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

17th January, 2018

Dear Sir or Madam

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

I would like to invite you to attend a special meeting of the above Integration Joint Board which is to be held in Committee Room 1, 14 City Square, Dundee on Wednesday, 24th January, 2018 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 SCOTTISH GOVERNMENT DRAFT BUDGET 2018/19 – IMPLICATIONS FOR DUNDEE INTEGRATION JOINT BOARD - Page 1

(Report No DIJB1-2018 by the Chief Finance Officer, copy attached).

4 REVIEW OF HOME CARE SERVICES - Page 9

(Report No DIJB2-2018 by the Chief Officer, copy attached).

5 INTEGRATED CARE FUND RECOMMENDATIONS - Page 29

(Report No DIJB4-2018 by the Chief Finance Officer, copy attached).

6 DATE OF NEXT MEETING

The next meeting of the Integration Joint Board will be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 27th February, 2018 at 2.00 pm.

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
DISTRIBUTION LIST

(a) DISTRIBUTION - INTEGRATION JOINT BOARD MEMBERS

(* - DENOTES VOTING MEMBER)

Role	**Recipient**
Elected Member (Chair)	Councillor Ken Lynn *
Non Executive Member (Vice Chair)	Doug Cross *
Elected Member	Councillor Roisin Smith *
Elected Member	Bailie Helen Wright *
Non Executive Member	Judith Golden *
Non Executive Member	Munwar Hussain *
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 prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978(b)	Frank Weber
Registered medical practitioner employed by the Health Board and not providing primary medical services	Cesar Rodriguez
Registered nurse who is employed by the Health Board	Sarah Dickie
Chief Social Work Officer	Jane Martin
Third Sector Representative	Christine Lowden
Staff Partnership Representative	Raymond Marshall
Trade Union Representative	Jim McFarlane
Director of Public Health	Drew Walker
Person providing unpaid care in the area of the local authority	Martyn Sloan
Service User residing in the area of the local authority	Andrew Jack

(b) DISTRIBUTION – FOR INFORMATION ONLY

Organisation	**Recipient**
NHS Tayside (Chief Executive)	Lesley McLay
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 Health and Social Care Partnership (Chief Officer's Admin Assistant)	Arlene Hay
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 …3……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 24 JANUARY 2018**

REPORT ON: **SCOTTISH GOVERNMENT DRAFT BUDGET 2018/19 - IMPLICATIONS FOR DUNDEE INTEGRATION JOINT BOARD**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB1-2018**

1.0 PURPOSE OF REPORT

The purpose of this paper is to provide the Integration Joint Board (IJB) with an overview of the implications of the Scottish Government's Draft Budget 2018/19 for Dundee Integration Joint Board.

2.0 RECOMMENDATIONS

It is recommended that the IJB:

2.1 Notes the content of the Scottish Government's Draft Budget as it relates to NHS Tayside and Dundee City Council;

2.2 Notes the additional funding of £66m included nationally in the local government settlement to support investment in social care in recognition of a range of pressures including the implementation of the Carers (Scotland) Act 2016, payment of the living wage (including extension to sleepover payments) and increase in Free Personal and Nursing Care payments;

2.3 Notes 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 to enable the IJB to deliver the priorities as set out within its Strategic and Commissioning Plan;

2.4 Remits to the Chief Finance Officer to lay the developing Transformation Efficiencies Programme before the IJB in February 2018 to inform the budget setting process;

2.4 Remits to the Chief Finance Officer to bring forward a proposed budget for 2018/19 in relation to delegated services for consideration by the IJB at a special meeting of the IJB prior to the end of March 2018.

3.0 FINANCIAL IMPLICATIONS

The financial planning projections highlighted in Appendix 1 are provisional at this stage of the budget process and will continue to be refined following subsequent negotiations with Dundee City Council and NHS Tayside. An updated position will be presented to the February IJB meeting with a special Budget meeting to be called in in March 2018 with a view to finalising the delegated budget.

4.0 MAIN TEXT

4.1 The Cabinet Secretary for Finance and the Constitution announced the Scottish Draft Budget on 14 December 2017. Since then, the Scottish Government has sought to provide clarity to Health and Social Care Partnerships, Local Authorities and NHS Boards on the detail behind the announcements in the settlement as they relate to health and social care. This report provides an overview of these announcements and outlines the impact they are likely to have on Dundee IJB's delegated budget for 2018/19.

4.2 Alongside the 2018/19 Budget, the Scottish Government also published its 2018/19 Public Sector Pay Policy. This includes a 3% pay increase for those earning less than £30,000; caps the pay bill at 2% for all those earning more than £30,000; and limits the maximum pay uplift for those earning over £80,000 to £1,600. The Public Sector Pay Policy does not apply directly to local authorities, however it is noted that the Scottish Government have stated that: "This policy also acts as a benchmark for all major public sector workforce groups across Scotland." Given the significant proportion of staff within the Health and Social Care Partnership's workforce, particularly within the social care staff group who earn less than £30,000 per annum, the impact of the removal of the pay cap is likely to be considerable and proportionately higher than other services and has been factored in to the financial projections shown as appendix 1 to this report.

4.3 Impact of Local Authority Finance Settlement

4.3.1 The Scottish Government announcement included figures in respect of the Local Government Finance Settlement for 2018/19. These figures have subsequently been confirmed in Local Government Finance Circular 5/2017, issued by the Scottish Government on 14 December 2017. The figures are provisional at this stage and are subject to consultation between the Scottish Government and COSLA. The Local Government Finance (Scotland) Order is due to be debated by the Scottish Parliament in late February 2018, as part of the wider parliamentary process for finalising the 2018/19 Scottish Budget.

4.3.2 The revenue grant figures for Dundee City Council are as follows:

	2018/19 £m
Updated Service Provision	313.159
2008-2019 Changes	5.602
Loan Charges & PPP Schemes Support	18.570
Main Floor	(4.405)
Total Estimated Expenditure (TEE)	332.926
Assumed Council Tax Contribution	(47.467)
85% Floor	-
Total Distributable Revenue Support	285.459

4.3.3 When adjusted to a "like-for-like" basis, the grant settlement for the Council for 2018/19 reflects an overall year-on-year increase of 0.7% in cash terms, but a 0.8% reduction in real terms (SPICe Briefing, 18 December 2017). The Council has marginally benefited from an updating of the needs-based indicators in the grant distribution calculation for 2018/19.

4.3.4 Based on current assumptions, the Council will require to identify budget savings totalling around £15.7 million in order to achieve a balanced budget in 2018/19. Councils have the flexibility to increase Council Tax levels by up to 3%. A 3% increase in the local Council Tax level would generate net additional income of around £1.5 million, after allowing for the impact of additional Council Tax reductions.

4.3.5 At this stage of the Council's budget process, discussions are ongoing with the Chief Executive and Executive Director of Corporate Services of Dundee City Council in relation to the proposed level of funding for the delegated budget. An update will be provided to the IJB at its next meeting in February 2018. The figures noted in Appendix 1 are estimated at this stage.

4.4 Investment in Social Care

4.4.1 The Cabinet Secretary for Finance and the Constitution wrote to COSLA on 14 December 2017 confirming the package of measures that make up the settlement to be provided to local government in return for the provisional funding amounts for 2018/19. For 2018/19, the Scottish Government will work in partnership with local government to implement the budget and joint priorities in return for the full funding package. A significant element of this funding package is in recognition of a range of pressures around social care. The importance of this investment in relation to health and social care integration was reinforced within the Scottish Draft Budget as follows:

"*Integration of health and social care is the most significant reform of the NHS since its establishment in Scotland in 1948. It brings together NHS and local government services to deliver person-centred care that supports people to retain their independence in their own homes and communities for as long as possible. In 2018/19 we will provide an additional £66m to bring the Carers (Scotland) Act 2016 into force, to continue to support the delivery of the Living Wage for adult social care workers and to increase payments for free personal and nursing care"*

4.4.2 In addition to meeting the requirements of the new Carers Legislation, the funding is expected to support the further increase in the Living Wage from £8.45 to £8.75 per hour for all adult social care workers and extending payment of the Living Wage to sleepover arrangements. The increases in payments for free personal and nursing care have not as yet been announced by the Scottish Government.

