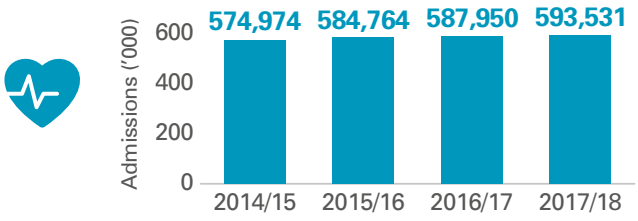
1. Acute unplanned bed days



Integration aims to reduce unplanned hospital activity

The number of acute unplanned bed days has reduced since 2014/15

2. Emergency admissions

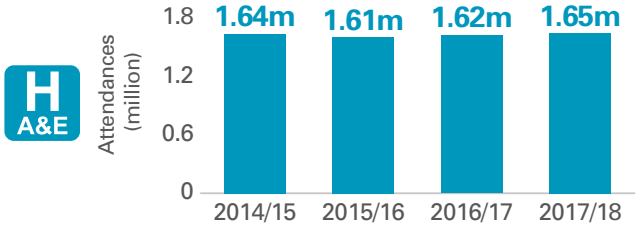


Integration aims to ensure that people's health and care needs are anticipated and planned appropriately, reducing unplanned hospital activity

The number of emergency admissions has risen each year since 2014/15

In 2017/18, local performance varied from 0.08 emergency admissions per head of population in NHS Orkney to 0.15 in NHS Ayrshire and Arran

3a. A&E attendances

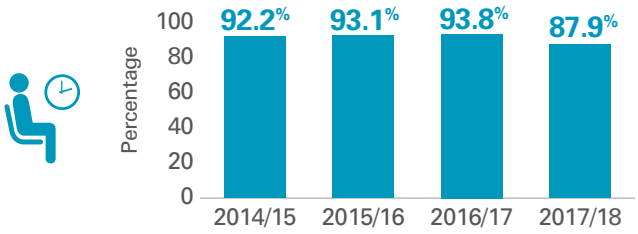


A&E attendances can be an indication of the degree to which community services are helping people receive care in the right place at the right time.

The number of A&E attendances has marginally increased since 2014/15

In 2017/18, local performance varied from 0.2 A&E attendances per head of population in NHS Grampian to 0.4 in NHS Greater Glasgow and Clyde

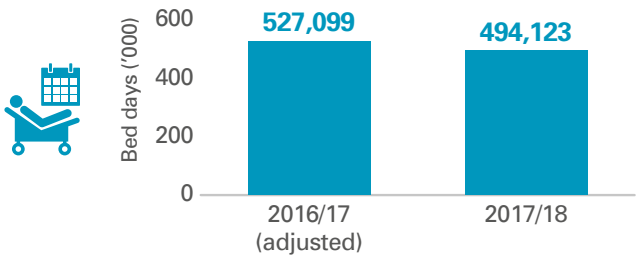
3b. Achievement of the four-hour A&E waiting time target



The achievement of the four-hour waiting time target has declined since 2014/15

Local performance varied in 2017/18 from 98.0% NHS Tayside to 75.4% NHS Lothian

4. Delayed discharge bed days (for population aged 18+)



Reducing delays in discharging people from hospital has been a long-standing aim for health and care services. With rising demand, some areas have struggled with this. Due to changes in data collection, comparable data is only available for two years.

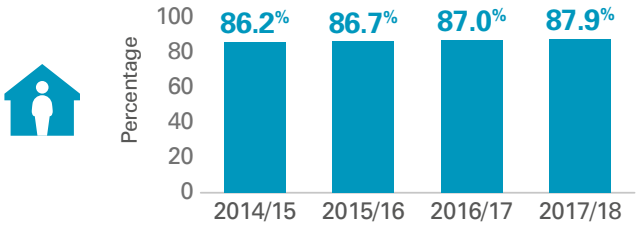
Delayed discharge rates have fallen since 2016/17

In 2017/18, local performance varied from 2.5% in Inverclyde to 26.5% in Eilean Siar delayed discharge bed days as a percentage of their population (18+)

Cont.

Exhibit 5 (continued)

5. End of life spent at home or in the community

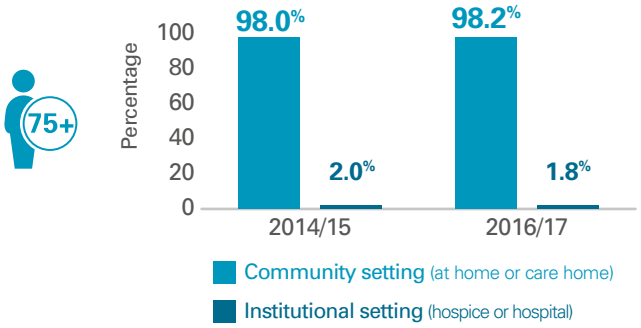


Integration aims to support people with health and care needs in their own home or in a community setting, especially at the end of life.

A gradual increase in the percentage of people's time spent at home or in a homely setting at the end of their life

In 2017/18, local performance varied from 95.1% of people's time spent at home or in a homely setting at the end of their life in Shetland to 85.2% in East Renfrewshire

6. Percentage of 75+ population in a community or institutional setting



Integration aims to shift the balance of care from an institutional setting to a community setting.

There has been a slight increase in the percentage of individuals aged over 75 who are living in a community setting. This is in line with the intentions of the Act.

Notes:

Indicator 1
1. These statistics are derived from data collected on discharges from non-obstetric and non-psychiatric hospitals in Scotland. Only patients treated as inpatients or day cases are included. The specialty of geriatric long stay is excluded.
2. Bed days for each year have been calculated based on the year in which the bed days were occupied. This differs from other analysis where length of stay or occupied bed days are reported by the year of discharge.
3. Unscheduled bed days relate to all occupied bed days within a continuous hospital stay following an emergency or urgent admission.
4. The Scotland total presented is the sum of all those resident in IA areas and excludes non-Scottish residents.
5. Approximately a quarter of IAs returned figures for people aged over 18 only. Where this is the case, bed days from 2016/17 for people aged under 18 in those partnerships have been applied to 2017/18 figures.
6. Based on data submitted to ISD in August 2018.

Indicator 2
1. ISD published data as at September 2018.

Indicator 3a
1. ISD published data as at August 2018.

Indicator 3b
1. ISD published data as at June 2018.
2. Performance for the month ending March for each year.

Indicator 4
1. ISD published data as at September 2018.
2. 2016/17 figures adjusted to reflect revised definitions across the whole year.

Indicator 5
1. ISD published data as at October 2018.

Indicator 6
1. Percentage of 75+ population in a community or institutional setting:
   - Community includes the following:
     - Home (unsupported) – refers to the percentage of the population not thought to be in any other setting, or receiving any homecare, on average throughout the year.
     - Home (supported) – refers to the percentage of the population estimated as receiving any level of homecare. Estimated from social care census carried out at the end of the reporting year (eg, Census carried out in March 2014 used to estimate home (supported) population during 2013/14).
     - Resident in a care home – based on care home census at the end of the reporting year (eg, Census at 31 March 2014 used to estimate 2013/14 care home population). The care home data is based on long-stay residents only. The proportion of incomplete long-stay residents aged 75+ cannot be calculated. Therefore, a scaling factor, based on the 65+ proportions, has been employed for the 75+ data. This assumes that there is the same degree of incompleteness in the census data returned for adults in each of the age bands.
   - Institutional includes the following:
     - Average population in hospital/hospice/palliative care unit throughout the year.
     - Hospital includes both community and large/acute hospitals.
     - Hospice activity is based on SMR records and will be incomplete as not all hospices submit this information.
2. Figures provided by ISD.

General
1. Population figures used taken from the National Records of Scotland mid-2017 estimates published in 2018.
2. Figures relate to all ages unless otherwise stated.

Source: Information Services Division (ISD) and Scottish Government

Integration Authorities' performance reports show local improvement

28. IAs are required to publish annual performance reports which contain information on local priorities and a range of local initiatives (Exhibit 6). These reports are an important way for IAs to inform the public about how well they have been performing against their stated priorities. The improvements that are set out in the performance reports are welcome and current pressures across the system have made them difficult to achieve. However, core indicators of performance are not improving in all areas of Scotland and nationally it is clear that there is much more to be done.

Exhibit 6

Examples of impact from integration

IAs have set out a number of local improvements in their performance reports.

Prevention and early intervention

Dumfries and Galloway

The D&G Handyvan provides information, advice and practical assistance with adaptations to people's homes. This is available to disabled people of any age and older people aged 60 and over. People are also supported to access financial assistance for major adaptations. This service helps people to feel more confident about continuing to live independently in their own home and to feel safe and secure in their home. People are less likely to have a fall, have improved health and wellbeing, and have a better quality of life. Often adaptations support people to be better connected with their friends and family and their wider community. 1,626 referrals were received during 2017/18. These resulted in 2,149 tasks being carried out by the service. 808 people were referred to prevent a fall, 577 people for home security, 16 people for minor adaptations and 225 people for small repairs.

Dundee

Social prescribing 'Sources of Support' (SOS) is one means of supporting people to better manage their health conditions. Link workers, working within designated GP practices, take referrals for people with poor mental health and wellbeing affected by their social circumstances and support them to access a wide range of non-medical services and activities that can help. In 2017/18, 256 patients were referred to three link workers and 220 people were supported. An external evaluation demonstrated that the service had a positive impact on both clients and on GPs themselves. 65 per cent of patient goals were met and 84 per cent had some positive outcome, including decreased social isolation, improved or new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem.

Outcomes from a GP perspective include reduced patient contact with medical services, providing more options for patients, raising awareness of non-clinical services, and increased GP productivity. 2017/18 saw a major scale-up of the SOS scheme through the Scottish Government Community Link Worker programme, extending the service from four GP practices to 16.

Delays in people leaving hospital

East Ayrshire

The Red Cross Home from Hospital Service supported about 1,700 people in 2017/18. The service is delivered across Ayrshire and Arran from University Hospitals Crosshouse and Ayr and supports people to be discharged as early as possible, reducing their length of stay and re-settling them in their home. Once home, the service helps to prevent falls and reduce social isolation, supporting people to regain their confidence, skills for living independently and organises telecare to support families to continue to care. A total of 1,730 bed days have been saved, equivalent to £302,750. 73 admissions to hospital have been avoided, and 625 bed days saved, equivalent to £109,375.

Perth and Kinross

There have been increases in staffing within social care discharge teams, Perth Royal Infirmary liaison services, and care home nursing. This, alongside improved funding procedures for care home placements, has supported speedier discharge to a care home setting or repatriation to such. There has been a reduction of 2,391 (12.5 per cent) delayed discharge bed days between 2016/17 and 2017/18 to 16,785.

Cont.

Exhibit 6 (continued)

Preventing admission to hospital

East Dunbartonshire

Rapid Response Service has established a different referral route for patients between A&E and the Community Rehabilitation Team to provide next-day response. During 2017/18, the service prevented approximately 33 per cent of people referred being admitted to hospital.

South Ayrshire

The Intermediate Care Team provide rapid multidisciplinary team support to people to support them to return home from acute hospital and to remain at home through GP referral. In particular, they have worked closely to establish pathways with the Combined Assessment Unit to prevent admission. The service provided by the Intermediate Care Team resulted in 674 hospital admissions being avoided and 301 early supported discharges during 2017/18. It is estimated locally that each avoided hospital admission saves five hospital bed days and each supported discharge saves three hospital bed days. Overall, it is estimated that the intervention provided by the Intermediate Care Team saved 3,370 bed days due to avoided admissions and 903 bed days due to early supported discharges.

Aberdeenshire

Set up in 2016, Aberdeenshire's Virtual Community Ward (VCW) aims to avoid unnecessary hospital admissions through bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention. This GP-led approach involves the teams working closely together, generally meeting daily under a huddle structure. They identify and discuss vulnerable/at risk patients and clients, and coordinate, organise and deliver services required to support them. The VCW identifies individuals who need health and social care services at an earlier stage, which can improve patient outcomes and experience. Based on an evaluation carried out by the VCW team, 1,219 hospital admissions have been avoided because of the VCWs .

Referral/ care pathways

Aberdeenshire

During 2017/18 a test of change was carried out in one GP practice to trial people's first appointment with a physiotherapist rather than a GP. Ongoing evaluation suggests that this has been successful and has proved popular with patients who now have immediate access to a physiotherapist for assessment and advice. If follow up is required, this can be booked at the time. 221 people have been directed to the physiotherapist first; only 58 per cent required a face-to-face appointment and 26 per cent were discharged following telephone advice.

Renfrewshire

Over the past three years, the Primary Care Mental Health Team (Doing Well) has introduced a self-referral route to the service. This has led to a decrease in clients attending a GP to be referred to the mental health team. The number of self-referrals to the service has increased from 207 in 2013/14 to 1,237 in 2017/18. This self-referral route has successfully redirected work away from GP surgeries.

Midlothian

An advanced practitioner physiotherapist for Chronic Obstructive Pulmonary Disease (COPD) was appointed to support people attending hospital frequently because of their COPD to help them manage their symptoms at home and avoid admission to hospital. In the first year the service has worked with 65 patients and successfully avoided 30 hospital admissions. This delivered a potential reduction of 520 days spent in hospital by Midlothian residents and a much better patient experience. It was also a more cost-effective approach to delivering services for the partnership.

Cont.

Exhibit 6 (continued)

Reablement

Falkirk

A Reablement Project Team (RPT) was developed in Social Work Adult Services Assessment and Planning service in January 2017 to test out various reablement approaches and processes. The team consists of occupational therapists (with community care worker background) and social care officers. The reablement team support service users for up to six weeks. Individuals are reviewed on a weekly basis and care packages are adjusted as the person becomes more independent. Fewer people required intensive packages at the end of six weeks, which has freed up staff time and has reduced the use of external providers. Early indications suggest this work has led to a £200,000 reduction in purchasing care from external homecare providers.

Scottish Borders

The Transitional Care Facility based within Waverley Care Home is a 16-bed unit which allows older people to regain their confidence and independence so that they can return to their own homes following a stay in hospital. The facility is run by a multidisciplinary team of support workers, allied health professionals and social workers. 81 per cent of individuals discharged from Transitional Care return to their own homes and the hospital readmission rate for these individuals is six per cent.

Pharmacy

South Lanarkshire

The pharmacy plus homecare initiative has created an opportunity to amend consultant and GP prescribing practices. A reduction in prescribing can lead to less homecare visits. The IA estimates that savings could be in the region of £1,800 per patient (within the trial).

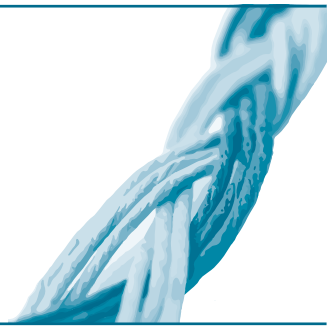
Angus

The Angus IA has improved how care homes manage medication. A new process developed by a Locality Care Home Improvement Group with GPs and pharmacy has led to zero medication waste in care homes.

Source: Audit Scotland review of Integration Authorities' Performance Reports, 2018

Part 2

Making integration a success

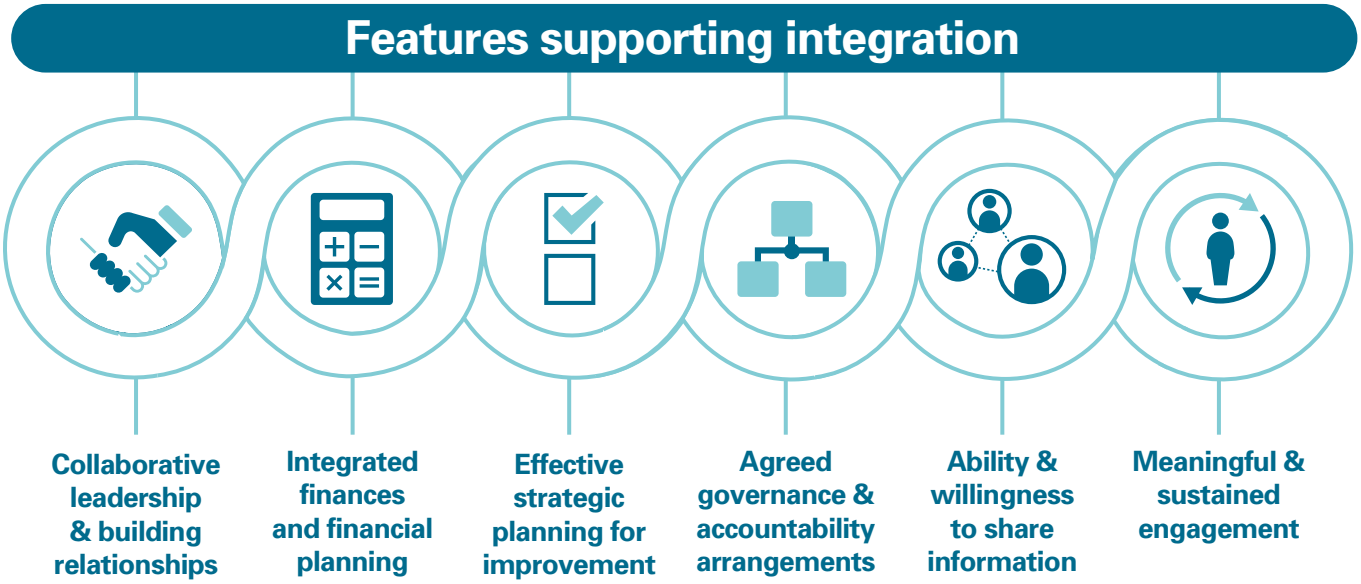


29. IAs are addressing some significant, long-standing, complex and inter-connected issues in health and social care. Our work has identified six key areas that, if addressed, should lead to broader improvements and help IAs to take positive steps toward making a systematic impact on health and care outcomes across their communities (Exhibit 7).

Exhibit 7

Features central to the success of integration

Six areas must be addressed if integration is to make a meaningful difference to the people of Scotland.



Source: Audit Scotland

A lack of collaborative leadership and cultural differences are affecting the pace of change

30. High-quality leadership is a critical part of the success of an organisation or programme of reform. Given the complexity of health and social care integration, it is important that leaders are highly competent, have capacity to deliver and are well supported. For transformation to succeed, the right leadership and strategic capacity need to be in place. Without this, the reforms will not succeed. We identified several risks in this area which need to be addressed:

- A significant number of IAs have had leadership changes with 57 per cent having had changes in their senior management team. As at October 2017, seven IJBs have a different Chief Officer (CO) in post than two years previously.

- There is significant variation in the role and remuneration of COs and Chief Financial Officers (CFO). Many have dual roles with positions held in partner organisations and there is a mix of full and part-time CFOs. This is a significant challenge, given the scale of the task facing IAs and the strategic role COs and CFOs have in directing change. In 2017/18, £3 million was spent on IJBs' CO remuneration and there are differences in salary levels, in part reflecting differences in roles and responsibilities.

- There is evidence of a lack of support services for IAs, in relation to HR, finances, legal advice, improvement, and strategic commissioning. This will limit the progress that they are able to make. It is important that the partner bodies support the IJB, including support services.

31. Top-down leadership which focuses on the goals of a single organisation does not work in the context of integration. NHS Education Scotland has described 'systems leaders' as having an ability to 'have a perspective from the wider system. They recognise that it is necessary to distribute leadership responsibilities to bring about change in a complex interdependent environment…They change the mind-set from competition to cooperation. They foster dialogue… which can result in new thinking… When leadership involves such a collective endeavour, the way people see their accountability matters.'[8] A lack of collaborative systems leadership and difficulties in overcoming cultural differences are proving to be significant barriers to change.

32. Leaders from all partners are operating in a complex and continually changing landscape and, without appropriate support in place, cannot fulfil their role effectively. Leaders need support if they are to deliver public services to improve wider outcomes and work collaboratively across organisational boundaries. This is hard to achieve, especially where there have been changes in key staff and local politicians, and in the context of the current financial and performance pressures. Accountability arrangements are important to encourage and incentivise the right kinds of leadership characteristics.

33. Cultural differences between partner organisations are proving to be a barrier to achieving collaborative working. Partner organisations work in very different ways and this can result in a lack of trust and lack of understanding of each other's working practices and business pressures. In better performing areas, partners can identify and manage differences and work constructively towards achieving the objectives of the IA. Overcoming cultural differences and improving understanding of each other's businesses will help partner organisations progress towards integration, particularly regarding integrated finances. Joint leadership development for people working in NHS boards, councils and IJBs can help with this. Exhibit 8 (page 25) provides an overview of the common leadership traits which are important in integrating health and social care services.

Exhibit 8

Traits of effective collaborative leaders

There are a number of leadership traits which are important in integrating health and social care services.

Influential leadership

- Clear and consistent message
- Presents a positive public image
- Ability to contribute towards local and national policy
- Shows an understanding of the value of services

Ability to empower others

- Encourages innovation from staff at all levels
- Non-hierarchical and open to working alongside others
- Respectful of other people's views and opinions
- Inspiring to others
- Creates trust
- Willing to work with others to overcome risks and challenges

Promotes awareness of IA's goals

- Confidence and belief in new technology to facilitate progress
- Facilitates planning of sustainable services
- Recruitment of staff to fit and contribute to a new culture
- Sets clear objectives and priorities for all
- Develops widespread belief in the aim of the integrated approach to health and social care

Engagement of service users

- People who use services feel able to contribute to change
- Ability to facilitate wide and meaningful engagement
- Open to and appreciative of ideas and innovation
- Ensures voices are heard at every level
- Transparent and inclusive

Continual development

- Encourage learning and development, including learning from mistakes
- Belief in training and understanding of who could benefit from it
- Encourage innovation, debate and discussion
- Driven to push for the highest quality possible

Source: Audit Scotland, 2018; from various publications by The Kings Fund; Our Voice; Scottish Government; Health and Sport Committee and the Scottish Social Services Council.

34. We have seen examples of good collaborative and whole-system leadership, including in Aberdeen City, where relationships have been built across the partnership. Although differences of opinion still exist and there is healthy debate, Aberdeen City is now better placed to implement widespread changes to improve outcomes. We saw:

- the promotion of a clear and consistent message across the partnership
- a willingness to work with others to overcome differences
- recruitment of staff to fit and contribute to a new culture
- development of openness and appreciation of ideas
- encouragement of innovation, learning and development, including learning from mistakes.

35. The Scottish Government and COSLA are co-chairing a group involving leaders from across councils and NHS boards. The aim of the group is to identify and overcome barriers to integration. The group has produced a joint statement on integration, confirming the shared responsibility of the Scottish Government, NHS Scotland and COSLA for ensuring the successful integration of Scotland's health and social care services. The statement acknowledges that the pace of integration needs to improve, and that the group needs to work together to achieve integration and to overcome challenges to better meet people's health and social care needs. The group is developing further support and training to support leadership for integration. The Scottish Government and COSLA are also co-chairing an Integration Review Reference Group. This group is reviewing progress on integration and will report its findings to the Ministerial Strategic Group for Health and Community Care. The group will conclude its work in January 2019. We will continue to monitor any actions resulting from the work of the group.

Integration Authorities have limited capacity to make change happen in some areas

36. IJBs are very small organisations, all of which have a CO and a CFO. Not all IJBs have the support they need, for example only half of IJBs have a full-time CFO and there have been difficulties in filling those posts in some areas. Each IJB has a chair and vice chair, but we have been told that many IJBs rely on its members working much more than contracted hours, and chairs and vice chairs have told us that they struggle to attend to IJB business during contracted time. Each IJB is made up of voting and non-voting members.

37. Typically, an IJB meets about six times a year. The IJB also has one or more Strategic Planning Group, which are consulted and give feedback on strategic plans and significant changes to integrated functions. For this structure to work, the IJB needs to draw on, and be supported by, skills and capacity from its partner NHS board and council. This can lead to a reliance on information and advice being provided by the statutory partner organisations which influences the decisions made by the IJB. In areas where information is being shared across the partnership, we can see that more progress is being made with integration. We saw this happening in Aberdeen City IJB, where senior officer and finance officer groups bring together staff from across partner organisations to share information and skills which are essential for joint decision-making. If this does not happen, the IJB has less capacity to make change and address challenges.

What is integration?
A short guide to the integration of health and social care services in Scotland

IJB membership
(page 10)

38. We saw several barriers affecting the way that IJBs are operating, and more action is needed to increase knowledge and understanding of those involved in the decision-making process:

- Topics for discussion at IJB and committee meetings are affected by problems with both the lack of time available and with people's knowledge.
- IJB papers are often lengthy and issued to members within timescales that do not allow for proper consideration.
- Papers are often technical and contain complicated financial information that lay representatives and representatives from voluntary sector bodies may struggle to understand.
- Officers are limited in the time available to provide IJBs with information. Many officers of the IJB fulfil their role alongside roles held within statutory partner bodies.
- High turnover of people in key positions in IJBs has affected the skills available and has led to a lack of continuity and extra time being spent in building trust and relationships.

Good strategic planning is key to integrating and improving health and social care services

39. In the past, health and social care services have not linked the resources they have to their strategic priorities or longer-term plans. IAs still have work to do to ensure that priorities are linked to available resources, and to demonstrate that new ways of working will be sustainable over the longer term. IAs can only achieve this change with the support and commitment of NHS boards and councils.

40. IJBs, with the support of council and NHS board partner bodies, should be clear about **how** and **when** they intend to achieve their priorities and outcomes, in line with their available resources; and ultimately how they intend to progress to sustainable, preventative and community-based services. This includes working with NHS boards and councils to: agree which services will be stopped or decommissioned to prioritise spend; plan effective exit strategies from current ways of delivering services; and being clear how they will measure improvements in outcomes. Exit strategies are an important element in the ability to move from one service provision to another.

41. Scenario planning will help IAs build a picture of what they will need in the future. This involves looking at current trends, such as the effects of an ageing population, current lifestyles and future advances in health and social care. IAs should then use this analysis to anticipate potential changes in future demand for services and any related shortfalls in available finances. Strategic planning groups of the IJB have a role to play in ensuring the needs of the community are central to service decisions (Case study 1, page 28).

Case study 1

Shetland Scenario Planning

As part of its Strategic Commissioning Plan, the Shetland IA identified a growing gap between service demand and resources. To support strategic planning, NHS Shetland hosted a session with health and social care staff, IJB representatives, NHS board representatives, councillors, community planning partners, third-sector organisations and representatives of people using services. It considered several high-level scenarios:

1. the lowest level of local healthcare provision that it could ever safely and realistically imagine being delivered on Shetland 5-10 years from now
2. a lower level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step down' from where it is now in terms of local service delivery
3. a higher level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step up' from where it is now in terms of local service delivery
4. a future that describes the highest level of local healthcare provision that it could ever realistically imagine being delivered on Shetland 5-10 years from now.

The group then concentrated on scenarios 2 and 3 and explored them in more detail.

This systematic approach towards strategic planning, involving a wide variety of stakeholders, allowed them to build consensus on the main priorities of the IJB. The key outputs from the scenario planning exercise involved clear actions that were linked to a wide range of plans and policies. The key messages from the scenario planning formed discussion points within the IJB meetings. Actions identified were then incorporated into the business programme and an action tracker is a standing agenda item.

Source: Shetland IJB, 2018

42. Although strategic planning is the statutory responsibility of the IAs, councils and NHS boards should fully support the IJB and provide the resources needed to allow capacity for strategic thinking. In addition, the Scottish Government has an important role to play in leading and enabling change to take place. There must be a consistent message and understanding of integration, but this is not always the case. For example, the current move towards some aspects of health planning taking place at a regional level is causing uncertainty for IAs. Many IAs are unclear as to how this fits with the need for local strategic planning and decision-making. For IAs to think long term, they must have confidence that Scottish Government policy will support integrated thinking.

43. Strategic planning also helps to encourage and promote joined-up working and a commitment to scaling up new ways of working. Angus IJB has shown a strong long-term commitment to its enhanced community support model. This has now been implemented in three of its four locality areas and therefore has the potential for long-term impact on people's outcomes (Case study 2, page 29).

Case study 2

Angus – Enhanced community support model

Angus IJB's Enhanced Community Support (ECS) workstream involves several multi-professional teams working together, including the third-sector. The teams provide care and support in people's own homes so that, where possible, hospital admission is avoided. As a result, staff can be more proactive, coordinate care and make referrals for additional support more quickly. The teams also hold weekly meetings to review the care that is being provided in a more coordinated way.

ECS has increased community and primary care capacity leading to an average of 37 empty hospital beds across Angus per day in 2017. This helped the IJB to close 21 of its 126 community hospital inpatient beds which are no longer needed. ECS has improved hospital readmission rates. It has also improved prevention and early intervention activity through an increase in the number of anticipatory care plans.

ECS has led to a more joined-up approach between the professional disciplines which has improved referral times and access to support. This has allowed people to be more independent, access local services and be supported to stay in their homes or a homely setting for longer.

The success of this approach has allowed the IJB to roll ECS out to three of its four localities, with plans to roll out to the final locality during 2018/19. The localities that have adopted this approach for the longest have seen improvements in the average length of stay and a reduction in the number of hospital admissions for people aged over 75.

Source: Angus IJB, 2018

44. A small number of IAs do not have detailed implementation/commissioning plans to inform their strategic plan. Of those which do, about half of these provide a link to resources. More needs to be done to show how the shift from the current ways of working to new models of care will happen and when positive changes to people's lives will be achieved.

45. Workforce pressures are a clear barrier to the implementation of integration plans and workforce planning is a particularly important element of strategic planning. Workforce planning remains the formal responsibly of councils and NHS boards. However, IJBs need to work closely with their partners to ensure that their plans for service redesign and improvement link with and influence workforce plans. IAs must be able to demonstrate what skills are required to ensure they can deliver services in the right place at the right time. IAs identify not being able to recruit and retain the workforce they need as a risk. The contribution of the third and independent sector should be part of workforce planning.

46. All three parts of the Health and Social Care National Workforce Plan have now been published, with the final part on the primary care workforce published in April 2018.[9] In our 2017 report, *NHS workforce planning*, we recommended that there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand.[10] We will publish a further report on workforce planning and primary care in 2019.

Housing needs to have a more central role in integration

47. Not enough links are being made between housing and health and social care which will improve outcomes and wellbeing. Housing services are an integral part of person-centred approaches and the wider delivery of health and social care integration. All IAs are required to include a housing contribution statement in their strategic plans and housing representation is mandatory on Strategic Planning Groups. Case study 3 illustrates strategic thinking within Glasgow City IJB which has used housing as a central aspect of health and social care. Three-quarters of IJBs reported some involvement of housing services in the planning of integrated health and social care services, although we found that the extent of this involvement varied greatly between partnerships.

Case study 3

The Glasgow Housing Options for Older People (HOOP) approach

The HOOP approach involves a small team working closely with social work, health and Registered Social Landlords (RSLs). The approach aims to: ensure a smooth transition for people from hospital to a homely setting; work closely with RSLs to prioritise people who are experiencing a delay in being discharged from hospital; develop knowledge of housing stock availability; and provide reciprocal information about RSLs tenants in hospital.

The team has worked on about 1,200 cases with surgeries in 19 sites across seven hospitals, six social work offices and six intermediate care units. The outcomes of the approach include helping:

- older people make informed choices along with their families, irrespective of tenure issues
- older people to return home or to community settings supported by a care package
- to reduce delayed discharge where there are housing issues
- prevent hospital admission and readmission, supporting older people with housing issues remain in the community
- secure appropriate accommodation for older people across the city suitable for their medical needs
- to increase knowledge of Glasgow's complex housing landscape among social workers and health professionals
- housing colleagues increase their knowledge about social work and health assistance to support older people returning home from hospital
- to future proof the city's new build investment by sharing information on customer needs and demand.

Source: Glasgow City IJB, 2018

Longer-term, integrated financial planning is needed to deliver sustainable service reform

48. Partners are finding it very difficult to balance the need for medium- to long-term planning, typically three to five years and five years plus, alongside annual settlements, current commitments and service pressures. We have called for longer-term financial planning in the health sector and local government for many years. While all IAs have short-term financial plans, only a third have medium-term plans and there were no longer-term plans in place at the time of our fieldwork. This is a critical gap as the changes under integration are only likely to be achieved in the longer term.

49. The Accounts Commission has previously reported that the 'Evidence from councils' annual audit reports generally demonstrates good medium-term (three to five years) financial planning, with some councils using scenario planning to provide a range of options'.[11] IAs should draw on the experience from councils to inform development of longer-term financial plans.

50. There is little evidence that councils and NHS boards are treating IJBs' finances as a shared resource for health and social care. This is despite the requirement to do this in the legislation, and budget processes set out in integration schemes describing budget-setting based on need. Partners must work with the IJBs to establish an approach to financial planning that considers the priorities of health and social care in the local community. Councils and NHS boards can be unwilling to give up financial control of budgets and IJBs can struggle to exert their own influence on the budget-setting process.

51. National data on the balance of spending between institutional care and care in the community is only available up to 2015/16. While this does not reflect any impact from IAs, it shows that the balance of spending changed little between 2012/13 to 2015/16 (Exhibit 9, page 32). Although this data is still collated, it is no longer published. This data should be publicly available and is a helpful indicator of whether IAs are influencing the shift of resources.

52. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework*.[12] The Framework is intended to help partners to improve strategic planning. It covers the period 2016/17 to 2023/24, and sets out trends in expenditure and activity, future demand and the future shape of health and social care expenditure.

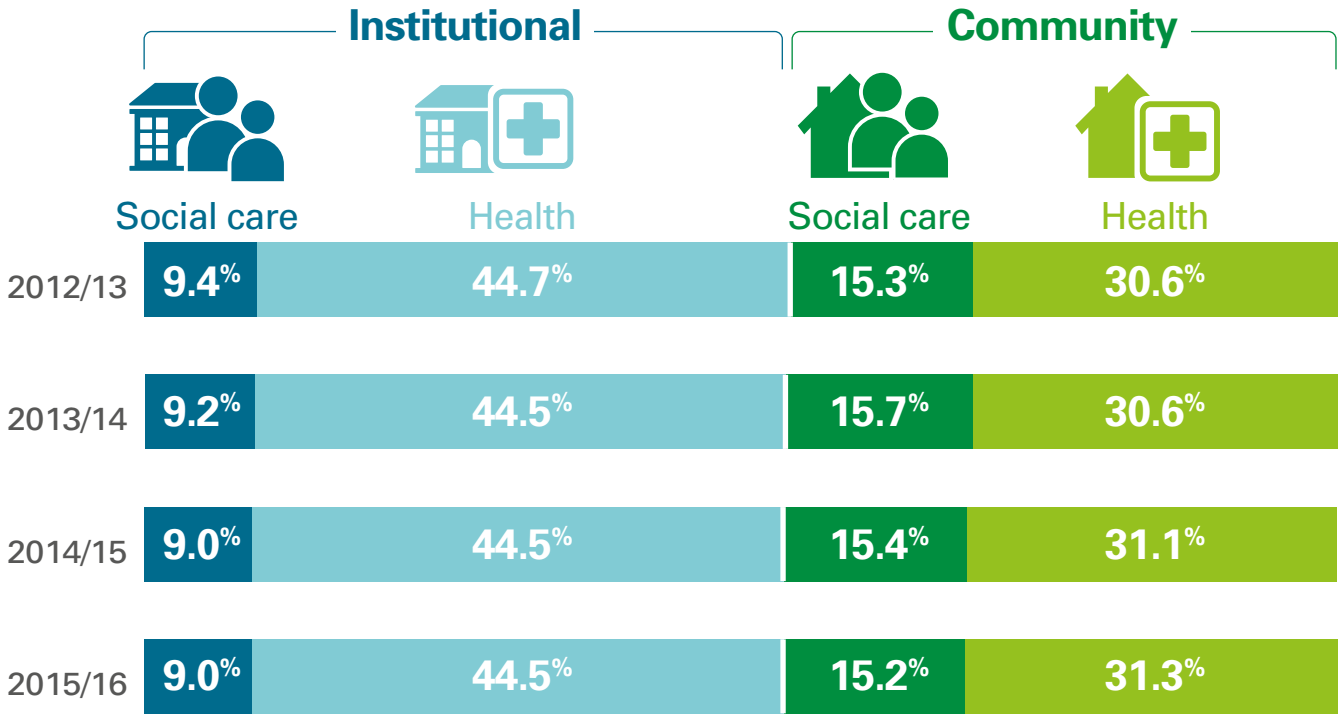
53. Attempts at integrating health and social care go back several years and it is not possible to identify the full cost of the reforms. This, in part, is due to the scale of the reforms and the interconnectedness with the rest of the health and social care system.

54. Due to ongoing financial pressures, most new service initiatives have been funded using additional financial support from the Scottish Government, rather than through the re-distribution of health and social care resources. Therefore, there should be an ongoing commitment from the Scottish Government to provide continued additional funding over coming years. This will provide financial stability to IAs while they implement new ways of working and plan how to redirect funding from current services.

Exhibit 9

The percentage of expenditure on institutional and community-based care

The percentage of expenditure on institutional and community-based care remained static between 2012/13 – 2015/16.



Source: Information Services Division, 2018

55. Major reforms have benefited from a degree of 'pump priming' money to help with change. In 2017/18, IAs total income included national funding which has been directed through NHS budgets, of:

- £100 million from the Integrated Care Fund to help shift the balance of care
- £30 million to help tackle delayed discharges
- £250 million to support payment of the living wage and help establish integration in its first year. This increased by £107 million in 2017/18.

56. The ring-fencing of funding intended to support delegated functions has not helped IAs' efforts to redirect resources, reducing their ability to use their resources flexibly. There are examples of small-scale transfers of resources and we appreciate that more time is needed for IAs to achieve this change (Case study 4, page 33). IAs need to demonstrate how they will sustain any improvements if specific dedicated funding is no longer available.

Case study 4

South Lanarkshire redirecting resources to provide more community-based care

In 2017, South Lanarkshire IJB decided to close 30 care of the elderly beds within Udston Hospital and invest in alternative community-based models of care. An assessment of need found that two-thirds of individuals on the ward could have been better cared for within a community setting. Recurring funding of about £1 million per annum was released as a result. The IJB planned for £702,000 of this to be redirected to community-based services, such as homecare and district nursing to build the area's capacity to support more people at home. To achieve this:

- engagement plans were developed to ensure people using care and their families, staff and elected members of the Udston area were involved in the changes
- financial modelling was undertaken to understand the profile of people on the ward and reallocate resources to more appropriate, alternative health and social services
- the IA worked in partnership with NHS Lanarkshire to ensure good governance.

The £702,000 provided a degree of financial flexibility to further develop intermediate care services and increase community-based rehabilitation services. The IJB plans to redesignate the Udston beds for use by step-down intermediate care patients to support a reduced reliance on the hospital and residential care.

Source: Bed Modelling in South Lanarkshire, IJB board paper, 30 October 2017

Agreeing budgets is still problematic

57. Fifteen IAs failed to agree a budget for the start of the 2017/18 financial year with their partners. This is partly down to differences in the timing of budget settlements between councils and NHS boards. It can also be due to a lack of understanding between councils and NHS boards of each other's financial reporting, accounting arrangements and the financial pressures faced by each. This lack of understanding can cause a lack of trust and reluctance to commit funds to an integrated health and social care budget.

58. There are difficulties with short-term and late budget settlements, but this should not preclude longer-term financial planning. IAs will only be able to plan and implement sustainable services if they are able to identify longer-term costs and funding shortfalls. This will also help to plan effective exit strategies from current services and larger-scale transfers of resources to community-based and preventative services.

