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

City Chambers
DUNDEE
DD1 3BY

TO: ALL MEMBERS, ELECTED MEMBERS AND OFFICER REPRESENTATIVES OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
(Please see distribution list)

25th June, 2018

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 Integration Joint Board to be held on Wednesday, 27th June, 2018 and now enclose the undernoted item of business which was not received at time of issue.

Yours faithfully

DAVID W LYNCH

Chief Officer

A G E N D A

11 DRAFT ANNUAL ACCOUNTS 2017/18 AND ANNUAL GOVERNANCE STATEMENT - Page 1

(Report No DIJB28-2018 by the Chief Finance Officer, attached).

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	TBC*
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)	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 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 …11…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2018**

REPORT ON: **DRAFT ANNUAL ACCOUNTS 2017/18**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB28-2018**

1.0 PURPOSE OF REPORT

The purpose of this report is to present the Integration Joint Board's Draft Annual Statement of Accounts 2017/18 for approval to initiate the external audit process.

2.0 RECOMMENDATIONS

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

2.1 Considers and agrees the content of the Draft Final Accounts Funding Variations as outlined in Appendix 1;

2.2 Approves the Draft Dundee Integration Joint Board Annual Corporate Governance Statement as outlined in Appendix 2;

2.3 Notes the Integration Joint Board's Draft Annual Statement of Accounts 2017/18 as outlined in Appendix 3;

2.4 Notes the application of reserves during 2017/18 to meet the Integration Joint Board's liabilities and support its activities during the financial year as outlined in 4.1.3.

2.5 Instructs the Chief Finance Officer to submit the Accounts to the IJB's external auditors (Audit Scotland) to enable the audit process to commence.

3.0 FINANCIAL IMPLICATIONS

The draft annual accounts statement for the year end 31 March 201 highlights that the IJB made an overall surplus of £29k in 2017/18 which arose as a result of a small underspend in the social care budget.

4.0 MAIN TEXT

4.1 Background

4.1.1 The IJB is required to prepare financial statements for the financial year ending 31 March 2018 following the Code of Practice on Local Authority Accounting in the United Kingdom ("the Code"). The Annual Accounts report the financial performance of the IJB. Its main purpose is to demonstrate the stewardship of the public funds which have been entrusted to the IJB for the delivery of the IJB's vision and its core objectives.

4.1.2 These accounts reflect the second year of Dundee IJB being responsible for delegated community based health and social care services. The IJB is required to follow Local Authority Accounts (Scotland) Regulations 2014. This requires the inclusion of a management commentary and remuneration report and recommends submission of the draft accounts by 30 June 2018 to the IJB's external auditors (Audit Scotland for 2017/18).

4.1.3 The 2017/18 Annual Accounts comprise:-

a) Comprehensive Income and Expenditure Statement – This statement shows that Dundee Integration Joint Board made an overall surplus of £29k in 2017/18 (£4,963k in 2016/17) on the total income of £262,184k (£263,784k in 2016/17). This overall underspend will be carried forward into 2018/19 through the Integration Joint Board's reserves.

b) Against Social Care budgets, an underlying underspend of £29k was reported (£4,963k in 2016/17). The Integration Scheme sets out that underspends will be retained by Dundee Integration Joint Board as reserves following agreement with the partners.

c) Against health budgets an underlying overspend of £2,119k was reported (£3,462k in 2016/17). This consisted of an overspend of £2,407k in prescribing, £448k net effect of charges for hosted services, with an underspend of £533k on services directly managed by the Integration Joint Board. However, in line with the risk sharing agreement agreed with NHS Tayside and Dundee City Council for the first two years of Dundee Integration Joint Board, NHS Tayside devolved further non-recurring budget to the Integration Joint Board to balance income with expenditure.

d) Movement in Reserves – Dundee Integration Joint Board has year-end reserves of £4,560k (£4,963k in 2016/17). These are held in line with the Integration Joint Board's reserves policy. Reserves were applied during the year to cover outstanding liabilities to Dundee City Council and the activities of the Integration Joint Board.

e) Balance Sheet – In terms of routine business Dundee Integration Joint Board does not hold assets, however the reserves noted above are reflected in the year-end balance sheet.

f) Notes - Comprising a summary of significant accounting policies, analysis of significant figures within the Annual Accounts and other explanatory information.

4.1.4 It should be noted that due to a range of technical accounting and other budgetary changes, there is some variation between the original agreed levels of funding from Dundee City Council and NHS Tayside to Dundee IJB as part of the delegated budget. The details of these are set out in Appendix 1 and it is proposed that the IJB accepts these changes.

4.1.5 The annual accounts document contains a Governance and Assurance Statement which is based on a self-assessment process. The IJB governance arrangements require to be independently assessed by Internal Audit and it is proposed that the draft statement set out within Appendix 2 is submitted to Internal Audit for consideration with the outcome and any associated action plan presented to the Performance and Audit Committee and incorporated into the Annual Accounts.