4.4.3 IJB members will note that the government has allocated this funding through local government for 2018/19 which is a shift from the previous two finance settlements where investment for commitments such as the implementation of the Living Wage and other national policies such as changes to social care charging was ring fenced within health budgets, with NHS Boards instructed to pass this funding through to Integration Authorities in full. The implication of channelling the £66m through local government is that local authorities can decide on the level of funding which flows through to IJBs. It is anticipated that Dundee City Council's share of the £66m will be around £2.004m and work is continuing to calculate the financial impact of the government's statutory and policy commitments to inform negotiations with the Council.

4.5 Impact of NHS Finance Settlement

4.5.1 The finance settlement in relation to all NHS Boards will result in a baseline uplift of 1.5% in Board budgets. NHS Tayside has also benefited in 2018/19 from an increase in baseline funding due to the effect of the national funding formula (NRAC). Despite this however, NHS Tayside's financial position remains challenging with significant transformation of services and efficiency savings to be identified and delivered to deliver a balanced budget in 2018/19. This level of efficiency savings is currently estimated to be around £44.5m or 6% of its baseline budget.

4.5.2 NHS Tayside's Director of Finance has indicated that the 1.5% baseline uplift will be passed on to IJB's in full as will a share of the NRAC uplift, linked to the prescribing budget. Discussions are ongoing between the Chief Officer and Chief Finance Officer and NHS Tayside with regards to the implications of the settlement including consideration of the various cost pressures highlighted to the IJB during 2017/18 as part of the financial monitoring process, including prescribing and hosted services. An update will be provided to the IJB at its next meeting in February 2018.

4.5.3 The Draft Scottish Budget also sets out an investment programme to be allocated to NHS Boards as part of investment in reform with some of this relating to delegated services to Integration Authorities and will be channelled through Health and Social Care Partnerships. This includes additional investment in Primary Care nationally of £50m, linked to the new GP contract (taking the total reform investment to £110m), Mental Health Services of £17m (taking total Mental Health Reform investment to £47m), Alcohol and Drug Partnerships of £20m (in addition to baseline allocations of £53.8m). This total investment funding has yet to be released to NHS Boards and discussions are taking place nationally and locally around the allocation of these resources. In addition, NHS Transformation Change Funding has increased by £101m to £126m, some of which may be applicable to Integration Authorities, particularly in relation to the development of digital capability. This Transformational Change Fund will be distributed regionally with discussions to be progressed by the North Region Boards on this will be allocated further. The full range of additional funding is noted as follows:

	2017/18 £m	2018/19 £m	Increase £m
Transformational Change Fund	25.0	126.0	101.0
Primary Care	60.0	110.0	50.0
Mental Health	30.0	47.0	17.0
Trauma Networks	5.0	10.0	5.0
Cancer	8.0	10.0	2.0
Alcohol and Drug Partnerships	53.8	73.8	20.0

4.6 Dundee IJB Financial Planning Assumptions 2018/19

4.6.1 The estimated financial impact of the range of factors likely to affect the level of delegated resources to the IJB is set out in the Financial Planning Summary shown at Appendix 1. These figures continue to be refined as cost implications become clearer however provide the IJB with an overview of the scale of the financial challenge ahead which in turn highlights the level of efficiency savings and transformation of services required to deliver a balanced delegated budget. This includes anticipated required investment to meet demographic pressures and growth and current cost pressures projected to continue in the short to medium term. The Financial Planning Summary applies the range of expected cost increases and pressures to the current base delegated budgets which lead to the level of "Budget Requisition" the IJB would require from the statutory bodies in 2018/19 before consideration of the bodies respective financial position. Applying provisional levels of funding uplifts and/or funding reductions to these figures then provides an estimation of the potential resources the IJB needs to find to deliver its obligations and the ambitions of the Strategic and Commissioning Plan.

4.6.2 These figures will continue to be developed over the coming weeks with a further report outlining the updated position and outline Transformation Programme to be presented at the February IJB meeting.

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 2018.

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 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 10 January 2018

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Dundee Integration Joint Board

Financial Planning Summary 2018/19

	Baseline Delegated Budget 2017/18	Estimated Pay Inflation Pressures 2018/19	Estimated Other Inflation / Demographic Growth 2018/19	Estimated Increased Demand/National Policy Commitments 2018/19	2017/18 Efficiency Savings to be Converted to Recurring Basis	Current Year Budget Pressures	Budget Requisition 2018/19	Baseline Delegated Budget 2017/18	Add: Indicative Funding Uplift	Less: Indicative Funding Reduction 2018/19	Estimated Budgeted Resources 2018/19	Estimated Budget Shortfall 2018/19
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Dundee City Council	73,486	964	1,173	2,186			77,809	73,486	1,964	-2,900	72,550	5,259
NHS Tayside												
Health and Community Services	71,100	1,300	100		1,140	870	74,510	71,100	1,201		72,301	2,210
Prescribing	33,300		1,095			2,200	36,595	33,300	600		33,900	2,696
General Medical Services	44,200						44,200	44,200	0		44,200	0
Large Hospital Set Aside	21,100						21,100	21,100	0		21,100	0
Direct Partnership Funding	5,000						5,000	5,000	0		5,000	0
Total	248,186	2,264	2,369	2,186	1,140	3,070	259,215	248,186	3,764	-2,900	249,050	10,165
						%ge of 17/18 Delegated Budget						4.1%
						%ge of Revised Budget for Operational Services						5.7%
						(nb excludes FHS, Large Hospital & additional social care commitments)						

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ITEM No …4……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 24 JANUARY 2018**

REPORT ON: **REVIEW OF HOME CARE SERVICES**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB2-2018**

1.0 PURPOSE OF REPORT

The purpose of the report is to advise the Integration Joint Board of the review of social care services within the Dundee Health and Social Care Partnership Home Care Service and to seek approval to request that Dundee City Council commission the current in-house social care service in line with the recommended option. The proposed changes will provide additional social care support and maximise the use of the resources within the service.

2.0 RECOMMENDATIONS

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

2.1 Notes the previous, ongoing and planned engagement with the workforce and their trade union representatives as detailed in Appendix 1.

2.2 Notes the Option Appraisal carried out to determine the future changes as appended at Appendix 1.

2.3 Agrees to implement Option 4 as the recommended option which provides additional hours, targets resources, minimises disruption for service users and provides the best option for the current workforce (as described in Section 4.3.4).

2.4 Seeks agreement from Dundee City Council to progress to implement the proposed option as described in Section 4.3.4.

2.5 Instructs the Chief Officer, Dundee Health and Social Care Partnership, and requests the Head of Human Resources and Business Support, Dundee City Council, to continue formal consultation with the affected workforce and their trade union representatives with a view to agreeing to implement the proposal as detailed in 4.3.5.

2.6 Delegates authority to the Chief Officer, Dundee Health and Social Care Partnership to implement the changes.

3.0 FINANCIAL IMPLICATIONS

The proposed changes will release resources from the current in-house service delivery model of approximately £1.2m, providing a contribution to efficiency savings and to support increased social care capacity to meet demographic demand.

4.0 MAIN TEXT

4.1 Background

4.1.1 Demographic and economic challenges have led to an exponential rise in demand for care at home and has had a direct impact on the availability and delivery of social care services. This challenge is replicated across Scotland with Health and Social Care Partnerships tasked to ensure that they maintain the ability to support more people to remain at home, to ensure people are discharged timeously from hospital and to meet the needs of people with complex needs who require higher levels of support. Local information has identified that over the last six years there has been an increase in the number of service users who receive more than 10 hours of support per week (23% of delivered hours in 2010 rising to 33% in 2016) and in the number of service users who required two members of staff in attendance (double ups) in order to deliver their support tasks. Internal services are generally more targeted at those service users requiring higher packages of support or more complex care. As a result, the number and percentage of service user receiving less than two hours care per week has significantly reduced (900 services users/41% in 2010 reducing to 430 service users/23% in 2016).