It is critical that governance and accountability arrangements are made to work locally

59. Integrating services is a significant challenge, particularly when partners are dealing with current demand and constrained resources, while trying to better understand how services need to change. The Act should be a basis for all local partners to come together to implement changes. A perceived lack of clarity in the Act is adding to local disagreements and is delaying integration. This lack of clarity and misunderstanding is evident even among people working at senior levels and can impede good relationships.

60. Having a clear governance structure where all partners agree responsibility and accountability is vital. Disagreements can be particularly apparent when it is perceived that accountability for a decision rests with individuals who no longer have responsibility for taking them. Chief executives of councils and NHS boards are concerned that they will be held accountable for failures in how services are delivered when they are no longer responsible for directing those services. In practice, partners need to set out how local accountability arrangements will work. Integration was introduced to shift from a focus on what worked for organisations to what works for the person who needs a health and social care service. Applying this approach should help partners to implement the Act. In some areas partners are working through governance challenges as they implement the Act, and more should be done to share this experience.

61. Our first report on the integration of health and social care recommended that integration partners 'need to set out clearly how governance arrangements will work in practice…This is because there are potentially confusing lines of accountability...People may also be unclear who is ultimately responsible for the quality of care.' Clarity is still needed for local areas over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesign of services provision. Not enough has been done locally to address this.

62. IJBs have a commissioning role but most IJB COs also have delegated operational responsibility for those functions and services that are delegated to the IJB, with the exception of acute care. There are difficulties in understanding how the 'operational responsibility' aspect works in practice. Auditors report that members of IA leadership teams have differing views about governance, especially clinical governance, and roles and responsibilities. In some areas, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB. The IJB approach was introduced in part to simplify arrangements, not to add complexity. There are also significant concerns about the impact of integration on the rest of the acute hospital system.

63. It is the IJB's role, through the CO, to issue directions to its partner council and NHS board about service delivery and allocation of resources. This can be made more difficult by disagreements about governance arrangements. It is complicated further by the reporting lines of the CO, who directly reports to both chief executives of the council and NHS board. COs have reported that it can be difficult to direct those who are effectively their line managers. This reinforces the need for strong relationship building and the establishment of a collective agreement over policy direction, funding arrangements and vision for integration.

Decision-making is not localised or transparent in some areas

64. The Act envisaged that decision-making would be devolved as locally as possible. In some areas, IAs, councils and NHS boards have not yet devolved decision-making in the spirit of the Act and locality plans and management structures are still in development. Officers, staff and local service providers have reported that this is because of a risk-averse response to integration that sees NHS boards and councils retain central control over decision-making. Decision-making by IAs is often influenced by statutory partners' priorities. Often, IJB members rely on their statutory partners for information, advice and policy formulation rather than taking the lead on planning and implementing new ways of providing services.

65. There are examples of IAs working hard to establish decision-making arrangements in their partnership. Aberdeen City has put in place governance systems to encourage and enable innovation, community engagement and participation, and joint working. This should leave it well placed for progressing integration and implementing new services in its community (Case study 5). We have also seen how IAs such as South Lanarkshire and Dundee City are beginning to develop locality-based approaches to service delivery (Case study 6, page 36).

Case study 5

Governance arrangements in Aberdeen City IA

Aberdeen City IJB worked with the Good Governance Institute to develop its risk appetite statement and risk appetite approach. The IJB wanted to consider which decisions and risks should, and importantly those which should not, be considered by the IJB. The idea was to ensure there was capacity for decisions to be made locally, so that staff could influence the outcomes of individuals by ensuring that care was tailored to individual needs. Staff and managers say they now feel trusted to make decisions and implement new ideas to benefit individuals in their communities.

The IJB considers that it has demonstrated an aspiration to develop and encourage innovation in local service provision, and local managers and staff understand that decision-making within localities and input of ideas is welcomed and encouraged within agreed risk parameters. Aberdeen City has worked hard to build relationships and trust throughout the partnership. It accepts that achieving its priorities will involve balancing different types of risk and that there will be a need to balance the relationship between different risks and opportunities. There is also an acceptance and tolerance that new ideas will not always be successful.

Source: Aberdeen City IJB, 2018

Case study 6

Locality approach in South Lanarkshire

In 2017, South Lanarkshire IJB realigned its management structure around its four localities. Each locality has a manager responsible for a range of multidisciplinary teams and a health and social care budget. Moving the management of services to a locality level has empowered local teams to review the models of care in their area to see what fits best for the local community. A public forum in each locality gives the local community a voice in shaping local services. Each locality has produced a local strategic needs assessment setting out local needs and priorities and directing attention towards more locally specific outcomes. A 'community first' model of care places the emphasis on developing more community capacity and support.

Staff report that multidisciplinary working and, where possible, co-location, has improved communication and learning across disciplines. They have better knowledge of skills within the wider integrated team, allowing the most appropriate professional to see people at the right time. Working with separate IT systems is a source of frustration and requires less efficient work arounds. Another challenge is balancing trying to change at pace with a need to maintain day-to-day workload. Teams have taken an incremental approach to change, starting with a small number of staff and people using the health and social care services, and, if the new model goes well, gradually increasing this until the change becomes normal practice.

Source: North Lanarkshire IJB, 2018

Best value arrangements are not well developed

66. As IJBs are local authority bodies, the statutory duty of Best Value applies to them. This means that IJBs, from the outset, must clearly demonstrate their approaches to delivering continuous improvement. In July 2017, IJBs submitted their first annual performance reports in accordance with statutory requirements. One of the reporting requirements is that they demonstrate Best Value in the delivery of services.

67. We found that some aspects of Best Value are widely covered within IJBs' annual performance reports and annual accounts, including financial planning, governance and use of resources. About half of all IJBs had a section in their annual performance reports setting out how they intended to demonstrate the delivery of Best Value. Overall the coverage varies between IJBs and is often not in enough detail to allow the public to judge the IJB's activity on continuous improvement.

IAs are using data to varying degrees to help plan and implement changes to services but there are still gaps in key areas

68. Information Services Division (ISD) is part of NHS National Services Scotland, a special NHS board. ISD provides Local Intelligence Support Team (LIST) analysts to each IA area, along with social care information known as SOURCE. Using a LIST analyst to tailor and interpret local data helps IAs to better understand local need and demand and to plan and target services. LIST also works with Community Planning Partnerships in several areas including care for prison leavers presenting to the Homeless Service and children affected by parental imprisonment.

69. Part of the work IAs are doing, supported by the LIST, is to better understand how to support the top two per cent of people using services who account for 50 per cent of hospital and GP prescribing expenditure. By doing this, they can better direct resources and take preventative steps to ensure these users receive more targeted care. This prevents unnecessary hospital admissions and improves personal outcomes through providing more appropriate care in a homely setting.

An inability or unwillingness to share information is slowing the pace of integration

70. There are several areas which need to further improve to help IAs and their council and NHS board partners make better use of data. These include:

- GP practices agreeing data-sharing arrangements with their IA
- IAs being proactive about sharing performance information, ideas and new practice with other IAs
- IAs and ISD agreeing data-sharing protocols for using data in national databases
- IAs identifying gaps in data about community, primary care and social care services and establishing how this information will be collected. This is something we have highlighted in several of our previous reports
- improving consistency in IAs' data, making comparisons easier.

71. Sharing of information, including both health and performance information, is a vital part of providing effective care that is integrated from the point of view of the people who use services. It is also vital in helping to anticipate or prevent need. Throughout our work we were told of examples where this was not happening in practice, because of local systems or behaviours. Examples include: GP practices being unwilling to share information from new service pilots with other IAs; IAs themselves being unwilling to share performance and good practice information with others; and difficulties in setting up data-sharing agreements between IAs and ISD. Different interpretations of data protection legislation are not helping with the ease with which information is being shared.

72. NHS and social care services are made up of many different specialties and localities, often with different IT systems, for example, systems to record X-ray results or record GP data. Many of these systems have been built up over years and commissioned separately for different purposes. Some services still rely on paper records.

73. This disjointedness has an impact on people who need care and on the ability of health and care professionals to provide the best support that they can. For example, people with multiple and complex health and care conditions can have to explain their circumstances to many different professionals within a short space of time. This can delay people getting the help they need, waste resources and gets in the way of care provision being more responsive to people's needs. Local data-sharing arrangements need to be in place so that professionals can appropriately share and protect the data they hold.

74. Time and money are being spent on fixing local IT problems when national solutions should be found. Local fixes are being put in place to help overcome data-sharing barriers. This includes bringing teams of staff together under one roof, so

they can discuss individual cases, rather than relying on electronic systems such as internal emails to communicate. Local areas are spending time and money implementing solutions which may continue to be incompatible in the future. There is a need for a coordinated approach to the solution, which includes the need to consider a national, single solution for Scotland.

75. New IT systems and technology are crucial to implementing new ways of working. For example, many areas are beginning to introduce virtual means of contacting people using care services, such as video links to people's homes so they do not have to visit a health or care centre. To do this successfully, a reliable communication infrastructure is needed, particularly in rural areas.

76. In April 2018, the Scottish Government published *Scotland's Digital Health & Care Strategy: Enabling, Connecting & Empowering*. As part of this, a new national digital platform is to be developed to enable the sharing of real-time data and information from health and care records as required, across the whole care system. We will monitor developments as part of our work programme.

Meaningful and sustained engagement will inform service planning and ensure impact can be measured

77. IAs were set up to have active public involvement, for example through the make-up of their boards and requirements that they publish and engage with communities about their plans. We found some good local examples of engagement. From our analysis of IA strategic plans, we saw evidence of community engagement that influenced the IA's priorities (Case study 7, page 39). Levels of ongoing engagement, and how much it shapes service redesign, are more difficult to judge, but several IAs explicitly mention the importance of engagement and see it as a priority.

78. Several third and independent sector organisations reported that they do not feel that IAs seek or value their input, although they have innovative ways to improve local services that will positively affect the lives of local people. Providers believe that service decisions are based on the funding available over the short term, rather than the needs of the community. Third-sector providers also report that there is often not time to attend engagement meetings, gather information for consultations or research lengthy committee papers. Therefore, IAs have a responsibility to help them become involved and to work with them earlier. IAs must discuss potential changes to services and funding with providers as early as possible.

79. Early engagement with staff, as with the public, has reduced since IAs published strategic plans. Staff want to know how they are contributing to the progress of integration. More communication and involvement will both help increase knowledge of the services available across partnerships and help overcome cultural differences and reluctance to accept change in ways of working.

80. Throughout this report we have recognised the challenging context IAs are operating in. This is inevitably having an impact on the extent to which they can meaningfully engage communities in discussions about improvements to services. IAs need to have in place wide-ranging and comprehensive arrangements for participation and engagement, including with local communities. Where local arrangements for engagement have been shown to work, these should continue. Engagement does not have to be managed and directed solely by the IA. If a local department or service has established relationships and means of engaging with third and independent sector providers which have proved successful, these should continue as before.

Case study 7

Edinburgh IJB: public engagement

The enhanced and proactive engagement approach adopted by Edinburgh IJB facilitated the involvement of the voluntary sector organisations in the co-production of strategic planning. Via the Edinburgh Voluntary Organisation Council, which sits on the IJB board as a non-voting member, the IJB invited the Lothian Community Health Initiatives' Forum (LCHIF) onto its Strategic Planning Groups (SPG). This allowed the LCHIF to get involved in developing the IJB's five strategic Commissioning Plans: Older People, Mental Health, Physical Disabilities, Learning Disabilities, and Primary Care.

LCHIF was subsequently invited to be part of the Older People's and Primary Care Reference Groups. Through involvement on the two reference groups, LCHIF and its members were able to contribute to the work that most reflected the services being delivered by them. The initial involvement of LCHIF on the SPG led to further engagement with other key influencing groups and networks which they felt ultimately benefited the sector, the forum and its members.

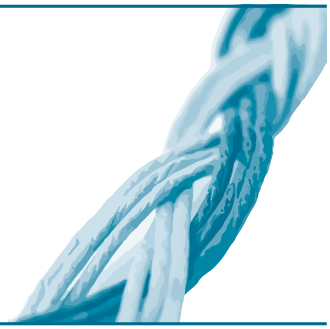
In addition to this involvement, the IJB has also embarked upon a review of its grants to the third-sector. This has been done in full collaboration and partnership with the third-sector. Through the SPG, a steering group was appointed, again with the involvement of LCHIF. This involvement contributed to a commitment being made to establish a grants forum in recognition of the ongoing dialogue that is required to ensure that prevention, early intervention and inequalities remains a priority for the IJB.

Source: Edinburgh IJB, 2018.

81. In September 2017, the Scottish Parliament's Health and Sport Committee published *Are they involving us? Integration Authorities' engagement with stakeholders*, an inquiry report on IAs' engagement with stakeholders.[13] The Committee also found a lack of consistency in stakeholder engagement across IAs. While some areas of good practice were cited, the Committee heard concerns over engagement being 'tokenistic', 'overly top down' and 'just communicating decisions that had already been made'. The Committee argued that a piecemeal approach to engagement with stakeholders cannot continue and that meaningful engagement is fundamental to the successful integration of health and social care services.

82. There is also a role for the Scottish Government in continuing to develop how learning from successful approaches to integration is shared across Scotland. IAs are not being proactive about sharing success stories and the principles behind the planning and implementation of new ways of working which have worked well. Much could be learnt from the work done to date in local areas and IAs should be encouraged to engage with each other and share knowledge and performance information.

Endnotes



1 More details about the joint inspections are available at the Care Inspectorate website.

2 *Health and social care integration*, Auditor General and Accounts Commission, December 2015.

3 *English local authority reserves,* Chartered Institute of Public Finance and Accountancy, June 2015.

4 This takes account of North Ayrshire IJB, which was the only IJB to have an accumulated negative reserve balance. This amounted to £5.8 million and was because of overspends in social care services that were not funded by additional allocations from the NHS board or council.

5 *NHS in Scotland 2018*, Auditor General, October 2018.

6 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

7 National Performance Framework, Scottish Government, June 2018.

8 *Systems thinking and systems leadership*, NHS Education for Scotland, 2016.

9 *National Health and Social Care Workforce Plan Part 3 – improving workforce planning for primary care in Scotland*, Scottish Government, April 2018.

10 *NHS workforce planning*, Auditor General, July 2017.

11 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

12 *Medium Term Health and Social Care Financial Framework*, Scottish Government, October 2018.

13 *Are they involving us? Integration Authorities' engagement with stakeholders*, Health and Sport Committee, Scottish Parliament, September 2017.

Appendix 1

Audit methodology

Our objective: To examine the impact public bodies are having as they work together to integrate health and social care services in line with the Public Bodies (Joint Working) (Scotland) Act 2014.

Our audit questions:

- What impact is integration having and what are the barriers and enablers to this change?
- How effectively are IAs planning sustainable, preventative and community-based services to improve outcomes for local people?
- How effectively are IAs, NHS boards and councils implementing the reform of health and social care integration?
- How effectively is the Scottish Government supporting the integration of health and social care and evaluating its impact?

Our methodology:

- Reviewed documents, such as integration schemes, IAs' strategic plans, IJBs' annual audit reports, annual performance reports, national performance data and other key documents including the Scottish Government's National Health and Social Care Financial Framework.
- Interviews, meetings and focus groups with a range of stakeholders including third-sector and independent sector providers. Our engagement involved hearing about experiences of engaging with IAs and how services had changed through integration.
- Interviews at four case study sites – Aberdeen City IJB, Dundee City IJB, Shetland Islands IJB and South Lanarkshire IJB. We met with:
  - Chief Officers and Chief Finance Officers
  - Chairs and vice-chairs of IJBs
  - NHS and council IJB members
  - Chief social work officers
  - IJB clinical representatives (GP, public health, acute, nursing)
  - IJB public representatives (public, carer and voluntary sector)
  - Heads of health and social care, nursing, housing and locality managers and staff
  - NHS and council chief executives and finance officers
  - IT, communications and organisational development officers.

Appendix 2

Advisory group members

Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit.

Member	Organisation
Alison Taylor	Scottish Government
Alistair Delaney	Healthcare Improvement Scotland
Allison Duncan	IJB Vice Chair
Eddie Fraser	IJB Chief Officer
Fidelma Eggo	Care Inspectorate
Gerry Power	Health and Social Care Alliance
Jeff Ace	NHS Chief Executive
John Wood	Convention of Scottish Local Authorities (COSLA)
Julie Murray	Society of Local Authority Chief Executives
Robin Creelman	IJB Vice Chair
Tracey Abdy	IJB Chief Finance Officer

Note: Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 3

Progress against previous recommendations

Recommendations	Progress
Scottish Government should:	
• work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this: – work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system.	IAs are reporting locally on outcomes but this is not being drawn together to give a national picture of outcomes for health and social care.
• monitor and publicly report on national progress on the impact of integration. This includes: – measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans – reporting on how resources are being used to improve outcomes and how this has changed over time – reporting on expected costs and savings resulting from integration.	We found there are a significant number of indicators and measures being used nationally and locally to understand whether integration is making a difference and to monitor changes. But, for the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way. The Scottish Government has introduced a series of national outcomes for health and social care. The outcomes are not being routinely reported at a national level. The savings estimated to be made from integration were expected to derive from a reduction in unplanned bed days, fewer delayed discharges, improved anticipatory care and less variation in bed day rates across partnerships. The savings from these have not been specifically monitored by the Scottish Government, although actual and projected performance across these measures is reported to the Scottish Government's Ministerial Steering Group.
• continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.	Some leadership development has been commissioned from the Kings Fund by the Integration Division at Scottish Government but there is a lack of joint leadership development across the health and social care system to help to embed and prioritise collaborative leadership approaches. There is an appetite for examples of good practice from local partnerships but still a lack of good learning resources.

Cont.

Recommendations	Progress
Integration Authorities should:	
• provide clear and strategic leadership to take forward the integration agenda; this includes: – developing and communicating the purpose and vision of the IJB and its intended impact on local people – having high standards of conduct and effective governance, and establishing a culture of openness, support and respect.	We found that a lack of collaborative leadership and cultural differences are proving to be significant barriers to change in some areas.
• set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny. This includes: – setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice – ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB.	There is a lack of agreement over governance and a lack of understanding about integration which is acting as a significant barrier to progress in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesigning how services are provided. Not enough has been done locally to address this.
• ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes: – setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required – ensuring relationships between the IJB, its partners and the public are clear, so each knows what to expect of the other.	IAs have helped to improve engagement with the public and providers in the local area in some instances but there is more to do.
• be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including: – developing and maintaining open and effective mechanisms for documenting evidence for decisions – putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice – developing and maintaining an effective audit committee – ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints. – ensuring that an effective risk management system is in place.	We found that decision-making is not localised or transparent in some areas and risk management arrangements are not well developed.

Cont.

Recommendations	Progress
• develop strategic plans that do more than set out the local context for the reforms; this includes: – how the IA will contribute to delivering high-quality care in different ways that better meets people's needs and improves outcomes – setting out clearly what resources are required, what impact the IA wants to achieve, and how the IA will monitor and publicly report their progress – developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils – making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act.	IAs are beginning to link their resources to strategic priorities but more needs to be done to show when their planned outcomes will be achieved. They also need to show how the shift from the current ways of working to new models of care will happen.
• develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes: – developing financial plans for each locality, showing how resources will be matched to local priorities – ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively.	There is some evidence of small-scale transfers of resources, but most IAs have funded changes to services using ring-fenced funding, such as specific additional integrated care funding provided by the Scottish Government. This is instead of shifting resources from an acute setting, such as hospitals, to community settings such as local clinics and GP surgeries. While this may have achieved performance improvement in things such as delayed discharges, ring-fenced funding may not be available long term. Therefore, IAs need to ensure the financial sustainability of ongoing support for changes made. Financial planning is not integrated, or long term and financial pressures make meaningful change hard to achieve. Arrangements for understanding and measuring Best Value arrangements are not well developed.
• shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.	We found there has been limited change in how resources are being used across the system at this stage – see above.

Cont.

Recommendations	Progress
Integration Authorities should work with councils and NHS boards to:	
• recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early in the relationship and that a shared understanding of the roles and objectives is maintained.	We found a lack of agreement over governance and a lack of understanding about integration remain significant barriers in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty was hampering decision-making and redesigning how services are provided. In our opinion, not enough has been done locally to address this.
• review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils.	Auditors report that members of IA leadership have differing views about governance, especially clinical governance, and roles and responsibilities.
• urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners.	We found that at present, not all councils and NHS boards view their finances as a collective resource for health and social care. Some councils and NHS boards are still planning budgets around their own organisations rather than taking account of their IJBs local strategic priorities. The ambition for integration is that the health and social care resources in the local area would be brought together and used to deliver integrated services with improved outcomes for people. While this is happening in some areas, councils and NHS boards in other areas can be unwilling to give up financial control of budgets and IJBs can struggle to exert influence over their budgets. Some IAs have little or no involvement in the budget-setting process. At a very basic level IJBs struggle in some areas to agree budgets. Fourteen IJBs failed to agree a budget for the start of the 2017/18 financial year.
• establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and social care services.	We have seen that IJB board papers are shared with council and NHS board partner organisations. In some areas though, rather than streamlining governance and scrutiny arrangements, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB.
• put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.	IAs and ISD are have difficulties in agreeing data-sharing protocols for using national databases.

Appendix 4

Financial performance 2017/18

IJB	**Position** (pre-additional allocations) **Overspend/** (underspend)	**Additional allocation/ (reduction)** **Council**	**NHS board**	**Use of reserves**	**Year-end position Deficit/ (Surplus)**
	(£million)	(£million)	(£million)	(£million)	(£million)
Aberdeen City	2.1	0	0	2.1	0
Aberdeenshire	3.5	1.5	2.0	0	0
Angus	(0.4)	0	0	0	(0.4)
Argyll and Bute	2.5	1.2	1.4	0	0
Clackmannanshire and Stirling	2.2	0.6	0.6	1.1	0
Dumfries and Galloway	(2.5)	0	0	0	(2.5)
Dundee City	2.5	0	2.1	0.4	0
East Ayrshire	3	2.2	1.3	0	(0.5)
East Dunbartonshire	1.1	0	0	1.1	0
East Lothian	0.7	0.6	0.1	0	0
East Renfrewshire	(0.4)	0	0	0	(0.4)
Edinburgh	7.4	7.2	4.9	0	(4.7)
Eilean Siar	(3.0)	0	0	0	(3.0)
Falkirk	1.3	0	1.4	0.2	(0.3)
Fife	8.8	2.5	6.4	0	0
Glasgow City	(12.0)	0	0	0	(12.0)
Inverclyde	(1.8)	0	0	0	(1.8)
Midlothian	(0.7)	0.2	0	0	(0.9)
Moray	1.9	0	0	1.9	0
North Ayrshire	3.5	0	1.0	0	2.6
North Lanarkshire	(11.7)	0	0.6	0	(12.3)
Orkney	0.7	0.2	0.5	0	0
Perth and Kinross	(1.4)	(2.6)	1.3	0	0
Renfrewshire	4.8	2.7	0	2.1	0
Scottish Borders	4.5	0.3	4.2	0	0
Shetland	2.4	(0.3)	2.9	0	(0.2)
South Ayrshire	0.3	0	0	0.3	0
South Lanarkshire	(1.2)	0	1.0	0	(2.2)
West Dunbartonshire	(0.6)	0	0	0	(0.6)
West Lothian	1.8	0	1.8	0	0

Note: Arithmetic differences arising from roundings.
Source: Audited Integration Authority annual accounts, 2017/18

Health and social care integration

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ITEM No …7……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 26 FEBRUARY 2019**

REPORT ON: **STRATEGIC COMMISSIONING PLAN 2019-2022 – PROGRESS UPDATE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB5-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to inform the Integration Joint Board of progress made in revising the Partnership's Strategic Commissioning Plan, and provide an opportunity for the Board to comment on the draft Strategic Commissioning Plan 2019-2022.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Note the content of the report and the progress made in reviewing the Partnerships Strategic Commissioning Plan (sections 4.2 to 4.6), including the significant contributions made by a range of stakeholders to the preparation of the draft Strategic Commissioning Plan 2019-2022 and further planned consultation activity (section 4.7).

2.2 Notes that the current Strategic Commissioning Plan (2016-2021) will remain in place until the replacement plan is approved by the IJB.

2.3 Provides comments regarding the draft Strategic Commissioning Plan 2019-2022 (Appendix 1).

3.0 FINANCIAL IMPLICATIONS

3.1 The draft Strategic Commissioning Plan outlines a 3 year financial framework within which delivery of the priorities will be set against. This framework will continue to be refined over the period of the plan as assumptions around cost pressures, funding levels, demographic demand and the pace of transformation become clearer. This will in turn, effect the pace of change required to deliver on the priorities.

4.0 MAIN TEXT

4.1 Section 37 of the Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Authorities within a three year period of their establishment to undertake a review of the effectiveness of their current strategic plan. Subsequent to this review Integration Authorities may decide to prepare a replacement strategic plan. In August 2018 the IJB directed the Chief Officer, following appropriate engagement and collaboration with stakeholders, to prepare a replacement Strategic Commissioning Plan for the Partnership prior to 31 March 2019 (Article VII of the minute of the meeting held on 28 August 2018 refers).

4.2 The process of revising the Strategic Commissioning Plan has been led by the Integrated Strategic Planning Group (ISPG). Since October last year the ISPG has dedicated their meetings to progressing the revision of the plan, with an additional development session being held in December 2018 for ISPG members and other key community planning stakeholders.

4.3 The process of revision has drawn on the Scottish Government's overview of the original set of plans published by Integration Authorities (published in 2016) and our own learning from the Partnership's first three years of operation. In-line with the Partnership's ongoing commitment to co-production with communities and drawing on our experience of co-producing a range of strategic commissioning statements for specific care groups over the last three years, the draft Strategic Commissioning Plan has been written primarily to meet the needs of communities, users of health and social care services, their families and carers. Consequently this means that the draft replacement plan is significantly shorter and is more accessible than the current plan. The draft plan does not seek to reflect all of the activity that the partnership will lead or participate in over the next three years, but instead sets out our most important collective priorities for transformation and improvement. The plan complements other strategic plans across the Community Planning Partnership and within the corporate bodies (NHS Tayside and Dundee City Council), emphasising the criticality of partners working together to enhance the health and wellbeing of people across all Dundee localities.

4.4 The draft plan sets out four priority areas for the Partnership over the next three year period:

- Health Inequalities - Health inequalities across Dundee have reduced so that every person, regardless of income, where they live or identification with a protected equalities group, has the potential to experience positive health and wellbeing outcomes.
- Early Intervention / Prevention - Enhanced community based supports are enabling people to take greater control of their lives and make positive lifestyle choices that enhance their health and wellbeing and reduce the need for service based interventions.
- Localities and Engaging with Communities - People can access services and supports as close to home as possible, with these services and supports responding to the specific needs of the local community.
- Models of Support / Pathways of Care - People will live more independently at home for longer, supported by redesigned community based, person centered services.

As the Partnership works through these priorities to continue to shift the balance of care it will also embed in all areas of activity improvements in person-centred care and support and strengthened support for carers, and maintain a focus on building capacity and managing our resources effectively. The draft plan recognises the significant demographic and fiscal challenges faced by the Partnership, however sets out key principles regarding how we will utilise available resources (financial, workforce, IT and property) to achieve our vision and to maintain a focus on reducing inequalities and on early intervention and prevention.

4.5 Work is also underway to revise the suite of companion documents that support the Strategic Commissioning Plan. Revisions of the Housing Contribution Statement, Workforce and Organisational Development Strategy and Equality Outcomes and Equality Mainstreaming Framework are at an advanced stage and will be presented to the IJB alongside the final Strategic Commissioning Plan. The Partnership's Strategic Needs Assessment was updated in early 2018 and is already available on the Partnership website. The draft plan commits to the revision of the Market Facilitation Strategy and Participation and Engagement Strategy during 2019.

4.6 The draft plan has been produced in full compliance with statutory provisions relating to strategic plans (sections 29 to 39 of the 2014 Act) and supplementary national guidance. The current Strategic Commissioning Plan (2016-2021) shall remain in place until the replacement plan is finalised and approved by the IJB.

4.7 The replacement plan continues the Partnership's existing strategic commissioning approach and draws from our continuous conversations over the last three years with communities, people accessing health and social care services, their families and with carers. A range of stakeholders from the public, third and independent sector have actively contributed to the production of the draft plan. A stakeholder consultation is currently underway (including leadership groups in NHS Tayside, Dundee City Council, the Staff Forum and Community Planning Executive Boards) and an online public consultation will be undertaken during February 2019. The draft plan will also been submitted to NHS Tayside Board and Dundee City Council, Policy and Resources Committee for feedback and endorsement of content. Key themes from these consultation exercises will inform final amendments to the draft plan prior to submission to the IJB on 29 March 2019 for approval. The final plan will be accompanied by a full Integrated Impact Assessment.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Integrated Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it is for information and does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

The Integrated Strategic Planning Group, Chief Officer, Chief Finance Officer, Head of Service, Health and Community Care, and the Clerk have been consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Directions Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 11 February 2019

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Principal Information Development Manager

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Appendix 1

Dundee Health and Social Care

Strategic and Commissioning Plan

2019 - 2022

Dundee Health & Social Care Partnership

DUNDEE HEALTH AND SOCIAL CARE STRATEGIC AND COMMISSIONING PLAN 2019-2022

Contents

1. Foreword

Welcome to our Strategic Commissioning Plan 2019-2022. This Plan sets out an ambitious programme of transformational change, building on the achievements we have made since our first Strategic Commissioning Plan was developed in 2016.

This Plan set outs our broad strategic priorities for the next three years. It is not a detailed description of all past and future activity, rather it is a Plan that outlines our focus and direction. The Plan transparently describes to all Dundee citizens what we will prioritise and what successful delivery of our actions will mean for people accessing our services, their carers and our communities.

Our first plan stated that we wanted to make a difference to the lives of those who needed our support, and to achieve the best outcomes for families and communities. We also acknowledged that people are at the heart of everything we do and that our communities are unique.

Our commitment to working with the people we serve, remains unchanged. We hope you can identify from our Plan how our priorities have been shaped by our continued conversations with you, the citizens of Dundee, and our partners in Dundee City Council , NHS Tayside, third and independent sectors and others.

The many challenges facing our city are well known. Low life expectancy, too many people living in deprivation and health equality gaps between communities. We are also however an innovative, vibrant city with strong, cohesive communities and an enviable resilience of spirit. We need to build on the recent investment in the City Waterfront area and the opening of the V and A museum. Our city is entering a new era and our Plan describes a strategic direction that captures this ambitious spirit.

It is a Plan that does not shy away from the significant challenges that lie ahead, but we strongly believe that if we focus our resources in the right places, we can improve the health and wellbeing of individual people and whole communities across Dundee.

Over the next three years, we will target our resources across the following four priority areas:

1. Health Inequalities
2. Early Intervention/Prevention
3. Localities and Engaging with Communities
4. Models of Support/Pathways of Care

Our refreshed strategic priorities will maintain our focus on shifting resources from hospitals to community based care to achieve better outcomes for people and to provide easily accessed more personal support, closer to home. Delivery on the ambitions set out in this Plan will bring us closer to our vision that *each citizen of Dundee will have access to the information and support that they need to live a fulfilled life*.

There is however no doubt that the next three years will continue to be financially challenging. We need therefore to focus our resources in a more targeted way. By doing this, we are confident we can still achieve the positive, transformational change needed to improve the health and wellbeing of our citizens. Recent key achievements such as reducing delayed discharges from hospital and improving outcomes for carers illustrate how transformation can still be delivered, despite financial constraints and increasing demand for services.

Over the next three years, we will work ever more closely with our partners to consider our collective resources and how best to use them in more joined up ways of working.

We are enormously grateful to our workforce across all partner organisations. The ideas, creativity and commitment of our workforce and the citizens of Dundee will be central to our success. We urge all those with an interest in health, social care and the wellbeing of the residents of Dundee to contribute to the delivery of our Plan and we look forward to working with partners in this.

Trudy McLeay Chair, IJB Board	Councillor Ken Lyn Vice-Chair, IJB Board	David Lynch Chief Officer, Health and Social Care Partnership

2. Introduction

2.1 Who We Are

The Dundee Health and Social Care Partnership ('Partnership') is responsible for delivering person centred adult health and social care services to the people of Dundee. The Partnership consists of Dundee City Council, NHS Tayside and providers of health and care services from across the third and independent sector. These organisations work together to provide improved, more integrated, health and social care services.

The Dundee City Health and Social Care Integration Joint Board ('IJB') is the body responsible for the planning, oversight and delivery of the Partnership's services. The IJB consists of voting members from Dundee City Council and NHS Tayside, as well as representative members who are drawn from the third and independent sector, staff, people using services and their carers. The IJB is advised by senior staff including the Chief Officer, Chief Finance Officer, Chief Social Work Officer and Clinical Advisors for Nursing, Primary Care and non-Primary Care.

In accordance with the **Public Bodies (Joint Working) (Scotland) Act 2014** ('Public Bodies Act'), an Integrated Strategic Planning Group ('ISPG') has been established by the IJB to develop this Health and Social Care Strategic and Commissioning Plan ('Plan') to review progress against the Plan.

2.2 This Plan

This Plan describes our strategic priorities for the next three years and the key actions required as we strive towards delivering our ambitious vision for our city. The Plan provides the citizens of Dundee with an understanding of the main challenges faced by the Partnership and how we intend to prioritise our activity. It represents the knowledge we have gained through our ongoing engagement with communities, people who use health and social care services, their families and with carers. The actions that will underpin our activity are detailed in a series of strategic commissioning statements rather than in this Plan. These actions will continue to evolve alongside this Plan, co-produced along with local people.

Our Plan continues with our existing strategic commissioning approach, strengthening how we use this approach to design, develop and deliver, ever more effective services to meet the changing needs of Dundee's population.

The Plan builds on what has been achieved. It sets out what still needs to be done to ensure that we arrange services and support in a way that helps the citizens of Dundee receive the right information and support at the right time, to live life in the way they want.

The core themes and priorities of the **Health and Social Care Strategic and Commissioning Plan 2016-2021** were established following extensive engagement and remain very relevant today. We have embedded strategic planning groups into our everyday ways of working. These groups ensure the voices of specific interest groups are heard and understood. This Plan draws on the key themes from these groups and from national, regional and local policies.

The Partnership will monitor progress on an ongoing basis, reporting through the ISPG, to the IJB and partner bodies. This Plan is not a finite document, rather it is part of a continuing conversation with the people of Dundee and our partners. As the Partnership moves forward we will continue with our longstanding approach to planning sustainable services with Dundee citizens and local communities. We will continue to work through and local and citywide engagement structures in collaboration with partners in the public, independent and third sectors, and in local communities, over the lifetime of the Plan.

2.3 In Summary

Joint working and the effective co-ordination of services across all the key strategic partnerships, including the NHS, third and independent sectors, Community Planning, Children and Families, Community Justice, Neighbourhood Services and Public Protection[1], is essential to the integration of service delivery for individuals, their carers and communities across Dundee.

Health and social care supports and services are already supporting the citizens of Dundee to live longer, increasingly in their own homes and communities. However, more people are also living with increasingly complex needs and we are experiencing a protracted period of challenging public finance; it is therefore

[1] In Dundee our public protection grouping includes the strategic groups with responsibility for the protection of adults and children who are at risk and those tackling violence against women, substance misuse and suicide prevention, as well as for the management of serious violent and sex offenders and responses to humanitarian protection.

understandable that the shape and sustainability of health and social care are in the spotlight. This Plan provides Dundee citizens with a candid insight into the substantive challenges we continue to face within Dundee and how we are working in partnership with Dundee City Council, NHS Tayside, the third and independent sectors, specific interest groups, communities and other partners, to address these challenges.

This Plan is a critical companion document to other substantive plans such as the **City Plan for Dundee 2017-2026**. Success can only be assured through continued longstanding working with partner organisations. As a Partnership we are emboldened by the new vibrancy felt across the city and we are determined to play a significant role in realising the full potential of each Dundee citizen through enhancing individual health and wellbeing.

3. Vision and Ambition

Our vision for health and social care in Dundee was initially set out in the Partnership's **Health and Social Care Strategic and Commissioning Plan 2016-2021**:

Each citizen of Dundee will have access to the information and support that they need to live a fulfilled life

The vision sits alongside Scotland's long term aim for people to live longer, healthier lives at home or in a homely setting. Scotland's **National Health and Wellbeing Outcomes** guide our work, with activity since 2016 concentrated across eight strategic priorities. Figure 1 below demonstrates the relationship between these strategic priorities and the **National Health and Wellbeing Outcomes**:

Figure 1

NATIONAL HEALTH AND WELLBEING OUTCOMES	DUNDEE STRATEGIC PRIORITIES								
		1.Health Inequalities	2.Early Intervention / Prevention	3.Person Centred Care and Support	4.Carers	5.Localities and Engaging with Communities	6.Building Capacity	7.Models of Support / Pathways of Care	8.Managing our Resources Effectively
	1.Healthier living		X	X					
	2.Independent living		X	X	X			X	
	3.Positive experiences and outcomes	X	X	X	X	X	X	X	X
	4.Quality of life	X	X	X	X	X	X	X	X
	5.Reduce health inequality	X				X	X		
	6.Carers are supported				X				
	7.People are safe	X	X	X	X	X	X	X	X
	8.Engaged workforce			X				x	X
	9.Resources are used efficiently and effectively						X	X	

Our vision recognises that the demands for health and social care and the environments in which it will be delivered will be profoundly different in future years, including:

- the proportion of people aged over 75 in Dundee – who tend to be the highest users of health and social care services – will increase significantly;
- the continuing shift in the pattern of illness towards long term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia;
- an increasing population of younger adults (under 65) who have complex health and social care needs, often related to substance misuse and poor mental health;
- an increase in number of hours carers will be caring due to the increasing populations of people affected by long term conditions, frailty and complex needs;
- an enhanced focus on population wide public health responses to health and wellbeing issues such as obesity, mental health, smoking cessation and substance misuse; and
- need for more community and family based supports, including provision of services by the Partnership, third and independent sectors, during a period of sustained financial pressures.

As a Partnership we have made significant advances towards achieving our vision, some of which are highlighted later in this Plan. We are operating in a much more integrated way with our partners. We have made additional investment in early intervention and prevention and we are making positive strides in expanding the effectiveness of primary care to ensure that we deliver as much integrated health and social care as locally as possible. We are particularly proud of our achievements in getting people back to their home from hospital, as soon as is appropriate, through our work to shift the balance of care towards community based services and resources.

We recognise however that our journey has only just begun and the ambition described in our vision has yet to be fulfilled. The pace of transformational change required to improve the health and social care outcomes for the people of Dundee will need to be accelerated over the lifetime of this plan.

The vision established in 2016 for our city remains as relevant for this new Plan and will continue to direct our priorities over the next three years.
Alongside our partners, we will work towards our collective vision by:

- providing citizens with the opportunity to improve their wellbeing, to lead an active healthy life and to make positive lifestyle choices;
- supporting communities to address the impact inequalities has on the health and wellbeing of our citizens;
- investing in early intervention and prevention approaches that are designed to prevent health and social care needs escalating, including prioritising such approaches to those people who are at most significant risk of poor health;
- supporting individuals to make informed choices on living and dying well, and in a place of their choice at the time of end of life care;
- developing outcome focused and asset based approaches which are co-produced with individuals, carers and communities;
- working with our partners, particularly Children and Families Services, to address the needs of people at risk of harm;
- taking a fair and transparent approach to how resources are allocated to ensure investment is made where health and social care needs are greatest;
- maintaining a confident, professional and valued workforce; and
- measuring and reporting our performance on an ongoing and transparent basis.

We look forward to creating a more hopeful and positive future for Dundee citizens by taking a whole systems approach. Our vision however can only be realised by working with all partner organisations, tapping into our collective strengths and creating a cohesive response to the significant health and social care challenges faced across our city. We need to be both bold in our actions and realistic in what is achievable. Resources are limited and we need to therefore work collaboratively with local people, communities and partner organisations, embracing a culture of shared resolve, continuous improvement and innovation.

The **City Plan for Dundee 2017-2026** sets out the wider economic, environmental and social aspirations for Dundee. The transformation and renewed vibrancy of the Dundee Waterfront is testament to how our city can change when partners come together with common purpose. The vision set out in the **City Plan for Dundee 2017-2026** is:

Through Our Partnership, Dundee:

- will have a strong and sustainable city economy that will provide jobs for the people of Dundee, retain more graduates and make the city a magnet for new talent;
- will offer real choice and opportunity in a city that has tackled the root causes of social and economic exclusion, creating a community which is healthy, safe, confident, educated and empowered;
- will be a vibrant and attractive city with an excellent quality of life where people choose to live, learn, work and visit.

Building on the momentum of the **City Plan for Dundee 2017-2026** and other recent transformational local health and wellbeing strategies, there is no better time to reinvigorate our vision for health and social care across Dundee.

4. About Dundee: Demographic Context

4.1 Introduction

Dundee is Scotland's fourth largest city. Like many densely populated cities, Dundee faces a number of serious and pronounced health and social challenges, including reduced life expectancy and higher levels of long term health conditions, teenage pregnancy, domestic abuse, drug and alcohol misuse and imprisonment. These are longstanding challenges, which correlate to the levels of deprivation across the city.

An understanding of communities and people across Dundee is therefore vital in the planning and provision of health and social care services. This section provides a summary of the Dundee population profile and the potential impact on health and social care services, highlighting the challenges that need to be addressed.

Dundee covers the smallest land area of any council in Scotland, with the second highest population density. Studies indicate that higher levels of population density can increase anxiety levels and life satisfaction.[2]

4.2 Population

The mid 2017 population statistics from the National Records of Scotland confirmed Dundee's population was 148,710[3], with a further 22,000 people living outside the city who are registered with Dundee GP practices.

Dundee's population increased by 0.3% over the previous year, slightly lower than the all Scotland population increase of 0.4%. In line with the overall Scottish population, Dundee experienced a slight reduction in the local population, but a 0.4% increase in inward migration.

The proportion of people in each age band in Dundee is generally similar to the rest of Scotland, with the distribution of those under 16, working age and pensionable age broadly similar. It is noteworthy however that the proportion

[2] How does where you live affect your wellbeing? The Knowledge Exchange blog
[3] Mid 2017 population estimates Scotland – National Records of Scotland

of people in Dundee aged 19 – 27 is 5% higher than the all Scotland average, which in part reflects the student population resident within the city.

Dundee like the majority of Scotland, has a higher proportion of females (51.8%) to males (48.2%).

The city has a higher proportion of people with one or more disability in comparison to Scotland overall. There is also considerable variation between the eight locality areas in Dundee with East End, Lochee and Coldside having a higher proportion of people with one or more disability. East End, Lochee and Coldside have a higher prevalence of people with mental health conditions, physical disabilities, learning disabilities and sensory impairment. (source: 2011 census).

Population projections for Dundee to 2026 show minimal population growth (0.7%), while Scotland's overall population is forecast to grow by 3.2%[4]. Looking further ahead to 2041, Dundee population growth is predicted to continue to lag behind Scotland overall (1.4% versus 5.3%).

4.3 Life Expectancy

Across Scottish councils, Dundee has the second lowest life expectancy. Female life expectancy in Dundee is 79.6 versus 81.1 across Scotland. The gap in male life expectancy is greater, with male life expectancy in Dundee currently 74.5 compared to 77.1 across Scotland.[5]

Across Dundee, life expectancy gaps however increase more dramatically when overlaid with the levels of deprivation experienced. Life expectancy of a female who lives in one of the least deprived areas of Dundee is over ten years more than a male who lives in one of the most deprived areas. While life expectancy is increasing across Dundee and at a faster rate in the least deprived areas, there is still a cohort of people who die prematurely.

4.4 Deprivation

Given these stark variants in how long a person lives and critically how long they live healthily, Dundee needs to invest resources where deprivation is at its most pronounced.

[4] Population projections for Scottish areas (2016 based) – National Records of Scotland
[5] Life expectancy for administrative areas within Scotland 2014/2016 – National Records of Scotland

Deprivation is a deep-rooted and complex web of factors that manifests itself in lower attainment in education, less income, poorer physical and mental health, increased family breakdown and higher levels of drug and alcohol abuse.

37% of Dundee's population is living within the 20% most deprived areas across Scotland, with only 15% of Dundee residents living within the 20% least deprived areas. The levels of deprivation are even more glaring when they are viewed across the eight Dundee localities. More than half of those living in East End, Coldside and Lochee live in the 20% most deprived areas in Scotland, with all three localities suffering from high levels of income and employment deprivation, as well as poor levels of health and housing.

Research looking at how much deprivation impacts on life expectancy between Glasgow and other Scottish cities concluded that over 90 % of premature death could be explained by deprivation. The study confirmed that tackling deprivation should "reduce the health inequalities that exist".[6]

The Scottish Index of Multiple Deprivation recognises the interconnectedness of socio-economic factors, with the Index incorporating seven domains - income, employment, health, education, housing, access and crime. All domains of deprivation need answers and solutions and this Plan should be seen as part of a whole systems response.

4.5 Health Inequalities

Our knowledge of the variant levels of deprivation across Dundee is critical as we plan for the future provision of health and social care services. Deep rooted deprivation is closely linked to health inequalities.

Action on health inequalities requires action across all the social determinants of health. To address health inequalities in Dundee will require actions that involve growing the availability of quality employment and housing and strengthening education. While this Plan can only ever be part of a wider, concerted effort to reduce health inequalities, it is an important piece of the complicated jigsaw of actions.

[6] How much of the difference in life expectancy between Scottish cities does deprivation explain?

An illustration of the health inequalities which exist between people living in the most and least deprived areas is shown clearly in the incidence of lung cancer. Registrations of people diagnosed with lung cancer are almost three times higher in the most deprived areas of Scotland when compared to the least deprived areas[7]. The level of Chronic Obstructive Pulmonary Disease (COPD) related hospital discharges provides even greater evidence of the health inequalities that exist, with the incidence of COPD hospital discharges in the most deprived areas ten times that of the least deprived. This is most likely attributed to the historical smoking rate differences between the most and least deprived areas.

Health and wellbeing is known to vary by deprivation. Smoking, unhealthy diet, the consumption of excess alcohol and recreational drugs are more prevalent in the most deprived localities.

Dundee has the 3rd highest prevalence of substance use in Scotland. There are an estimated 2,900 problem drugs users in Dundee; 1,700 are male and 1,200 are female. This represents a ratio of 59% males: 41% females, which is significantly different from the average Scotland ratio of 70% males: 30% females.

A clear inequality exists in drug related hospital discharges with the rate of drug related discharges being 20 times higher in the most deprived areas.

Between 2013 and 2017, an average of 37 drug related deaths occurred each year in Dundee, representing a death rate of 0.25 per 1,000 of population, and the highest rate across Scotland. Both locally and nationally the number of drug related deaths has increased markedly over the past decade and is of significant public health concern.

[7] Cancer statistics – ISD Scotland

One example of how we have been working to tackle health inequalities associated with substance misuse within specific localities is the Lochee Hub. Located at the heart of the Lochee community, this hub provides sustainable, secure, respectful, friendly, open and accessible resources that are valued and supported by local people. This includes 'Stay and Play' for parents and children, advice and advocacy for housing and benefits, support to tackle substance misuse and recovery, support for carers, employment support, access to food banks, and peer support.

Staff and volunteers work together to provide activities and services that are open and easily accessible for all. The hub has adopted a whole-family approach, to improve families' experience of services and enhance their outcomes.

There is a strong link between deprivation and alcohol related harm, with individuals from the most deprived areas accounting for four times the rate of A&E attendances.

A further illustration of the health inequalities that exist between the least and most deprived areas of Dundee can clearly be seen in the higher incidence of domestic abuse.

Dundee has the 2nd highest incidence of domestic abuse per 10,000 population, 40% higher than the rate across all Scotland[8]. Given this, Dundee has a clear focus through the Violence Against Women Partnership on addressing domestic abuse as part of a wider response to Public Protection. This includes initiatives such as Safe and Together and the Caledonian Programme which aim to enhance the accountability of male perpetrators of domestic abuse and improve the lives of women and children affected.

The suicide rates in Dundee per 100,000 is 29.2 for males and 19 for females for the period 2013 - 2017. Males in Dundee have the second highest suicide rate in Scotland.

[8] Domestic abuse recorded by the Police in Scotland, 2016-17

4.6 Further Information

Further information about Dundee's demographic context and health and social care needs, including how these vary across localities, can be found in our **Strategic Needs Assessment** and accompanying **Locality Needs Assessments**.

5. Our Achievements

5.1 Introduction

The Partnership's statutory annual performance reports set out in detail the progress we are making on a daily basis to improve the health and care of Dundee residents and ensure we live as fulfilled and independent lives as possible. The **Annual Performance Report 2017-2018** provides a comprehensive insight into the many achievements of the Partnership in its second year of operation.

It is gratifying that Dundee citizens rate their experiences of health and care services very highly. Against most health and social care integration indicators, the people of Dundee express greater satisfaction with local services than the average results across Scotland. Examples of high performing areas for the Partnership include ensuring people feel supported to live as independently as possible, ensuring services are well coordinated and services are maintaining or improving quality of life.

While this Plan quite rightly centres on what more we must do as we move forward, it is useful to reflect on how far we have come since our formation. Over the last three years we have learned that when we focus our resources and commit to a whole systems approach to improvement, we can make substantive progress. We have also learned that positive outcomes are achieved when we co-produce solutions with people who use services, their families and carers. This is best demonstrated by shining a light on two of our achievements:

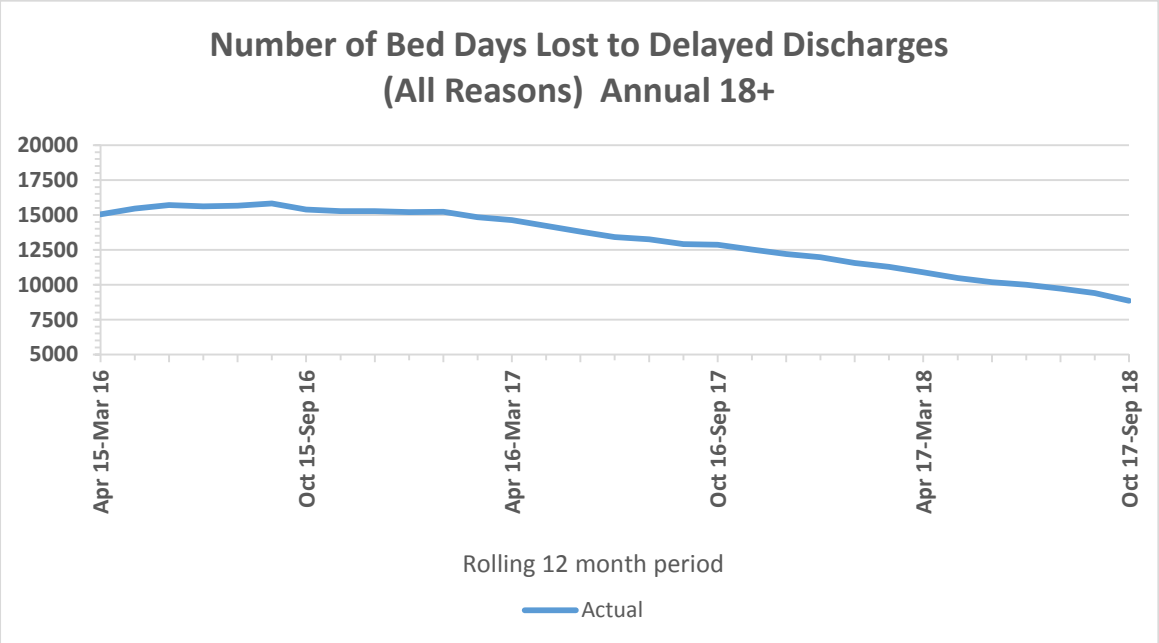
- our progress in reducing the impact of delayed discharge and the length of time people spend in hospital after being admitted in an emergency; and
- our unwavering commitment to recognising the critical importance of carers to delivering on our organisational vision.

5.2 Discharge Management

Across the health system in Scotland, people can often be delayed in hospital as they wait for the right support to return home. Agreeing that a person is fit for discharge, as well as coordinating a support package and enabling carers to be part of discharge planning can be complex and time consuming. Delays can occur when a person is awaiting assessment, care packages, housing, care home or nursing placements (these are known as standard delays). There is also recognition that there are some patients whose discharge will take longer to arrange, such as patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate or where an adult may lack capacity under adults with incapacity legislation.

All delays have the potential to negatively impact on the person experiencing the delay, their carers and family members. Longer stays in hospital are associated with increased risk of infection and poor mental health, which can increase the chances of readmission to hospital. Delays in discharging patients can sometimes affect the flow of patients through a hospital meaning that beds may not be available for new admissions, with consequences for waiting times in accident and emergency departments and for planned surgery. This can then impact on cost of hospital care.

In terms of Partnership performance, following a series of concerted initiatives and investment, we have shown a sustained reduction in discharge delays:



The Partnership is proud of its achievements in reducing hospital delayed discharges. Our successes have only been possible by all partners taking a whole systems approach and working collaboratively to deliver better outcomes for Dundee residents. The Partnership has targeted investment in several programmes and projects with the single, conscious objective of ensuring that when people do have to go to hospital they are only there as long as they need to be.

As well as offering additional care at home placements, a Home Care and Resource Matching Unit has increased the efficiency of care at home services. Step down resources have been increased to offer people intermediate care if they need that before returning home. The Integrated Discharge Hub provides a single route for referrals and response to discharge activity, reducing duplication of activity between social work and health services. We have improved the effectiveness and efficiency of assessments for home adaptions and provision of aids for daily living. By increasing mental health officer resources, we have reduced the time taken to review power of attorney and guardianship requests, further streamlining person centred discharge planning.

Our integrated approach to reducing delayed discharges clearly demonstrates that long term challenges can be turned around successfully with the necessary focused response and investment. Our work however is not complete and we plan to introduce improvement actions to enhance our performance further, particular for people aged 18 to 74 who have a complexity of needs.

5.3 Carers

The Partnership recognises the critical contribution that carers make in supporting people they care for and the vital place that carers have in communities across our city. According to the Census 2011, there were around 13,000 carers in Dundee providing support to family or friends who are older, disabled or seriously ill. This equates to approximately 1 in 9 people being carers within Dundee.

Carers face unique challenges and experiences. Local carers tell us that the nature of their caring role means that they often focus on someone else's needs to the detriment of their own, causing negative impacts on their own health and wellbeing. Despite having experience of the needs of the person they care for, carers can sometimes be overlooked when support plans are developed. Carers have told us that want to tell their story only once and not have to repeat it each time they meet different people. They also tell us supports must work better together and should be more flexible to suit the circumstances of both the person cared for and the carer.

We are however making significant progress in working with and supporting carers of all ages in their caring role in our local communities. In 2017, the Dundee Carers Partnership produced, the **Dundee Carers Strategy – A Caring Dundee**. Carer voices were key to how the strategy developed, with a carer noting that *"I feel that things are moving in the right direction for carers. We now have a voice – let's make sure it continues to be heard and acted upon"*.

The carers strategy sets out how we will achieve our vision for:

A Caring Dundee in which all carers feel listened to, valued and supported so that they feel well and are able to live a life alongside caring.

The strategy, developed with local carers, is acting as a beacon for a range of actions being taken forward by the Partnership to improve the lives of Dundee carers.

"It's all about the Break" scheme initially developed as a pilot to support people who use mental health services and their unpaid carers to access new types of short breaks more suited to their needs has since become a mainstream service. The success of the service has been demonstrated by the increasing referral rates and the number of short breaks provided to carers, as well as in the positive personal outcomes achieved by people using services and their carers. The variety of ways in which carers request their breaks also continues to widen.

In partnership with the Dundee Carers Centre, and others, we are further strengthening our focus on the health of carers, through increased promotion of wellbeing checks for carers through the Keep Well Team. Carer feedback has been very positive of the added value of this support. As with the short breaks scheme, referral rates for health and wellbeing checks are increasing.

A major focus for the Partnership to further enhance experiences for carers has been the local implementation of the **Carers (Scotland) Act 2016**, which came into effect in April 2018. Some key activities recently undertaken to fulfil our duties included:

- the provision of learning and development activities for our workforce and partners to enhance their understanding of carers and the Act;
- further developing, with the Dundee Carers Centre, locality models for supporting carers within the service delivery area in which they live;
- creating and delivering a 'Carers of Dundee' website and carers factsheets to provide information and advice for local carers and professionals; and,
- introducing a Carers Interest Network to involve practitioners across health, social care, third and independent sector in developing coordinated approaches to supporting carers.

As a Partnership we have taken some big steps to recognise the invaluable and unrivalled contribution carers make in our communities and we are pleased with our expanding range of services, supports and information specifically designed for carers, with carers. We recognise however that there is much more that needs to be done as we work towards delivering **A Caring Dundee**. We have learned that working alongside carers needs to be a mainstream activity across all areas of the Partnership and embedded in everything that we do.

6. Strategic Priorities

6.1 Introduction

When we developed the first strategic plan, we outlined the case for change based on a comprehensive analysis of need, demographics and available resources. We stated that this would involve a process of investment towards some areas of service and disinvestment in others, with resources deployed towards a more preventative and integrated community based approach.

From this we developed a set of eight strategic priority areas, based on our vision, our strategic needs assessment, the case for change, the views of our citizens and partners and the nine **National Health and Wellbeing Outcomes**.

These strategic priorities were:

1. Health Inequalities
2. Early Intervention/Prevention
3. Person Centred Care and Support
4. Carers
5. Localities and Engaging with Communities
6. Building Capacity
7. Models of Support/Pathways of Care
8. Managing our Resources Effectively

We have made significant progress in pursuing a series of actions under each of these priorities. It is now time to review how far we have come in achieving our vision for the citizens of Dundee. As part of our continued conversation with our stakeholders, including people using services and their carers, we have asked ourselves:

- How successful have we been?
- How do we build on what is working well?
- What do we need to do differently to achieve better outcomes for people?
- Can we resource what we would like to do?

By asking ourselves these questions, we have refined and reframed our priorities for the next three years (2019-2022). While we believe that the priorities established in 2016 are still important, we have learned from our models of success, such as how we are reducing delayed discharges, improving outcomes for carers and improving services for older people, that if we focus our attention and resource in a more targeted way, we can achieve transformational change much more quickly.

With this in mind, we are targeting our resources in this Plan to respond to the following four priority areas:

5. Health Inequalities
6. Early Intervention/Prevention
7. Localities and Engaging with Communities
8. Models of Support/Pathways of Care

We will continue to drive positive improvements in Person Centred Care and Support, strengthen support for Carers and ensure a sustained focus on Building Capacity and Managing our Resources Effectively. Rather than having these elements viewed as separate from mainstream activity, we will now embed these as an integral part of how we progress our four refreshed strategic priority areas.

The four refreshed strategic priorities will help us maintain focus on improving outcomes for the people of Dundee. This means bringing change at different levels across the whole system to care for more people in the community. This will bring a shift in resources from hospitals to community based care to achieve better outcomes for people and to provide easily accessed more personal support, closer to home.

This requires us to ensure a shift in:

- **Location** – a move from acute hospital setting to more community based provision, this also includes the development of information systems and workforce capacity that are critical supports for community based services
- **Responsibility** – as we provide more care and treatment in the community professionals and staff will be required to develop their skills, expertise and roles and to work alongside communities to build capacity for care through wider community services and supports

- **Prevention** – care and treatment to prevent or delay more intensive and expensive interventions - by increasing the rate of health improvement particularly in deprived communities by anticipating and addressing the need for care at an earlier stage.

The implementation challenges involved in shifting care out of hospital are considerable, and we acknowledge that more needs to be done to narrow the gap between resources available and demand. Our commissioning intentions as detailed in our refocused strategic priorities will help us bring resources closer to communities.

6.2 Triple Aim

In each of our four strategic priorities we will focus on the 'triple aim' as set out in the Scottish Government's **Health and Social Care Delivery Plan**. The triple aim can be summarised as:

- **'Better Care'** - improving the quality of care by targeting investment at improvement and delivering the best, most effective support;
- **'Better Health'** - improving health and wellbeing through support for healthier lives through early years, reducing health inequalities and focusing on prevention and self-management; and
- **'Better Value'** – increasing value and sustainability of care by making best use of available resources, ensuring efficient and consistent delivery, investing in effectiveness, and focusing on prevention and early intervention.

6.3 Strategic Priority 1 - Health Inequalities

Our Ambition: Health inequalities across Dundee have reduced so that every person, regardless of income, where they live or identification with a protected equalities group, has the potential to experience positive health and wellbeing outcomes.

Health inequalities are preventable and unjust differences in health status experienced by certain population groups. We know that people who live in areas of deprivation have significantly poorer health and live shorter lives. This is evidenced in Dundee, where a disproportionate amount of people affected by substance misuse and long term physical and/or mental conditions live in our most disadvantaged communities.

As well as considering the impact of deprivation on health inequalities, we also need to consider the specific challenges experienced by people who belong to protected equalities groups.[9] We know that people with protected characteristics can find it difficult to access health and social care services and/or have a poorer experience of their care, often compounding or contributing to poorer health outcomes.[10] Our Equalities Outcomes and Mainstreaming Equalities Framework sets-out our priorities for addressing equality issues.

Dundee has a long history of innovative activity to reduce health inequality across the city. At the time of the first plan we undertook to build on this activity. We understand however that closing the gap on heath inequalities will require the concentrated efforts and skills of many statutory, third and independent sector organisations. Partnership activities will only ever form part of a much larger and necessary tapestry of joined up thinking.

[9] Protected characteristics under the Equality Act 2010 are: age; disability; sex; gender reassignment; pregnancy and maternity; sexual orientation; marriage and civil partnership; religion, belief or lack of religion / belief; and, race.

[10] Scottish Better Together Survey Patient Survey Programme

Key Achievements over 2016-2018

We have taken the following positive steps to improve health equity in the localities in Dundee where there are the most people with the greatest needs:

- redesigned more integrated substance misuse and mental health services to make it easier for individuals and communities to access services;
- developed health inequality sensitive practice amongst health and social care staff, including training more than 1,600 staff to better utilise prevention focused interventions and social prescribing approaches;
- invested in community link workers and other "social prescribing" activity;
- supported initiatives such as the review of Dundee Fairness Strategy and contributed to the Dundee Drugs Commission;
- implemented a multi-agency approach to supporting refugees;
- become a test site for nutrition in communities to support people to eat more healthily and manage weight and have funded and supported voluntary groups to deliver exercise programs in the community;
- invested in programs of peer support across mental health, drug and alcohol and older people services;
- developed a range of GP based services including welfare benefits, listening services and social prescribing; and
- supported the roll out of the Recovery Friendly approach in Dundee's communities.

Our work to address health inequalities has already had some encouraging results. For example, we have reduced the variation in performance between the most and least deprived areas of Dundee in key health and social care indicators such as emergency bed days, delayed discharges and readmissions within 28 days.

Action Points 2019-2022

Over the next three years, we will further embed our response to reducing health inequalities by:

- developing community health and care centres, community hubs and other models of local service delivery to bring a range of assessment and treatment services to local communities and enhance the accessibility of services and supports;
- aligning our services to support communities experiencing most health inequalities;
- developing a city wide approach to social prescribing and enhancing the skills of staff to use social prescribing approaches in their practice;
- making better use of community resources such as libraries and community pharmacies to promote health and wellbeing, improve accessibility and tailor services to community need;
- changing the approach to employment support to increase employment across marginalised groups;
- working with our partners to support the development and rollout of strategies which help reduce health inequalities, for example the Tayside Public Health Strategy and Dundee City Plan; and,
- developing the way in which we measure and report differences between service use and outcomes for people who experience health inequalities and in the general population of Dundee.

As a Partnership, we have a collective determination to reduce the current health inequalities across our city. We are confident that taking forward the above actions, alongside the critical work of our partners, the health inequality gap experienced by people from protected characteristic groups and from those living in our most deprived areas will have reduced further by 2022.

6.4 Strategic Priority 2 - Early Intervention and Prevention

Our Ambition: Enhanced community based supports are enabling people to take greater control of their lives and make positive lifestyle choices that enhance their health and wellbeing and reduce the need for service based interventions.

By working with people earlier, we can reduce the incidence and impact of ill health and need for social care and target our resources more effectively. It is a difficult choice to prioritise prevention and early intervention when resources are limited. We believe however that a focus on prevention and early intervention is a positive choice which can help offset the need for more intensive or acute involvement at a later date. It is by prioritising early intervention and prevention that we improve outcomes in the longer term, manage demand and release resources. A positive illustration of one of the Partnership's recent successful early intervention and prevention programmes is our work promoting mental health recovery:

To advance mental health recovery in Dundee, the Partnership and the Scottish Recovery Network launched a new initiative called "Making Recovery Real" (MRR).

MRR has placed lived experience of mental health at the centre of all activity, with the understanding those who use services/supports are best placed to design them. In so doing MRR has been able to develop a strategic vision for recovery in Dundee, which is entirely person centred and focuses on improving the experiences and outcomes for people using mental health services/supports.

Extensive and ongoing engagement over the life of the project has told us what best supports recovery is: being heard and understood, particularly by others who have lived experience, sharing recovery stories and being able to support others who have similar experiences.

In the 3 years that MRR has been in place in Dundee we have: created films and workshops to help share recovery stories with the public, service providers, and decision-makers, held events to share the learning and delivered peer to peer training courses.

The work of MRR has resulted in: the creation of more peer recovery roles, both voluntary and paid positions in a variety of settings and the establishment of a

Peer Recovery Network for mutual support and ongoing development. Of the 24 peer graduates who have undergone the peer training six regularly deliver story sharing workshops and participate in events; five have progressed into further training or personal development courses, five have taken up volunteering opportunities, three have gone on to University courses, and three are now in employment.

Our approach to early intervention and prevention must also recognise the critical need to work closely with Community Planning Partners to implement agreed priorities from the **Tayside Plan for Children, Young People and Families**. Improving the health and wellbeing of children and young people, through whole system family based approaches, has the potential to significantly reduce the health and social care needs of the future adult population. This work includes working through Dundee's Protecting People approach to address the impact of trauma experienced in childhood due to experiences such as domestic abuse, parental substance misuse and neglect, and support recovery in the adult population. We also recognise the important role that the Partnership has as a corporate parent in responding to the needs of looked after children and young people, particularly in providing health and social care supports to care leavers until the age of 26.

Key Achievements over 2016-2018

We have pursued a range of successful initiatives to deliver earlier interventions and expand preventative services. Some of our achievements to date include:

- developing and increasing the capacity of money advice services to support prevention;
- developing a programme of co-designed, person centred activities to support mental health recovery in line with the 'Making Recovery Real' initiative;
- co-producing development of supports to young carers along with Dundee Carers Centre and Children & Families;
- implementing pre – exposure prophylaxis to contribute to a reduction in HIV;
- introducing physiotherapists in GP practices as part of primary care transformation programme;
- developing a single referral community rehabilitation pathway across social care, occupational therapy, community rehabilitation and enablement services;
- testing a model of direct access to substance misuse services;

- developing shared priorities with Community Planning partners as part of the Tayside Plan for Children, Young People and Families; and
- establishing with our Public Protection partners, a Transforming Public Protection Programme to enhance leadership and quality of service provision for people at risk.

These actions are ensuring that our services are becoming more efficient, person centred and more easily accessed as early as possible by the people who need them most.

Actions for 2019 - 2022

We will build on our achievements and maintain our focus on prevention and early intervention by having a focus on **Asset Building, Promoting Health and Wellbeing, Improving Service Redesign and Access to services,** and consolidating our approach to **Public Protection.**

Part of the priority on early intervention and prevention is how we increase the capacity of people, families and communities to find the right support for themselves. We will focus on **Asset Building** by:

- optimising people's opportunities to contribute to their families, their community and to the city;
- supporting individuals to maximise their financial situation through work, access to learning and access to the benefits they are entitled to;
- working collaboratively with Children and Families Services and Criminal Justice Services to support families to understand their strengths;
- building capacity within the third sector to identify and meet needs in our communities that support people to live full and healthy lives;
- building on current engagement methods to identify community need and initiatives and further develop community capacity; and
- refreshing the Community Capacity Building Strategy and agree resources to implement and support further development.

We will **promote health and wellbeing** by:

- working with community health networks to promote and support positive health changes;

- engaging people around health and wellbeing, to increase self-care, and avoid longer term ill health through a range of models at an individual level and community level;
- developing services and supports to reduce isolation and loneliness which connect individuals to others, supporting positive mental and physical health; and
- developing approaches that support life style changes to improve health and address our key priorities of tackling obesity, improving mental health and wellbeing and reducing reliance on substances.

We will improve **service redesign and access to services** by:

- developing community health resources within neighborhoods in line with developments across primary care services;
- developing community rehabilitation and enablement approaches which integrate pathways and further develop access to services by communities;
- expanding the Enhanced Community Support Multidisciplinary Team for each G.P. cluster in line with Reshaping Non Acute Care Programme, to ensure individuals receive the appropriate health support at the right time;
- supporting health and social care staff to identify community resources and to sign post/support individuals to access these resources;
- ensuring care pathways, including in practices, are person focused not condition focused, and what matters to the individuals is reviewed, using a collaborative conversation;
- redesigning for chronic pain pathways and develop quality prescribing for chronic pain;
- redesigning sexual and reproductive health service delivery;
- commissioning services with Children and Families Services, particularly in relation to substance misuse, mental health, obesity and parenting support;
- working collaboratively with neighbourhood services, third sector and key partners to deliver joint approaches to preventing homelessness; and
- working with our public protection partners to re-design how we respond in an integrated way to concerns about people at risk and their wider family circumstances.

Our continued commitment to early intervention and prevention is clearly demonstrated in the above actions. We believe this unwavering commitment will improve the health and wellbeing of citizens across the city.

6.5 Strategic Priority 3 - Locality Working and Engaging with Communities

Our Ambition: People can access services and supports as close to home as possible, with these services and supports responding to the specific needs of the local community.

Dundee has a strong ethos of working in partnership with its communities and the people it supports, despite several significant factors, which make the strategic planning of health and social care in Dundee a unique challenge. A number of factors significantly impact on the way in which services are accessed by the population within Dundee:

- geography of Dundee – unlike Scotland's other major cities Dundee occupies a small geographical area (approximately 60 km^2). The city's compact size coupled with a tradition of community activism creates significant opportunities for collaboration between our workforce, communities and people using services and means that any specific sites of service delivery will be relatively accessible to the whole population;
- GP cluster areas (where GP surgeries are located) – in Dundee GP registration does not correlate with area of residence and therefore, in most instances, it cannot be assumed that GP surgeries are responding to the needs of the local population;
- administrative boundaries – services delivered by Dundee City Council, including those within Children and Families and Neighbourhood Services, are organised in relation to administrative boundaries, however these boundaries do not overlap with GP clusters; and
- definitions of community – Dundee's communities do not necessarily identify with the locality designations ascribed to them by the Council's administrative boundaries, with distinctive community identities existing within and across localities.

The Partnership has taken a '**locality model**' approach to delivering services to locality areas within the city. This ensures that multi-agency services and specialist services are targeted appropriately to meet the needs of people with specific or complex care needs and their carers. This also supports a manageable communication framework for professionals and providers across localities.

The Partnership is organised into four service delivery areas, with two LCPP areas forming a single Partnership service delivery area, these are:

- Maryfield and East End;
- Strathmartine and Lochee;
- The Ferry and North East; and
- West End and Coldside.

The eight LCPPs are made up of 54 natural neighbourhoods. This can mean that the natural neighbourhoods that sit within the LCPP areas often have differing demographic, health and socio-economic profiles. In addition, people who feel they belong to a neighbourhood or locality may also identify as a member of a non-geographical community based on personal characteristics or experiences, such as people from the same ethnic background or people who are carers or extended family members.

In the first plan we identified Locality Working and Engaging with Communities as one of our eight key strategic priorities. We acknowledged that Dundee has a wide range of people with diverse needs across different parts of the city and pledged to invest in an infrastructure to support the development of locality planning and to allocate resources to implement locality plans.

Since then have worked hard with communities and our planning partners to make progress in how we understand community need and to increase the capacity to plan and deliver services across the city. We have taken a proactive approach to planning and delivering our services in localities, although we acknowledge that there is still much more work to do.

Key Achievements over 2016-2018

We have:

- Through the Engage Dundee consultation process identified and understood better the differences in community priorities for health and social care across the natural neighbourhoods that make up the city. This informed the development eight Local Community Plans, which address health and social care need in each LCPP area.
- Developed Locality Needs Assessments for each LCPP area that have helped us to better understand the specific needs of communities across the city and use this to inform service planning and improvement.

- Enhanced our performance reporting to include performance information at locality and neighbourhood level wherever possible. This is improving the transparency of our public performance reporting and supporting us to target improvement actions to addresses inequality
- Targeted resources, service planning and service delivery at LCPP and neighbourhood level, including:

    - Assessment and service delivery models in services such as Home Care, Care Management for Older People and for Adults with physical disabilities, Community Mental Health Services, Occupational Therapy and Physiotherapy.
    - A locality approach to supporting carers in Coldside and Strathmartine.
    - Testing of the Macmillan Improving the Cancer Journey Service in Coldside and Lochee
    - Health and wellbeing networks
    - Expansion of the leg ulcer clinic to different localities
    - The whole system approach to supporting children and families in Lochee.
    - An East End Health and Wellbeing Drop In Initiative offering a free drop-in service with a focus on wellbeing information, activities and support.

- We have commenced a programme of work to identify where resources are spent within locality areas in the city for some services. This work is helping us to understand how resources are currently distributed across localities.
- We have expanded the use of data to better understand how resources might need to be allocated in the future to meet changing demands for social care services, taking into account factors such as health inequalities and demographics projections.

Actions for 2019-2022

In recognition of the importance of delivering quality services to our citizens we will continue to engage with communities and focus on our programme of work in localities. Much of the work undertaken over the last three years has been focused on helping us to better understand the distinctive needs and expectations of Dundee's localities and neighbourhoods. Over the next three years we intend to specifically focus on how we structure and deliver services to respond to these needs and expectations by **Realigning Statutory Services** and **Maintaining Community Engagement.**

Realigning Statutory Services

- Continue to realign our services to the four service delivery areas in order to ensure people can access services where they are needed most. This also means increasing the level and range of services delivered in localities, in line with the Primary Care Improvement Plan and supporting the implementation of this plan and the role of GPs as 'expert medical generalists'.
- Further develop our carers locality support model to enable implementation across all localities of Dundee.

Maintaining Community Engagement

- Continue with engagement and the delivery of Local Community Plans with communities and planning partners, making sure that communication initiatives resonate across all care groups, young and old.
- Sharing data with communities to enable citizens to continue to inform the Partnership on what success should like from a citizen perspective.
- Refreshing the Partnership's Participation and Engagement Strategy to ensure an integrated approach with wider Community Planning Partners, particularly Community Learning and Development.

6.6 Strategic Priority 4 - Models of Support, Pathways of Care

Our Ambition: People will live more independently at home for longer, supported by redesigned community based, person centered services.

The focus on shifting the balance of care towards more community based models is well recognised, including in the recent Kings Fund report **Reimagining Community Services - Making the most of our assets** published in 2018. This report stated that *"A radical transformation of community services is needed, making use of all the assets in each local community wherever these are to be found, breaking down silos between services and reducing fragmentation in service delivery."*

In line with this thinking, our last plan stated that we wanted to improve the way that people move between large hospitals and the community, and to redesign models of non-acute hospital-based services, re- investing in community-based services including our response to protecting people concerns. We understood that we needed more targeted and specialised residential resources and to invest in accommodation with support and day opportunities. We also needed to maximise the telehealth and telecare supports available to help people live more independently for longer.

Key Achievements over 2016-2018

As discussed earlier, several Strategic Planning Groups have developed strategic plans. These strategic plans outline how we want to improve the way we provide services and support to people in the community. These strategies clearly set a number of priorities for us to action over the next three years. These build on existing service re design which shifts the balance of care into the community.

In addition to the development of these strategies, we have**:**

- continued to invest in care at home services to increase capacity;
- reviewed current models of residential care for older people, disinvested in residential forms of care and increased investment in accommodation with support;

- initiated the Reshaping Non-Acute Care Program of work, which has reduced the number of hospital beds at Royal Victoria Hospital and reinvested resources released in the multi-disciplinary Enhanced Community Support Service;
- reviewed the current Learning Disability acute liaison service to develop a future model;
- redesigned our discharge models to create an integrated Discharge Hub and implemented the Home and Transition Plan to increase step down options from hospital;
- reconfigured our substance misuse services to create an integrated health and social care service and implemented a redesign of substance misuse services to enable a whole system approach to change;
- developed and commissioned additional accommodation with support houses for adults living with Mental Health difficulties and/or Learning/Autism;
- developed a Rapid rehousing transition plan, as a partnership with Neighbourhood Services, to enable a shift from use of temporary accommodation to supporting people in their own tenancy;
- developed integrated support models to enable refugees to live independently in partnership with Neighbourhood Services and NHS Tayside; and
- introduced the Caledonian Programme to work with perpetrators of domestic abuse.

Actions for 2019-2022

We want to continue to focus on the actions detailed within each of our care group strategic commissioning plans. This will help to further improve the models and pathways of care we have already developed and need to develop for the future. At the same time, we will also continue to support the work of NHS Tayside to support their work in re-designing clinical pathways across a range of service delivery areas.

We have made a commitment to person centred care and to create more flexible options around the type of care available to enhance the outcomes people experience. By remodelling integrated care and support planning we can improve the achievement of the personal outcomes that are important to each person. By furthering the development of self-directed support, we will enable people to take more direct control over their care.

There are a number of 'must dos' across all of our service developments to ensure that it is person centred:

- Sustain and continue to review staff and organisational development programmes to embed person centred practice.
- Simplify our processes and systems to make access to care and support easier.
- Further develop systems and processes to ensure standards of quality and safety and best outcomes for individuals are achieved in the provision of services.
- Invest further in the workforce to develop integrated roles, improve quality and increase capacity.
- Commission internal and external services on a locality basis.
- Increase the balance of care towards care at home services over the period of the plan.