4.1.2 As more older people with complex needs remain at home for longer, there will be a requirement to consider how the services continue to develop. This will require a skilled, flexible and supported workforce. The Dundee Health and Social Care Partnership is currently developing an integrated approach across social care and community nursing (Enhanced Community Support). This approach will facilitate the development of integrated roles, with a multidisciplinary approach to assessing and delivering care. A further development of this approach will see the testing of an Enhanced Community Support (Acute) model over the next 6 months. In parallel there will be a refocussing of the approach to hospital discharge and of enablement/rehabilitative services to support a model of early intervention.

4.1.3 In the last financial year an additional £1,000,000 was invested into temporary social care provision (externally commissioned services) within Dundee. This recognised and responded to the demand at this time. Despite this investment, demand for services continue to outstrip availability and there has been a shift in service delivery models in order to support pressures around hospital discharge and crisis care. There is therefore a requirement to develop services that will consider how best to address the increase in demand, provide sustainable services and meet contemporary thinking around service provision.

4.2 Review of Home Care Services

4.2.1 An analysis of the current internal social care/enablement services identified that the historical patterns of work were inefficient and did not provide a level seven day service provision. This resulted in periods of the day where staff were underutilised and did not allow the flexibility to support a changing model of service. A range of rota options were presented and then later co-designed with staff, this included a split shift pattern as a way of minimising the service inefficiencies and maximising the level of staff/service user contact time. The consultation with staff identified that there were concerns regarding the split shift nature of the service and the proposed start time of 7am (staff previously commenced at 7.30am).

4.2.2 Through discussion, agreement was reached to pilot the new rota arrangements with teams of volunteers. The pilot showed that the majority of staff undertaking the new rota changes were in favour of the work pattern and there was a willingness to move to this as a permanent rota change. Of those staff volunteering, only one member of staff opted out of this approach following the commencement of the pilot. Regular meetings were held during the pilot with both staff and trade unions representatives. This resulted in a change to the rota pattern with a reduction in the number of days worked continuously, providing more rest time. In total 76 staff participated. Staff undertaking the pilot continue to work the split rota pattern with a 7am start.

4.2.3 The pilot was under taken in a range of geographical areas in Dundee. Service users receiving the support through the pilot teams raised no concerns relating to the change. In addition the following benefits were realised:

- More older people received support.

- Service users requiring routine personal care on waking were provided with this at 7am rather than later in the morning.
- There was more continuity of care with service users generally receiving the same carer throughout the day.
- This continuity allows for better monitoring of needs and quicker identification of change or deterioration.

4.2.4 While the pilot demonstrated improvements to the efficiency of the service, the level of efficiency was not as high as originally anticipated. This can be attributed to the following reasons:

- The volunteer nature of the pilot restricted the ability to test teams aligned to an area (enablement and mainstream home care).
- The teams volunteering included geographical areas where there is a diminishing requirement for services and there continued to be a level of downtime (underutilised hours).
- The timing of service user's service delivery was not changed prior to the commencement of the pilot. It therefore took time to allocate services to the earlier start time and during the additional hours, and to realign duties to maximise staff/service user contact time.
- The contractual hours of staff were not reduced to match the most productive rota pattern. This would require staff to reduce their working pattern from 30 hours to 25 hours. As staff continued to work 30 hours this maintained the position of between three to five hours unused hours for each member of staff per week.

4.2.5 Included within the roll out of the review will be a move to walking teams and driving teams, with a redistribution of staff. To confirm the required level of workforce, a virtual exercise was undertaken by the managers of the service to redraw the geographical boundaries of the teams to align to the eight Dundee Health and Social Care Partnership localities and to place current service users into the new rota patterns. The proposed realignment of the teams would result in a reduction in the number of teams and a reduction in travel time between duties.

4.2.6 If implemented, both the proposed option and the wider review, as detailed above, would reduce the number of front line and supervisory/management staff required to deliver the service. Section 7 in Appendix A, details the number of social care workers required for each option, with Option 4 proposing a reduction of 32 social care workers. It is anticipated that there will also be a reduction in Organisers (2) and Team Managers (1). In 2017, staff consultation indicated that this reduction could be met through Voluntary Early Retirement/Voluntary Redundancy and through redeployment to vacancies.

4.2.7 To progress the home care review will require a roll out of a revised working pattern across the whole workforce with an amendment to the contractual arrangements for the staff (contractual hours/split shifts).

4.3 Option Appraisal

4.3.1 An option appraisal of the current service was undertaken to determine whether or not other options should be explored. The option appraisal assessed each option against the following criteria.

- Minimises disruption to service users
- Improved quality of service delivery for service users
- Cost effectiveness against current budget
- Provides additional hours of service
- Increased capacity for future demand
- Flexibility to develop future integrated and targeted services
- Minimises impact on staff contracts/maintains range of contractual opportunities.

4.3.2 Five options were considered as part of the appraisal. The rota piloted was not considered in its current form because of the continued inefficiencies, however an amended version was produced which followed the principles, offered an opportunity to maintain contractual hours but reduced the working day. The five options considered were:

Option 1: Maintain the Status Quo
Continue to provide the service as delivered currently.

Option 2: All staff be retained on 25 hour contracts, double-shift work pattern
Through the improved efficiencies that the new work pattern can realise, this Option would see an overall increase in the level of staff/service user contact time by up to 1000 hours per week including travel time. There would be an overall reduction in the number of Social Care Workers required to deliver the on-going service commitments by 27 staff. All staff would be engaged on a 25 hour contract working two double shifts followed by a single shift. Staff working an early shift would commence at 7am increasing the number of service users who could be supported. Teams would be made up of seven staff working over a seven week period with all staff having an equal distribution of days worked and days off. Within the number of staff retained there will need to be a percentage of staff required to cover absences, etc.

Option 3: All staff be retained on 23 hour contracts, single shift
Through the improved efficiencies that the new work pattern can realise, this Option would see an overall increase in the level of staff/service user contact time by up to 572 hours per week including travel time. Staff would be engaged on an alternative rotating pattern based on teams of five working across a five week rotating cycle. All staff would be retained on single shifts only. Staff working an early shift would commence at 7am increasing the number of service users who could be supported. As there would be a reduction in the overall contracted hours then an additional 18 staff would be required to fulfil current commitments. All staff would have an equal distribution of work and days off through their rotating period. Within the number of staff retained there will need to be a percentage of staff required to cover absences, etc.

Option 4: A mixed contract solution with staff retained on 30 hour, double shift contracts (7am start) or 25 hour double shift contract (7.30 am start) or 23 hour, single shifts (7am start).
Through the improved efficiencies that the new work pattern can realise, this Option would see an overall increase in the level of staff/service user contact time by up to 1,118 hours per week including travel time. There would be an overall reduction in the number of Social Care Workers required to deliver the on-going service commitments by 32 staff. This option implements a mixed contract solution based on a % of staff retained on 30 hour, split-shift contracts with a 7:00am start time; a % on 25 hour split-shift contracts with an option of a 7:30am start time, and a % on 23 hour, single shift contracts with a 7:00am start time. The 30 hour contracts include the banking of up to 5 hours per week that will be aggregated and used periodically throughout the year to offset absences.

Option 5: Shift the balance of care provision from the current allocation of contracted hours across in-house/external provision from a position of 47% in-house, 53% external providers to 30% in-house and 70% external.
Presently the overall budget for the provision of social care is split almost equally between internal services and the commissioned external providers, however the inefficiencies in the internal service results in a lower level of service provision than contracted hours. This option will require a further externalisation of in-house services and would provide a potential to increase commissioned hours per week to match current provision, with an option to increase further through released budget resources. For the services remaining in house, depending on the workforce makeup, staff will be required to move to a new working pattern as described in Option 4. There would be an overall reduction in the number of Social Care Workers required to deliver the on-going service commitments by 102 staff.