In describing how we will continue to implement change, we have highlighted in this section the main transformation programmes which will take place over the next 3 years. Some highlighted priorities in specific areas include:

- Primary Care Transformation and Improvement Plan – modernise primary care services, with a specific focus on general practice and the introduction of the new GP contractual arrangements and the development of a multidisciplinary approach to primary care.
- Community Health Services – review the model of health interventions in the community to develop locality models which include Health and Community Care Centres, community based clinics; integrated community health and care roles and a modernized community nursing service.
- Community and Independent Living Services- remodel services to deliver an integrated model which supports early intervention, active and independent living and improved outcomes.

- Care at Home Services – remodel the in-house service to ensure it is person centred, efficient and responsive to the increasing needs of the population. Implement the tendering of commissioned services.
- Substance Misuse – redesign integrated services for adults who use substances to improve access to recovery orientated treatment services and supports and improve outcomes for people and their families. This will include a shift towards locality aligned service delivery to meet the needs of a population with complex needs and risks.
- Mental Health and Wellbeing – remodel community services by developing early intervention services and crisis care models, including services delivered from GP practice. This will build on the emerging Mental Health and Wellbeing Strategy and Suicide Prevention Strategy.
- Homelessness and Complex Needs – implement lead professional model, redesign of temporary accommodation and rapid rehousing to improve access and coordination of support and outcomes for people who have a complexity of needs.
- Sexual and Reproductive Health - redesign sexual health and reproductive services to maximise efficiency and a focus on outcomes while maintaining access to adults and young people with specialist sexual and reproductive health needs.
- Learning Disability – increase the provision of community health supports and opportunities for adults with a learning disability and/or autism to receive more personalised support in leisure, recreational and social activities, including in the evening and at weekends.
- Palliative Care – remodel specialist services and develop pathways which support a shift to community service delivery.
- Protecting People – actively lead and contribute to the implementation of the Transforming Public Protection Programme.
- Community Justice – work with the Scottish Prison Service and other partners to support the planning and delivery of the Women's Custody Unit.

7. Digital Technology

7.1 Background

The Partnership, providers, people who use services and their carers already access and use digital technologies such as telecare, equipment and adaptations to support independent living and access health and social care information through a range of websites.

Over the next three years, we will continue to develop digital technologies to deliver more positive outcomes for people across Dundee. Digital technology will become an ever increasing enabler as the Partnership seeks to deliver on its ambition and vision, with technology playing a critical role in areas such as shifting the balance of care from the acute to primary care sector.

7.2 Dundee Smart Health and Care Strategy

We have developed a strategy on the use of technology - Dundee Smart Health and Care Strategy.

This strategy will ensure that the use of technology within the Partnership will support the achievement of all four strategic priorities set out in this Plan by:

- promoting equality and social inclusion;
- addressing health inequalities;
- supporting early intervention and prevention;
- protecting people from harm;
- increasing the accessibility and efficiency of services so that people can gain the right support at the right time; and
- increasing opportunities for people to be involved in the design and development of supports and services.

To support implementation of our strategic approach to technology, we have adopted the following guiding principles:

- co-producing our developments with people who use services, carers and our workforce;
- ensuring technology is easy to access and available for use in citizens' homes and communities;

- using technology to improve outcomes for citizens and communities;
- integrating technology into system redesign so that technology is fully accessible and integrated into service delivery;
- promoting innovation and personalisation in the use of technology;
- ensuring equality in our approach so access to technology is fair, consistent and free from discrimination; and
- promoting best practice in use of technology and ensuring compliance with national standards.

7.3 Outcomes

The Partnership's focus on technology and achievement of the strategic outcomes set out in the Dundee Smart Health and Care Strategy should improve health and wellbeing, support increased independent living, engender greater personal accountability and enhance personal empowerment. Each of these positive outcomes, complements our determination to reduce health inequalities across Dundee.

7.4 Longer Term

The Scottish Parliaments Health and Sport Committee report on technology and innovation in health and social care stated that '*Digital technology has the potential to change the face of health and social care delivery*.' The Annual Report by England's Chief Medical Officer titled 2040 – Better Health Within Reach looks even further ahead, providing examples of currently available artificially intelligent health diagnostic and monitoring devices and envisages a future that includes their expanding use.

Over the longer term, the Partnership recognises it will need to radically develop the way technology is used to ensure we can provide sustainable, person centred, locally delivered services that can adapt to the city's changing demographics and financial outlook.

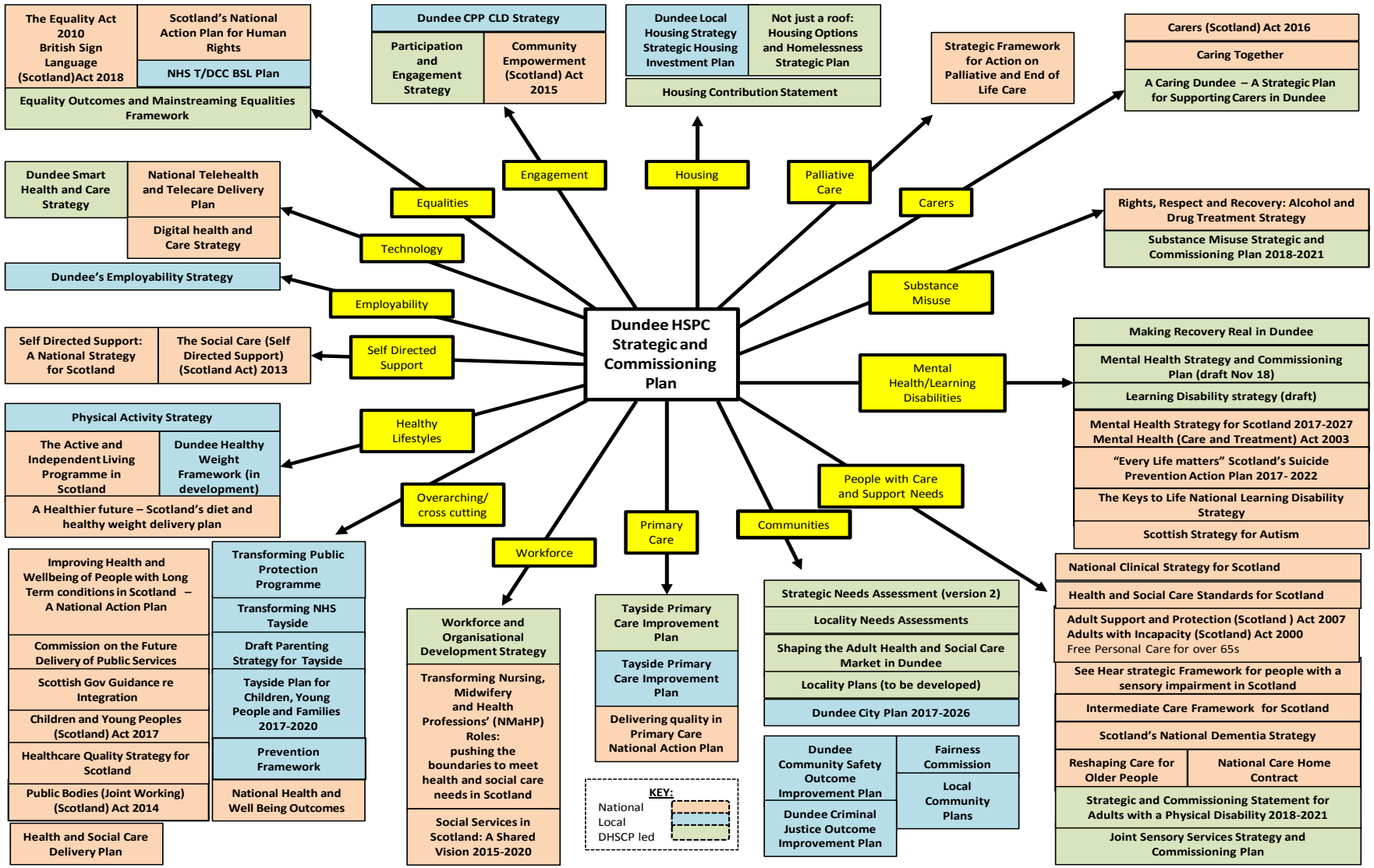
8. Legislative and Policy Context

8.1 Background

To ensure that we achieve more positive health and wellbeing outcomes for the people of Dundee, it is important that we incorporate relevant national, regional and local policies as we plan, design and deliver services.

The policy context which supports and drives this Plan is comprehensively detailed in the **Health and Social Care Strategic and Commissioning Plan 2016/ 2021**. There have however been noteworthy changes in terms of the legislation and policy context since our first plan was agreed. Figure 2 provides a summation of the current national, regional and local policy context:

Figure 2


Dundee HSPC Strategic and Commissioning Plan
Equalities
The Equality Act 2010 British Sign Language (Scotland)Act 2018
Scotland's National Action Plan for Human Rights
NHS T/DCC BSL Plan
Equality Outcomes and Mainstreaming Equalities Framework
Engagement
Dundee CPP CLD Strategy
Participation and Engagement Strategy
Community Empowerment (Scotland) Act 2015
Housing
Dundee Local Housing Strategy Strategic Housing Investment Plan
Not just a roof: Housing Options and Homelessness Strategic Plan
Housing Contribution Statement
Palliative Care
Strategic Framework for Action on Palliative and End of Life Care
Carers
Carers (Scotland) Act 2016
Caring Together
A Caring Dundee – A Strategic Plan for Supporting Carers in Dundee
Technology
Dundee Smart Health and Care Strategy
National Telehealth and Telecare Delivery Plan
Digital health and Care Strategy
Employability
Dundee's Employability Strategy
Self Directed Support
Self Directed Support: A National Strategy for Scotland
The Social Care (Self Directed Support) (Scotland Act) 2013
Substance Misuse
Rights, Respect and Recovery: Alcohol and Drug Treatment Strategy
Substance Misuse Strategic and Commissioning Plan 2018-2021
Mental Health/Learning Disabilities
Making Recovery Real in Dundee
Mental Health Strategy and Commissioning Plan (draft Nov 18)
Learning Disability strategy (draft)
Mental Health Strategy for Scotland 2017-2027
Mental Health (Care and Treatment) Act 2003
"Every Life matters" Scotland's Suicide Prevention Action Plan 2017- 2022
The Keys to Life National Learning Disability Strategy
Scottish Strategy for Autism
Healthy Lifestyles
Physical Activity Strategy
The Active and Independent Living Programme in Scotland
Dundee Healthy Weight Framework (in development)
A Healthier future – Scotland's diet and healthy weight delivery plan
People with Care and Support Needs
National Clinical Strategy for Scotland
Health and Social Care Standards for Scotland
Adult Support and Protection (Scotland) Act 2007
Adults with Incapacity (Scotland) Act 2000
Free Personal Care for over 65s
See Hear strategic Framework for people with a sensory impairment in Scotland
Intermediate Care Framework for Scotland
Scotland's National Dementia Strategy
Reshaping Care for Older People
National Care Home Contract
Strategic and Commissioning Statement for Adults with a Physical Disability 2018-2021
Joint Sensory Services Strategy and Commissioning Plan
Overarching/ cross cutting
Improving Health and Wellbeing of People with Long Term conditions in Scotland – A National Action Plan
Commission on the Future Delivery of Public Services
Scottish Gov Guidance re Integration
Children and Young Peoples (Scotland) Act 2017
Healthcare Quality Strategy for Scotland
Public Bodies (Joint Working) (Scotland) Act 2014
Health and Social Care Delivery Plan
Transforming Public Protection Programme
Transforming NHS Tayside
Draft Parenting Strategy for Tayside
Tayside Plan for Children, Young People and Families 2017-2020
Prevention Framework
National Health and Well Being Outcomes
Workforce
Workforce and Organisational Development Strategy
Transforming Nursing, Midwifery and Health Professions' (NMaHP) Roles: pushing the boundaries to meet health and social care needs in Scotland
Social Services in Scotland: A Shared Vision 2015-2020
Primary Care
Tayside Primary Care Improvement Plan
Tayside Primary Care Improvement Plan
Delivering quality in Primary Care National Action Plan
Communities
Strategic Needs Assessment (version 2)
Locality Needs Assessments
Shaping the Adult Health and Social Care Market in Dundee
Locality Plans (to be developed)
Dundee City Plan 2017-2026
Dundee Community Safety Outcome Improvement Plan
Dundee Criminal Justice Outcome Improvement Plan
Fairness Commission
Local Community Plans
KEY:
National
Local
DHSCP led

8.2 National Context

At a national level, new ideas have emerged around the delivery of health and social care, with an intensifying focus on further shifting the balance of care from hospital to community based settings. This Plan responds to the changing national policy landscape, including the:

- Carers (Scotland) Act 2016, which places a range of duties on Integration Joint Boards to support unpaid carers, including developing a carers strategy and having clear eligibility criteria in place.
- **Free Personal Care for under 65s** extends free personal care to all under 65s who require it regardless of condition.
- General Medical Services (GMS) Contract in Scotland 2018 envisages a radical change and expansion within primary and community care across Scotland. The Contract acknowledges the need to shift the balance of work from GPs to multi-disciplinary teams.
- Health and Social Care Standards set out what people should expect when using health, social care or social work services in Scotland. For the Partnership, the standards mean a new framework for inspections will be progressively introduced for own services. We will work with our third and independent sector providers to evaluate contracted services against the new standards.
- Mental Health Strategy 2017-2027 ensures we respond to mental health problems with the same commitment as we do with physical health problems. Consistent with the national strategy, we are setting an ambitious set of priorities in our emerging strategic commissioning plan for mental health and wellbeing, focusing on prevention and early intervention and guided by the views of people living in Dundee who have experienced mental health challenges.
- Public Health Priorities for Scotland sets out a national approach to improving the health of the population, centred on six priorities - healthy communities; early years; mental wellbeing; use of alcohol, tobacco, drugs; a sustainable economy; and healthy eating and physical activity.

In addition, to these most recent, significant national developments, the Partnership has developed this Plan within the context of a wide range of other national policies, reviews and strategies produced since the development of our **Health and Social Care Strategic and Commissioning Plan 2016-2021**, including:-

- **Health and Social Care Delivery Plan**;
- **National Clinical Strategy for Scotland**;
- **National Health and Social Care Workforce Plan**;
- **Scotland's Digital Health and Care Strategy**;
- **Social Services in Scotland: A shared vision and strategy 2015-2020;** and
- **Strategic Framework for Action on Palliative and End of Life Care**.

8.3 Regional/Local Context

This Plan also aligns our new priorities with the developing Tayside public health strategy and several landmark regional and local plans, including:

- **City Plan for Dundee 2017-2026** - Dundee's City Plan identifies the biggest strategic priorities, opportunities and challenges ahead as the Community Planning Partnership improves the city over the next ten years. The City Plan strategic priorities are Fair Work and Enterprise; Children and Families; Health, Care and Wellbeing; Community Safety and Justice; and Building Strong and Empowered Communities. All of these priorities will complement this Plan in delivering a better future for Dundee citizens.
- **Dundee Community Justice Outcome Improvement Plan** – Sets out how we and our community justice partners will work together with communities to reduce re-offending through developing the community justice workforce and providing interventions at every stage of the community justice pathway (prevention, community alternatives, and support to those in custody and post custody support).
- **Fighting for Fairness** – This report, prepared for the Fairness Commission, sets out a series of recommendations to help Dundonians struggling with poverty. These recommendations have been collated under the themes of people and money, mental health and stigma.
- **Tayside Drug Death Annual Report** – sets out a series of recommendations to reduce drug deaths across Tayside;

- Tayside Plan for Children, Young People and Families **2017 – 2020** – Community Planning Partners in Angus, Dundee and Perth & Kinross have set out their vision for reducing inequalities and improving outcomes for all children in Tayside. This includes joint priorities to address the impact of substance misuse, mental health and obesity on the lives of children and to enhance parenting support.
- Tayside Primary Care Improvement Plan (PCIP) builds on the **General Medical Services (GMS) Contract in Scotland 2018**. Developed by the Partnership with Angus and Perth & Kinross partnerships and NHS Tayside, it will systematically reshape primary care services over the next three years to meet the needs of communities.
- **Transforming NHS Tayside Programme** - NHS Tayside is leading on a range of improvement projects including the development of an Integrated Clinical Strategy that will support NHS Tayside and Integration Joint Boards to develop new service models and pathways for the local population for the next five to 10 years.

We are closely aligning how we plan and deliver services across localities. Aligning services in this way helps support the requirements of other plans, particularly the **General Medical Service Contract** and PCIP, with the PCIP requiring a shift to allow GPs to fulfill their role as "expert medical generalists" at the heart of coordinating clinical care for patients. GPs will be leaders of multi-disciplinary teams delivering a range of services such as:

- Community mental health - delivered by nurses, occupational therapists
- Community treatment – delivered by nursing, healthcare assistants
- Pharmacotherapy services – delivered by pharmacists
- Physiotherapy
- Urgent care services - delivered by paramedics
- Vaccination services - delivered by nurses

This Plan is also influenced by a series of Partnership strategies, each of which respond in detail to different needs across the city. It is by planning and working together with council, NHS, third and independent sector organisations and people accessing services and their carers that we can make the positive changes that Dundee citizens need. These local strategies are led by Strategic Planning Groups, which comprise of people who use services, their carers and people delivering services.

The Partnership currently has the following Strategic Planning Groups:

- Alcohol and Drugs *
- Carers
- Community Rehabilitation and Independent Living
- Frailty
- Homelessness and Complex Needs
- Learning Disability and/or Autism
- Mental Health and Wellbeing
- Physical Disability
- Sensory Services
- Suicide Prevention *

* The Strategic Planning Groups for Alcohol and Drugs and for Suicide Prevention also form part of wider strategic planning arrangements for Public Protection.

Many of the Strategic Planning Groups have developed strategic plans since the first **Health and Social Care Strategic and Commissioning Plan 2016-2021** was developed. The following strategic plans have been approved by the IJB:

- **A Caring Dundee: A Strategic Plan for Supporting Carers in Dundee** – This plan focuses on the vision to create a '*Caring Dundee, in which all carers feel listened to, valued and supported so that they feel well and are able to live a life alongside caring*.' The plan identifies the actions required to achieve four outcomes for carers – '*I am identified, respected and involved; I have had a positive caring experience; I can live a fulfilled and healthy life; I can balance my life with the caring role*.'
- **Dundee Smart Health and Care Strategy** – This plan sets out the commitment to becoming a leader in the use of technology to improve the lives of people living in Dundee.
- **Joint Sensory Services Strategic and Commissioning Statement 2017-2020** – The statement provides the strategic direction for developing services and support for people with sensory requirements.
- **Not Just a Roof! Housing Options and Homelessness Strategic Plan 2016-2021** – This plan sets out how partners, including people with lived experience of homelessness, will work together to ensure that the people of Dundee live a fulfilled life in their own home or homely setting and are able to able to access quality information, advice and support if they do become homeless.

- **Strategic and Commissioning Statement for Adults with a Physical Disability 2018-2021** – This plan focuses on five key action areas to improve outcomes for people with physical disabilities in Dundee - improving health and social care support; having somewhere to live and the support to live there; learning and working , keeping safe and taking risks.
- **Substance Misuse Strategic Commissioning Plan for Dundee** - This plan proposes a focus on the prevention of substance misuse to achieve the vision that '*People in Dundee thrive within safe, nurturing and inclusive communities supported by effective alcohol and drug services that focus on prevention, protection, resilience and recovery*.'

In addition, strategies are currently in development for frailty, learning disability and autism, mental health and wellbeing, suicide prevention and humanitarian protection and active and independent living. These strategies are being developed with some consistent guiding themes that include a focus on mental health promotion, prevention and early intervention and person centred, strength based approaches to care and support services.

There are also other important documents that complement this plan, including:

- **Equality Outcomes and Mainstreaming Equalities Framework**, which describes the equality outcomes that have been developed for the Partnership, alongside a framework and reporting cycle for the review of the Partnership's progress in mainstreaming equalities.
- **Housing Contribution Statement** outlines the contribution of the local housing sector to achieving the outcomes identified in this Plan.
- **Strategic Needs Assessment (version 2)** describes the socio demographic characteristics of Dundee as well as levels and patterns of health and social care needs
- **Shaping the Adult Health and Social Care Market in Dundee (2017-2021)** represents a continuing dialogue between the Partnership, providers, people using services, carers and other stakeholders about the future shape of our local social care market and how, together, we can ensure this is responsive to the changing needs and aspirations of Dundee's citizens.
- **Workforce and Organisational Development Strategy** sets out how the Partnership recruits, develops and retains the right people, in the right place, at the right time to deliver positive outcomes for the people of Dundee.

9. Resources

9.1 Financial

Context

The 2016-2021 Strategic and Commissioning Plan was set within a context of an increasingly challenging financial time for the public sector. This was due to the UK Government's tight control over the nation's finances, increased demand and rising costs of service provision particularly health and social care services. Three years on, this position remains unchanged and with the impact of Brexit on the UK economy unclear, it is unlikely that this will change over the duration of this plan.

The delegated budget consists of financial resources provided by NHS Tayside and Dundee City Council. The financial position of both statutory partners has been well publicised in recent times with both organisations being required to make significant levels of efficiencies and savings to bring expenditure in line with available funding. The financial challenges facing these organisations therefore has a direct impact on the level of funding the IJB receives to plan and deliver effective integrated health and social care services.

However, this challenging financial environment also offers opportunities for us to work closely with our partners to deliver services more effectively. Although our finances have reduced, we still have a substantial budget of around £250m, which when used in combination with our skilled workforce and the resources our partners have at their disposal, we can confidently deliver the ambitions as set out in this Plan.

What We Have Done With Our Resources

Since the establishment of the Partnership in 2016, we have worked hard to make the best use of our resources and to effect change in the way services are delivered in line with our strategic priorities. Despite the national funding challenges, the Scottish Government has supported the integration of health and social care, mainly through "top slicing" NHS funding and directing it to partnerships. This is part of a key policy of shifting the balance of care from hospital or bed based care to more community based services.

We have used this funding to support testing different models of care, to recognise increased demand for services, to implement key policies such as ensuring the payment of the living wage for all adult social care workers, to support social care pressures and to fund new legislation such as the Carers Act, and from April 2019, Free Personal Care for Under 65s.

It is by investing in tests of change, that we have been able to develop a multi-professional model of care within the community (the Enhanced Community Support model) and start to shift resources locked in hospital beds to support the roll out of this model across the city.

We have also invested over £1.1m to increase the number of social care at home hours provided by the third and independent sectors. This increases community capacity and supports people returning home from hospital thereby shifting the balance of care from hospital to community and reducing the number of people unduly delayed.

However, although our resources are substantial, they remain under considerable pressure when offset by demand and cost of services. Much of our activity is currently underpinned by non-recurring funding, this includes the use of reserves built up in previous years. This position has been highlighted by Audit Scotland who stated their concerns about the financial sustainability of the Partnership within the 2017/18 Annual Report.

Three Year Financial Framework

In recognition of the financial challenges we face we have developed a Transformation Programme, this acts as an over-arching programme of activity, which is key to ensuring that we can be financially sustainable in the long term. The Programme includes consideration of how we bring more services together in our main service areas, and how we explore ways of doing things differently to provide better outcomes for those in need within the city.

The estimated scale of transformation and efficiency savings required will be set out as part of the Three Year Financial Framework and will be detailed in the table below (to be completed). This framework sets out the estimated resources the IJB is likely to have over the next three financial years set against anticipated increases in expenditure due to increases in demand and cost of providing services (e.g. pay inflation) – and resultant gap between funding and service provision.

	2019/20 (Year 1) £000	2020/21 (Year 2) £000	2021/22 (Year 3) £000
Base Budget	tbc	tbc	tbc
Estimated Additional Costs	tbc	tbc	tbc
Estimated Budget Requirement	tbc	tbc	tbc
Estimated Funding Provided	tbc	tbc	tbc
Transformation Required	tbc	tbc	tbc

These will be completed once final delegated budgets are confirmed by Dundee City Council and NHS Tayside

Note: These figures are subject to change throughout the lifetime of the plan as assumptions become reality.

The Scottish Government continues to support the integration of health and social care through the latest Scottish Budget, with the announcement of a further transfer of funding from the NHS budget to Partnerships via local authorities. This consists of £160m in 2019/20, year 1 of this plan. This is required to cover the cost of the implementation of Free Personal Care for Under 65s, the costs associated with the second year of the Carers Act, an increase in the living wage, and other cost pressures within the sector including demographic demand. This is in addition to other specific additional funding for areas delegated to IJB's such as Primary Care Improvement Funding and Mental Health Funding which provide significant opportunities to enhance community based health and social care services.

The estimated additional funding for 2019/20 for Dundee IJB for these areas are:

Funding Stream	Estimated Dundee Allocation (£000)
Carers Act – Stage 2	301
Free Personal Care for Under 65s	888
Investment in Community Health and Social Care	3,252
Primary Care Improvement Funding	275
Mental Health Action 15 Funding	178
Total Additional Funding	4,894

It is not anticipated that support for investment in community based health and social care will come solely from additional Scottish Government funding. The legislation underpinning integrated health and social care services makes provision for partnerships to influence the size and shape of some elements of acute sector hospital based services, and enables the transfer of funding from that sector to the community. This is called the Large Hospital Set Aside and is largely based on the cost of unplanned admissions to hospital.

By planning across the whole unplanned care pathway with the health board and the council we can make this pathway more effective. We can influence this by ensuring community based services are effective in preventing people being admitted to hospital in an unscheduled way. It is by reducing unscheduled admissions and having a safe and supportive environment for people to go home to that people are discharged more quickly from hospital. This should reduce the number of hospital beds required and release savings which can be used to reinvest in the community services.

The Scottish Government states that there should be a focus on this activity over the coming period and that they will work with partnerships, health boards and councils to support change in this area. The number of days Dundee citizens spend in hospital as a result of an emergency has fallen significantly from 120,989 in 2016 to around 103,000 in 2018. We expect this number to fall further throughout 2019/20 to around 97,000. While there is still much to do, this shows that the work we've done to date can make a significant difference

9.2 Workforce

We have developed a Workforce and Organisational Development Strategy to ensure that the Partnership recruits, develops and retains the right people, in the right place, at the right time to deliver positive outcomes for the people of Dundee. This strategy covers all staff within those service areas as detailed within the Integration Scheme. This includes staff employed by NHS Tayside, Dundee City Council, third and independent sectors, volunteers, peer mentors and unpaid carers. The Partnership acknowledges that the vision and priorities within the Plan will ultimately be realised by the actions and behaviours of our integrated workforce.

The strategy will:

- provide a framework for a positive and enabling organisational culture;
- give clarity of direction to our workforce working in health and social care services;
- ensure that the priorities for our workforce are aligned with the priorities of our citizens and the priorities set out by the Integration Joint Board and our change programmes;
- support leadership at all levels to give clear direction to employees and the success of integrated services; and
- deliver a framework for continuous professional development.

We recognise the distinct perspective each individual brings to their role and value the contribution they make to the health and well-being of the people of Dundee. Understanding of both the similarities and differences of the integrated workforce is key to the successful implementation of our strategy.
The strategy details how we will support and develop our whole workforce to work in a co-productive, engaged, flexible way to improve the outcomes for the citizens of Dundee.

9.3 Information Technology

Using Information Technology (IT) to its full potential is essential if our workforce is to operate efficiently, flexibly and securely. In a sustained period of financial constraint and increasing demand for more individualised services, access to effective, innovative IT and real time information has never been more pronounced.
As the Partnership is provided with IT support services by Dundee City Council and NHS Tayside, it is critical that all partners continue to work together to meet the specific IT needs of the integrated health and social care workforce.
Working with our partners, our IT priorities over the next three years include:

- the implementation of modern, secure, compatible, email systems;
- the introduction of secure interfaces between recording systems to allow for streamlined systems, improved access to information and reduced duplication of data entry; and
- supporting our workforce with technology for mobile working.

Delivering on these priorities will not only drive efficiencies for our workforce, but importantly will deliver a more personalised, local experience for people using our services. We will also continue to build on recent innovations such as Attend Anywhere, which allows online outpatient clinics for up to six people in online meeting rooms. This means saved travel time for health professionals and patients.

9.4 Property

The Partnership delivers a range of services from properties across Dundee. This includes office accommodation, hospital based services, commissioned services provided by third or independent sector providers and residential or day services. Property is a critical component of our ability to deliver services within environments that are modern, compliant, functionally suitable, and sustainable and, where applicable – close to the localities where people live.

As decision making with regards to purchase, rental, decommissioning and capital investment rests with Dundee City Council and NHS Tayside Health Board, we will continue to work closely with our partners to ensure we strengthen our integrated approach to property so that it supports delivery of this Plan.

The Partnership's key objectives for developing property to support our Vision are:

- to rationalise our centralised office based property footprint through better use of flexible working arrangements and information technology. This will include supporting Dundee City Council and NHS Tayside to deliver their property rationalisation plans and managing the property implications of our Reshaping Non-Acute Care Programme.
- to shift the balance of service delivery from large centralised, office based accommodation to more shared, localised accommodation. This will include considering how we move towards a property estate that supports general practice and wider community based teams, in the right locations. This may mean fewer practice buildings, with practices co located with the teams that support them as part of an integrated approach to service delivery.

- to continue to develop a range of accommodation for individuals with health and social care needs. Priorities within this include taking account of those people transitioning from young adult services to adult services, those people currently placed outwith the city in specialist services, and those people currently or likely to stay in hospital unless individually designed accommodation and support is available.
- to enhance the provision of health and social care services in local communities in order that the Partnership makes better use of all available accommodation across the city. This approach will support enhanced local delivery of services, more integrated ways of working and help to shift the balance of care towards community settings.

Additional detail on these objectives can be found in our Property Strategy 2019-2021.

10. What Success Looks Like

We believe that if we have achieved the Vision set out in this plan that:

- communities and individuals will thrive in the areas they live in;
- the need for the intervention of services will have reduced and there will be a greater role for community based supports;
- the health and social care inequality gap will have reduced for both people living in deprivation and who are part of protected equality groups;
- fewer people will access hospital acute services and more resources will have been released to support enhanced provision of community care responses;
- citizens will be receiving the support they want, in the locations they want, at the time they need it from a workforce that is actively working together across the health and social care system;
- more people will be taking greater control of their lives and feel more motivated to make lifestyle choices that will positively enhance their health and wellbeing; and
- citizens will be protected from harm and are supported to recover from the impact of trauma.

As a Partnership we will continue to monitor and report our progress in these areas through the range of performance reporting and quality assurance activities that we have developed over the last three years. However, we know that we must now have a clearer focus on understanding what success looks like from a citizen perspective and co-producing with communities approaches to measuring our progress against this. Whilst we will continue to report publicly against the National Health and Wellbeing Indicators, we are committed to further developing approaches that focus on health and social care outcomes at a locality and neighbourhood level.

The Dundee Strategic and Commissioning Plan
and associated documents were produced,
on behalf of the Dundee Integration Joint Board,
in partnership with a wide range of stakeholders
and was overseen by the Integrated Strategic Planning Group.

Get in touch:

If you have any questions about the information contained in this document, please email:

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Dundee
Health & Social Care
Partnership

ITEM No …8……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 26 FEBRUARY 2019**

REPORT ON: **MEASURING PERFORMANCE UNDER INTEGRATION 2019/20 SUBMISSION**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB6-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to seek approval of the 2019/20 submission to be made by the Integration Joint Board to the Ministerial Strategic Group for Health and Community Care (MSG) as part of the Measuring Performance under Integration work stream.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the summary table of targets under each service delivery area (Appendix 1).

2.2 Notes the methodology used to develop proposed targets for submission to the Ministerial Strategic Group (sections 4.2.1 and Appendix 2).

2.3 Approves the 2019/20 for submission to the MSG by 28 February 2019 (Appendix 3).

2.4 Notes that 2019/20 targets will remain in draft until such times as the Integration Joint Board budget for 2019/20 has been confirmed (section 4.2.2).

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Previous Measuring Performance under Integration Submissions

4.1.1 In mid-January 2017 the Scottish Government and COSLA, on behalf of the MSG, wrote to all Health and Social Care Partnerships to invite them to set out local objectives, trajectories and performance targets for 2017/18 under the following six key service delivery areas:

- Unplanned admissions;
- Occupied bed days for unscheduled care;
- A&E performance;
- Delayed discharges;
- End of Life care: and,
- The balance of spend across institutional and community services.

4.1.2 In February 2017 the Dundee Partnership provided an initial response to the Scottish Government for consideration by the MSG, setting out targets in each service delivery area for 2017/18. AT this time the Scottish Government asked that targets be submitted for indicators across all age groups. Article X of the minute of the meeting of the Integration Joint Board held on 28 February 2017 provides detailed information regarding the request and response submitted. The submission from Dundee was identified by MSG as a particularly high quality submission.

4.1.3 In January 2018 a further submission was made to the Scottish Government setting targets in the six service delivery areas for 2018/19. At this time the Scottish Government amended its approach to allow Partnerships to submit targets for indicators for the 18+ age group only if the Partnership has not been delegated responsibility for children's services functions. Article XII of the minute of the meeting of the Integration Joint Board held on 27 February 2018 provides detailed information regarding the request and response submitted.

4.1.4 Since 2017/18 the Scottish Government, via National Services Scotland Information Service Division, has provided a quarterly Measuring Performance under Integration dataset to all Partnerships for each of the indicators within the MSG submission for which data is available. To date information has been provided up to October 2018.

4.1.5 At a local level performance against targets set out in the 2018/19 submission has been reported as part of the regular Quarterly Performance Reports submitted to the Performance and Audit Committee (PAC). The most recent of these, Report PAC2-2019 presented to the February 2019 PAC meeting (Article V of the minute of the PAC meeting held on 12 February 2019 refers) includes the position in Dundee at end of quarter 2 2018/19. . In summary, there has been positive performance against 2018/19 interim targets; three areas have exceeded interim targets for the period (unplanned admissions, occupied bed days for unscheduled care and delayed discharges) and A&E performance partially met the interim target. For two areas (end of life care and the balance of spend) data is not available monthly or quarterly to allow for performance monitoring due to time lags associated with the production and provision of datasets to National Services Scotland, Information Services Division from external sources. Emergency admissions as a rate of A&E attendances have consistently not met the interim target.

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4.2 Measuring Performance under Integration – 2019/20 Request and Submission

4.2.1 As in previous years the Health and Community Care Operational Management Team have been closely supported by the Strategy and Performance Team to develop targets for each service areas for the 2019/20 submission. The following information was utilised in preparation of the current submission (see appendices 1 and 2):

- 15/16 baseline data;
- 15/16 based projections for 17/18 and 18/19 and 19/20;
- Trajectories / targets previously submitted in the February 2017 and January 2018;
- Actual data from 1 April 18 – 31 October 18 and estimated data from 1 November 18 – 31 March 19 to estimate the 18/19 position; and
- 19/20 trajectories / targets based on the 18/19 estimated position (at city wide and, for some indicators, LCPP level.

Where special cause variation, for example improvement work to reduce delayed discharges, caused extraordinary data results, subsequent year targets were adjusted so that the same rate of increase or decrease was not expected in subsequent years. 19/20 targets for delayed discharge were adjusted for these reasons.

Appendix 3 contains the template provided by the Scottish Government. This has been completed and will form the entire Dundee submission.

4.2.2 A submission will be made to the Scottish Government to meet the 28 February 2019 deadline following consideration at the IJB. At this time it will be highlighted that the targets contained within the submission for 2019/20 cannot be confirmed until such times as the 2019/20 IJB budget has been finalised and an assessment made of the adequacy of resources to deliver planned improvement actions factored into the calculation of targets.

4.2.3 Performance against targets (for both 2018/19 and 2019/20) will continue to be reported as part of the quarterly performance reports submitted to the Performance and Audit Committee.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Integrated Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	The risk of not meeting targets against Measuring Performance under Integration service areas could affect; outcomes for individuals and their carers, and spend associated with poor performance.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (Extreme Risk)
Mitigating Actions (including timescales and resources)	- Continue to develop a reporting framework which identifies performance against Measuring Performance under Integration targets. - Continue to report data quarterly to the PAC to highlight areas of poor performance. - Continue to support operational managers by providing in depth analysis regarding areas of poor performance, such as complex delayed discharges. - Continue to ensure that data informs operational practices and improvements and also that operational activities and priorities are used to interpret trends shown by the data.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (High Risk)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (Moderate Risk)
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable.

7.0 CONSULTATIONS

The Performance and Audit Committee, Chief Finance Officer, Head of Service, Health and Community Care, and the Clerk have been consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Directions Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 11 February 2019

Kathryn Sharp
Senior Manager, Strategy and Performance

Appendix 1

			15/16 baseline	17/18 Projection (15/16 based)	17/18 Trajectory agreed Feb 17	17/18 Actual and Estimated	18/19 Trajectory agreed Jan 18	18/19 Actual and Estimated	19/20 Proposed Trajectory Jan 19	%Change (15/16 baseline to 19/20 trajectory)
Unplanned admissions										
1.	Number of emergency admissions	submitted	14,125	15,168	15,153	15,122	15,464	15,225	15,225	7.8%
2.	Number of emergency admissions from A+E	submitted	6,483	7,345	6,797	7,616	7,616	7,440	7,440	14.8%
3.	A+E conversion rate (%)	to be developed								
Occupied bed days for unscheduled care										
4.	Number of emergency bed days	submitted	120,989	115,305	114,132	111,893	108,129	102,844	96,674	-20.6%
5.	Number of emergency bed days; geriatric long stay	to be developed								
6.	Number of emergency bed days; mental health specialities	to be developed								
A+E Performance										
7.	Number of A+E attendances	submitted	23,437	23,336	22,686	26,562	26,562	24,680	24,680	5.3%
8.	A+E % seen within 4 hours	to be developed								

			15/16 baseline	17/18 Projection (15/16 based)	17/18 Trajectory agreed Feb 17	17/18 Actual and Estimated	18/19 Trajectory agreed Jan 18	18/19 Actual and Estimated	19/20 Trajectory Jan 18	% Change (15/16 baseline to 19/20 trajectory
Delayed Discharges										
9.	Number of bed days lost – standard and code 9	submitted	15,050	14,502	14,042	12,480	11,856	7,860	6,105	-59.4%
10.	Number of bed days lost – code 9	Not submitted	6,668	7,740	7,740	6,273	6,461	5,046	3,785	-43.2%
11.	Number of bed days lost – Health and Social Care Reasons	No data provided from ISD								
12.	Number of bed days lost – Patients/Carer/Family related reasons	No data provided from ISD							2,320	
End of Life Care (*based on 16/17 deaths but will change in 17/18 and 18/19 as % proportions are applied to the total number of deaths in each year)										
13.	% of last 6 months of life in community	submitted	86.9%		88%		89%		+2%	88.9%
14.	% of last 6 months of life in hospice / palliative care unit	submitted	1.4%		2%		3%		-5.0%	
15.	% of last 6 months of life in community hospital	Not applicable								
16.	% of last 6 months of life in large hospital	submitted	11.7%		10%		8%		-4.0%	
17.	Number of days of last 6 months of life in community	submitted	252,351		252,275*		255,143*		n/a as no. of deaths each year varies	
18.	Number of days of last 6 months of life in hospice / palliative care unit	submitted	3,965		5,733*		8,600*		n/a as no. of deaths each year varies	
19.	Number of days of last 6 months of life in community hospital	not applicable								
20.	Number of days of last 6 months of life in large hospital	submitted	34,042		28,668*		22,934*		n/a as no. of deaths each year varies	

			15/16 baseline	17/18 Projection (15/16 based)	17/18 Trajectory agreed Feb 17	17/18 Actual and Estimated	18/19 Trajectory agreed Jan 18	18/19 Actual and Estimated	19/20 Trajectory Jan 18	% Change (15/16 baseline to 19/20 trajectory
Balance of Care										
21.	**% of population living at home (unsupported) – All ages**	**submitted**	**97.7%**		**2**					
22.	**% of population living at home (supported) – All ages**	**submitted**	**1.3%**		**1.5%**					
23.	**% of population living in a care home – All ages**	**submitted**	**0.7%**		**0.5%**					
24.	**% of population living in hospice / palliative care unit – All ages**	**to be developed**								
25.	**% of population living in community hospital – All ages**	**submitted**	**0%**		**0%**					
26.	**% of population living in large hospital – All ages**	**submitted**	**0.4%**		**0.4%**					
27.	**% of population living at home (unsupported) – 75+**	**submitted**	**79.8%**		**80%**					
28.	**% of population living at home (supported) – 75+**	**submitted**	**11.3%**		**11.6%**					
29.	**% of population living in a care home – 75+**	**submitted**	**6.8%**		**6.7%**					
30.	**% of population living in hospice / palliative care unit – 75+**	**to be developed**								
31.	**% of population living in community hospital – 75+**	**submitted**	**0%**		**0%**					
32.	**% of population living in large hospital – 75+**	**submitted**	**2%**		**1.7%**					

Appendix 2

Measuring Performance Under Integration

Charts and Methodologies

2019/20

Introduction

This report provides key information to assist with the interpretation of the Dundee submission to the Ministerial Strategic Group regarding 'Measuring Performance under Integration'.