4.3.3 When assessed against the criteria as detailed in the table below, the following were identified:

- Option 5 provides the best opportunity to improve capacity and reduce cost. This option could potentially destabilise the market in the short term and would require consideration of the commissioning framework to be used in the future.
- Option 4 retains an in-house provision, with the maximum level of in-house service provision and a range of contractual options for staff. It provides an opportunity for further targeting of services and remodelling in line with localities and integrated services.

Assessment Criteria	Option 1	Option 2	Option 3	Option 4	Option 5
Minimum disruption to service users	x	x	x	x	
Improved quality of service delivery for service users		x	x	x	
Cost effectiveness against current budget		x	x	x	x
Provides additional hours		x	x	x	x
Increased capacity for future demand					x
Flexibility to develop future integrated and targeted services		x	x	x	
Minimises impact on staff/maintains range of contractual opportunities	x			x	

4.3.4 Taking into account the above criteria and analysis, the recommended option is Option 4. Option 4 provides the greatest increase in support to services users while still retaining an in-house service. In addition, this Option, alongside the wider review, will support a more targeted and flexible workforce which will enable us to schedule activity at times of greatest need and facilitate the future remodeling of more integrated services.

4.3.5 It is therefore proposed that the Chief Officer, Health and Social Care in conjunction with the Head of Human Resources and Business Support, Dundee City Council continue formal consultation with the affected workforce and their trade union representatives with a view to agreeing the required reductions in contracted hours, where applicable, the change to hours of work and the extension of the use of split shifts. Should no agreement be reached it would be necessary for the Chief Officer, Health and Social Care to take appropriate steps to implement the changes. It is further proposed that delegated authority be provided to the Chief Officer to progress the required changes.

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	Potential reduction in available resources during the period of change. This would impact on hospital flow and community capacity to commence new packages of support.
Risk Category	Availability of Resources
Inherent Risk Level	9 High
Mitigating Actions (including timescales and resources)	Maintain open communication across workforce, trade union representatives and service users. Communication and engagement plan prepared with clear timescales for action. Clarify and maximise available resources. Implement resilience plans as required.
Residual Risk Level	9 High
Planned Risk Level	6 Medium
Approval recommendation	Approve

Risk 2 Description	Unable to secure an agreement to implement recommended change.
Risk Category	Human Resource, Availability of Resources
Inherent Risk Level	9 High
Mitigating Actions (including timescales and resources)	Maintain open communication across workforce, trade union representatives and service users. Communication and engagement plan prepared with clear timescales for action. Clarify and maximise available resources. Implement resilience plans as required.
Residual Risk Level	9 High
Planned Risk Level	6 Medium
Approval recommendation	Approve

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 11 January 2018

Diane McCulloch
Head of Service

APPENDIX 1

OPTION APPRAISAL – REVIEW OF HOME CARE SERVICES (SOCIAL CARE SUPPORT)

1.0 STRATEGIC CONTEXT

The demographic and economic challenges facing the Dundee Health and Social Care Partnership (DHSCP) has led to an exponential rise in demand for care at home over the past few years and has consequently had a direct impact on the availability and delivery of social care services. The ability to provide the capacity to meet demand for social care services continues to challenge the DHSCP. An additional £1,000,000 has been invested into social care provision through externally commissioned services. Despite this investment, demand for services continues to outstrip availability and there has been a need to revise service delivery models to support pressures around hospital discharge and crisis care.

In addition, policy initiatives set by the Scottish Government put in place an expectation for future services that will: (i) consider how best to address the increase in demand; (ii) provide services that will be financially sustainable in the future, and (iii) meet contemporary thinking around service provision.

2.0 THE NEED FOR AND OBJECTIVES OF THE OPTIONS APPRAISAL

The ageing population is the predominant issue faced by the health and social care sector today. The increased numbers of people reaching their later years and the corresponding demand for support services are now beginning to impact on the organisation's abilities to meet obligations and fulfil policy objectives. The shift in the balance of care to move away from institutionalised settings, has resulted in more people being supported in the community than at any other point in time. Whilst this continues to remain an overarching objective, without further increases in available resources there will be difficulties in sustaining the move to support more people to remain in the community for longer.

The prevalence of people living longer with complex or multiple health conditions requires a flexible approach and in some instances a more substantial level of support. This increasing focus will become central as to how we determine and plan future service commitments. Consequently, strategies require to be developed that address not only today's presenting challenges but also establish the infrastructure that will support the future increases and demands within the available financial resources.

Whilst we continue to develop our future service provision with a focus on prevention, evidence suggests that statutory services continue to support those who have high-end, complex care needs. This shift is demonstrated in Figure 1 below. In 2010, 41% of service users received 2 hours or less, in 2016 this had reduced to just over 20%. Conversely, those service users in receipt of care in excess of 10 hours has risen by over 10% in the same time frame.

Hours taken	Number / %	2010	2011	2012	2013	2014	2015	2016
2 hours or less per week	No. of Clients	900	860	660	650	600	580	430
	% of total	41%	40%	35%	37%	32%	31%	23%
Between 2 and 4 hours per week	No. of Clients	360	330	300	190	250	240	250
	% of total	16%	16%	16%	11%	14%	13%	13%
Between 4 and 10 hours per week	No. of Clients	450	440	390	400	430	500	570
	% of total	20%	20%	21%	23%	23%	27%	31%
Greater than 10 hours per week	No. of Clients	500	520	530	510	580	540	620
	% of total	23%	24%	28%	29%	31%	29%	33%
Total clients		**2,210**	**2,150**	**1,880**	**1,750**	**1,860**	**1,860**	**1,870**

Figure 1 – Source: Home Care Census up to 2012, Social Care Survey from 2013

Across the partnership we are currently developing an integrated approach to social care and community nursing (Enhanced Community Support). This approach will support the development of integrated roles, with a multidisciplinary approach to assessing and delivering care. A further development of this approach will see the testing of an Enhanced Community Support (Acute) model over the next 6 months. In parallel we will be redesigning hospital discharge services and enablement/rehabilitative services to support a model of early intervention. Our benchmarking with neighbouring authorities shows that, in general, discharge and enablement services have remained within partnerships. However, to continue to develop models that will best support the increasing demand in the future, DHSCP needs to obtain best value from the resources currently available.

Presently, the current budget allocation of approximately £13m for the provision of social care services across the City, is equally split between the DHSCP managed in-house services (47%) and the commissioned external providers (53%). When equating this to hours, the budget allocation allows us to purchase 7,500 hours in-house service with 8,600 hours externally commissioned services, a total of 16,100 hours per week. For in-house services this equates to the contracted hours for staff which differs from the level of actual staff/service user contact time and travel time, for external services this figure relates to actual staff/service user contact time and travel time. The actual total number of delivered hours is more akin to 13,700 hours including travel time (internal 4,680 hours/external 8,500 hours). Whilst elements of this difference between the financial allocation and the delivered hours of service can be attributed to differences in employee costs and infrastructure, it is also linked to the different deployment patterns of staff.

A review of the current in-house services identified that the historical patterns of work do not provide a level seven day service provision and have in-built periods of time that are under-utilised. In addition, taking into account staff leave etc this historical work pattern has resulted in a low level of staff/service user contact time within the in-house service when compared with the potential level of contact time available. In summary, the current working patterns are no longer fit for purpose and we are required to maximise the level of services we have available to meet the future needs of service users.

The aim of the Home Care Review was to identify a model of service which provided a more flexible model of support and which maximised the available level of service provision for service users. As a result a pilot was undertaken which introduced a revised rota pattern. Whilst this pattern did not release the full potential of the service it went some way to testing the assumptions aligned to the test of change. This option appraisal included a wider exploration of service models which further maximise the level of service.

The aim of the option appraisal was to:

- Consider the associated risks within the changes for service users and the quality of service.
- Consider both the impact on service capacity and the cost effectiveness from both revised working patterns and further externalisation of services.
- Consider the potential for ongoing change to meet future demand and the ability to develop integrated models of service.
- Consider the impact of change on the workforce.