Under each of the six high level service delivery areas are charts which illustrate:

- 'Projected Actual' for 2018/19 is a combination of actual data (up to August 2018) taken from ISD's MSG Integration Integrators Report and estimated data (September 2018 to March 2019) taken from ARIMA modelling. (Data points on charts).

- 'Projected Actual' for 2019/20 – this is calculated in January 2019 using an autoregressive integrated moving average (ARIMA) model based on historical data between November 2014 and August 2018[1]. Historical seasonal variation and overall trends are taken into account when modelling projections. Projections for 2019/20 assume that services will continue as they did in 2018/19, including sustaining the same rate of improvement, and that no further changes which either accelerate or decelerate the rate of improvement will be made – this helps the partnership to set their trajectories by estimating what impact changes to services will make on the projections. (Blue data points on charts).

- '2018/19 Trajectory' is the trajectory submitted in January 2018 for 2018/19 which is the projection plus / minus the target applied to each year. This illustrates the improvement or deterioration which was envisaged from 2015/16 onwards. (Red line on charts).

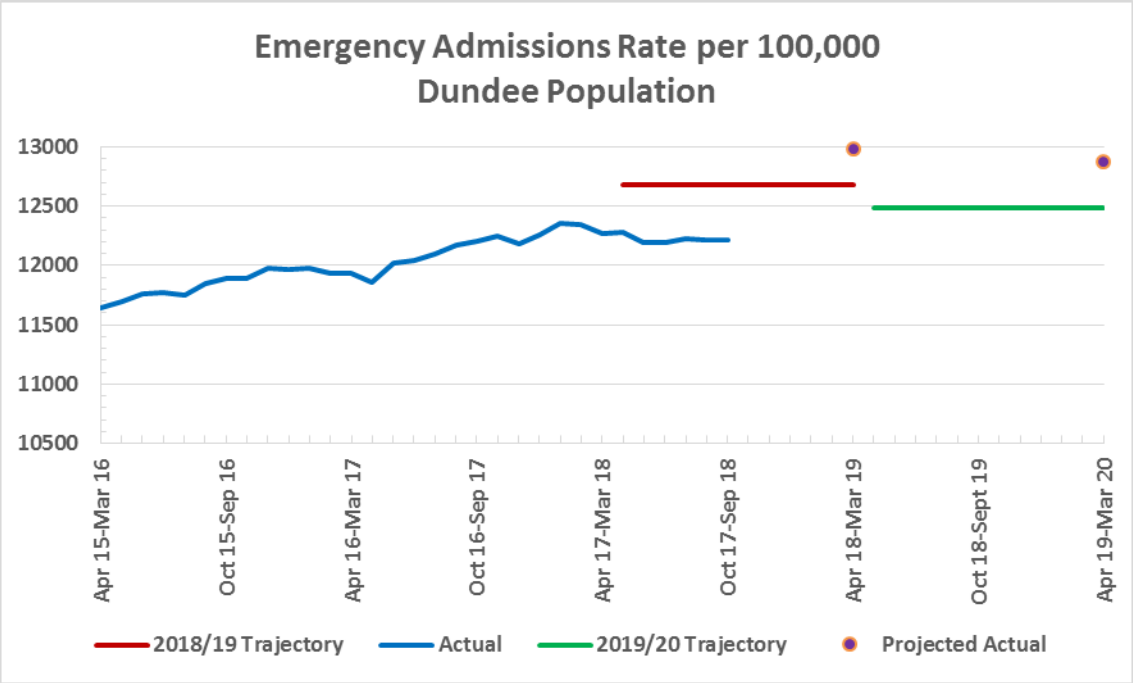
- '2019/20 Trajectory' is the trajectory proposed in January 2019 for 2019/20. Both the 'Projected Actual' for 2018/19 and 2019/20 are used as a baseline to help determine the '2019/20 Trajectory' figure. (Green line on charts).

- 'Actual' shows the actual performance of the Partnership up until September 17 to August 18. (Blue line on charts).

[1] Please note the projections for end of life care are not calculated using the ARIMA model, but instead are based on linear regression using historical annual data. In addition, projections produced through the ARIMA model for delayed discharge have been adjusted to take account of special cause variation associated with steep improvement gradients experienced over the last 3 years.

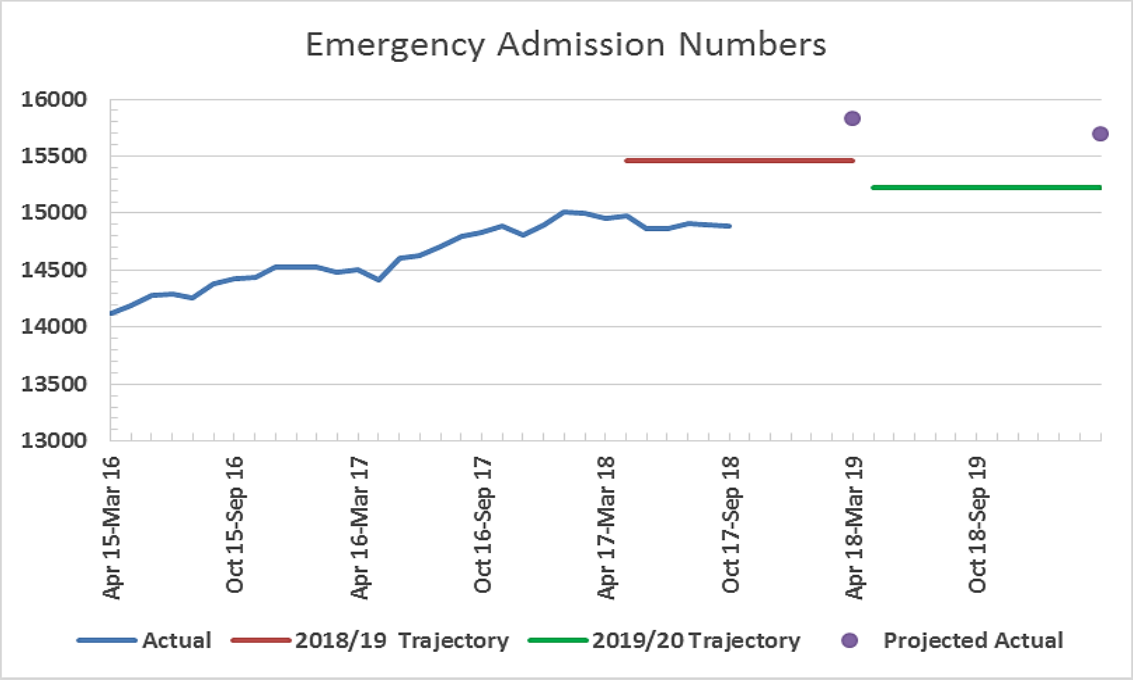
Emergency Admissions

Management Information - Chart 1: Emergency Admissions as a Rate per 100,000 Population in Dundee 18+



Source: ISD LIST management information (not official statistics)

Management Information - Chart 2: Emergency Admission Numbers 18+



Source: ISD LIST management information (not official statistics)

What is the data telling us?

For Emergency Admission Numbers:

- 18/19 estimated and actual performance (15,225) is better than the projection for 18/19 (15,827) and the 18/19 trajectory (15,464) set in January 18.
- Emergency admission numbers were projected to increase in 18/19 to 15,827 from the actual 2017/18 total (14,950) and the trajectory set in January 18 for 18/19 was for emergency admissions to increase slightly less than the projection (15,464).
- The actual and estimated data for 18/19 shows that Dundee is likely to perform better than predicted and there will be approximately 15,225 emergency admissions. This is a further improvement of 239 emergency admissions compared with the 18/19 trajectory set in January 18.

The 19/20 target

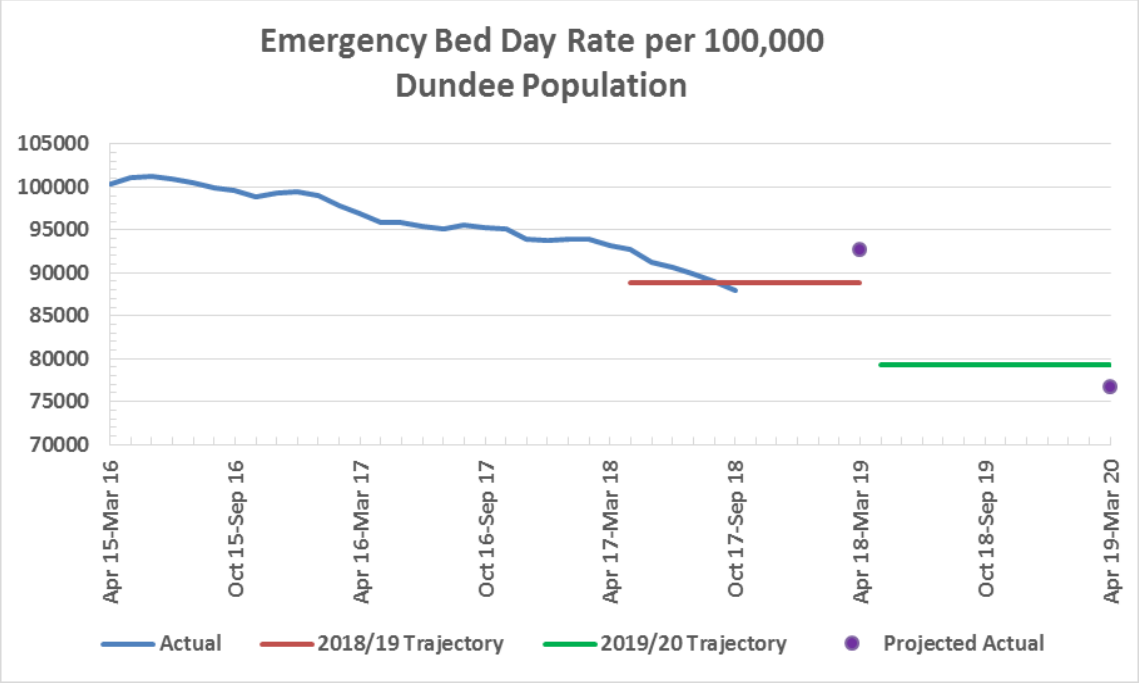
- The 19/20 target number of emergency admissions is 15,225. This is 3.0 % lower than the projected 19/20 number (15,695). This equates to a decrease of 470 in the number of emergency admissions.
- The 19/20 target is to maintain the number of emergency admissions at the 2018/19 actual and estimated figure (15,225).

How will trajectories agreed in Jan 19 for 19/20 be achieved?

- Roll out development of Enhanced Community Support, including acute.
- Implement 7 day targeted working (EA5-USC).
- Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.
- Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.
- Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.
- Transformation of work with primary care and the implementation of the new GP contract.
- Development of locality based out- patient clinics.
- Progression of Reshaping Non-acute Care Redesign Programme.
- Implement Home and Hospital Discharge Plan.
- Implement Tayside Unscheduled Care Improvement Plan.
- Implement Tayside Winter Pressures Plan.

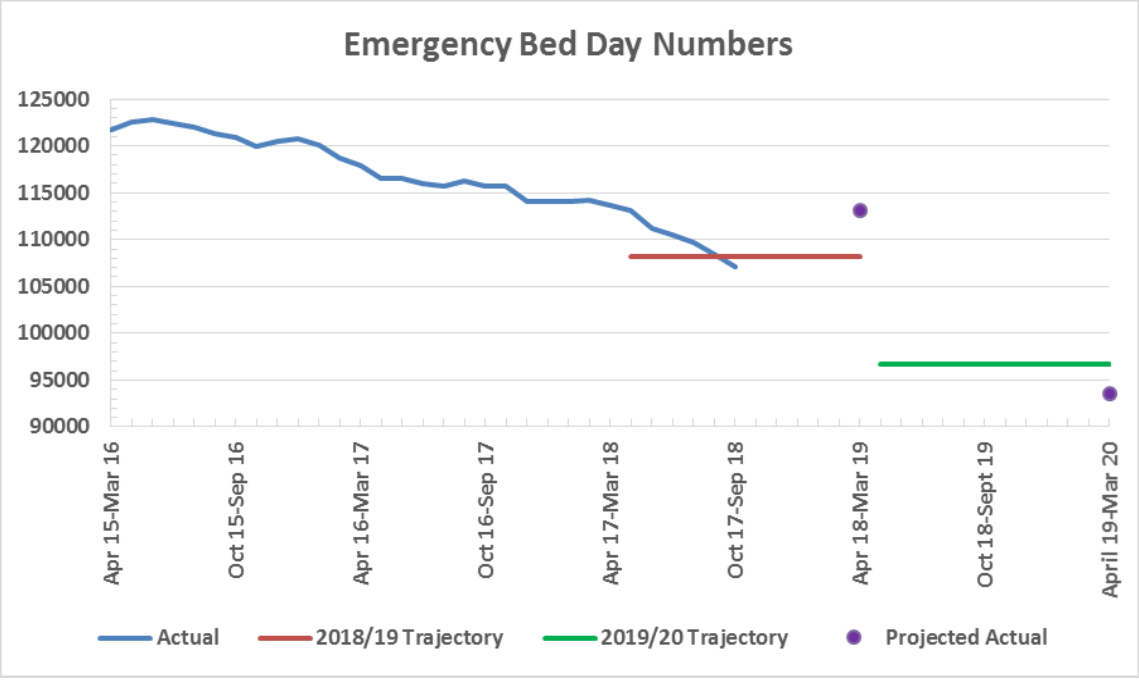
Emergency Bed Days

Management Information - Chart 3: Emergency Bed Days in Acute specialties as a Rate per 100,000 Population in Dundee 18+



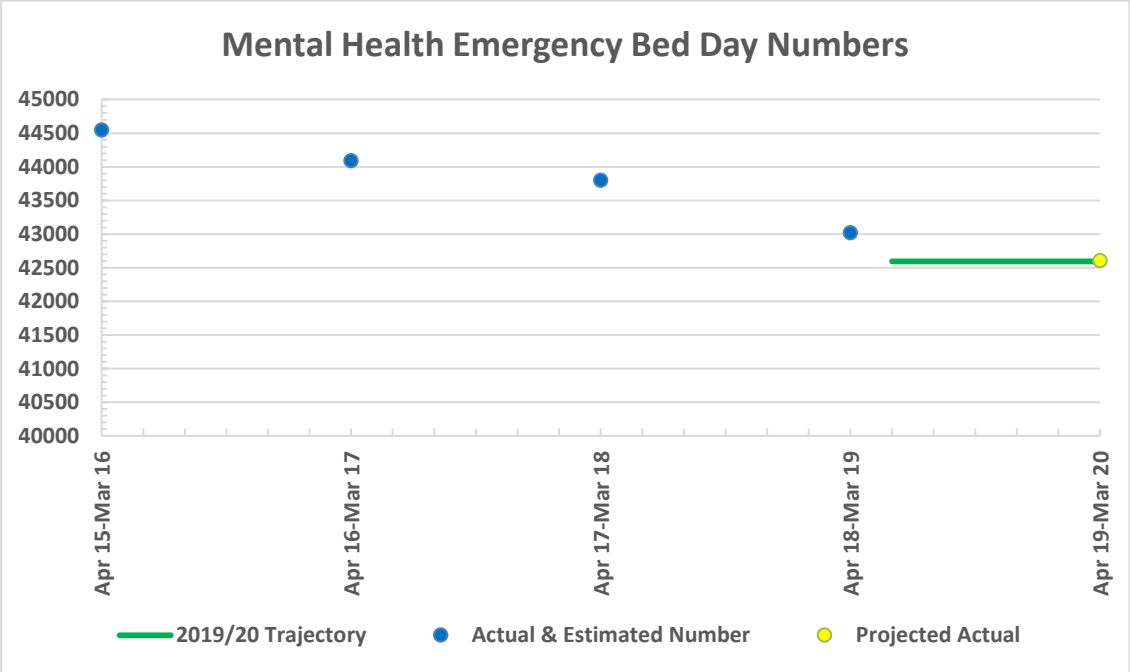
Source: ISD LIST management information (not official statistics)

Management Information - Chart 4: Emergency Bed Day Numbers in Acute specialties 18+



Source: ISD LIST management information (not official statistics)

Management Information - Chart 5: Mental Health Emergency Bed Day Numbers 18+



Source: ISD LIST management information (not official statistics)

What is the data telling us?

For Emergency Bed Day Numbers in Acute specialties:

- 18/19 estimated and actual performance (102,844) is better than the projection for 18/19 (113,085) and the 18/19 trajectory (108,129) set in January 18.
- Emergency bed day numbers were projected to decrease in 18/19 to 113,085 and the trajectory set in January 18 for 18/19 was for emergency bed day numbers to decrease further than the projection (108,129).
- The actual and estimated data for 18/19 shows that Dundee is likely to perform even better and there will be approximately 102,844 emergency bed days. This is a further improvement of 5,285 bed days compared with the 18/19 trajectory set in January 18.

For Mental Health Emergency Bed Day Numbers:

- There was no trajectory set in January 18 for 18/19.
- The actual and estimated number of bed days has been decreasing year on year since 15/16, and is projected to decrease again by 1% during 19/20 to 42,611 from the actual and estimated number for 18/19 (43,025).

The 19/20 target

For Emergency Bed Day Numbers in Acute specialties:

- The 19/20 target number of emergency bed days is 96,674 for Acute specialties. This is 3.3% higher than the projected 19/20 number (93,593). This equates to an increase of 3,081 in the number of emergency bed days.
- The 19/20 target is to reduce emergency bed days from the 18/19 actual and estimated number (102,844) by 6 % to 96,674 emergency bed days.

For Mental Health Emergency Bed Day Numbers:

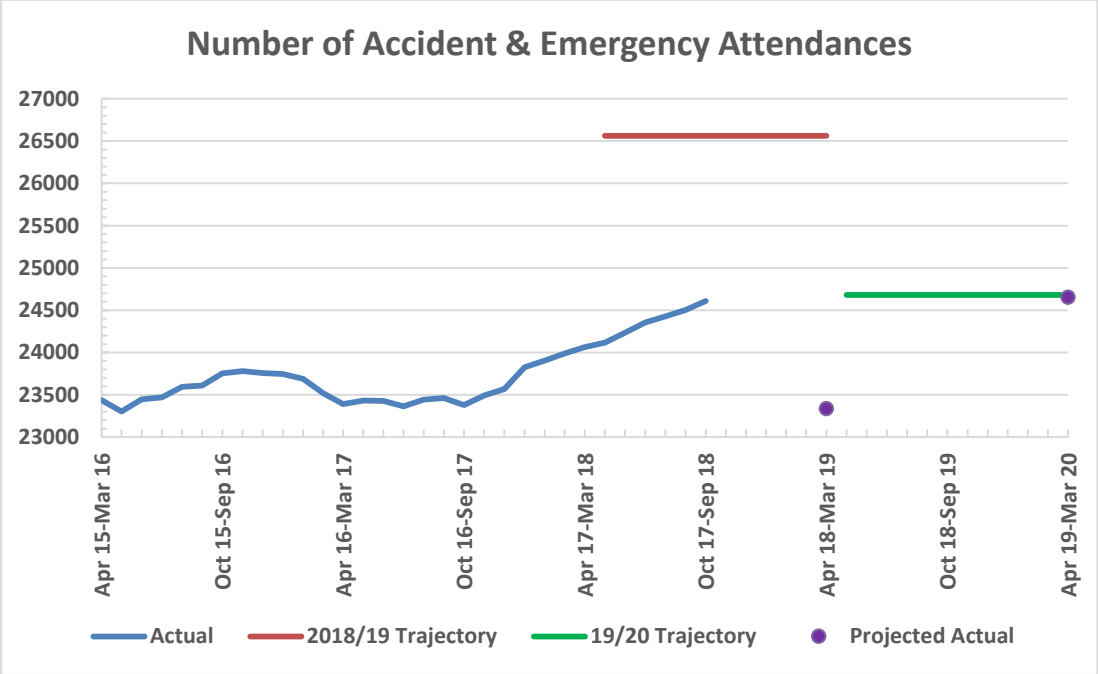
- The 19/20 target number of emergency bed days is 42,595 for Mental Health specialties. This is slightly lower than the projected 19/20 number (42,611).
- The 19/20 target is to reduce emergency bed days from the 18/19 actual and estimated number (43,025) by 1 % to 42,595 emergency bed days.

How will trajectories agreed in Jan 19 for 19/20 be achieved?

- Continue to review in patient models in line with community change.
- Further implement planned date of discharge model.
- Further develop discharge planning arrangements for adults with a learning disability and / or autism, mental ill-health, physical disability and acquired brain injury.
- Increase investment in intermediate forms of care.
- Co-locate the Learning Disability Acute Liaison Service within the Hospital Discharge Team base at Ninewells Hospital.
- Further develop resources which support assessment for 24 hour care taking place at home or home like settings.
- Implement a pathway for people with substance misuse problems and who have multiple morbidities.
- Hold Power of Attorney local campaigns.
- Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.
- Integrated pathways are being developed across care home teams, ortho-geriatrics and older people psychiatry.
- Remodel AHP services within acute settings to improve pathways.
- Further remodel integrated discharge hubs which will improve joint working arrangements.
- Progression of Reshaping Non-acute Care Redesign Programme.
- Implement Home and Hospital Discharge Plan.
- Implement Tayside Unscheduled Care Improvement Plan.
- Implement Tayside Winter Pressures Plan.

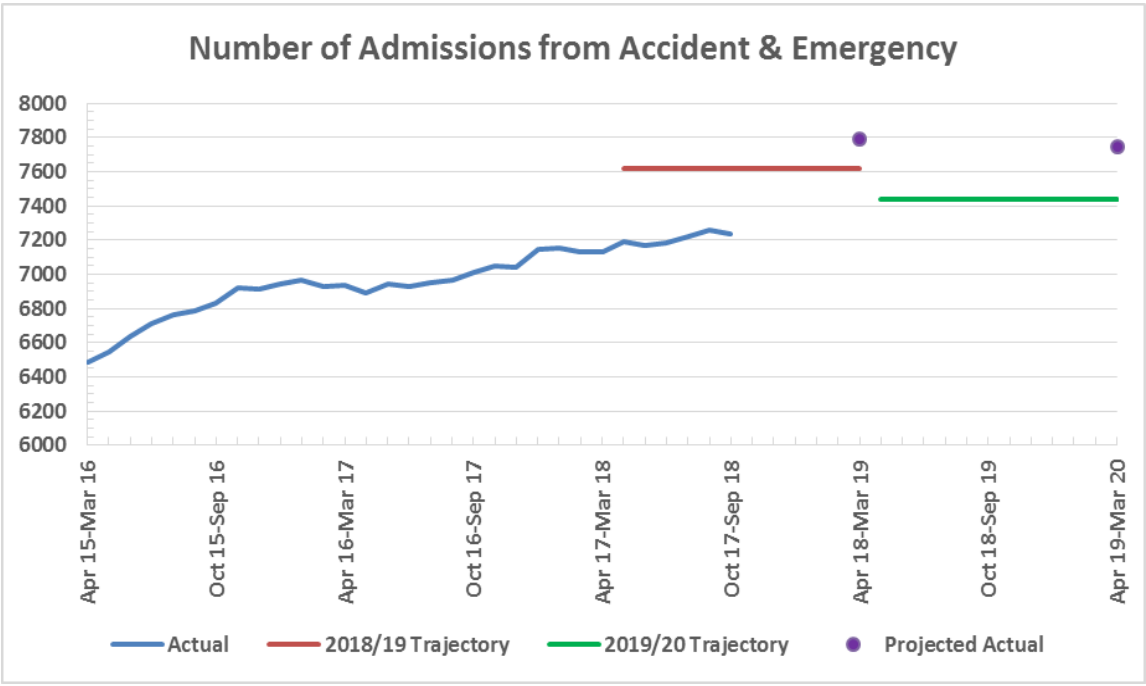
Accident & Emergency

Management Information - Chart 6: Number of Attendances at A+E



Source: ISD LIST management information (not official statistics)

Management Information - Chart 7: Number of 18+ Admissions from A+E



Source: ISD LIST management information (not official statistics)

What is the data telling us?

For Accident & Emergency Attendances:

- 18/19 estimated and actual performance (24,680) is poorer than the projection for 18/19 (23,336) but better than the 18/19 trajectory (26,562) set in January 18.
- Accident & Emergency attendances were projected to decrease in 18/19 to 23,336 from the actual 2017/18 total (24,063) and the trajectory set in January 18 for 18/19 (26,562) was for A&E attendances to increase more than the projection (23,336).
- Note: the 18/19 projection was for there to be zero change from 17/18 and because the number of A&E attendances in 17/18 was higher than predicted due to the flu epidemics and falls caused by adverse weather, this meant that the 2018/19 trajectory set in January 2018 was set higher than otherwise may have been expected.

For Admissions from A&E:

- 18/19 estimated and actual performance (7,440) is better than the projection for 18/19 (7,792) and would indicate an improvement of 176 admissions on the 18/19 trajectory (7,616) set in January 18.
- Admissions from Accident & Emergency were projected to increase in 18/19 to 7,792 from the actual 2017/18 total (7,131) and the trajectory set in January 18 for 18/19 (7,616) was for A&E admissions to be less than the projection (7,792).

The 19/20 target

For Accident & Emergency Attendances:

- The 19/20 target for A&E Attendances is 24,680. This is 0.1% higher than the projected 19/20 number (24,656). This equates to an increase of 24 in the number of A&E attendances.
- The 19/20 target is to maintain the number of A&E attendances at the 2018/19 actual and estimated figure (24,680).

For Admissions from A&E:

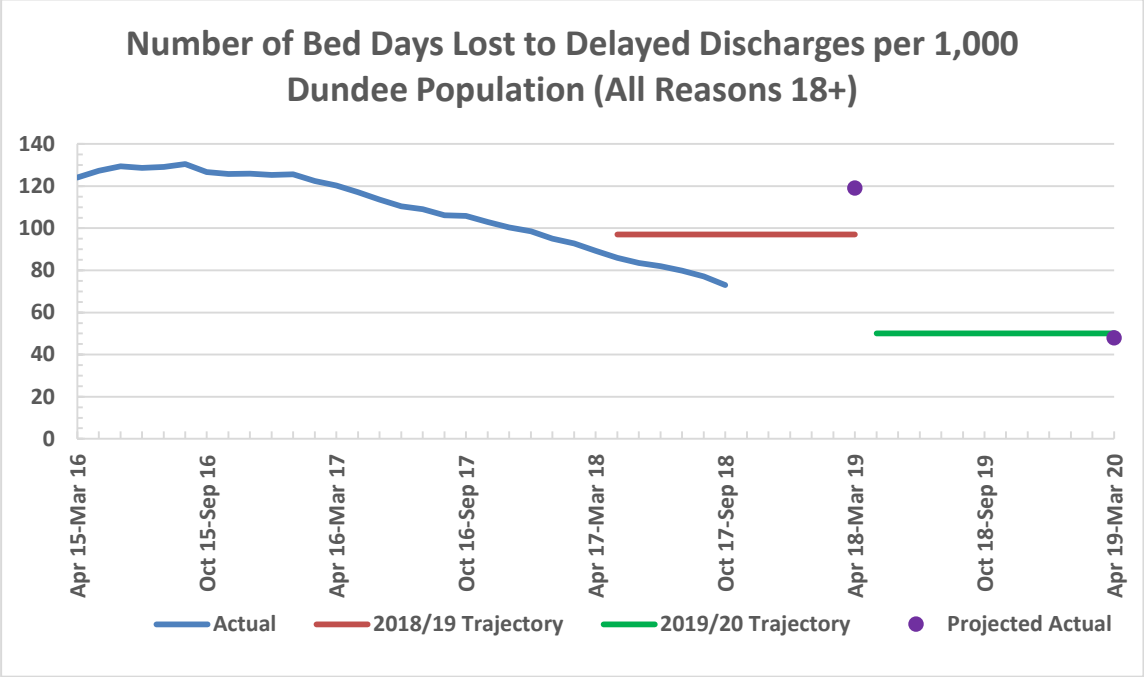
- The 19/20 target for Admissions from A&E is 7,440. This is 3.9% lower than the projected 19/20 number (7,743). This equates to a decrease of 303 in the number of admissions from A&E.
- The 19/20 target is to maintain the number of admissions from A&E at the 2018/19 actual and estimated figure (7,440).

How will trajectories agreed in Jan 19 for 19/20 be achieved?

- Further development of Enhanced Community Support, including acute.
- Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.
- Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.
- Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.
- Implement a pathway for people with substance misuse problems and who have multiple morbidities.
- Transformation of work with primary care and the implementation of the new GP contract.
- Remodelling of polypharmacy.
- Further remodel integrated discharge hubs which will improve joint working arrangements.
- Progression of Reshaping Non-acute Care Redesign Programme.

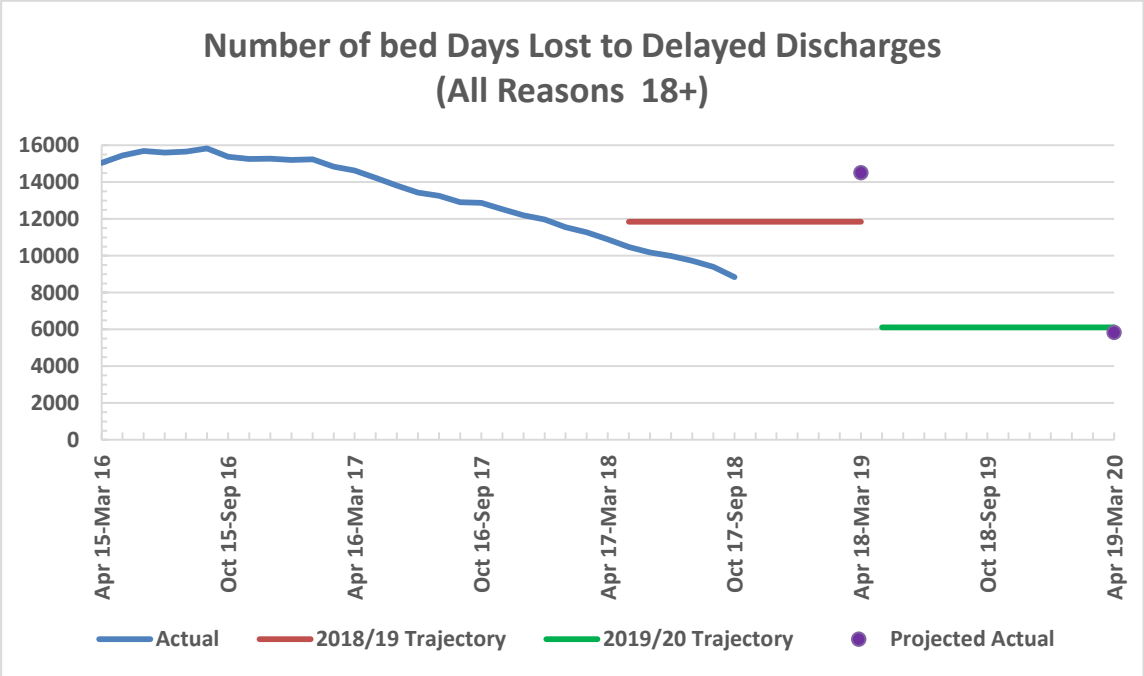
Delayed Discharges

Management Information - Chart 8: Bed Days Lost to Delayed Discharge 18+ as a Rate per 1,000 Population in Dundee



Source: ISD LIST management information (not official statistics)

Management Information - Chart 9: Number of Bed Days Lost to Delayed Discharges 18+



Source: ISD LIST management information (not official statistics)

What is the data telling us?

For Number of bed Days Lost to Delayed Discharges (All Reasons):

- 18/19 estimated and actual performance (7,960) is better than the projection for 18/19 (14,502) and the 18/19 trajectory (11,856) set in January 18.
- Bed days lost to delayed discharge were projected to decrease in 18/19 to 14,502 and the trajectory set in January 18 for 18/19 was for bed days lost to delayed discharges to decrease further than the projection (11,856).
- The actual and estimated data for 18/19 shows that Dundee is likely to perform even better and there will be approximately 7,960 bed days lost. This is a further improvement of 3,896 bed days compared with the 18/19 trajectory set in January 18.

The 19/20 target

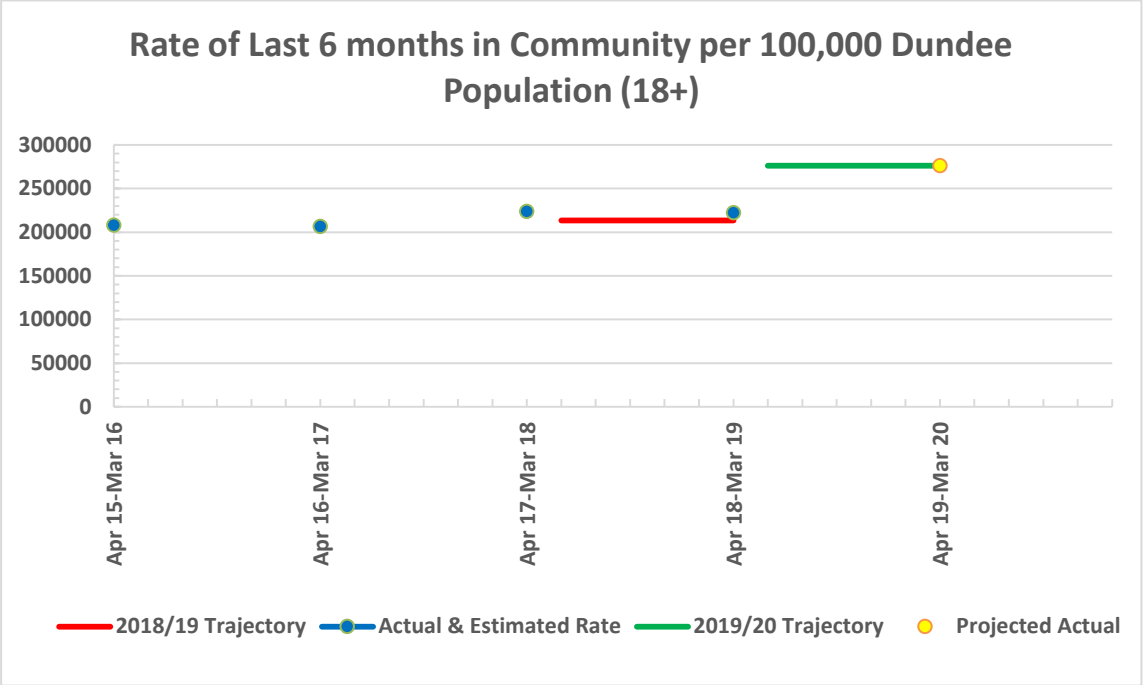
- The 19/20 target number of bed days lost is 6,105. This is 4.7 % higher than the projected 19/20 number (5,832). This equates to an increase of 273 bed days lost due to delayed discharges.
- The 19/20 target is to further reduce bed days lost from the 18/19 actual and estimated (7,960) by 20 % for Standard Delays and 25 % for Code 9 Delays to 6,105 bed days lost.

How will trajectories agreed in Jan 19 for 19/20 be achieved?