3.0 WORKFORCE

The current working arrangements are not aligned to present-day demands. The existing contractual commitments operate on a 30, 24 or 18 hour weekly contract, based on a six hour working day. Over the course of the work pattern, staff work a number of early shifts and a number of late shifts. Whilst these arrangements have been acceptable in the past, when the service user requirements were less demanding or complex, today they no longer reflect the service expectation and/or the variation in demand that the service is experiencing. With the current requirement to provide support to individuals who require multiple visits throughout the day, there is now a need to have resources available at critical times and with equal provision over seven days per week.

At October 2017, the in-house service provided by the DHSCP employed 277 Social Care Workers (SCWs) to deliver 4500 hours of care/support to 1199 service users each week. Over 65% of the SCWs are retained on 30 hour contracts with the remainder on a mix of 24 hour contracts and 18 hour contracts.

The service effectively splits into two sections with one section providing the enablement and support service and the other section providing the long-term, care-at-home support. Services are structured around geographical areas and are managed on a day-to-day basis by Social Care Organisers (SCOs). Each of the SCOs are line managed by a Team Manager. These arrangements, again, have been in place for some time. Within the wider Home Care Review a move to separate walking teams and driving teams, along with a redistribution of staff to realigned patches is proposed. To determine the future level of workforce required, an exercise was undertaken by the managers of the service to redraw the geographical boundaries of the teams to align to the DHSCP localities.

A range of rota options were presented to the workforce and then later co-designed with staff. This included a split shift work pattern[1] rotating over the seven days in the week. This provides the opportunity to maximise the available social care hours to increase the level of direct service user contact. Following discussion with SCWs an agreement was reached to pilot the proposed rota arrangements with teams of volunteers; this has been in place over the past year. Attached at Appendix A is a detailed account of the revised rota patterns. The general consensus on the revisions has been positive and these options are now demonstrating a level of improvement to the efficiency of the service. Despite the acceptance of the new rota pattern, by those involved in the pilot, there remains a core group of staff who previously indicated their opposition to the split shift pattern. It still remains, however, that by further rolling out the changed working

[1] Work pattern is the rotating nature of work that SCWs undertake in a given period

patterns there are opportunities to improve the management of the underutilised hours and further increase contact time with service users.

To progress the home care review it will require DHSCP to roll out the revised working pattern across the entire workforce. The pilot involved staff working 30 hours over a 3 day split shift pattern starting at 7am. We are aware that the main concerns for staff included a move to a 7am start and the split shift pattern, this paper therefore explores a range options which addresses these concerns.

4.0 EXTERNALISED/COMMISSIONED SERVICES

Dundee

Dundee continues to offer block contracted hours to commission care at home services from external providers. We agree individual rates with providers and providers submit their costs for travel time/mileage as part of this process.

As previously stated, the current budget allocation for the provision of social care services across the City is approximately equally split between DHSCP in-house services and the commissioned external providers (See Section 2 of this report). At the time of the option appraisal this equated to 8,600 hours of externally commissioned and tendered services within the block contracts.

It should be noted that, as a result of additional resources the externally commissioned services are currently providing 9,700 hours of service through temporary contractual arrangement.

Providers offer a range of contracts. Most offer minimum guaranteed hours of 24-35 hours per week. Some still operate zero hour contracts but generally refer to these as flexible contracts. Crossroads did consult with its staff with a view to offering guaranteed hours contracts but staff rejected this and stated they preferred the flexibility of working zero hours. The majority of Dundee's external providers only employ individuals on a split shift pattern, which maximises contact time with service users and decreases downtime.

At the time of writing this report, two of the current providers are working below their contracted block hours. Blackwood are working to stabilise the infrastructure following the service issues they started to experience towards the end of last year. Crossroads experienced recruitment issues across both frontline and office staff.

Red Cross recently attended a partnership Recruitment Fayre at the Marryat Hall and received 85 applications. However, in terms of the people that have been shortlisted for interview, most are with another homecare provider and have applied to Red Cross as they offer slightly better terms and conditions.

Recruitment is an emerging concern in the care at home sector. It has been evident for some time that there are now issues within Dundee and the number of those applying for jobs within the care sector has decreased. The providers believe that while the introduction of the living wage is a positive step forward for individuals living and working in Dundee, it has had a detrimental effect on recruitment and retention in the care sector. The awareness of comparable rates of pay has resulted in staff leaving social care employment because they can get the same rate of pay working in retail, or jobs where they do not have the responsibility of supporting individuals with complex needs. It has also been suggested that care related roles are often highly stressful and demanding and workers are choosing to work in roles where this is significantly decreased (again such as retail sector).

We are aware that the development of the city as a tourist attraction will bring more hospitality services and are likely to be a draw for staff working at the margins of the service. The move to

ensure a living wage contract will help stabilise the sector but is unlikely to address the emerging recruitment issues currently experienced across all providers.

From October 2017, staff employed in care at home services will be required to register with the Scottish Social Services Council and this may present another barrier for people considering working in the sector. We are in discussion with Scottish Care to develop a partnership approach to attract more people to a career in care.

Information received from neighbouring authorities/providers has provided the following information.

Angus Care at Home Service has a service provision of 16% in-house service and 84% external provision. They are focused on their Enablement Service and Social Care Response. Incorporated in their work patterns are split shifts and single shifts.

Angus are currently operating a framework agreement for external services and this includes a partnership with the majority of the block providers who operate in Dundee. Providers are advising that there are issues within Angus as providers do not have the infrastructure to be able to pick up care packages, due to recruitment and retention issues. Angus Health & Social Care Partnership were about to retender contracts for external providers so these contracts may look different in the future.

Perth Care at Home Service has a split provision of 9% in house service and 91% externalised. Perth's main focus is on their Rapid Response service which is a service that enables the person to return home from hospital and remains in place for up to 72 hours. Their work patterns include split shifts. They are advising that they are experiencing major challenges across the home care sector. Perth are currently experiencing issues with sourcing care packages for individuals and were only able to support those in critical need.

The providers within Perth and Kinross area advise that they are operating within a framework agreement and are having to decline the request for care packages across the area due to lack of availability and recruitment issues.

Fife Care at Home Service has a 50-50% split between in-house and external commissioned services. They have introduced a split shift rota to their Enablement Teams and the rest of their workforce have an unpaid break in their downtime. Their in-house service focuses on services to their 'Critical' service user group only.

The providers within Fife operate over a framework agreement. This poses problems relating to providers picking up care packages and providers have handed back work due to a collapse in their infrastructure caused by sickness and recruitment and retention. Fife has significant challenges relating to the framework only agreement and are only supporting critical service users.

The review considered the option to further externalise the service. Whilst the cost will significantly reduce, allowing for either an increased saving and/or investment, there are risks associated with this move which include:

- Destabilisation of the market during a period of change
- Further recruitment difficulties as the Local Authority is considered to be a better employer
- Increase in costs by providers as Local Authorities are no longer major provider
- Lack of control over quality
- Difficulty in supporting frailer more complex service users.

5.0 DESCRIPTION OF OPTIONS

The aim of the option appraisal was to:

- Consider the associated risks within the changes for service users and the quality of service.
- Consider both the impact on service capacity and the cost effectiveness from both revised working patterns and further externalisation of services.
- Consider the potential for ongoing change to meet future demand and the ability to develop integrated models of service.
- Consider the impact on the workforce.

The following options were therefore developed and considered:

Option 1: Maintain the Status Quo

Continue to provide the services as delivered currently.

Option 2: All staff be retained on 25 hour contracts, split-shift work pattern

Through the improved efficiencies that the new work pattern can realise, this Option would see an overall increase in the level of staff/service user contact time by up to 1000 hours per week including travel time. There would be an overall reduction in the number of Social Care Workers required to deliver the on-going service commitments by 27 staff. All staff would be engaged on a 25 hour contract working two double shifts followed by a single shift. Staff working an early shift would commence at 7am increasing the number of service users who could be supported. Teams would be made up of seven staff working over a seven week period with all staff having an equal distribution of days worked and days off. Within the number of staff retained there will need to be a percentage of staff required to cover absences, etc.