- Further develop intermediate forms of care.
- Further develop and remodel social care services to increase capacity and provide more flexible responses
- Further development of Community Rehabilitation and enablement.
- Review discharge pathways and corresponding procedures and guidance.
- Develop a statement and pathway for involving carers in discharge planning process.
- Extend the range of third sector supports for adults transitioning from hospital back to the community.
- Extend the step down and assessment model for residential care.
- Hold Power of Attorney local campaigns.
- Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.
- Establish an integrated model of support for people with a learning disability and / or autism who also have extremely complex health and care support needs.
- Progression of Reshaping Non-acute Care Redesign Programme.
- Implement Home and Hospital Discharge Plan.
- Implement Tayside Unscheduled Care Improvement Plan
- Implement Tayside Winter Pressures Plan

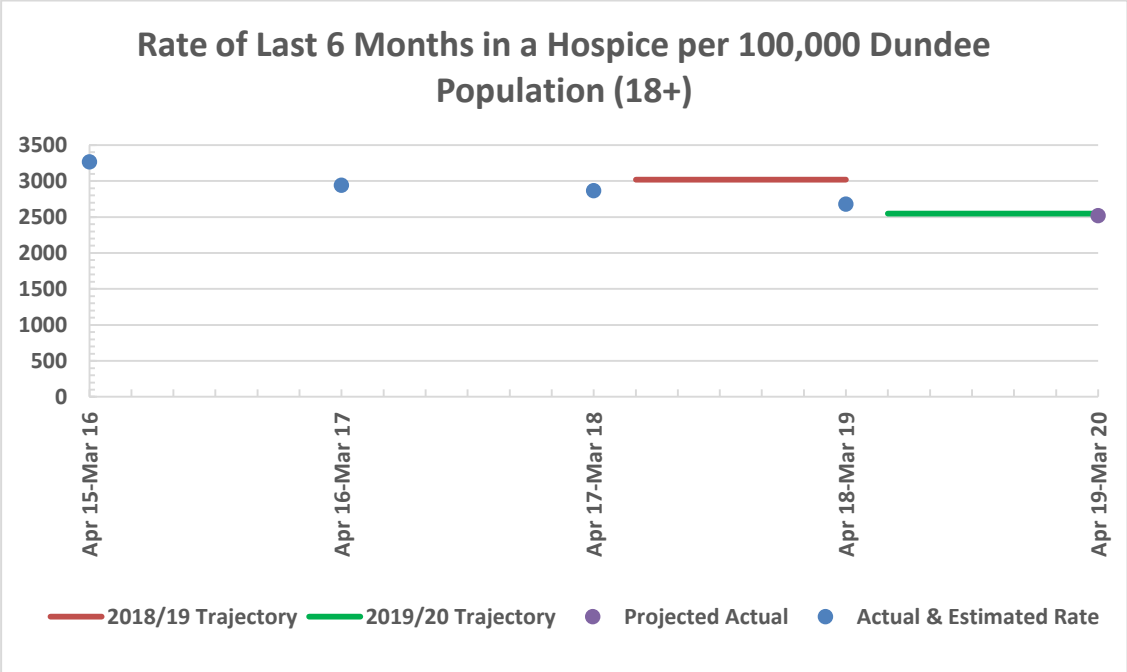
Last 6 Months of Life

Management Information - Chart 10: Last 6 months in community



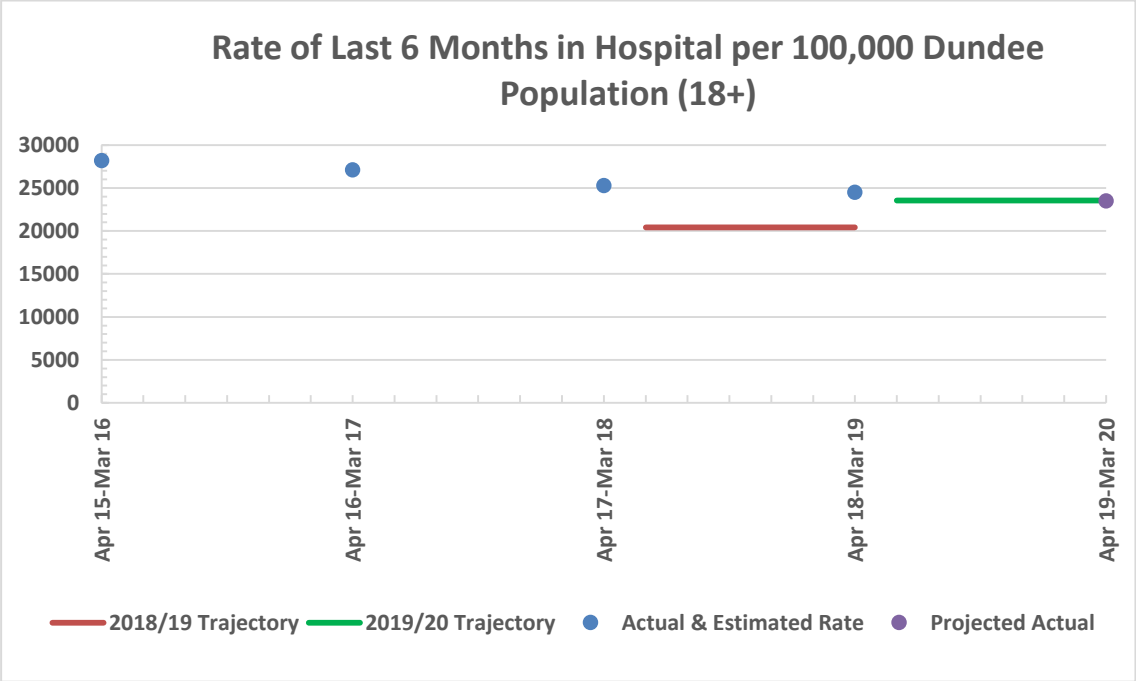
Source: ISD LIST management information (not official statistics)

Management Information - Chart 11: Last 6 months in hospice



Source: ISD LIST management information (not official statistics)

Management Information - Chart 12: Last 6 months in hospital rate per 100,000 18+



Source: ISD LIST management information (not official statistics)

What is the data telling us?

- There has been a year on year decrease since 15/16 in the actual and estimated numbers of people spending the last 6 months of their life in either a hospice or a hospital. The 18/19 actual and estimated number of people spending their last 6 months of life in a hospice (3,270) is well below the 18/19 trajectory (3,680) while the 18/19 actual and estimated number of people spending their last 6 months of life in a hospital (29,894) is above the 18/19 trajectory (24,878).
- Between 16/17 and 17/18 there was an 8.7% increase in the number of people spending the last 6 months of their life in the community, from 250,880 to 272,735. The 18/19 actual and estimated number of people spending their last 6 months of life in the community is 270,897 while the projected number for 19/20 is 276,204 (an increase of 2.0%).

The 19/20 targets

For last 6 months spent in the community:

- The 19/20 target number of bed days for last 6 months spent in the community is 276,314, with a rate of 226,660 bed days per 100,000 Dundee population - as shown in chart 10. This is 0.01 % higher than the projected 19/20 rate (226,569). This equates to an increase in the rate of 31 beds spent in the community during the last 6 months of life.
- The 19/20 target is to increase bed days from the 18/19 actual and estimated number (270,897) by 2 % to 276,314 bed days.

For last 6 months spent in a hospice / palliative care unit:

- The 19/20 target number of bed days for last 6 months spent in a hospice is 3,107, with a rate of 2,549 bed days per 100,000 Dundee population - as shown in chart 11. This is 1.2 % higher than the projected 19/20 rate (2519). This equates to an increase in the rate of 30 beds spent in a hospice during the last 6 months of life.
- The 19/20 target is to decrease bed days from the 18/19 actual and estimated number (3,270) by 5 % to 3107 bed days.

For last 6 months spent in a hospital:

- The 19/20 target number of bed days for last 6 months spent in a hospital is 28,698, with a rate of 23,541 bed days per 100,000 Dundee population - as shown in chart 12. This is 0.2% higher than the projected 19/20 rate (23,507). This equates to an increase in the rate of 34 beds spent in a hospital during the last 6 months of life.
- The 19/20 target is to decrease bed days from the 18/19 actual and estimated number (29,894) by 4 % to 28,698 bed days.

When interpreting this data it became apparent that the % change is determined by the total number of deaths in a year and if the number of deaths is less than the baseline year then targets may not be met. Common sense tells us that reduced numbers of deaths cannot be regarded as negative.

How will trajectories agreed in Jan 19 for 19/20 be achieved?

- PEOLC test site for dementia.
- Expand the use of Palliative Care Tool Bundle and Response Standards in use across community based health and social care services.
- Fully implement the Macmillan Improving the Cancer Project.
- PEOLC Managed Clinical Network in place, to focus on non-specialist palliative care.
- Increased availability of Key Information Summaries and ACPs.
- Develop a community Palliative Care Strategy to further progress support for people dying at home.
- Progression of Reshaping Non-acute Care Redesign Programme.

Balance of Care

Data to measure performance against the 18/19 targets is not currently available from NSS ISD therefore it is not currently possible to measure performance. The 2017/18 figures used to set the targets are provisional.

The 19/20 targets

For Care Homes:

- All Ages: 0.7% of the population living in care homes. (0.5% target set in January 18)
- Aged 75+ : 7.1% of the population living in care homes. (6.7% target set in January 18)

For Large Hospitals:

- All Ages: 0.3% of the population in large hospital. (0.4% target set in January 18)
- Aged 75+ : 1.8% of the population living in large hospital. (1.7% target set in January 18)

For Supported At Home:

- All Ages: 1.5% of the population supported at home.
- Aged 75+ : 11.6% of the population supported at home

For Unsupported At Home:

- All Ages: 97.6% of the population unsupported at home.
- Aged 75+ : 80% of the population unsupported at home.

How will trajectories agreed in Jan 19 for 19/20 be achieved?

- Further develop Enhanced Community Support, including acute.
- Develop a model of support for carers in line with the Carers Act.
- Continue to review in patient models in line with community change.
- Further develop models that support adults within their own homes.
- Further develop and remodel social care services to increase capacity and provide more flexible responses.
- Continue to develop step down to assess model.
- Increase the range of accommodation with support for people with complex needs.
- Further develop social prescribing model for Dundee and improve self-care.
- Further develop accommodation with support models in the community for adults.
- Further remodel the stroke pathway.
- Further develop short breaks and respite opportunities.
- Progression of Reshaping Non-acute Care Redesign Programme.

Template for MSG 2019/20 objectives (completed example)

Health and Social Care Partnership: Partnership A
Age Group for indicators 1 to 3: 18+

	1. Emergency admissions				2. Unplanned bed days					3. A&E attendances				4. Delayed discharge bed days (18+)					5. Percentage of last 6 months of life spent in community (all ages)				6. Proportion of 65+ population living at home (supported and unsupported)			
	Baseline year	*Baseline total*	*% change*	*Expected 2019/20 total*		*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*		*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*	*Baseline year*	*Baseline percentage*	*Percentage point change*	*Expected 2019/20 %*	*Baseline year*	*Baseline percentage*	*Percentage point change*	*Expected 2019/20 %*
Objective	2015/16	12,634	2% decrease	12,381	Acute	2015/16	143,872	4.4% decrease	137,542	2015/16	34,100	2% decrease	33,418	All reasons	2015/16	18,765	3.06% decrease	18,191	2015/16	85.6%	0.8 increase	86.4%	2015/16	83.2%	1.3 increase	84.5%
					Geriatric Long Stay	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*					H&SC/patient and family related reasons	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*								
						2015/16	8,985	1% increase	9,075						2015/16	15,000	3.5% decrease	14,475								
					Mental Health	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*					Code 9	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*								
						2015/16	21,638	Maintain	21,638						2015/16	3,765	1.3% decrease	3,716								
How will it be achieved																										
Notes																										

Health and Social Care Partnership: Partnership A
Age Group for indicators 1 to 3: < 18

	1. Emergency admissions				2. Unplanned bed days					3. A&E attendances			
	Baseline year	*Baseline total*	*% change*	*Expected 2019/20 total*		*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*
Objective	2015/16	2,683	1% reduction	2,656	Acute	2015/16	32,300	1.1% increase	32,623	2015/16	4,387	0.5% increase	4,606
					Menal Health	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*				
						Not applicable	Not applicable	Not applicable	Not applicable				
How will it be achieved													
Notes													

ITEM No …9……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD - 26 FEBRUARY 2019**

REPORT ON: **NATIONAL SUICIDE PREVENTION ACTION PLAN: EVERY LIFE MATTERS**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB2-2019**

1.0 PURPOSE OF REPORT

1.1 This report provides information about the National Suicide Prevention Action Plan: Every Life Matters and arrangements in place to enable its implementation across Dundee.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of the report and the National Suicide Prevention Action Plan: Every Life Matters and National Suicide Prevention Leadership Group Delivery Plan at Appendix 1 and progress in preparing for its commencement as described in Section 4.2.5.

2.2 Notes the Tayside Multiagency Suicide Review Group (TMARSG) Annual Report 2017 at Appendix 2.

2.3 Notes the intention that a Dundee Suicide Prevention Strategic Plan will be submitted to Dundee Integration Joint Board for endorsement by June 2019.

3.0 FINANCIAL IMPLICATIONS

3.1 A local review of financial and resource implications resulting from the National Suicide Prevention Action Plan: Every Life Matters is being undertaken. This review will inform an investment plan as part of the development of a Dundee Suicide Prevention Strategic Commissioning Plan.

4.0 MAIN TEXT

4.1 Overview of the National Suicide Prevention Action Plan: Every Life Matters

4.1.1 The Scottish Government's vision is of a Scotland where suicide is preventable; where help and support is available to anyone contemplating suicide and to those who have lost a loved one to suicide. Suicide prevention is everyone's business.

4.1.2 The National Suicide Prevention Action Plan: Every Life Matters was published on 9 August 2018 and sets out the Scottish Government's actions to achieve those objectives. A key objective of the Plan was to set up and fund a National Suicide Prevention Leadership Group to deliver upon the National Suicide Prevention Action Plan.

4.1.3 The National Suicide Prevention Leadership Group was established in September 2018 and subsequently published a delivery plan on 20 December 2018. The Delivery Plan is attached at Appendix 1.

4.1.4 The Delivery Plan sets out a timeline and expected delivery partners by which Scottish Government priorities in relation to Local Action Plans, Training, Public Awareness, and Support for Those Affected by Suicide, Crisis Support, Digital Technology, At Risk Groups, Children & Young People, Data Evidence and Review will be achieved.

4.2 Local Implementation of the National Suicide Prevention Action Plan: Every Life Matters

4.2.1 As with Scottish Government in Dundee we believe that no death by suicide should be regarded as either acceptable or inevitable. We also recognise the significant impact of suicide on family members or carers affected by suicide.

4.2.2 To ensure we maintain this focus, the Dundee Suicide Prevention Strategic Planning Partnership (the Partnership) has drafted a Suicide Prevention Strategic Plan (the Plan). This Plan is for all persons in Dundee, including young people and adults affected suicide. It will set out the approach, model and actions by which the Partnership will deliver on our vision, improve outcomes for citizens of Dundee and deliver on the National Suicide Prevention Action Plan: Every Life Matters.

4.2.3 Consultation on the Suicide Prevention Strategic Plan is taking place between February and April 2019. The feedback from the consultation will then inform final development of the Plan with a view that the Strategic Plan is submitted to Dundee Integration Joint Board and Dundee Chief Officer Group for endorsement by June 2019.

4.2.4 The Strategic Plan and local action has been informed by the recommendations from Tayside Multi – Agency Suicide Review Group (TMARSG). The purpose of the TMASRG is to review all completed suicides in Tayside to determine common demographic, social, health, service use and other factors that have contributed to each suicide. This information is used to determine recurring themes which can be used to develop priorities for local suicide prevention activity. The TMARSG Annual Report 2017 is appended at Appendix 2.

4.2.5 In addition to drafting the Suicide Prevention Strategic Plan the Partnership has progressed a number of actions linked to the National Suicide Prevention Action Plan: Every Life Matters, priorities to prepare for its commencement as detailed below.

Suicide Prevention Training	A Dundee Suicide Prevention Training Plan will be implemented by June 2019 to reflect Local and National Requirements and Targets. Suicide Prevention The Plan aims to build upon training arrangements already established across Dundee through DHSCP, NHS Tayside and national opportunities.
Public Awareness	A Dundee Suicide Prevention Communications and Engagement Group was established during 2018 to coordinate local communications and engagement activity relating to Suicide Prevention. Through the group targeted campaigns to promote awareness and reduce stigma have taken place during 2018. This has include promoting Suicide Help App, Samaritans Good Practice Guide and Tay Road Bridge Factsheet.
Support for those affected by suicide	Through the Dundee Carers Partnership and Suicide Prevention Partnership investment has been made in supporting carers, family members and young people affected by suicide and bereavement. Information and advice on life after caring is available through DHSCP and Carers of Dundee websites.
Crisis Support	Through a strategic alliance with the Mental Health Strategic Planning Group, provision of crisis support has been prioritised which has included extending Social Prescribing to all GP surgeries in Dundee, expanding the Do You Need to Talk Service to include support from the age of 13 upwards and developing a responding to Distress Framework.
Digital Technology	Through the SmartCare Strategic Plan and Independent Living Partnership, digital technology and technology enabled care is promoted. In particular a City of Recovery Website is in development which will provide information and support about how to access recovery orientated support in the city.

Prevention -At Risk Groups	The Dundee Suicide Prevention Strategic Plan outlines key risk factors, drawing on local and national evidence and data, relating to a higher risk of suicide and identifies priorities to focus on upstream prevention and policy change through targeting of high risk communities and early years. This includes informing the Substance Misuse, Sexual Health, Mental Health, Older People and Homelessness Redesigns currently underway in the city and through a partnership with the Older People Strategic Planning Group a focus on reducing social isolation.
Children and Young People	A Mental Health Strategy for Children and Young People is being developed by the Tayside Health & Wellbeing Priority Group (HWPG) – 1 of 5 priority groups to deliver on the Tayside Plan for Children, Young People and Families (C, YP & F) 2017-2020.

4.2.6 The focus of the Strategic Planning Group during 2017 - 2018 has been to build capacity so that we maximise resources available to prevent suicide in Dundee. This has focused on reviewing contractual arrangements, gaining an evidence base in order to target interventions and developing a range of partnerships.

4.2.7 In addition**,** the Dundee Suicide Prevention Partnership recognised that workforce development, communications, and quality assurance arrangements are key infrastructure requirements to prevent suicide and deliver upon the National Suicide Prevention Action Plan: Every Life Matters. To support this, the following will be implemented during the period 2019 - 2020:

- A workforce development programme focused on suicide prevention.
- A balanced scorecard which evidences impact of the Strategic Plan on preventing suicide, delivery of the National Action Plan and an ongoing focus on continuous improvement.
- A Multi-agency toolkit which will provide good practice guidance.
- A communications strategy to raise ongoing awareness about suicide prevention aligned to national delivery arrangements.

4.3 Costs Associated with Implementing the National Suicide Prevention Action Plan: Every Life Matters

4.3.1 To maximise use of resources to prevent Suicide in Dundee, the Partnership strategic intent is to build capacity by working in partnership with a range of partners so that Suicide Prevention is regarded as everyone's responsibility and with that it is embedded within all strategic planning activity across the City.

4.3.2 As part of the development of the Strategic Plan, an integrated budget statement has been developed. Once the Strategic Plan is finalised an Investment Plan will be developed aligned to the priorities identified in the Strategic Plan and priorities identified in the National Suicide Prevention Action Plan: Every Life Matters.

4.3.3 Once the financial resource to accompany the National Suicide Prevention Action Plan: Every Life Matters has been confirmed this will be added to the integrated budget statement and will be used to inform the Investment Plan.

5.0 POLICY IMPLICATIONS

5.1 This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that current funding will be insufficient to support provision implementation of National Suicide Prevention Action Plan: Every Life Matters.
Risk Category	Financial
Inherent Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is High Risk Level)
Mitigating Actions (including timescales and resources)	Securing multi-agency agreement on the actions required when developing the Dundee Suicide Prevention Strategic Plan.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (which is a High Risk Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	Given the risk mitigation actions in place the risk is deemed to be manageable and should be accepted.

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

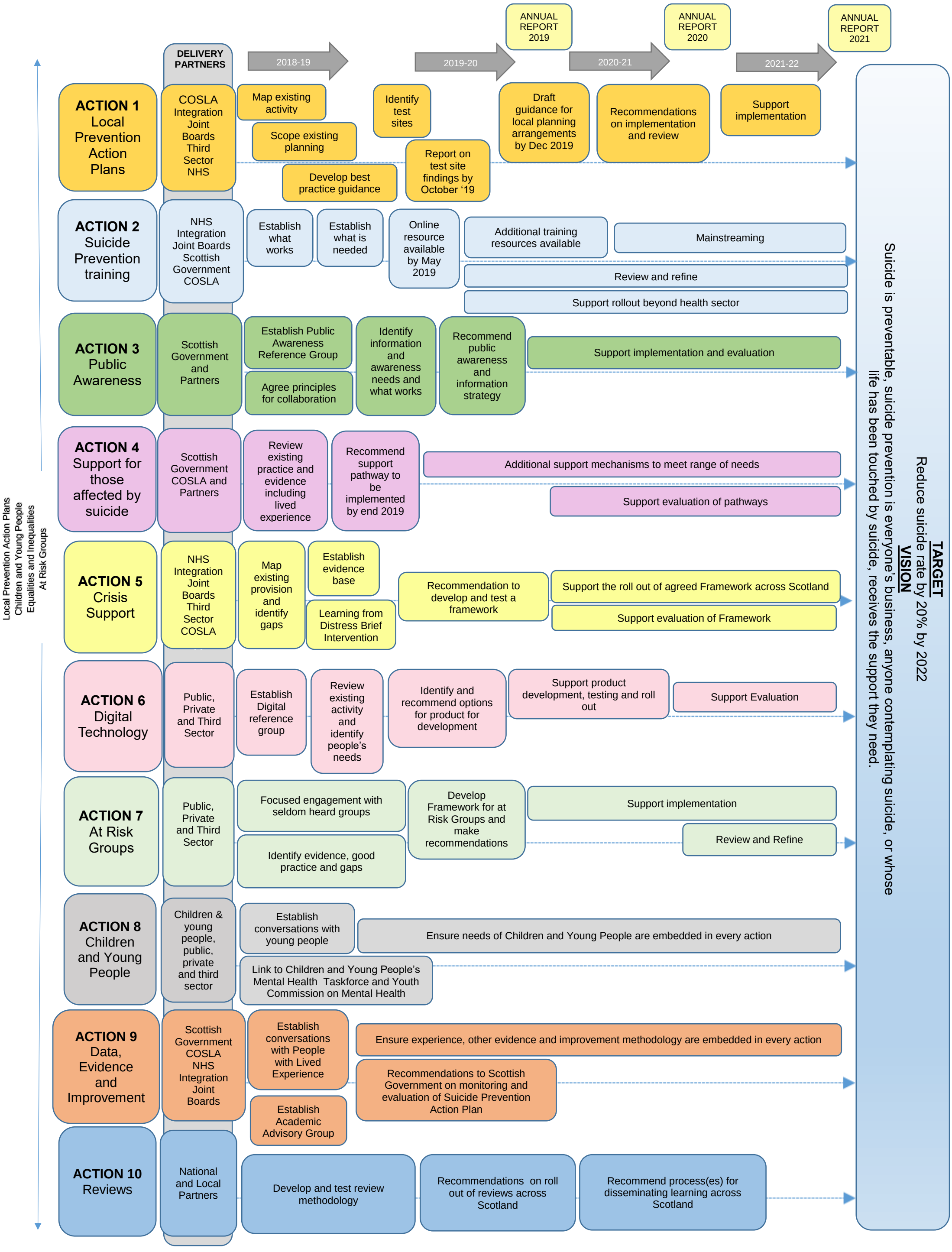
Direction Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	x
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

David W Lynch
Chief Officer

DATE: 11 February 2019

Alexis Chappell
Locality Manager

INITIAL NATIONAL SUICIDE PREVENTION LEADERSHIP GROUP DELIVERY PLAN



COSLA – Convention of Scottish Local Authorities

Tayside Multiagency Suicide Review Group

Annual Report 2017

TAYSIDE MULTIAGENCY SUICIDE REVIEW GROUP (TMASRG)

ANNUAL REPORT 2017

INDEX

ACKNOWLEDGEMENTS

The information and analysis presented in this report is the result of collaboration between a wide range of agencies who have undertaken to share information in cases of completed suicide in order that lessons can be learned from these tragic events. The Chair and Co-ordinator of the Tayside Multiagency Suicide Review Group would like to thank all members of the Review Group (see Appendix 1), all staff in the agencies across Tayside who have been involved in contributing to data collection and the case review process and Gillian Robertson for invaluable administrative support to the group.

We are grateful for funding of the review process from Angus, Dundee and Perth & Kinross Councils and NHS Tayside.

In addition, this year, we are extremely grateful to Dr Fiona Moore from the University of Dundee and MSc Psychology students Eva Bohlert, Gabriele Misgirdaite, and Nicole Wolf who have undertaken additional analysis of a subset of TMASRG data.

EXECUTIVE SUMMARY

Information is provided for the 126 suicide deaths in Tayside from 2016 and 2017:

- Dundee City had the highest proportion (49%) which is in keeping with the strong association between socio-economic deprivation and suicide.
- Males outnumber females 3:1.
- The peak age is 40-49.
- Hanging was the most common method.
- 52% were unemployed.
- 52% had had contact with Mental Health services in their lifetime.
- The suicide rate increased during the summer months.

Sub-populations

Half of the deaths from 2016 and 2017 fit into the following four sub-populations:

- Male opiate users (mean age 40): overlap with the drug related death population.
- Males (mean age 31): poor employment history, substance misuse (excluding opiates) and unstable relationships.
- Retired individuals: poor physical health, history of mental health disorder.
- Males (mean age 53): previous employment and relationships but who have experienced loss of employment and/or divorce and are socially isolated.

Other common factors

- Bereavement (particularly in women)
- Harmful use of alcohol
- Adverse childhood experiences
- Criminal history
- Physical health problems
- Infertility

Key risk times

- Following an additional loss/stress e.g. relationship breakdown, loss of employment, criminal charge.
- Following a change or commencement of antidepressant medication.

Outputs

- The TMASRG provides co-ordinated and timely information sharing around suicide deaths in Tayside to inform local suicide prevention activity.
- The TMASRG has identified areas for service improvement across agencies.

Recommendations

- Prevention should begin upstream with organisations taking a public health approach to reducing socio-economic inequalities in all areas e.g. environment, housing, employment, education.
- There should be a national agreement for information sharing around suicide.
- Information about suicide prevention and access to training courses should be promoted universally with organisations, communities and individuals. The Suicide? Help! App supports this.

- Suicide prevention activity should target services who are in contact with individuals at high risk times e.g. redundancy, financial issues, divorce, bereavement.
- Support should be offered proactively to those bereaved by suicide.

Conclusion

The TMASRG is improving knowledge around suicide deaths in Tayside to inform local suicide prevention activity and is identifying cross-organisational service improvements to promote and protect mental health.

However, it is important to highlight that despite improved local knowledge around suicide all the identified risk factors are common to a large number of people. Reducing the stigma associated with mental health conditions and encouraging engagement with support are also essential if we are to prevent suicide.

BACKGROUND

Every death by suicide is one too many. Scotland continues to have a higher suicide rate than the rest of the UK mainland and there is a strong association between suicide and socio-economic deprivation. It had not been standard practice to review all suicide deaths despite their gravity. However, Scotland's Suicide Prevention Action Plan 2018 now includes the recommendation that all suicides are reviewed by a multiagency group. The Tayside Multiagency Suicide Review Group was set up in 2016 and is jointly funded by NHS Tayside and Angus, Dundee City and Perth & Kinross Councils.

PURPOSE OF THE TMASRG

The purpose of the TMASRG is to review all completed suicides in Tayside to determine common demographic, social, health, service use and other factors that have contributed to each suicide. This information is used to determine recurring themes which can be used to develop priorities for local suicide prevention activity.

Suicide prevention activity is led by the three local Suicide Prevention groups in Angus, Dundee City and Perth & Kinross. In addition, lessons learned in terms of services and pathways, and recommendations based on findings, are made to the relevant governance and review structures within the NHS or to other organisations.

The TMASRG Annual Reports are presented to each of the local Suicide Prevention Strategic Planning Groups for discussion to inform its recommendations as commissioners and ensure local connection. Local planning for improvement will be carried out through the local Suicide Prevention Strategic Planning Groups.

GOVERNANCE

The TMASRG is led by the NHS and governance within the NHS is provided by the Adult Protecting People Committee. Other organisations are supported by their own governance structures.

METHODS

Definition of a suicide

For the purposes of the TMASRG, suicide deaths are those that are determined by Police investigation and categorised by the Crown Office and Procurators Fiscal Service (COPFS) as being an apparent suicide death.

Data Collection

Written Primary Care case summaries and Post Mortem reports including toxicology are obtained for all cases. Additional verbal reports are obtained were possible from Police Scotland on criminal history, secondary care Mental Health services on mental health and substance misuse history and from Social Services. Verbal reports are provided by the relevant service at the TMASRG meeting. This arrangement has been made for pragmatic reasons to encourage information sharing where those contributing have no resource or capacity to provide written summaries. Where it is apparent that additional information is relevant this is

obtained where possible, for example, from Scottish Ambulance Service, Housing Support Services and Third Sector. The data collected is therefore not complete (see Data Completeness and Reliability section later in report).

2013-17 SUICIDE RATES TAYSIDE

The mean number of suicide deaths per year by each local authority area can be seen in Table 1. It is of note that men in Dundee City currently have the second highest mean rate in Scotland at 29.2.

Table 1: 5 year suicide rates by local authority area[1]

Area	Total Numbers 2013-17			European age-sex-standardised rates per 100,000 population		
	Persons	Males	Females	Persons	Males	Females
Angus	73	52	21	13.2	19.4	6.9
Dundee City	131	100	31	19.0	29.2	8.7
Perth & Kinross	96	71	25	13.2	19.6	6.7
Scotland	3571	2623	948	13.5	20.2	6.9

One of the main factors causing variation in suicide rates between areas is the strong association between deprivation and suicide. In Scotland from 2013-17 the rate of suicide in the most deprived decile was around three times larger than the rate in the least deprived decile (21.9 deaths per 100,000 population compared to 7.6 per 100,000).[2]

2017 SUICIDE STATISTICS TAYSIDE

The number of suicide deaths in Tayside in 2017 was 55, 48 males and 7 females.

Table 2: Number of suicide deaths in 2017

	Angus	Dundee City	Perth & Kinross	Tayside
Total	**12**	**25**	**18**	**55**

20 of the 55 deaths have had a formal review by the TMASRG to date. 32 of the deaths are undergoing review by the NHS Tayside Local Adverse Event Review process as the individuals had had contact with Mental Health services in the year prior to their death. Information necessary for a review is still outstanding for the three remaining cases.

For all suicide deaths in 2017 the available records have been reviewed to obtain detailed information on the circumstances surrounding each death. For those deaths

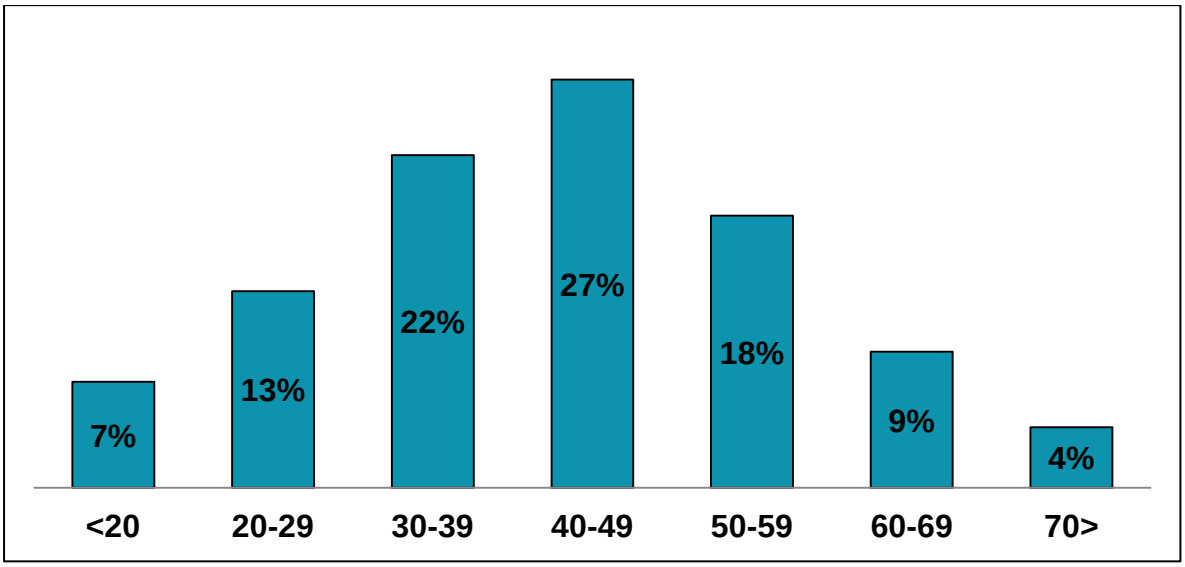
that have been reviewed by the TMASRG, additional verbal information has been recorded from case records held by member organisations.

Demographics

Age

- 67% were aged between 30-59.
- 27% were aged 40-49

Figure 1: Suicides by age demographic



Nationality

- All were Tayside residents at the time of death.
- 93% were of UK origin.
- 3.5% were of Eastern European origin and 3.5% were of other non-UK origin.

Gender

- 87% were male.

Employment

- Of the eligible workforce (excluding students, retired, disabled, unknown: 10 individuals) 40% were employed (compared to 68% in Scotland suicide deaths[2]) of whom 12% were on sick leave.
- 60% were unemployed (including 2 recent redundancies).

Table 3: Suicides by eligible workforce

	Tayside (eligible workforce)	Angus	Dundee	P&K	Scotland[2]
Employed	40% (42)	67% (9)	13% (21)	67% (12)	68%
Unknown (figure)	7%	0	1	3	<1%

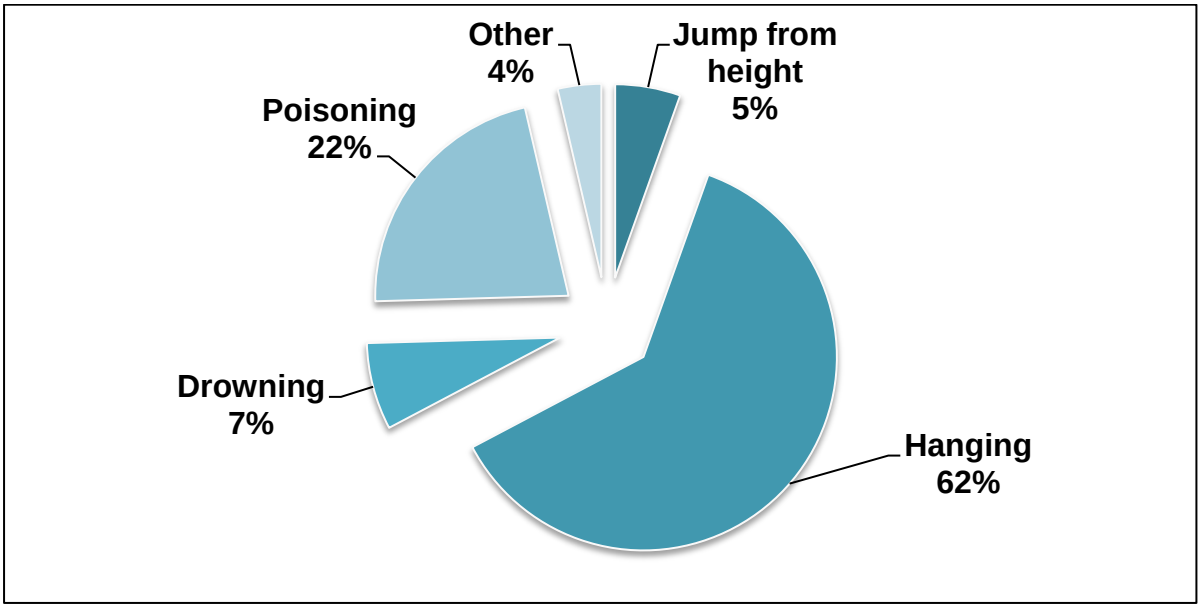
The main reason for the difference between Tayside and Scotland can be seen when the figures are divided by Local Authority area; where Dundee is the population that is different with 13% employed.

Social Circumstances

- 42% lived alone.
- 31% were either divorced/separated or had had a recent relationship breakdown.
- 25% were married or living with a partner.
- 11% lived with parents.

Method (following ScotSID definition of causes)

Figure 2: Suicides by method



- 68% of men used hanging/strangulation/ suffocation (compared to 50% in Scotland suicide deaths[2]).
- 43% of women used hanging/strangulation/ suffocation (compared to 32% in Scotland suicide deaths[2]).
- 43% of women and 17% of men used ‘poisoning’.
- Other causes include drowning, jumping from a high place and laceration.
- 11% took place at a recognised location of concern.

Mental Health Services

- 69% have had recent or past contact with mental health services (including substance misuse services).
- 58% had had contact with mental health services (including substance misuse) in the year before death (compared to 26% for Scotland suicide deaths[2]).
- 29% had had a Mental Health inpatient admission in the past.
- None were inpatients at the time of death.

Mental Health Diagnoses, Symptoms and Medication

- 73% had had a diagnosis of depression by a medical professional at some time in their life.
- An additional 11% were observed to be low in mood by others or had expressed suicidal thoughts.
- 49% had a history of self harm.
- 60% were prescribed an antidepressant.
- 21% of those prescribed an antidepressant had either been commenced on it or had had a change to their prescription within the previous month.

Substance Misuse

- 40% (all male) were documented to have used illicit drugs at some time in their life.
- 25% (all male, mean age 40) were known to have used illicit opiates such as heroin.
- 16% (all male, mean age 31) were known to have used other non-opiate illicit drugs.
- 13% (mean age 40) were recorded as having problematic use of alcohol but no use of illicit drugs.

Substance Misuse Services

- 33% had been seen by substance misuse services at some time in their life (compared to 11% for Scotland suicide deaths[2]). This included:
    - 78% who used opiates,
    - 60% of those where harmful use of alcohol was documented, and
    - 22% of those who used non-opiate illicit drugs.
- 28% had only had contact with substance misuse services and had not had contact with mental health services as well. All of this population were in contact with substance misuse services in the year prior to death.

Other health services and conditions

- 87% had had contact with Primary Care ('contact' includes ordering a repeat prescription) in the year prior to death.
- 7% attended A&E in the year prior to death.
- 36% had a chronic physical health condition

Social Factors

- 24% had suffered significant bereavement: in 31% of cases this was bereavement by suicide and in 8% it was a drug related death.
- Adverse childhood experiences such as abuse, neglect, divorce or bullying were documented in 25% of cases. This included childhood sexual abuse in 24% and physical abuse in 18% of this population.
- 24% had a history of offending.
- 16% had a history of violence.
- 15% were known to have spent time in prison.
- 18% were documented as having financial issues/issues with benefits.
- 16% were estranged from family.

2016 & 2017 SUICIDE STATISTICS TAYSIDE

The total number of completed suicides in calendar years 2016-17 was 126 as determined by Police Scotland and COPFS fatalities unit, through investigation. Of these,

- 71 have been reviewed in detail by the TMASRG.
- 46 have undergone a Local Adverse Event Analysis by Mental Health services.
- One case has been excluded as the person was not resident in Tayside at the time of death and there was no contact with local services or organisations.
- The remaining eight cases have been delayed due to either late notification, as the suicide was not immediately apparent, or there are other investigations to be concluded in order for COPFS to finalise their determinations. These deaths will be progressed through the TMASRG process when finalised.

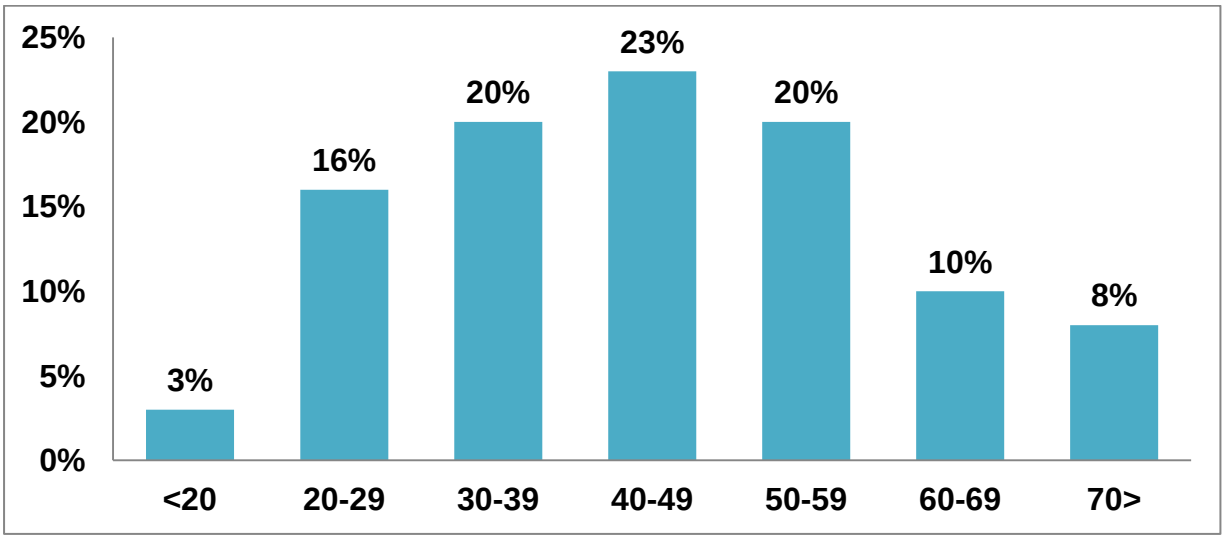
Analysis has been performed on the available information for the included 125 cases.