Option 3: All staff be retained on 23 hour contracts, single shift

Through the improved efficiencies that the new work pattern can realise, this Option would see an overall increase in the level of staff/service user contact time by up to 572 hours per week including travel time. Staff would be engaged on an alternative rotating pattern based on teams of five working across a five week rotating cycle. All staff would be retained on single shifts only. Staff working an early shift would commence at 7am increasing the number of service users who could be supported. As there would be a reduction in the overall contracted hours then an additional 18 staff would be required to fulfil current commitments. All staff would have an equal distribution of work and days off through their rotating period. Within the number of staff retained there will need to be a percentage of staff required to cover absences, etc.

Option 4: A mixed contract solution with staff retained on 30 hour, double shift contracts (7am start) or 25 hour double shift contract (7.30 am start) or 23 hour, single shifts (7am start).

Through the improved efficiencies that the new work pattern can realise, this Option would see an overall increase in the level of staff/service user contact time by up to 1,118 hours per week including travel time. There would be an overall reduction in the number of Social Care Workers required to deliver the on-going service commitments by 32 staff. This option implements a mixed contract solution based on a % of staff retained on 30 hour, split-shift contracts with a 7:00am start time; a % on 25 hour split-shift contracts with an option of a 7:30am start time, and a % on 23 hour, single shift contracts with a 7:00am start time. The 30 hour contracts include the banking of up to 5 hours per week that will be aggregated and used periodically throughout the year to offset absences.

Option 5: Shift the balance of care provision from the current allocation of contracted hours across in-house/external provision from a position of 47% in-house, 53% external providers to 30% in-house and 70% external.

Presently the overall budget for the provision of social care is split almost equally between internal services and the commissioned external providers, however the inefficiencies in the internal service results in a lower level of service provision than contracted hours. This option will require a further externalisation of in-house services and would provide a potential to increase commissioned hours per week to match current provision, with an option to increase further through released budget resources. For the services remaining in house, depending on the workforce makeup, staff will be required to move to a new working pattern as described in Option 4. There would be an overall reduction in the number of Social Care Workers required to deliver the on-going service commitments by 102 staff.

6.0 OPTION APPRAISAL

The following analysis provides the pros and cons of the proposed options.

Option 1: Maintain the Status Quo.

Pros:

1. No change position.
2. No disruption to service users who retain their current service teams.
3. Service users will not be required to move service provider.
4. No disruption to staff group.
5. Retaining service in-house facilitates greater control of the quality of service delivery.

Cons:

1. Limited capacity to increase support for people with complex needs (7 day service) as service capacity reduces at weekends.
2. Traditional delivery model is not cost effective.
3. Current work patterns do not provide a consistent level of cover required through the day/week with a high level of underutilised time.
4. The service is planned and delivered on a traditional service model making it inflexible and unable to support new integrated models.
5. Teams are currently made up of a variety of contractual arrangements which provides challenges in scheduling and running a consistent service.
6. No financial resources released and therefore unable to contribute to savings or reinvest to grow service capacity.

Option 2: All staff be retained on 25 hour contracts, double-shift work pattern

Pros:

1. Service users will not be required to move service provider.
2. Teams have ability to be constructed in such a way that would ensure a high degree of service continuity for service users and creation of relationships and individual centred care.
3. Retaining service in-house facilitates greater control of the quality of service delivery.
4. The compressed hours, combined with significant rest periods would be attractive to some staff.
5. Most cost effective means of providing support as a result of built in flexibility and reduction of unnecessary hours.
6. Staff would all be engaged on consistent working patterns and arrangements which would make it more effective and efficient to organise and schedule work.

7. Would support the potential for integrated health and social care initiatives supporting people to remain at home.
8. Potential to contribute towards savings or reinvest in growing capacity

Cons:

1. Will require some service users to adjust service times or change in workers.
2. Will require a change to terms and conditions for staff.
3. All staff on 30 hour contracts presently would see a reduction of 5 hours per week; staff on 24 hour contracts would increase by 1 hour with a resultant change for a large number of staff.
4. For those staff potentially dropping contract hours, consideration to a preservation or contract buy-out would need to be given.
5. All staff will be required to work a double shift which is contentious to some parts of the current staff group.

Option 3: **All staff be retained on 23 hour contracts, single shift**

Pros:

1. Service users will not be required to move service provider.
2. Teams have ability to be constructed in such a way that would ensure a high degree of service continuity for service users and creation of relationships and individual centred care.
3. Retaining service in-house facilitates greater control of the quality of service delivery.
4. Single shift contracts are potentially more acceptable to some parts of the current staff group.
5. More cost effective means of providing support as a result of built in flexibility and reduction of unnecessary hours than current model.
6. Staff would all be engaged on consistent working patterns and arrangements which would make it more effective and efficient to organise and schedule work.
7. Would support the potential for integrated health and social care initiatives supporting people to remain at home.
8. Potential to contribute towards savings or reinvest in growing capacity.

Cons:

1. Will require some service users to adjust service times or change in workers.
2. Will require a change to terms and conditions for staff.
3. All staff on 30 hour contracts presently would see a reduction of 7 hours per week; staff on 24 hour contracts would decrease by 1 hour.
4. For those staff potentially dropping contract hours, consideration to a preservation or contract buy-out would be required.

Option 4: A mixed contract solution based on a % of staff retained on 30 hour, split-shift contracts, a % on 25 hour split-shift contracts, and a % on 23 hour, single shift contracts

Pros:

1. Service users will not be required to move service provider.
2. Teams have ability to be constructed in such a way that would ensure a high degree of service continuity for service users and creation of relationships and individual centred care.
3. Retaining service in-house facilitates greater control of the quality of service delivery.
4. Retains staff on the contractual hours that they are on currently.
5. Scope to utilise the “unused” hours inherent in the current arrangements in such a way that all absences would be covered.
6. More cost effective means of providing support as a result of built in flexibility and reduction of unnecessary hours than current model.

7. Staff would all be engaged on consistent working patterns and arrangements which would make it more effective and efficient to organise and schedule work.
8. Would support the potential for integrated health and social care initiatives supporting people to remain at home.
9. Potential to contribute towards savings or reinvest in growing capacity

Cons:

1. Will require some service users to move to a new time for service or change in workers.
2. Will require a change to terms and conditions for staff.
3. Will require 30 and 23 hour staff to work double shifts which remain contentious to some parts of the current staff group.
4. High level of management involvement to manage the unused hours to ensure that there is a fair and equitable distribution of work across the team.

Option 5: Shift the balance of care provision from the current budgetary position of 47% in-house, 53% external providers to 30% in-house and 70% external

Pros:

1. Retains a level of service provision in-house to facilitate remodeling of service provision and targeted support.
2. Retaining a level of support in-house facilitates greater control of the quality of service delivery.
3. Potential to increase the number of hours provided week-on-week but at no additional cost and meet growing demands.
4. Reduction in overall infrastructure including management costs.
5. Supports further development of mixed economy.
6. Potential to contribute towards savings or reinvest in growing capacity.

Cons:

1. Will require a majority of service users receiving ongoing care to move to a new service provider.
2. Will require introduction of redundancy, Voluntary Early Retirement (VER), Voluntary Redundancy (VR) and/or Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) for high number of current staff workforce.
3. Reduction in flexibility and workforce able to adapt and work with new models of care and support as they develop.
4. Risk of vulnerability to market forces around provider's ability to recruit and retain, and therefore deliver on contracts.
5. Potential for increase in cost of external provision due to additional infrastructure costs for external providers which may be passed onto the HSCP through increased unit cost.

7.0 FINANCIAL/SERVICE DELIVERY ANALYSIS

The following table provides a summary of the associated costs to continue an in-house provision as defined by the options detailed above and the hours of staff to service user contact time provided by each option:

Assessment Criteria	Option 1	Option 2	Option 3	Option 4	Option 5
Minimum disruption to service users	x	x	x	x	
Improved quality of service delivery for service users		x	x	x	
Cost effectiveness against current budget		x	x	x	x
Provides additional hours		x	x	x	x
Increased capacity for future demand					x
Flexibility to develop future integrated and targeted services		x	x	x	
Minimises impact on staff/maintains range of contractual opportunities	x			x	

8.0 Impact Analysis

Options	Analysis									
	Number of Staff	Established Number of Staff Contracted Hours (per Week)	Amount	Planned Care Hours Provided (per Week)	Travel Time (hours per week)	Total Hours that can be Delivered (per week) (iv) + (v)	Slippage at 20% of Established for a/l, sickness, etc per week	Lost Hours inherent in contract per week against Established	Total staff to service user contact hours. (vi) - (viii)	% measure of productivity - staff to service user hours against contracted staff hours
	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)	(viii)	(ix)	(x)
Option 1: Status Quo	277	7500	£6,742,562	3500	1180	4680	1500	1320	3360	45
Option 2: To Meet Existing Commitments all staff be retained on 25 hour, double shift contracts.	250	6250	£5,105,750	3780	900	4680	1250	320	4360	70
Option 3: To Meet Existing Commitments all staff be retained on 23 hour, single shift contracts.	295	6785	£5,542,802	3780	900	4680	1357	568	4112	61
Option 4: To Meet Existing Commitments a mixed contract solution based on a % of staff retained on 30 hour, split-shift contracts, a % on 25 hour split-shift contracts, and a % on 23 hour, single shift contracts	245	6755	£5,518,295	3780	900	4680	1351	0	4680	69
Option 5: To meet Existing Commitments shift the balance of care provision from the current position of 50% inhouse, 50% external providers to 30% inhouse and 70% external	173	4500	£3,676,140	2520	604	3124	900	0	3124	69

9.0 Human Resource Issues

Options 2, 3 and 4 would each require the Chief Officer, Health and Social Care together with the Head of Human Resources and Business Support to continue formal consultation with the affected workforce and their trade union representatives with a view to agreeing the required reductions in contracted hours and the extension of the use of split shifts. Should no agreement be reached it would be necessary for the Chief Officer, Health and Social Care to take appropriate steps to implement the changes.

Should Option 5 be the preferred option, then consideration must be given as to how the staff numbers are reduced to effect the change. Three options are detailed below and all take into consideration the current social care market in Dundee, whereby it is noted that some providers are experiencing difficulties in recruiting sufficient numbers to fulfil obligations.

A – Transfer of Undertakings

This option in effect moves employees and any liabilities associated with them from the old employer to the new employer by operation of law. In this scenario it would be a service provision change involving the service transfer from Dundee Health and Social Care Partnership to an external contractor. Under the terms of the legislation all employees have the legal right to transfer to the new employer on their existing terms and conditions of employment and with all their existing employment rights and liabilities intact. This all-embracing concept, however, may be renegotiated after one year provided that the overall contract is no less favourable to the employee. Collective agreements from the date of transfer won't apply if the new employer hasn't taken part in the process.

In all likelihood the Partnership will see an increase in the hourly rates that the external providers charge as they absorb the Transfer of Undertakings into their unit costs or until they can "harmonise" all the costs across their service.

B – Arm's – Length External Organisation

This option would seek to set up and fund an arm's-length organisation that would be one step removed from council control; the Partnership would retain a degree of control or influence through a funding agreement. Potentially all the surplus staff could be moved into the "new" organisation. Through a reduction in overheads it may be possible to drive down the current unit cost to allow the arms-length organisation to compete in the market place. There is further scope to set up the organisation as a trading company which would allow it to secure other work through the competitive tendering process. This option would also allow the services to move away from conventional supports and establish a more bespoke service aligned to current service demands.

C – Redeployment of Staff/VER/Non Replacement of Posts

This option would look at the internal relocation of staff and the opportunity to release staff from their posts through a voluntary early retirement package. There is scope at present to increase the number of staff with the Social Care Response Service to meet the increased demands that are placed upon that service. Equally, there may be scope to transfer some staff to other internal services. Finally, there is a number of VER requests that remain outstanding from December 2015 which could be actuated.

An early exercise undertaken last year, identified approximately 20 social care workers, one Team Manager and more than two Organisers who met the criteria for VER/VR. This position may have changed to increase the number who are now eligible.

10.0 OPTION ANALYSIS

From the analysis of the options the following can be concluded:

- Option 5 provides the best opportunity to improve capacity and reduce cost. This option could potentially destabilise the market in the short term and would require consideration of the commissioning framework to be used in the future.
- Option 4 retains an in-house provision, with the maximum level of in-house service provision and a range of contractual options for staff. It provides an opportunity for further targeting of services and remodelling in line with localities and integrated services.

Appendix A

Pilot of New Rotas

In 2015 a review of the current model of service delivery for care at home services commenced. The purpose of the review was to determine the future model of service delivery, to modernise the service and to maximise the use of resources.

The review collated information utilising the available systems and identified that the traditional rota patterns of staff, using predominantly staff employed to work 30 hours (5 days at 6 hours; 7.30am – 1.30pm and 4pm - 10pm), did not align with the demand periods for services, namely at 7am – 11am and 6pm – 10pm. As a result staff had periods of the day where there were fewer duties and the service was unable to meet demand at peak times. In addition, the rota pattern meant that there was an uneven distribution of staff across the week and the service was unable to provide an equal level of service across seven days. This variance and mismatch against demand periods, meant that the service was inefficient with only 40% of staff available time used to deliver care (including travel time).

New rota patterns were developed by the management team and included a range of hourly contracts and a proposed split shift working pattern. This rota was based on staff working 33 hours per week, with a 4 days off/ 4 days working pattern. Following meetings with the Trade Unions, six staff briefing sessions were held in August 2015 to present both the findings of the review and the proposed rota changes. While there was interest in the opportunity to have an increase in contractual hours, the majority of staff were opposed to the split shift. It was agreed to undertake 1-1 discussions with staff to determine their views. This process identified that there were staff willing to move to the new rotas but the majority remained opposed. Focus groups were held with staff to explore the options available and a new rota devised and proposed by staff was agreed. This retained a 30 hour contract with staff working a split shift and commencing at 7am. Trade union meetings were held with the workforce at which time a difference of views were perceived across the workforce with some staff willing to move to the new rota patterns and others still against this.

An agreement was reached to pilot the rota developed by staff on a volunteer basis. Six social care teams volunteered and the pilot commenced on the 21st November 2016. Other staff also volunteered but as there was not full agreement of the team we were unable to include them in the pilot. Of the teams volunteering, three members of staff asked to be moved to other areas and not participate. Regular meetings were held during a 14 week period with both staff and trade unions representatives. This resulted in a change to the rota pattern with a reduction in the number of days worked continuously. In total 77 staff participated with only one member of staff asking to leave the pilot after this commenced. At the end of the 14 week period a questionnaire was sent out to staff which showed that most staff were favourable to remaining on the piloted working pattern. The six teams continue to work the new rota pattern.

The pilot had mixed results with the key advantages of the change being the addition of support at critical times (morning and night) and an increase in service provision with an additional 36 service users supported. There was also an increase in hours of service provided to service users.

While the pilot demonstrated improvements to the efficiency of the service, the level of efficiency was not as high as originally anticipated. This can be attributed to the following reasons:

- The volunteer nature of the pilot meant restricted ability to test teams aligned to an area (enablement and mainstream home care).
- The teams volunteering included geographical areas where there is a diminishing requirement for services and there continued to be a level of downtime.
- The timing of service user's service delivery was not changed prior to the commencement of the pilot and it took time to allocate services to the earlier start time and during the additional hours.

- The contractual hours of staff were not reduced to match the ideal rota pattern over 3 days. This would require staff to reduce their working pattern to 25 hours from 30 hours. As staff continued to work 30 hours this maintained the position of between three to five hours inefficiencies for each member of staff per week.

Following the pilot an exercise was undertaken to further develop the efficiencies within the service and increase the available hours of support made available. This will include a move to walking teams and driving teams, with a redistribution of staff to realigned geographical patches. To confirm the future level of workforce required, a virtual exercise was undertaken by the managers of the service to redraw the geographical boundaries of the teams to align to the Dundee Health and Social Care Partnership localities and to consider the placement of service users in line with the proposed rota patterns. These changes would assist to reduce travel time and maximise the available service provision.