Table 4: Number of completed suicides 2016/17

	Angus	Dundee City	Perth & Kinross	Tayside
Male	18	45	32	95
Female	9	16	5	31
Total	**27**	**61**	**37**	**125**

Age The mean age was 44 with the most frequent age band being between 40-49.

Figure 3: Suicides by age 2016/17



Nationality

All were UK residents at the time of death with all but three from Tayside. 93% were of UK origin, 5% were of Eastern European origin, 2% other non-UK.

Employment

Of the eligible workforce (excluding students, retired, disabled: 26; unknown: 8), 48% were employed (14% on sick leave) and 52% were unemployed (including 9% recent redundancies).

Table 5: Suicides by eligible workforce 2016/17

	Tayside (eligible workforce)	Angus	Dundee	Perth & Kinross	Scotland (2009-15)[2] (working age population)
2016/17 Employed	48% (92)	61% (18)	40% (47)	54% (27)	68%

- In 2016 the proportion of the eligible workforce in employment was 54% in Tayside.
- In 2017 the proportion of the eligible workforce in employment was in 40%.

Retired

- 13% were retired - mean age 71.
- 100% of those who were retired had been diagnosed with depression at some time in their life.
- 20% had been seen by mental health services within the last year.

- 5/10 of the retired men had had a previous inpatient admission to mental health services but none of these had had any contact with mental health services in the year prior to death.

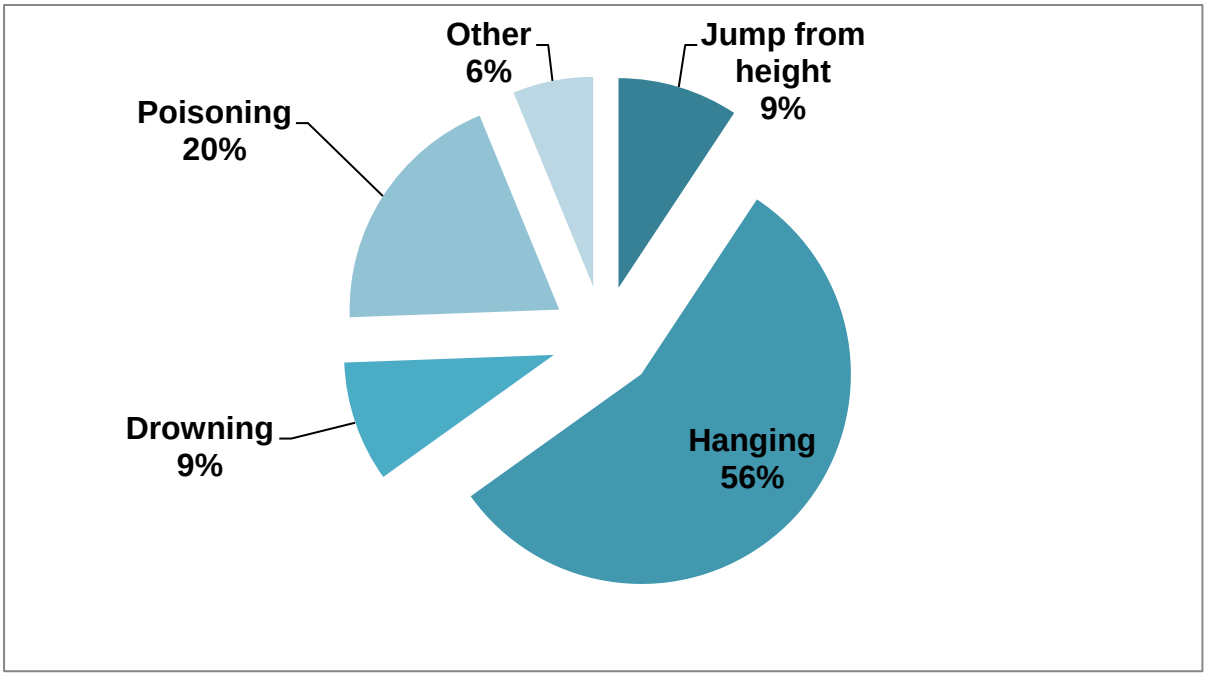
Social Circumstances

- 42% were living alone.
- 28% were married/living with a partner.
- 25% were either divorced/separated or had had a recent relationship breakdown.
- 12% lived with parents.

Method (see figure 4)

- Hanging/strangulation/ suffocation was the most common method used by 56% (23% of females, 65% of males), followed by poisoning which includes overdose.
- 15% took place at a recognised location of concern.
- 35% had alcohol in their body at the time of death.

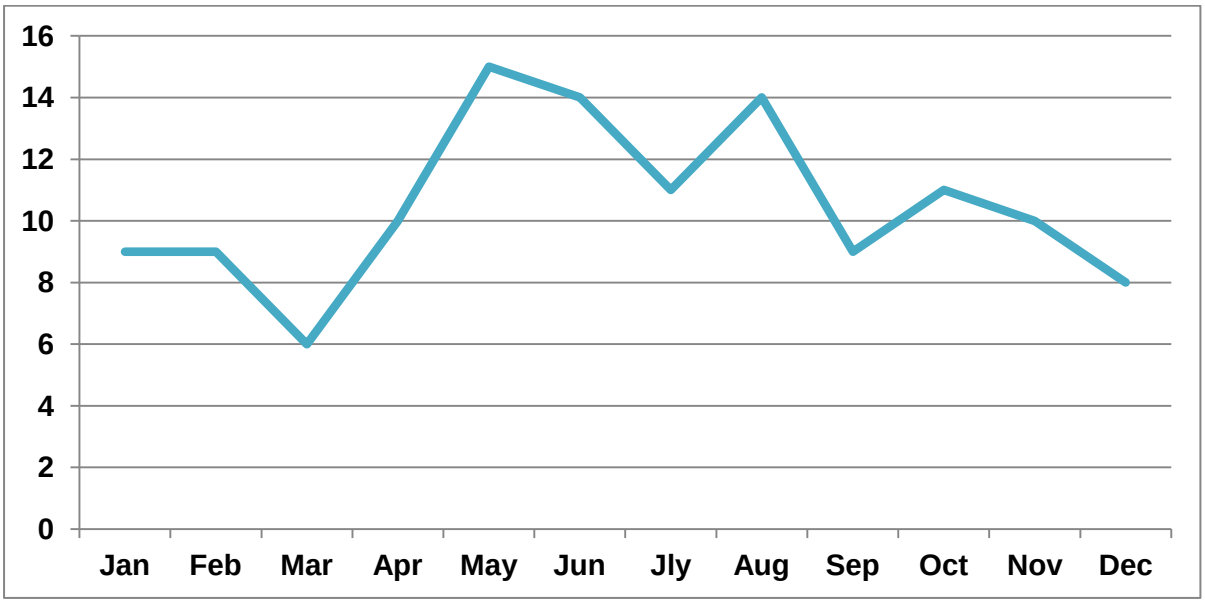
Figure 4: Suicides by method 2016/17



Timing

The rate of suicide increases in the summer months and reduces between November and April (see figure 5).

Figure 5: Suicide rates by month



Mental Health Services

- 52% had had contact with Mental Health services in their lifetime.
- 37% had had contact with Mental Health services in the year prior to death (compared to 26% for Scotland suicide deaths[2]).
- 24% had had a Mental Health inpatient admission in the past.

Mental Health Diagnoses, Symptoms and Medication

- 69% had had a diagnosis of depression by a medical professional at some time in their life.
- An additional 14% were observed to be low in mood by others or had expressed suicidal thoughts.
- 50% had a history of self harm.

Substance Misuse

- 15% were known to use illicit opiates such as heroin.
- 27% were documented to have used any illicit drugs at some time in their life.
- 24% (30% of females and 22% of males) were recorded as having problematic use of alcohol; 20% of whom also used illicit drugs.

Substance Misuse Services

- 20% had been seen by substance misuse services at some time in their life (compared to 11% for Scotland[2]). This included:
    - 74% who used opiates,
    - 28% of those where harmful use of alcohol was documented.

Other health services and conditions

- 78% had had contact with Primary Care (contact includes collecting a repeat prescription) in the year prior to death.
- 9% attended A&E in the year prior to death.
- 40% had a chronic physical health condition which increased to 71% of those aged 60 or over.

Social Factors

- 30% had suffered significant bereavement (43% of females, 17% of males):
    - 10% had suffered bereavement by suicide. (13% of females, 8% of males)
    - 20% had suffered other significant bereavement. (30% of females, 9% of males).
    - 4% had suffered bereavement by suicide and another significant bereavement.
- 9% had a history of sexual abuse (7% of females 2% of males).
- 6% were confirmed/alleged perpetrators of sexual abuse (all male).
- 19% had a history of offending (2% of females, 17% of males).
- 14% had a history of violence.
- 6% had a history of domestic abuse.
- 6% had spent time in prison.
- 18% were documented as having financial issues/issues with benefits (4% of females 14% of males).
- 18% were estranged from family (2% of females, 16% of males).
- 2% were known to have had significant caring responsibilities.
- 2% had problem gambling.

Key Risk Times/Predictors

- Qualitative information highlights that an additional loss or stress is often present, for example loss of relationship, loss of a job, financial issues or a new criminal charge.
- Qualitative information highlights that for many there are life experiences and/or personality factors that may have led to a pattern of poor coping with losses and difficulties.
- The period where antidepressant medication is commenced or changed is a time of increased risk for suicide shown by research evidence and TMASRG data.

Previous self harm and social factors

A more detailed analysis was undertaken by Dr Moore and students from the University of Dundee on 36 sequential cases from 2016 (see appendix 2). This analysis highlights that:

- Change in method between previous self harm and completed suicide is usual.
- As many as 83% may have had a recent change in a relationship.
- Over 75% had only one or two social groups/circles.
- A third may have personality traits which increase the likelihood of suicide.

Analysis was undertaken to assess the relationship between individual characteristics and help seeking behaviour but no associations were found in this small sample.

SUB-POPULATIONS AND THEMES

Combined information from the years 2016 and 2017 has given a large enough dataset to identify some sub-populations and themes to help inform targeted suicide prevention activity.

Sub-populations

The number fitting into sub-populations was 62, approximately half the total population. Therefore just as many cases do not fall into any of these sub-populations and the more common themes for this group are listed. Suicide prevention activity should always be universal as well as targeted towards high risk groups.

a) **Male opiate users** (n=19) (mean age 40): This population has the same mean age as the 2016 Tayside drug death population.[3] There is significant overlap between both populations and it is often difficult to determine whether a death is an accidental overdose or suicide. 79% resided in Dundee, 21% in Perth & Kinross. The key issues identified in this population by the TMASRG reviews included chronic physical health conditions, depression, relationship breakdowns, bereavement, financial issues, history of offending and unstable accommodation.

b) **Younger males – unemployed/poor employment history, substance misuse** (n=18) (mean age 31): Typically, this population had high consumption of alcohol, cannabis, cocaine or other substances and intermittent low mood for a number of years. They also tended to have poor relationships with family, minor offending history and financial issues. A recent loss or event was the most likely precipitant such as loss of a relationship, new criminal charge, worsening financial issues or a bereavement.

c) **Retired** (n=17) (age range 54-84): In this population nearly all had a chronic physical health condition and most have been known to the mental health services at some time in their life.

d) **Males – with families and employment history** (n=8) (mean age=53): This population has typically experienced recent losses such as divorce/relationship breakdown, loss of employment. These men tend to be socially isolated, some have harmful use of alcohol and family/friends identify low mood. One further loss or event is often the precipitant to suicide.

Common Themes

Women: the most common factors include bereavement (43%), harmful use of alcohol, chronic physical health conditions/terminal illness, adverse childhood experiences, sexual abuse in childhood or adulthood and infertility.

Men: the most common factors include harmful use of alcohol, significant criminal history including perpetration of abuse, bereavement, psychotic or organic brain conditions, history of sexual abuse, Eastern European, ex-military, Autistic Spectrum Disorder.

DATA INTERPRETATON

In any analysis where the sample size is less than 100 interpretations can be problematic due to small numbers and there is a risk of over-interpretation. The interpretations that can be made from this report therefore are limited in their wider applicability due to the small numbers involved.

The most reliable interpretations can be made from the full data set available for the combined years of 2016 and 2017. However, when that sample is divided into smaller groups such as local authority areas or employment status any interpretation becomes much less reliable.

Comparisons with Scotland suicide deaths from ScotSID[2] are in relation to the time period 2009-2015 therefore any differences may be due to the difference in time period. For example, it is known that the use of hanging as a method has been increasing over time and increasing in young women and this may be the cause of a greater proportion using this method in the Tayside figures.

DATA COMPLETENESS AND RELIABILITY

The TMASRG has no legal mandate to support collection of information and this remains a challenge. Data collection relies on the good will of partners in providing information to the review process either in written format and/or by attendance of a representative at meetings. As this was a new process there has been variation in the extent of information provided from 2016 and 2017. However, the TMASRG has now improved standardisation of the information obtained across Tayside particularly from Police Scotland and Primary Care.

When cases are reviewed by TMASRG additional verbal information is provided where possible from the detailed written records held by individual agencies. These records are not shared otherwise. However, this detailed qualitative information is often invaluable. For example, COPFS collects information from close family and this can provide detail around recent stressors and personal circumstances. Similar qualitative information is also usually available for cases that have been through the LAER process.

It is of note that where services are under pressure and a representative is unable to attend the TMASRG meeting, or when there are staff changes in organisations that provide information, the extent of information collected can reduce. The extent of information held on each individual also varies significantly and in cases where the individual was not in close contact with family or health services additional qualitative information can be sparse.

When the TMASRG is aware that there has been contact with social services or 3rd sector organisations information is sought from these organisations but whether any information is received has been very variable.

Due to these limitations it is likely that many of the data fields are an under-recording of their true presence in this population. For example, it is likely that there are greater levels of Childhood Adverse Experiences than are recorded in our data. Similarly there is likely to be an under –recording of those who can't work due to disability, those who have financial difficulties and those who are on benefits and other social factors.

The qualitative data that is collected after the death is provided by family or friends and the deceased individual may have had different perceptions of his or her circumstances than that of their family.

OUTPUTS FROM THE TMASRG

A) LOCAL SUICIDE INFORMATION

The TMASRG provides regular reports to the local Suicide Prevention Groups in each Local Authority area. This information is based on both Tayside wide suicide deaths and more detailed information around local suicide deaths. This data is used to inform the work of the Suicide Prevention groups and local authority action plans. For example:

- **Timely preventative activity**: Information is now provided as soon as possible to local Suicide Prevention co-ordinators following any suicide in order to allow timely local preventative/supportive action and early identification of any suicide clusters. The purpose is to reduce the risk of an increase in suicide and self harm by those in that community or location that can follow a suicide.
- **Timely knowledge of suicide deaths for services:** Prior to the TMASRG, there was no consistent or timely means for NHS and other services to be informed of a patient's death due to suicide. The TMASRG now informs all services of a suicide death. This ensures that services can respond sensitively and take appropriate action to support family in these difficult circumstances and instigate review processes where appropriate**.**
- **High risk local populations**: For example, the unemployed, recently redundant and those with financial difficulties. Additionally, carers and supporters are an identified key support for those vulnerable to suicide whilst also being vulnerable themselves.
- **High risk locations**: Locations of concern, or locations where a suicide may have a significant effect on the community.

B) SERVICE IMPROVEMENT RECOMMENDATIONS

General

- Prevention should begin upstream with organisations taking a public health approach to reducing socio-economic inequalities across all areas e.g. environment, housing, employment, education.
- There should be a national agreement for information sharing around suicide.
- Information about suicide prevention and access to training courses should be promoted universally with organisations, communities and individuals. In Tayside the Suicide? Help! App supports this.

Specific

The TMASRG reviews are used to identify any system failures or service issues in individual agencies or between services where lessons can be learned. For example:

- **Bereaved by suicide:** It was identified that bereaved families/friends have a need for support. Perth & Kinross offer this service and it has evaluated well. A working group set up by the TMASRG undertook a needs assessment for this population and a recommendation paper has been submitted to the Local Suicide Prevention Groups (see Appendix 3).
- **Recommendation for multiagency Significant Clinical Event Analysis:** One case highlighted potential multiagency issues where it appeared opportunities were missed to provide intervention that might have reduced the risk of suicide. A local Significant Clinical Event Analysis was recommended, involving all relevant agencies, to examine the case and identify the service improvements required to protect vulnerable individuals.
- **Ambulance mental health support:** It was identified that Tayside ambulance staff do not have access to mental health records or advice. This can mean that the most appropriate care is not provided. In contrast, Police Scotland are able to obtain telephone support from Mental Health service staff which includes access to mental health records. This issue has been raised with the Mental Health management team and a response is awaited.
- **Financial pressures & welfare reform advocacy:** A number of cases have highlighted the impact of issues around benefits in potentially contributing to local suicide deaths. This information is being collated by Public Health and will be used to advocate for changes to reduce socio-economic inequalities and poverty.
- **High risk situations:** Suicide prevention activity should target services associated with high risk situations e.g. redundancy, financial issues, divorce, bereavement.
- **Primary Care assessment:** Primary Care staff should ask everyone with low mood/distress about suicidal thoughts, discuss safety planning, arrange review where appropriate and document the discussion.

C) LOCAL AND NATIONAL STRATEGY DEVELOPMENT

The TMASRG provides information and evidence to inform local and national strategy development. For example providing input to the Scottish Government Suicide Prevention Action Plan, Police Scotland Mental Health strategy, the National Public Health priorities and local strategy and service developments across Tayside.

Local Education and Awareness Raising
The TMASRG works in partnership with the local suicide prevention co-ordinators to provide education and knowledge around suicide and the work of the TMASRG. This has been provided to NHS colleagues, particularly Primary Care and other partners including the Procurator Fiscal's office, Local Authorities and Dundee University.

Education around the TMASRG process to other Health Boards
The TMASRG has been the first group of its kind set up in Scotland and we have provided information to other Boards on the work of the group and the challenges to be addressed in order to develop similar groups.

CONCLUSION

Suicide is a premature death which can be classed as the most serious form of adverse event. However, it has not been routine to have multiagency reviews of these deaths. The TMASRG has developed a process for collation of information and review of these deaths and the value of this learning is now emerging. For example, it has been possible to highlight local sub-populations at higher risk and local areas of variation from national data.

The TMASRG has also had an important role in highlighting the importance of suicide prevention and in identifying cross-organisational service improvements to promote and protect mental health.

It is important to highlight that despite improved local knowledge around suicide all the identified risk factors are common to a large number of people. Individual suicide deaths therefore remain extremely difficult to predict and each suicide death will have profound impacts on the families and professionals involved. Reducing the stigma associated with mental health conditions and encouraging engagement with support are essential if we are to prevent suicide.

FUTURE ACTIONS

- The sub-populations and themes identified will be used to consider a multiagency partnership approach to improving the targeted component of suicide prevention activity in collaboration with the local Suicide Prevention groups.
- At national level the learning from the TMASRG process will be shared with the new National Suicide Leadership group and this will include advocating for a national approach to information sharing between organisations to facilitate data collection for all suicide deaths.
- The TMASRG local data set will be combined with the ScotSID dataset for 2016 when it is released later in 2018. This will improve the reliability of data which has a standardised national collation process; such as secondary care attendance and employment status. This process will also allow an estimate of the reliability of the current TMASRG data collation process.
- Research around self-harm presentations to Ninewells, undertaken by Dr Moore and Dundee University students, will be reviewed with a view to considering whether the TMASRG could be used to improve the surveillance of and response to self-harm.

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APPENDIX 1

MEMBERSHIP OF THE TMASRG

- Mr Robert Bain, Clinical Team Manager (Learning Disabilities), NHS Tayside
- Ms Pamela Banks, Team Leader, Criminal Justice Service, Perth & Kinross Council
- Police Constable Lynsey Boyle, Preventions & Performance Hub, Police Scotland
- Dr Jane Bray, Consultant in Public Health Medicine, NHS Tayside *(Chair)*
- Ms Ruth Brown, Mental Health Networking Co-ordinator, Dundee Voluntary Action
- Mrs Claire Burnett, Child and Adolescent Mental Health Services Occupational Therapist, NHS Tayside
- Dr Roberto Cotroneo, Consultant Psychiatrist, Tayside Substance Misuse Service
- Dr Fiona Cowden, Consultant Psychiatrist, Tayside Substance Misuse Service
- Dr Stephen Curran, Consultant Psychiatrist, General Adult Psychiatry, NHS Tayside
- Ms Jackie Daly, Head of Nursing (Community), Psychiatry of Old Age, NHS Tayside
- Ms Donna Davidson, Procurator Fiscal Depute, Scottish Fatalities Investigation Unit, Crown Office and Procurator Fiscal Service
- Mr Martin Dey, Senior Manager, Criminal Justice Service, Dundee City Council
- Ms Carla Donnachie, Area Service Manager, Scottish Ambulance Service
- Ms Susan Duncan, Development Officer (Suicide Prevention and Violence Against Women), Protecting People, Angus Council
- Sergeant Derek Elder, Police Sergeant, British Transport Police
- Dr Tim Elworthy, Consultant Psychiatrist, Tayside Substance Misuse Service
- Ms Rhian Ferguson, Development Officer, Protecting People Team, Dundee Health & Social Care Partnership

- Mrs Jillian Galloway, Head of Prisoner Healthcare, Out of Hours and Forensic Medicine Services, NHS Tayside
- Mrs Grace Gilling, Head of Service/NHS Tayside Lead for Adult Protection, NHS Tayside
- Ms Lex Greig, Social Work Team Leader, Criminal Justice Service, HMP Perth/Perth & Kinross Council
- Ms Laura Henderson, Senior Health Promotion Officer (Mental Health & Wellbeing/Substance Misuse), NHS Tayside
- Mr Paul Henderson, Service Manager (Mental Health, Drug & Alcohol), Housing & Community Care, Perth & Kinross Council
- Mrs Val Johnson, Head of Inpatient Mental Health & Learning Disabilities Services (Tayside), NHS Tayside
- Mr Scott Kane, Nurse Consultant, Liaison Psychiatry, NHS Tayside
- Mr Brian Kidd, Clinical Senior Lecturer in the Psychiatry of Addiction, Tayside Substance Misuse Service
- Mr Colin MacDougall, Suicide/Self Harm Prevention Co-ordinator, NHS Tayside
- Mr Piers McGregor, Inpatient Services Manager, General Adult Psychiatry, NHS Tayside
- Mr Adrian McLaughlin, Chair of Angus Suicide Prevention Collaborative, Angus Council
- Dr Fhionna Moore, Senior Lecturer in Psychology, University of Dundee
- Ms Mary Notman, Adult Protection Co-ordinator, Perth & Kinross Council
- Mrs Tracey Passway, Clinical Governance & Risk Management Team Leader, NHS Tayside
- Professor Kevin Power, Director of Psychology, Area Psychological Therapy Service, NHS Tayside
- Mrs Marliese Richmond, Planning & Policy Officer, Perth & Kinross Council
- Mrs Gillian Robertson, Personal Assistant, NHS Tayside
- Ms Nicola Rogerson, Service Manager, Community Safety Service, Perth & Kinross Council
- Ms Irene Sharkie, Lead Clinical Pharmacist (Mental Health), NHS Tayside
- Sergeant Andrew Sheppard, Safer Communities, Police Scotland

- Mr Craig Thomson, Station Manager, Prevention and Protection, Scottish Fire & Rescue Service
- Mr Bill Troup, Head of Mental Health Services, Angus Health & Social Care Partnership
- Mr Stephen Valentine, Hath Behaviour Change Co-ordinator, Learning & Development, NHS Tayside
- Ms Sara Vaughan, Team Leader, Perth & Kinross Intensive Home Treatment Team, NHS Tayside
- Dr Michelle Watts, Associate Medical Director, Primary Care Services, NHS Tayside

APPENDIX 2

DETAILED ANALYSIS OF A SUBSET OF TAYSIDE COMPLETED SUICIDES

The Public Health Department has been fortunate to be able to collaborate with Dr Moore from the University of Dundee whose MSc Psychology students have undertaken an in depth analysis of a small proportion of the TMASRG case records.

The TMASRG case records of 36 consecutive deaths from 2016 were scrutinised in greater detail as part of a research study. This sample consisted of 24 suicide deaths from Dundee, seven from Angus and five from Perth and Kinross. There were 22 males and 14 females.

Overview:

- 67% had a history of previous self harm/suicide attempts
- 47% had communicated suicidal thoughts to someone prior to their death.
- 83% had had a negative change in a relationship.
- Social groups/circles: 34% had one, 43% had two and 23% had three or more social groups.
- 42% had had a major change in financial state recorded.
- 58% had had a major change in the health or behaviour of a family member documented.
- 25% had a history of adverse childhood experiences for example; sexual abuse, witnessing physical abuse, loss of a parent, neglect.
- 33% were assessed to have personality traits which may increase the likelihood of suicide for example high levels of impulsivity, internalising of emotional distress, introversion or dependency.

Self Harm History

67% had a history of previous self harm/suicide attempts. For this group hanging was the most common method used by 54%. However, this was only used by 17% in previous self harm/suicide whereas 71% of previous self harm/suicide were self poisoning. In women the only previous method used was poisoning. In these completed suicides only 13% used poisoning as the method. This is in keeping with research evidence that indicates 57-65% of people who have self harmed/attempted suicide modify the method when they complete suicide.[5,6] The main change in method is that those who have previously undertaken poisoning or cutting then change to a more lethal method to complete suicide. In contrast, where previous attempts have used a more lethal method such as hanging or jumping completed suicide is undertaken by the same means.[7]

In this population 83% had experienced a negative change in a relationship prior to competing suicide. This definition includes arguments, major conflict and ending of a relationship. Strains on, or changes in relationships can cause a loss of connection with social groups affecting the feeling of 'belonging' and increasing feelings of 'being a burden' or that one is not needed in society.[4]

57% of this population who had had a relationship change had also had a recent change of accommodation/living arrangements shortly before death. 70% were prescribed medication for a mental health disorder at the time of their death and 67% had had been noted to have had a recent worsening of their mental health.

Over 75% were estimated to only have one or two social groups/circles. Having a greater number of social group identifications has been associated with a reduced likelihood of depression.

A further analysis was undertaken on this sample to assess the relationship between individual characteristics and help seeking behaviour. No significant factors were identified in this small sample. However, it confirms the need for further research in risk assessment. This is keeping with a meta-analysis of suicide prevention initiatives for GPs which found that these could not be recommended currently due to equivocal results.[8]

APPENDIX 3

BEREAVED BY SUICIDE (POSTVENTION) SUPPORT: RECOMMENDATION PAPER

SUMMARY

Situation
The Tayside Multiagency Suicide Review Group identified a potential unmet need for support for those bereaved by suicide in Tayside.

Background
People bereaved by suicide are at increased risk of complex grief and suicide. Currently the only local provision of postvention support is in Perth and Kinross.

Assessment
A short life working group of the Tayside Multiagency Suicide Review group (TMASRG) was set up to examine whether there was a need for postvention support across Tayside. Local and national evidence indicate that there is a need to provide support to this population.

Recommendation
Each Local Authority area should undertake to provide a postvention support service.

NEEDS ASSESSMENT

Local Evidence of Need

Anecdotally statutory and 3rd sector colleagues were aware of an unmet need for support for people bereaved by suicide. In 2016/17, 8% of suicides reviewed by TMASRG had experienced bereavement by suicide in someone close to them.

The Perth and Kinross Bereaved by Suicide Initiative, a joint initiative between Police Scotland and Social Work, has been providing a service to local people since November 2013. This followed a number of linked suicides between people who had been bereaved by suicide in 2012. Following a referral from the Police, and ensuring consent has been obtained from the family/friend, an initial phone call is made to the bereaved family/person. If requested, Bereaved by Suicide Support Packs are sent out to family members and/or friends of people who have completed suicide. The packs contain different sources of information on emotional and practical issues to support people during the aftermath of a completed suicide. If they wish, the Access Team continue to provide support either on a short or long term basis.

There has been considerable learning from this project which could be applied to a Tayside-wide Bereaved by Suicide Project:

- Good working relationships and referral processes are essential in order that the bereaved person is contacted in an appropriate, sensitive and timely manner.
- The bereaved person should be given a named person who they can contact for information and/or support.
- *Packs and letters should be personalised, with initial contact made by phone.*
- Linking with other services on specific issues such as child protection is important.
- Support should be available over an extended period of time, and follow up contacts made after 3 – 6 months.
- ASIST and Bereaved by Suicide Training is essential in up-skilling those providing the support, in terms of understanding the risk of suicide to the person bereaved, the complex grief process, the stigma attached to death by suicide, and the isolation the person can feel.

In Dundee, Ruth Brown from Dundee Voluntary Action co-ordinated the collection of detailed information from local people who have had lived experience of bereavement by suicide. The key findings from this were:

- Those bereaved by suicide would find it very beneficial to be offered support.
- Support should be available as soon as possible after the death.
- This support would help initially in acknowledging what has happened and if needed to provide ongoing support.
- Support from someone who has knowledge of the processes, procedures and practical issues that arise following a suicide would be helpful.
- Help in accessing statutory services if required would be helpful.
- Feedback from those bereaved by suicide was that it would be preferable for support to be provided by an independent, non-statutory agency.
- Local community hubs or similar venues would be useful points of delivery for support.
- Others require support too, not just the immediate family.
- Children and young people in particular require support.
- Community support might be beneficial where suicide has affected many community members.
- Family and friends can be important in providing support, but some people don't have this.
- Information packs on where support is available are useful.
- Sensitive handling of bereaved families by Police of people can help prevent additional distress.
- Primary Care varies in how well they manage those bereaved by suicide.

Research Evidence of Need

Public Health England has said that research suggests there is a substantial unmet need for support and it is important that all are aware of the range of resources and services available.(1) A UK survey of young adults found that friends and relatives of people who die by suicide have a one in ten risk of making a suicide attempt.(2)

Close family members are the most vulnerable after a suicide but support should be available to people throughout the deceased individual's social network, as well as to health professionals and others affected by the suicide.(1)

A systematic review of suicide risk following bereavement by suicide identified several negative outcomes including an increased risk of suicide in partners bereaved by suicide; of admission to psychiatric care in parents bereaved by suicide of offspring; of suicide in mothers bereaved by an adult child's suicide; and of depression in offspring bereaved by suicide of a parent. The range of kinships affected suggests that all members of the immediate family might need screening and appropriate support. Gaps in knowledge about the effect of peer suicide should be addressed, and investigators should delineate how extensively to offer support within the deceased's social circle. (3)

The cost of a suicide has been calculated as £1.67m, with 70% of that figure representing the emotional impact on relatives. Although we do not yet have estimates for the effect that postvention programmes could have on social functioning, stigma, mental health, physical health and mortality in England, existing evidence suggests the potential for health and economic benefits.(1)

Local Quantitative Estimate of Need

In Tayside there is a 6 year cumulative mean of 50 suicide deaths per year. An average of 4 people will suffer intense grief after each suicide(3) and a conservative estimate is that 10 people will be directly affected by each suicide death.(1) If 4 –10 people is used as the estimate for numbers who would benefit from postvention support after a suicide then in Tayside this equates to 200 – 500 people annually. The Local Authority estimates are:

- Angus 50 – 125 people per year,
- Dundee City 100 – 250 people per year,
- Perth and &Kinross 50 – 125 people per year.

REVIEW OF RESEARCH EVIDENCE FOR POSTVENTION SUPPORT

Models of service provision

Public Health England has identified a variety of different models of support including local suicide bereavement support groups, one-to-one support, family support, online resources telephone help lines, individual and group counselling or psychotherapy. Evidence based training has also been developed to guide GPs and mental health professionals to support parents bereaved by suicide.[1] Specialist support is needed for children who have been bereaved by suicide.

A systematic review of research evidence for postvention programmes undertaken in 2010 found 49 studies of which only 16 were of sufficient methodological equality to be included in the review.[4] Evidence in this field is therefore limited but the following programmes showed the most potential benefit:

- Gatekeeper training for proactive postvention was effective in increasing knowledge pertaining to crisis intervention among school personnel.
- Outreach at the scene of a suicide was found to be helpful in encouraging survivors to attend a support group at a crisis centre and seek help in dealing with their loss.
- Contact with a counselling postvention service for familial survivors (spouses, parents, children) of suicide generally helped reduce psychological distress in the short term.
- Results of studies of group-based counselling suicide postvention programs for certain survivor groups suggest that these should be made available to those individuals who indicate a need for them (e.g., individuals experiencing more severe or prolonged mental distress or psychological symptoms).[4]

The issue of stigma in relation to suicide death has been highlighted in a number of studies. A systematic review of studies to help explore the consequences of this demonstrated that suicide survivors experience stigma in the form of shame, blame, and avoidance. 'Suicide survivors showed higher levels of stigma than natural death survivors. Stigma was linked to concealment of the death, social withdrawal, reduced psychological and somatic functioning, and grief difficulties'.[5]

Service user preferences for postvention support

The systematic review of postvention support points out that 'the views of participants were noticeably absent from the studies; their views on the interventions received were generally not obtained and it was unclear whether the support given was viewed as helpful and appropriate to their needs'.[4]

However, one qualitative study has investigated the support needs of British young adults bereaved by suicide and it had the key finding that there is 'the need for proactive offers of support from family, friends, and professionals after suicide'.[5] It was also highlighted that this offer of support should be repeated regularly, in case a bereaved person does not feel ready for support early on. People said they felt less comfortable asking for help from professionals and many felt let down by GPs who did not intervene to help them access support, or failed to pick up on cues that support was needed. It was recognised that it was particularly in the immediate aftermath of the loss, where people reported feeling too distressed to seek help on

their own or act on any information provided, that proactively offering support would have been most helpful.[6]

An Australian study of parents who had lost a child to suicide identified three key themes in parental responses to suicide bereavement: searching for answers and sense-making; coping strategies and support; and finding meaning and purpose.[7]

'Coping strategies and levels of support varied considerably among parents in our study. A range of both maladaptive and adaptive strategies were described-from avoidance (not discussing the death, excessive work and alcohol use) to maintaining physical and mental health, and rituals such as writing letters and celebrating birthdays to ensure continuing bonds with the child. Where the prevailing thought was once that grief should be resolved by disconnecting from the deceased, new models of grief and loss allow for ongoing relationships and emotional connections, for example supporting ongoing rituals and marking of special occasions. Research now suggests that continuing bonds with a loved one may have an adaptive function through the maintenance of a psychological rather than physical bond. [7]

'In our study, parents found it important to maintain psychological bonds with their child through rituals. This study supports previous research indicating that support groups may play a crucial role in suicide-bereaved parents' ability to make sense of their loss and reconstruct their lives in a helpful way. An important issue identified through studying individual parents' bereavement experiences was that a number of parents had difficulties in sharing their feelings and/or talking about the loss of their child with their partner. Suicide-bereavement support groups may also offer opportunities for individuals in this situation to share their feelings in a supportive and understanding environment'. [7]

Scottish Government Guidance Postvention Support

Scotland's Suicide Prevention Action Plan, 2018, in action four states that 'the time following a death by suicide or a suicide attempt represents a critical time for compassionate, high quality care. Good and timely support and information need to be available to people who have been directly affected by suicide'.

Good Practice Guidance Postvention Support

Health Scotland (2017): Supporting people bereaved by suicide
http://www.healthscotland.com/documents/20648.aspx

Public Health England (2016): Support after a suicide: A guide to providing local services
A practice resource
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

CONCLUSIONS

- There is a need for postvention support following bereavement by suicide as indicated by local and national evidence and Scottish Government Guidance.
- It is estimated that 200 – 500 people in Tayside per year are likely to need this support.
- Postvention support should be offered pro-actively because of the particular issues of stigma and complex grief in this population and ideally the offer of support should be repeated.
- Provision by a non-statutory agency was preferable to the small number of people surveyed. However, this cannot be assumed to be essential and timely provision of a service is more important.
- Police, Primary Care and other agencies would benefit from training/education around how to best support those bereaved by suicide.

RECOMMENDATION

Each Local Authority area should undertake to provide a postvention support service.

Dr Jane Bray
Chair, Tayside Multiagency Suicide Review Group
August 2018

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Suicide Prevention is Everybody's Business

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ITEM No …12……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 26 FEBRUARY 2019**

REPORT ON: **PROPOSED NEW "PAUSE" SERVICE FOR DUNDEE**

REPORT BY: **CHIEF SOCIAL WORK OFFICER**

REPORT NO: **DIJB1-2019**

1.0 PURPOSE OF REPORT

This report provides information on proposals to introduce a new service, Pause, for women who have had multiple children removed from their care to Dundee. These proposals were approved at the Children and Families Committee of the City Council on 28 January 2019.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board:

2.1 Notes the content of this report.

2.2 Notes that, subject to available funding, a pilot Pause Practice will be established in Dundee. This will be informed by a steering group involving relevant partner agencies including staff from the Health and Social Partnership.

2.3 Directs the Chief Officer to identify appropriate representation on the proposed steering group from the Health and Social Care Partnership.

2.4 Instructs the Chief Social Work Officer to report back to the Integration Joint Board prior to the end of 2021 regarding the evaluation and longer term sustainability of a Pause Service for Dundee.

3.0 FINANCIAL IMPLICATIONS

3.1 Funding is being made available to introduce a 2 year pilot Pause Practice in Dundee (called 'Pause Dundee') and probably 1 other local authority area in Scotland. Funding is only available for this specific project and would commence from the 2019/20 financial year.

3.2 The cost of a Pause programme for the 2 year pilot period is £300,000 per annum. It is anticipated that funding will be provided by the Big Lottery, Scottish Government and the Robertson Trust. There are no immediate financial implications for Dundee City Council however the expectation is that if the pilot was seen to be effective that the service would be mainstreamed and funded from existing resources using a Social Bridging Finance (SBF) model as outlined in paragraph 4.4.1. There are no financial implications for the IJB.

4.0 MAIN TEXT

4.1 Background

4.1.1 Pause is a charity that operates in a number of local authority areas in England and Northern Ireland. The charity supports local areas to set-up and deliver Pause Practices, which work with women who have experienced, or are at risk of, repeated pregnancies that result in children needing to be removed from their care. Pause Practices offer an intense programme of therapeutic, practical and behavioural support through an integrated and systemic model. Each woman has a bespoke programme designed around their needs.

Participation in the programme is voluntary, but with a requirement for the woman to take a "pause" from pregnancy so that they can use their time on the programme to effectively tackle destructive patterns, develop new skills and avoid further trauma. This helps them set in place strong foundations on which they can build a more positive future for themselves. Pause Practices are delivered in each area via a local partner agency (either the local authority or a third sector organisation). The Pause national charity has grown since the first pilot service began in 2013, with 21 Pause Practices reaching 25 local authority areas. In each area where there is a Pause Practice, agencies have come together to support its development and delivery, and help confirm the target population for a service.

4.1.2 A national external evaluation of the pilot Pause Practices concluded that women who access support from Pause had a very significant reduction in pregnancies, with a very high level of confidence that the reduction is directly attributable to women's engagement with the programme. The evaluation also found that participants' access and engagement with services, including health, housing and substance misuse, generally increased and was associated with improved outcomes for some women.

4.2 Scoping Work

4.2.1 The Scottish Government and Pause held an event during 2017 to raise awareness of the model in Scotland. Following some initial scoping work by officers which clarified that Dundee had a substantial population who could benefit from the service model, Dundee agreed to be a site for a formal scoping project, which involved a review of casework and a cost/benefit analysis. This work was funded by the Robertson Trust and the Big Lottery.