ITEM No …5……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 24 JANUARY 2018**

REPORT ON: **INTEGRATED CARE FUND RECOMMENDATIONS**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB4-2018**

1.0 PURPOSE OF REPORT

The purpose of this paper is to outline the recommendations of the Integrated Care Fund Monitoring Group in relation to the extension and mainstreaming of a range of tests of change in the way community supports and health and social care services are provided and to seek approval to extend funding for these services, as outlined in Appendix 1, in the short term pending the conclusion of the IJB's budget setting process 2018/19.

2.0 RECOMMENDATIONS

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

2.1 Notes the recommendations of the Integrated Care Fund Monitoring Group in relation to the extension and mainstreaming of the range of tests of change as outlined in Appendix 1;

2.2 Agrees to extend the funding of these services, as outlined in Appendix 1, in the short term from 31 March 2018 until 30 June 2018 pending the outcome of the IJB's budget considerations;

2.3 Remits to the Chief Finance Officer to present these recommendations to a special IJB Budget meeting in March 2018 as part of the wider prioritisation of resources under the budget setting process.

3.0 FINANCIAL IMPLICATIONS

The current recurring funding included within the Health and Social Care Partnership's delegated budget in relation to the Integrated Care Fund is £3.1m. The costs associated with extending the projects outlined in Appendix 1 for the first 3 months of 2018/19 are £348k with a full year effect of £1,393k. Given the IJB has yet to consider the full implications of the developing delegated budget for 2018/19, including the extent of potential budget shortfalls and range of measures required to develop a balanced budget it is considered financially prudent to approve funding for these projects in the short term until the budget process is complete. Where relevant, this will enable projects to retain their staff on temporary contracts past the projects initial funding period of 31st March 2018.

4.0 MAIN TEXT

4.1 The Integrated Care Fund forms part of the IJB's overall Transformation Programme Investment Fund with the aim of funding innovation and development and supporting tests of change in the way community infrastructure and health and social care services are provided. This investment has been identified as a key component in supporting the actions set out within the Strategic and Commissioning Plan to meet the IJB's strategic priorities.

4.2 The IJB has been presented with and has approved previous reports outlining the range and scale of the additional resources allocated to the Health and Social Care Partnership to support the integration of health and social care. Report DIJB15-2016 (May 2016), Planning for Additional Resources advised the IJB of the range and purpose of these investment funds, including Integration Funding, Integrated Care Fund and Delayed Discharge Funding. This report set out proposals to fund a number of projects within the Integrated Care Fund over 2016/17 and 2017/18 based on the recommendations of the Integrated Care Fund Monitoring Group. This is a multi-agency/representative group which has the responsibility for overseeing the development of proposals and progress of these change projects, assessing the outcomes and impact they have made prior to making recommendations to mainstream or stop the service.

4.3 A further report was presented to the IJB in October 2016, Transformation Programme, Additional Innovation and Development Fund Investment (Report DIJB50-2016) which recommended funding for a further range of innovation projects. At the time of these reports, the Scottish Government had indicated that the Integrated Care Fund would be provided for financial years 2016/17 and 2017/18 only however it has since been confirmed that the funding is permanent and forms part of the delegated budget.

4.4 An example of the impact the investment in tests of change has had on traditional health and social care delivery models is in respect of the investment in the pilot Enhanced Community Support model of care. The learning and the confidence gained in developing this fully integrated, locality based approach lead to the development of the Proposed Model of Care for Older People report, approved by the IJB in October 2017 (Report DIJB37-2017) which supported the reduction in the bed base at Royal Victoria Hospital, released resources for investment in the roll out of the community based model and set out efficiency savings for the IJB.

4.5 Given those projects not already mainstreamed primarily have an end date of 31 March 2018, the Integrated Care Fund Monitoring Group met in December 2017 to consider the project outcomes and evaluations and have made a number of recommendations to mainstream some services and in some cases extend for another year. A number of other services have reached their natural end as tests of change, with many having demonstrated their contribution to the extent that they will be supported through other mainstream budgets, sources of funding or service re-design opportunities. In addition, some projects will be sustained with lower levels of funding. Recommendations on a small number of projects have been deferred while additional information is sought and these will be brought back to the IJB for consideration in due course. The projects recommended for continuation are outlined in Appendix 1.

4.6 It is recognised that at this stage, the IJB's 2018/19 budget process is still ongoing and as noted in report DIJB1-2018 on this agenda, there are considerable financial challenges ahead which will require the IJB to consider a range of options to balance the delegated budget, including prioritising resources. This would include decision on committing to investing in services for the longer term and therefore it is recommended that any longer term decisions around the use of Integrated Care Fund are tied in with the IJB's budget discussions. However, many of the projects approved for longer term funding in principle have staff on temporary contracts to reflect the nature of the previous short term funding commitments. Given the IJB will not be in a position to make decisions on the level of commitment it can make to these projects until the end of the budget process in March 2018 it is recommended that funding be approved to extend these projects until the end of June 2018 to allow for any staff notice period to be applied if required.

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	By agreeing to the recommendations in the report, there is a financial risk that depending on the outcome of budget negotiations with Dundee City Council and NHS Tayside, there will be insufficient funding to support the committed expenditure
Risk Category	Financial
Inherent Risk Level	Likelihood 3 x Impact 4 = 12 (High)
Mitigating Actions (including timescales and resources)	The proposals outlined in the report only commit the IJB to funding for a 3 month period in 2018/19 and the implications of any longer term commitments will be assessed by the IJB as part of its final budget setting process.
Residual Risk Level	Likelihood 2 x Impact 3 = 6 (Moderate)
Planned Risk Level	Likelihood 2 x Impact 3 = 6 (Moderate)
Approval recommendation	Given the moderate level of planned risk it is proposed that the IJB accepts the risks.

7.0 CONSULTATION

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

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 11 January 2018

Innovation & Development Plan	Full Year Funding	3 Months Funding 2018/19	ICF Monitoring Group Proposal
	£'000s	£'000s	
1. Community Capacity Building			
Capacity Building Fund			
Dundee Supporting Your Recovery Service	45	11	Mainstreamed
Community Cars (Dundee Community Transport)	47	12	Mainstreamed
Community Companion	37	9	Mainstreamed
Small Grants Fund	80	20	Mainstreamed
Good Governance Awards	42	11	Approved for 1 year
2. Prevention			
Welfare Rights in Primary Care	68	17	Approved for 1 year
Do You Need to Talk? Listening Service	19	5	Mainstreamed
3. Protecting People			
Dundee Recovery Partnership Co-ordinator/Albert St Hub Coordinator	40	10	Mainstreamed
4. Carers			
Caring Places	111	28	Mainstreamed
Carers (Scotland) Act Implementation Officer	32	8	Approved for 1 year
5. Community Assessment Model			
Step Down to Assess for 24 Hour Care & Moving Assessment into Community	87	22	Mainstreamed
6. Models of Care			
Housing With Care - Intermediate Care / Respite Site	255	64	Mainstreamed
Telehealth/Equipment - Comm officer	47	12	Approved for 1 year
Community Treatment Centre (Leg Ulcer Clinics)	77	19	Mainstreamed
The development of a resource to support the management of malnutrition in the community	63	16	Approved for 1 year
7. Workforce Development/Engagement - Learning & Org Dev			
OD / Integration	20	5	Mainstreamed
Organisational Development Localities	61	15	Mainstreamed
8. Community Rehabilitation Models			
ECS - Speech Therapy Input (2.0 WTE Band 6)	81	20	Mainstreamed
ECS - Pulmonary Rehabilitiation (1.0 WTE Band 4)	26	7	Mainstreamed
ECS - Falls Co-ordinator Development Post (0.6 WTE Band 4)	21	5	Mainstreamed
AHP Roving Team	87	22	Mainstreamed
Implementing Community Falls Prevention Exercise Classes	13	3	Mainstreamed
9. Independent Sector			
New Opportunities: Scoping the Contribution of Independent Sector Home Care and Care Homes	35	9	Approved for 1 year
Total Planned ICF Expenditure	**1,393**	**348**	