4.2.2 The scoping report highlighted the significant needs of the group of women who would be the potential focus of 'Pause Dundee'. The key findings are as follows;

- Between October 2012 and October 2017 a cohort of 113 women in Dundee had 341 children removed.
- 73% of women have had two or three children removed.
- The average number of children removed per woman is 3.0. In other Pause scoping exercises to date, the number of children removed per woman has ranged from 2.7 to 4.4 across a number of different areas.
- The average age of the women is 33, with over 50% of the women being aged between 32 and 38.
- In terms of intervals between births, 31% of women gave birth to another child within 1-2 years of a previous birth, and 23% within 2-3 years of a previous birth.
- The women have many complex and often inter-linking needs. 62% of the cohort have mental health needs (not necessarily diagnosed), 40% have experienced domestic abuse, 54% have issues with drug misuse (49% of which was heroin use) and 58% have criminal justice issues.

4.2.3 It is likely that quality of life of participants would improve, with improved family relationships including the potential for improved relationships with children who have previously been removed from their care. The report estimated that delivering Pause could help avoid between 6 and 10 pregnancies over 18 months. There are also potential significant consequential cost savings to a variety of agencies if these vulnerable women's needs are better met, eg through less incidences of domestic abuse, substance misuse and offending; fewer housing problems such as eviction; and greater likelihood of a positive contribution to society eg through increased employability. Estimates indicated that this would help reduce the significant costs associated with permanently removing these children into care – between £914,035 and £1,656,689 over a five year period (depending on age range worked with). The scoping report concluded that Dundee City Council could potentially realise substantial cost savings by delivering a Pause programme, principally relating to care and legal costs. The evaluation will help identify any savings or efficiencies for other organisations/bodies including the IJB.

4.2.4 The service aims to work with some of the most vulnerable women within Dundee. Without the Pause intervention, costs to the local authority are likely to increase cumulatively, since children removed often remain in care for extended periods of time. The data collated gives an indication of the resource implications expended by other partners in engagement with a woman and her children, particularly in addressing physical and mental health needs, drug and alcohol addiction, insecure housing, domestic abuse and other criminal justice issues.

4.3 Planned Implementation

4.3.1 The scoping report highlighted the need for a multi-agency approach when dealing with vulnerable women with such complex needs, but noted a real desire from partner agencies for positive outcomes for this group of women. Relevant services and developments that can therefore contribute to improved outcomes for this group of women will include:

- Health and Social Care
- Substance misuse services
- Justice responses including the proposed Women's Custody Centre
- Violence Against Women Services
- The multi-agency New Beginnings Team
- Family Nurse Partnership

4.3.2 Senior stakeholders from relevant services in Dundee have attended information and briefing sessions about the findings of the scoping report, which received favourable feedback. To implement this programme successfully, a steering group of local stakeholders will be formed to ensure that all relevant services are actively involved in ensuring strong strategic connections and that key services are available and provided to the service recipients if required.

4.3.3 The provider of the Pause Dundee will be TCA (Tayside Council on Alcohol). Using criteria developed by the Robertson Trust, the Pause national charity and Dundee City Council officers, TCA were awarded the contract to provide this service in Dundee.

4.4 Sustainability

4.4.1 It is anticipated that the primary funder of the proposed 'Pause Dundee' will be the Robertson Trust. The Trust has developed the Social Bridging Finance (SBF) model, which is a model of grant funding which supports third sector delivery of services whilst also ensuring the long-term sustainability of services which can evidence success through the development of a contract with the public sector. The contract ensures that funding of the service is sustained by the local public sector commissioner, providing that agreed success criteria have been met. Independent grant funding is provided for the demonstration period, alongside an independent evaluation to enable the outcomes to be evidenced. The primary use of these outcomes and indicators will be to retrospectively review Pause Dundee's impact at the end of the demonstration period.

4.4.2 Council officers are currently in discussion with Pause, the Robertson Trust and TCA about the specific success criteria for Pause. Such criteria is likely to include:

- Levels of engagement
- Positive feedback from participants
- High levels of women who do not get pregnant during the programme
- Positive impact on participants, including self-esteem, increased lifestyle stability, improved engagement with services and improved family relationships
- The ongoing need for the service across the Council area

4.4.3 During the period of the pilot phase, work will also be ongoing to identify and confirm the financial assumptions made about savings contained within the scoping report; work with the evaluators to identify social benefits and relevant cost savings across partner agencies; clarify the ongoing demand for the service within Dundee; and engage with neighbouring authorities about any collaborative approaches for this service user group.

4.5 Conclusion

4.5.1 The introduction of Pause Dundee will provide a unique opportunity to take advantage of external funding to provide an innovative and intensive service to some of Dundee's most vulnerable women. This investment in preventative work aims to shift resources to meet needs and thereby prevent the need for higher costs elsewhere.

4.5.2 This opportunity will also allow Dundee to be at the forefront of this innovative service and test out the Pause model in a Scottish context, providing vital evaluative information that will help clarify its longer term value within the Scottish social services and health landscape.

4.5.3 Clearly the work of Pause will be cross cutting and will also impact on both Justice and Health and Social Care and they will require to be represented on the Steering Group. A report will also be presented to the Integration Joint Board outlining the initial proposals.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Integrated Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it is for information and does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

The Chief Officer, Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	**X**
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

9.1 None.

Jane Martin
Chief Social Work Officer

18 February 2019

ITEM No …13……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 26 FEBRUARY 2019**

REPORT ON: **ARRANGEMENTS FOR MANAGING HIGH RISK OFFENDERS**

REPORT BY: **CHIEF SOCIAL WORK OFFICER**

REPORT NO: **DIJB4-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to present Integration Joint Board members with the eleventh annual report on arrangements for managing high risk offenders across Tayside, covering the period 1 April 2017 - 31 March 2018. A copy of the report is appended.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report.

2.2 Notes the ongoing developments in relation to the risk assessment and risk management of high risk offenders (section 4.4 to 6.0 and appendix 1).

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 The Management of Offenders etc. (Scotland) Act 2005 introduced a statutory duty on Responsible Authorities - Local Authorities, Scottish Prison Service (SPS), Police and Health - to establish joint arrangements for the assessment and management of the risk of harm posed by certain offenders. The Health and Social Care Partnership has an important role in supporting the corporate bodies to discharge this statutory duty within delegated services. The Act also placed a duty on agencies who come into regular contact with high risk of harm offenders to co-operate in risk assessment and risk management processes. These 'Duty to Co-operate' agencies include, for example, Third Sector partners and suppliers of Electronic Monitoring. The Responsible Authorities are required to keep the arrangements under review and publish an annual report.

4.2 The introduction of Multi Agency Public Protection Arrangements (MAPPA) in 2007 created a consistent approach towards the implementation of the Act and initially focused on Registered Sex Offenders (RSO's). In 2008, arrangements were extended to include Restricted Patients who are persons who, by virtue of their mental health, are confined for treatment under current Mental Health legislation and present a risk of harm to the public. In 2016, arrangements were further extended to include 'Category 3' persons, defined as anyone who has been convicted of an offence and by reason of that conviction, is considered to present a high or very high risk of serious harm to the public and requires multi-agency management. These people have typically committed a serious, violent offence(s) and are also subject to statutory supervision.

4.3 In Tayside, a MAPPA Strategic Oversight Group (SOG) oversees developments and consists of the Responsible Authorities, local Duty to Cooperate agencies and Victim Support. Where an RSO subject to Notification Requirements is also subject to a Community Payback Order or License Conditions after serving a prison sentence of 4 years or more, they are managed jointly by the Local Authority and Police Scotland. Where only Notification Requirements apply, the lead agency is Police Scotland. The lead for Restricted Patients is the NHS and for Category 3 persons, the Local Authority. Individuals are assessed at Levels 1, 2 or 3 and managed proportionately. However, regardless of the level, the management of high risk of harm offenders is a complex task and requires appropriate information sharing, defensible decision making, collaborative actions, case reviews and robust enforcement. Whilst some emphasis is placed on rehabilitation, public safety is always paramount.

4.4. In April 2017, risk assessment processes were enhanced to require additional Risk of Serious Harm (ROSH) assessments in the 'critical few' cases where there are more serious initial concerns. These ROSH assessments involve a more detailed multi-agency risk assessment and management which includes scenario and contingency planning to help prevent, monitor and effectively respond to indications of heightened risk. In 2018, national minimum practice standards in respect of Level 1, the lowest risk, cases were also introduced. In Tayside, ROSH assessments are carried out on all appropriate cases and practice standards exceed the minimum requirement for Level 1 cases.

4.5 In the same period, a multi-agency audit of MAPPA meetings and the minutes was carried out and the overall findings were positive. Findings noted that meetings continued to reflect a purposeful level of multiagency information sharing, risk assessment and risk management planning. A small number of recommendations were made in relation to being even more explicit about the links between the risks identified and actions agreed to mitigate these risks. As a result, the minute template was amended to include the agreed level of risk within the body of the minute, a numbering of identified risk factors and direct cross-referencing within the risk management plan.

4.6 Over the period, there has also continued to be an increase both nationally and locally in the proportion of RSOs (Registered Sex Offenders) with convictions for internet offences. As of 31 March 2018, there were 364 RSOs across the region and 44% had been convicted of an internet offence. Given the serious nature of these offences, which do not automatically lead to contact offences but do always cause children significant harm, it presents particular challenges. In response, this is a joint priority with the Child Protection Committee and from a preventative perspective the Responsible Authorities work to promote awareness raising and internet safety in schools and with children and families. When a person has been convicted and sentenced or is due to be released from prison, the Responsible Authorities also work with the Sheriff Court and Parole Board to ensure appropriate conditions can be applied to monitor and effectively respond to internet access and activity. Nationally, legislative changes also extend the powers available to address such behaviour. The Abusive Behaviour and Sexual Harm (Scotland) Act 2016, for instance, introduces a new offence of disclosing, or threatening to disclose, an intimate image. This extends beyond downloading indecent images and includes sharing photographs via social networking sites and mobile phones. Specific tools to help assess the type and level of risk posed by internet sex offenders are also being developed.

4.7 The changes to the profile of RSOs and the types of offences which are increasingly being committed have also prompted an announcement by the Scottish Government and Scottish Prison Service that they intend to make changes to the accredited Moving Forward Making Changes (MFMC) programme for sex offenders. It is likely that a new programme or programmes will involve distinct components relating to internet and contact offences. Whilst the process of re-development is underway, the existing MFMC remains available to the Court as a programme requirement within a sentence.

4.8 Over the same period, the Tayside MAPPA SOG continued to have oversight and scrutiny of the assessment and management of individuals managed under the framework who re-offend. This involved the Chair of the MAPPA SOG, currently the Chief Social Work Officer in Angus, being notified of 4 individuals from across Tayside, 2 of which resulted in a Serious Case Review (SCR) being commissioned to examine the circumstances in more depth. One of these cases was managed in Dundee and this will be reported on in the near future. These reviews are important as they examine whether policies, processes were followed and where improvements are suggested plans they ensure these are put in place promptly.

4.9 Awareness raising is an agreed priority of the SOG and two briefing sessions were held with Dundee elected members over the last 12 months involving the full range of MAPPA partners. In addition the Chief Social Work Officer undertook presentations to the Council Management Team and elected members on protecting people in Dundee which included information on work with high risk of harm individuals. All MAPPA Responsible Authorities also continued to work with other Protecting People partners involved, for instance, in Child Protection, Adult Support and Protection and Violence Against Women. Locally, this integrated approach towards the protection of vulnerable groups continued to be overseen by the Chief Officer Group for Protecting People.

4.10 A number of individuals managed under the MAPPA framework have health and social care needs necessitating close collaborative working between the Health and Social Care Partnership and the Responsible Authorities. Robust information sharing to inform risk assessment and risk management is particularly important. In addition, across Scotland it has been recognised that there is an increasing proportion of older people managed under MAPPA. At a national level work is ongoing to better understand this trend and the implications for the provision of health and social care services within the Scottish Prison Service estate.

5.0 KEY DATA

- 131 of the 364 RSOs are managed jointly by Police Scotland and Social Work, a decrease of 43 from the previous report.
- 36% of RSOs are on statutory supervision involving a Community Payback Order with supervision requirements or License Conditions from custody.
- The distribution of RSOs across the 3 authorities is Dundee 148, Angus 105 and Perth and Kinross 111.
- There are 21 Restricted Patients managed by NHS Tayside, a decrease of 6 from the last report.
- The number of RSOs returned to custody for a breach of statutory conditions was 5. This is 1.3% of the total.

6.0 PRIORITIES IN 2018-2019

- In the 2018/19 reporting period the 2 Serious Case Reviews undertaken by Independent Reviewers to examine practice will be completed and recommendations will be considered and acted upon by Responsible Authorities.
- Learning from SCRs will also be enhanced by ongoing self-evaluation mechanisms, such as case file audits, reviews of the use of the Violent and Sex Offender Register (VISOR) and reviews of Initial Notifications that are assessed not to require a SCR.

- An Independent Chair of the SOG will be recruited to bring oversight of MAPPA into line with other Protecting People Forums, such as the Child Protection Committee, Adult Support and Protection Committee and Violence Against Women Partnership.

- The Responsible Authorities will contribute towards and respond to developments relating to the risk assessment of people who commit internet offences and an accredited programme to replace MFMC.

7.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Integrated Impact Assessment. There are no major issues.

8.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it is for information and does not require any policy or financial decisions at this time.

9.0 CONSULTATIONS

The Chief Officer, Chief Finance Officer, Head of Service, Health and Community Care, the Chief Officers Group (Protecting People), members of the Tayside MAPPA Strategic Oversight Group and the Clerk have been consulted in the preparation of this report.

10.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Directions Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

11.0 BACKGROUND PAPERS

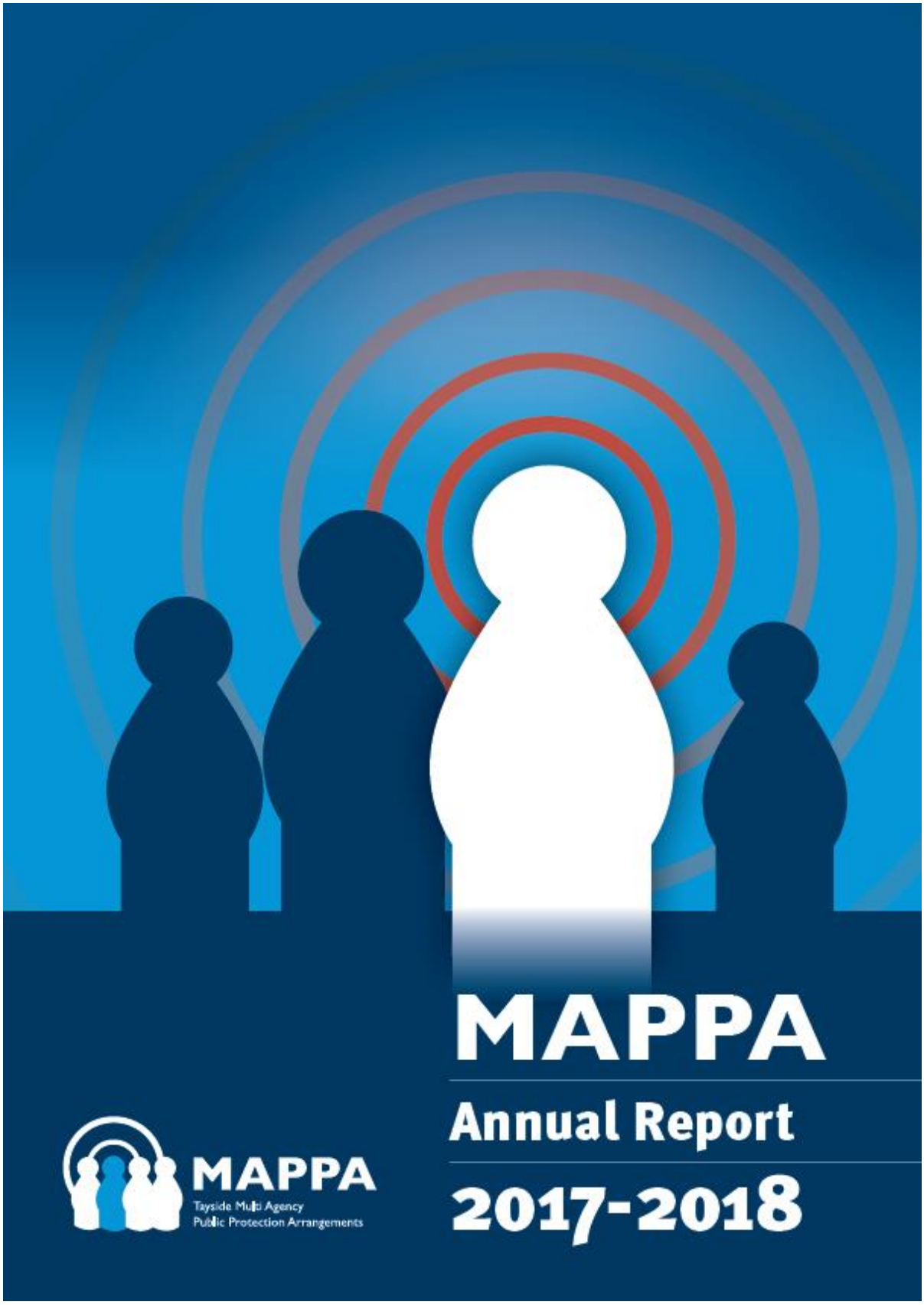
None.

Jane Martin
Chief Social Work Officer

DATE: 11 February 2019

Kathryn Sharp
Senior Manager, Strategy and Performance

Appendix 1


MAPPA
Annual Report
2017-2018
MAPPA
Tayside Multi Agency
Public Protection Arrangements

FOREWORD

Welcome to the 2017/2018 annual report on Tayside's Multi Agency Public Protection Arrangements (MAPPA).

MAPPA is the framework which joins up the agencies who manage offenders. The fundamental purpose of MAPPA is public safety and the reduction of serious harm. The introduction of MAPPA across Scotland in April 2007 gave a consistent approach to the management of offenders across all local authority and police force areas, providing a framework for assessing and managing the risk posed by some of those offenders.

By embracing joint working within MAPPA we can communicate more effectively, reduce duplication and ensure a strong partnership response. No single agency can tackle these challenges alone and it is vitally important that agencies continue to support and inform the MAPPA process. This way, together, I believe we are able to offer the best protection for the public of Tayside.

This annual report reflects the contributions made by all of the agencies involved in MAPPA across Tayside and sets out our commitment to continue to develop strong partnerships and explore new ways of working to face the challenges of protecting the public from serious harm.

I hope that you find this report informative and that it helps answer some key questions about the operation of MAPPA in Tayside.

Kathryn Lindsay
Chair of Tayside MAPPA Strategic Oversight Group
MAPPA

THE LAST 12 MONTHS

Multi-Agency Public Protection Arrangements in Tayside

Multi-Agency Public Protection Arrangements (MAPPA) provide a framework to manage the risk posed by registered sex offenders, restricted patients (mainly violent offenders, with a small number of sex offenders) and offenders who by reason of their conviction are subject to supervision in the community and are assessed as posing a high or very high risk of serious harm to the public which requires which requires active multi-agency management at MAPPA Level 2 or 3.

MAPPA bring together professionals from the police, social work, housing, health and the Scottish Prison Service. These agencies are known as the 'responsible authorities'. While the Tayside arrangements are co-ordinated by a central unit based in Dundee, the practical management of offenders remains the responsibility of these agencies at a local level.

The geographic area covered by our arrangements incorporates the local authority areas of Dundee City, Perth and Kinross, and Angus. Services cover a mixture of urban and rural areas.

The responsible authorities represented are:

- **The Dundee City Council**
- **Perth and Kinross Council**
- **Angus Council**
- **Police Scotland**
- **Scottish Prison Service**
- **NHS Tayside**

ROLES AND RESPONSIBILTIES

The responsible authorities for each area are required to involve other key agencies in the management of offenders. This is an important part of MAPPA, involving the exchange of information and drawing on the collective knowledge and expertise of numerous agencies.

Police Scotland is responsible for the operation of the Sex Offender Notification Requirements (SONR). They will normally be the responsible authority for those RSOs, who are not subject to statutory supervision by the local authority. In cases where the statutory supervision ends, but the RSO is still subject to SONR, the police will become the lead responsible authority. There are a small number of cases where an RSO receives a community sentence disposal, but there are no licence conditions and no involvement by local authority criminal justice social work. In such cases the police will be the responsible authority.

Activities include enforcement of notification and compliance requirements of sex offender registration, policing activities, risk assessment, preventative and monitoring strategies, coupled with investigation and prosecution of any registered sex offender who re-offends.. These duties are carried out in partnership with all responsible authorities and 'duty-to-cooperate' agencies.

The local authority is the responsible authority for registered sex offenders who are subject to statutory supervision. Each Council's criminal justice social work service is responsible for the supervision of such offenders, but housing, adult social care and children and families services also play a key role in the effective management of sex offenders in the community.

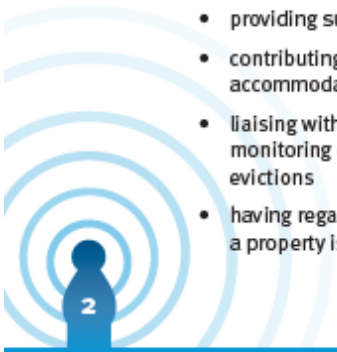
Criminal justice social work makes a significant contribution to public protection by supervising and managing registered sex offenders in accordance with the requirements of MAPPA and other public protection-related legislation.

Social workers supervise offenders subject to community payback orders and those who have been released from prison and remain subject to formal supervision like parole. Social workers use nationally recognised, accredited risk assessment tools and in collaboration with other agencies, develop plans for the risk management and supervision of offenders.

Local authority housing officers are responsible for offenders' access to housing, which includes accessing temporary accommodation and identification of suitable permanent housing.

The role of the housing service is to contribute to the responsible authorities' management of risk through:

- providing suitable accommodation
- contributing to environmental risk assessments to ensure accommodation is appropriate
- liaising with the responsible authorities regarding the ongoing management and monitoring of the risk of the offender as a tenant, including any tenancy moves or evictions
- having regard to community safety and having in place contingency plans for when a property is no longer suitable and/or the offender's safety is at risk.



NHS Tayside continues to play an important role in MAPPA locally, as the responsible authority for mentally disordered, restricted patients, and in fulfilling the wider duty to cooperate in the management of other registered sex offenders. NHS Tayside have an identified MAPPA liaison officer, to promote consistent approaches to information sharing and joint working between NHS Tayside and other MAPPA agencies.

The Tay Project, a partnership project across the three local authority criminal justice social work services continues to support risk management through supporting assessments of relevant offenders and delivering community-based group treatment programmes and individual interventions to addressthe behaviour and attitudes associated with sexual offending.

PRACTICE DEVELOPMENTS

In 2016/17 we said we would

- Raise awareness of MAPPA
- Link with other public protection fora
- Carry out an audit of MAPPA activity
- Progress the work of the MOG (operational group) in ensuring learning from self-evaluation activities and inspection is implemented across all agencies

The MAPPA Co-ordinator continues to link with other lead officers in Child and Adult Protection across Tayside and attends the Protecting People Angus and Protecting People in Dundee meetings.

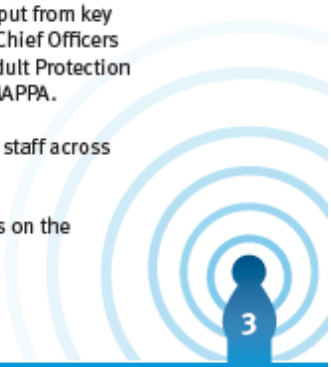
In April 2017, guidance was issued by Social Work Scotland Criminal Justice Standing Committee to improve the interface between social work staff and MAPPA by embedding Risk of Serious Harm processes into practice to assist with decisions relating to MAPPA management levels.

National minimum practice standards in respect of MAPPA Level 1 were introduced in 2018. Within Tayside, our local practice standards continue to exceed the national minimum standards.

In March 2018, Protecting People Angus hosted their first conference, with 113 participants including Chief Officers and Elected Members. There was input from key speakers, six workshops for professionals and a separate workshop for Chief Officers and Elected Members. Workshops covered a range of topics including Adult Protection and Sexual Exploitation, Social Media and Sexting and Understanding MAPPA.

The MAPPA Co-ordinator has delivered lunchtime awareness sessions to staff across all areas of Angus Council.

In Dundee, a series of briefing meetings were held with Elected Members on the implementation of MAPPA.



The MAPPA Operational Group (MOG) continue to meet and have carried out a number of key actions this year, including:

- Audit of MAPPA meetings
- Multi-agency MAPPA Chair event to discuss and review use of key risk assessment and risk management documents
- Implementation of recently developed Risk Assessment & Risk Management Plan templates for all Level 2 offenders

STRATEGIC OVERVIEW ARRANGEMENTS

Tayside Strategic Oversight Group

This group is responsible for the overview and co-ordination of the Multi-Agency Public Protection Arrangements, ensuring the sharing of best practice and learning from significant case reviews. The group also provides a strategic lead for developing local multi-agency policy and strategy in relation to shared priorities regarding the management of offenders.

A critical role for the Tayside MAPPA SOG is to consider the circumstances of any re-offending by a person managed under MAPPA. Statistically, very few offenders subject to MAPPA processes re-offend. This rarity needs to be balanced with serious harm than can result from any single instance of reoffending by such an offender and the legitimate level of public interest generated in such cases. Four individuals subject to MAPPA in Tayside were reconvicted this year. The MAPPA Strategic Oversight Group considers every reported case to establish whether a review should take place. Within the last annual reporting period, two cases have been identified as requiring a review and external reviewers have been commissioned to conduct a Serious Case Review (SCR).

Tayside MAPPA Operational Group

This multi-agency operational group supports the work of the Strategic Oversight Group. The remit of the group is to share learning, develop best consistency of practice.

One of the tasks this year was to carry out an Audit of MAPPA meeting minutes. The Audit examined cases from across the Tayside area and across all three levels of MAPPA. The minutes of MAPPA meetings were found to demonstrate a good standard. The Strategic Oversight Group has asked the group to conduct twice yearly audits to ensure standards are maintained.

SUMMARY AND FORWARD PLANS

The structures and processes that contribute to the operation of MAPPA have continued throughout the past year. The following information is of note:

- The management of over 450 offenders (includes community and custody figures) through all levels of MAPPA arrangements
- The continued development of the MAPPA Operational Group
- Implementation of the Risk Assessment & Risk Management Plans for all Level 2 offenders
- The audit of MAPPA meetings across the three local authority areas
- Continued involvement with Protecting People in Dundee and Protecting People Angus

The following priorities have been identified for 2018/2019:

- Deliver an agreed programme of quality assurance audits
- Examine and action any recommendations from reviews of practice and self-evaluation
- Continued effort to increase the usage of the ViSOR database by all relevant agencies.

STATISTICAL INFORMATION

As of 31 March 2018 there were 364 Registered Sex Offenders managed in the community in Tayside, an increase of 3 offenders on the previous year. Of these, 131 (36%) were subject to a statutory supervision order with Community Justice Social Work and managed jointly with Police Scotland Offender Management officers.

The number of offenders managed in each area is detailed below;

- **ANGUS** - 105
- **DUNDEE** - 148
- **PERTH & KINROSS** - 111

Crime trends change over time and an increasing part of the management of offenders is the supervision and monitoring of offenders who have committed 'cybercrime' or computer oriented crime.

Of the 131 offenders subject to statutory supervision, 58 (44%) have committed cybercrime or computer oriented crime having been found in possession of indecent imagery of children.

In March 2016, certain high risk offenders became eligible for management through MAPPA (known as Category 3). This year, five offenders across Tayside have been considered under Category 3 processes.

APPENDIX A

STATISTICS FROM 1 APRIL 2017 UNTIL 31 MARCH 2018

Table 1: Registered Sex Offenders	
REGISTERED SEX OFFENDERS (RSO's)	
a) Number of Registered Sex Offenders: 1) At liberty and living in your area on 31st March : 2) In custody as of 31st March:	 364 120

Table 2: Civil Orders applied and granted in relation to RSO's.	
THE NUMBER OF	
a) Sexual Offences Prevention Orders (SOPO'S) in force on 31 March	50
b) SOPO'S imposed by courts between 1 April & 31 March	5
c) Risk of Sexual Harm Orders (RSHO's) in force on 31 March	0
d) Number of RSO's convicted of breaching SOPO conditions between 1 April & 31 March	<5
e) Number of people convicted of a breach of a RSHO between 1 April & 31 March	0
f) Number of Foreign Travel Orders imposed by courts between 1 April & 31 March	0
g) Number of Notification Orders imposed by courts between 1 April & 31 March	0

Table 3: Registered Sex Offenders	
REGISTERED SEX OFFENDERS (RSO's)	
a) Number of RSOs managed by MAPPA level as at 31 March: 1) MAPPA Level 1: 2) MAPPA Level 2: 3) MAPPA Level 3:	 337 29 0
b) Number of Registered Sex Offenders convicted of a further group 1 or 2 crime between 1st April and 31st March: 1) MAPPA Level 1: 2) MAPPA Level 2 3) MAPPA Level 3:	 <5 <5 0
c) Number of RSO's returned to custody for a breach of statutory conditions between 1 April and 31 March (including those returned to custody because of a conviction for a group 1 or 2 crime):	5
d) Number of indefinite sex offenders reviewed under the terms of the Sexual Offences Act 2003 (Remedial) (Scotland) Order 2011 between 1 April and 31 March:	0
e) Number of notification continuation orders issued under the terms of the Sexual Offences Act 2003 (Remedial) (Scotland) Order 2011 between 1 April and 31 March:	0
f) Number of notifications made to Jobcentre Plus under the terms of the Management of Offenders etc. (Scotland) Act, 2005 (Disclosure of Information) Order 2010 between 1 April and 31 March:	54
g) Number of RSO's subject to formal disclosure:	0

Table 4: Restricted Patients	
RESTRICTED PATIENTS (RP'S):	
a) Number of RP's:	
1) Living in the Tayside area on 31st March:	21
2) During the reporting year:	0
b) Number of RP's per order:	
1) Compulsion Order with Restriction Order (CORO):	27
2) Hospital Detention (HD):	0
3) Temporary Treatment Detention (TTD):	0
c) Number within hospital/community:	
1) State Hospital:	<5
2) Other hospital no suspension of detention (SUS):	<5
3) Other hospital with unescorted SUS:	0
4) Community (Conditional Discharge):	5
d) Number managed by MAPPA level on 31 March:	
1) MAPPA Level 1	0
2) MAPPA Level 2	0
3) MAPPA Level 3	0
e) Number of RPs convicted of a further group 1 or 2 crime between 1 April and 31 March:	
1) MAPPA Level 1:	0
2) MAPPA Level 2:	0
3) MAPPA Level 3:	0
f) No of RPs on Suspension of detention:	
1) who did not abscond or offend:	5
2) who absconded:	0
3) who absconded and then offended:	0
4) where absconsion resulted in withdrawal of suspension of detention:	0
g) No. of RPs on Conditional Discharge:	
1) who did not breach conditions, were not recalled, or did not offend:	5
2) who breached conditions (resulting in letter from the Scottish Government):	0
h) recalled by Scottish Ministers due to breaching conditions:	0
I) recalled by Scottish Ministers for other reasons:	0

Table 5: Delineation of RSO'S by age on 31st March:	
Age	
a) Under 18	<5
b) 18-20	25
c) 21-30	84
d) 31-40	110
e) 41-50	69
f) 51-60	103
g) 61-70	63
h) 71 and above	31
Total	**471**

Table 6: Delineation of population of RSO's on 31st March:	
Sex	
a) Male	483
b) Female	<5
Total	**486**

Table 7: Delineation of RSO's by ethnicity on 31st March:	
Ethnic Origin	
White Scottish Other British Irish Gypsy Traveller Polish Other white ethnic group	358 65 <5 <5 5 9
Mixed or multiple ethnic group	<5
Pakistani, Pakistani Scottish or Pakistani British Indian, Indian Scottish or Indian British Bangladeshi, Bangladeshi Scottish or Bangladeshi British Chinese, Chinese Scottish or Chinese British Other Asian	5 0 0 <5 0
African, African Scottish or African British Other African Carribean, Carribean Scottish or Carribean British Black, Black Scottish or Black British Other Carribean or Black	0 0 <5 0 0
Arab, Arab Scottish or Arab British	<5
Other ethnic group	0
Subject declined to define ethnicity	<5
Data not held	33
Total	**486**

Table 8: Number of RSO's managed under statutory conditions and/or notification requirements on 31st March:	
Number of RSO's	
a) On Statutory supervision:	170
b) Subject to notification requirements only:	316
Total	**486**

For further information on MAPPA, the national picture and MAPPA Guidance please see the Scottish Government website at https://beta.gov.scot/publications/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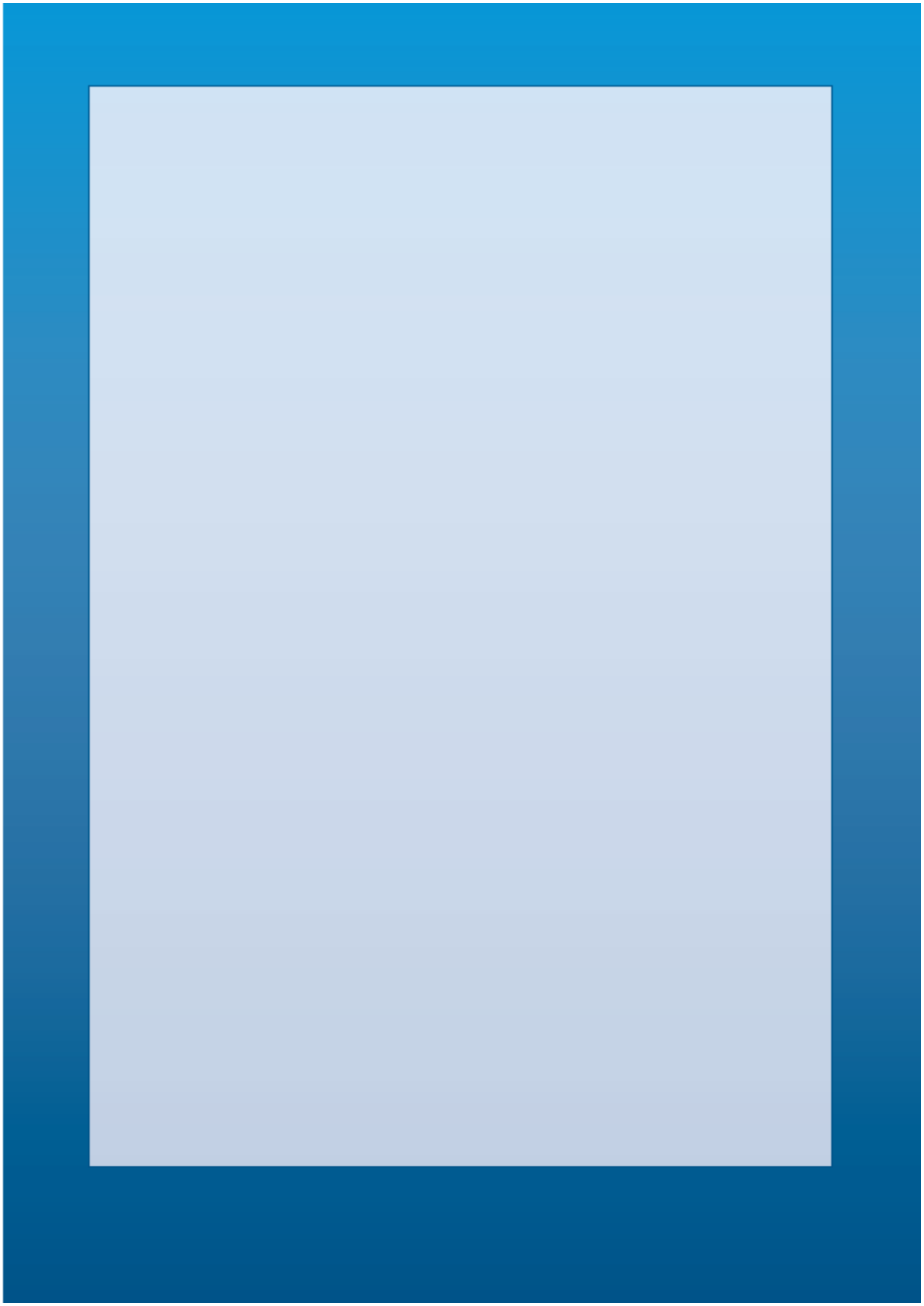

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MAPPA
Tayside Multi Agency
Public Protection Arrangements

DIJB10 - 2019

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD - ATTENDANCES - JANUARY 2018 TO DECEMBER 2018

Organisation	Member	Meeting Dates January 2018 to December 2018							
		24/1	27/2	30/3	24/4	27/6	28/8	30/10	18/12
NHS Tayside (Non Executive Member)	Doug Cross	✓	✓	✓	✓	✓	✓		
Dundee City Council (Elected Member)	Cllr Ken Lynn	✓	✓	✓	√	✓	✓	✓	✓
Dundee City Council (Elected Member)	Roisin Smith	✓	A	✓	A	✓	✓	✓	✓
Dundee City Council (Elected Member)	Helen Wright	✓	A	✓	✓	✓	✓	✓	✓
NHS Tayside (Non Executive Member)	Judith Golden	✓	✓	✓	A				
NHS Tayside (Non Executive Member)	Munwar Hussain	✓	✓	✓	A	A	✓		
NHS Tayside (Non Executive Member)	Jenny Alexander							✓	A
NHS Tayside (Non Executive Member)	Trudy McLeay							A	✓
NHS Tayside (Non Executive Member)	Norman Pratt							✓	✓
Dundee City Council (Chief Social Work Officer)	Jane Martin	✓	√	√	✓	A	A	✓	✓
Chief Officer	David W Lynch	✓	✓	✓	✓	✓	✓	✓	✓
Chief Finance Officer	Dave Berry	✓	✓	✓	✓	✓	✓	✓	✓
NHS Tayside (Registered Medical Practitioner (whose name is included in the list of primary medical performers)	Frank Weber	A	✓	A	✓	✓	A	A	A
NHS Tayside (Registered Nurse)	Sarah Dickie	✓	✓	✓	A	A	✓	A	✓
NHS Tayside (Registered Medical Practitioner (not providing primary medical services)	Cesar Rodriguez	A	√	A	√	✓	A	A	A
Trade Union Representative	Jim McFarlane	✓	✓	✓	✓	✓	✓	✓	✓
NHS Tayside (Staff Partnership Representative)	Raymond Marshall	✓	A	A	✓	A	A	✓	✓
Voluntary Sector Representative	Christine Lowden	✓	A	√	✓	✓	✓	✓	✓
Service User Representative	Andrew Jack	A	✓	✓	✓	✓			
Carer Representative	Martyn Sloan	✓	✓	A	✓	✓	A	✓	✓
NHS Tayside (Director of Public Health)	Drew Walker	✓	A/S	A	✓	✓	✓	✓	✓

✓ Attended

A Submitted Apologies

A/S Submitted Apologies and was Substituted

No Longer a Member and has been replaced / Was not a Member at the Time