4.1.6 Once submitted, Audit Scotland will assess these accounts in line with their Annual Audit Plan for Dundee IJB approved at the Performance and Audit Committee on 27 March 2018 (PAC23-2018) and produce an independent auditors' report setting out their opinion on the annual statement by 30 September 2018. The outcome of this will be incorporated into the annual accounts and will subsequently be presented to the IJB for final approval. The draft unaudited accounts are shown in Appendix 3.

5.0 POLICY IMPLICATIONS

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 through the audit process, Audit Scotland identify areas of concern or material misstatement leading to a qualified audit certificate
Risk Category	Financial/Governance
Inherent Risk Level	Likelihood 2 x Impact 4 = Risk Scoring 8 (which is High Risk Level)
Mitigating Actions (including timescales and resources)	The accounts have been prepared in accordance with good practice principles and statutory requirements by suitably qualified officers
Residual Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	Given the nature of the risks, these are deemed to be acceptable

7.0 CONSULTATIONS

The Chief 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	✓
	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: 25 June 2018

4

Final Accounts – Funding Variations (and Adoption of Specific Presentation)
Extract - Note to Dundee Joint Integration Board regarding variations to the existing Scheme of Integration and the adoption of specific presentation of information within the framework of the International Financial Reporting Standards (IFRS).

Background
The following note provides details of variations to the delegated budget for which approval is sought by the Dundee Integration Joint Board. The adjustments and explanations for these adjustments are outlined below section 1.

In addition information has been presented within the requirements of the International Financial Reporting Standards (IFRS) and attributable supplementary Local Authority (Scotland) Accounts Advisory Committee (LASAAC). Specific applications of the guidance are outlined in section 2.

Section 1 – Variations to Delegated Budget

Local Authority Variations – The agreed delegated budget 2016/17 provided for a budgeted payment of £79.376m from Dundee City Council to the Dundee Integration Joint Board to fund the commissioning of services. . It is recognised that a number of technical year-end adjustments will result in variations in costs outwith the control of the IJB (e.g. adjustments to pension costs, inclusion of central support.). To compensate for this the Dundee Integration Joint board was provided with a corresponding increase in funding. This meant that the total funding provided to the IJB was £84.066m, an increase of £4.690m.

These year-end adjustments will be a feature of each year end accounts process. Notably they are difficult to quantify at the commencement of the financial year (e.g. pension costs adjustments can vary significantly within a single financial year) and cognisance of these variations requires to be taken of these variations in the Dundee Integration Joint Boards accounts.

The Dundee City Council adjusted funding is outlined below:-

DCC Funding to Dundee Integration Joint Board (DIJB)	**£000**
Initial Dundee City Council contribution to DIJB	**79,376**
Additional Funding from Dundee City Council	4,690
Total Funds provided by Dundee City Council	**84,066**

NHS Tayside Variations – The financial reporting process throughout the year highlighted significant pressures on NHS Tayside related services leading to an overspend which as part of the risk sharing arrangement was to be funded from NHS Tayside.. This means that the funding provided by NHS Tayside is in excess of that outlined in the integration agreement.

The NHS Tayside contribution also includes specific Integration funding which was provided by the Scottish Government with NHS Tayside acting as an agent. These monies have been provided to the Dundee Integration Joint Board and those not expended currently sit in the Board's reserves.

The NHS Tayside adjusted funding is outlined below:-

NHS Funding to Dundee Integration Joint Board (DIJB)	**£000**
Initial NHS Contribution to DIJB (incl Large Hospital Set Aside)	**169,487**
Add: Supplementary Budget Adjustments	1,789
Add: Additional Funding to Cover Overspends	3,462
Add: Net Effect of Hosted Services Budget	4,979
Final NHS contribution to DIJB	**179,717**

Section 2 – Specific application of International Financial Reporting Standards (IFRS)

Netting of Income – The Dundee Integrated Joint Board annual accounts have been prepared on the basis that all operational expenditure is shown net of income as it is reflects the actual environment the board is working under. In particular the Dundee Integration Joint Board does not have the legal power to set charges for services provided by either the Council or NHS Tayside. In addition the IJB cannot pursue an action to recover income from a service recipient. More specifically it reflects the role of the Dundee Integration Joint Board as a net funding vehicle. Audit Scotland has indicated that this is the preferred approach.

To support this position the following text is included on the face of the 2016/17 Annual Accounts

"The Dundee Integration Joint Board's Comprehensive Income and Expenditure Statement shows the net commissioning expenditure provided to partners to support services. It does not detail income received from service users as this remains the statutory responsibility of the partners."

Offsetting of Debtors & Creditors – The Dundee Integration Joint Board accounts have been prepared on the basis that the net expenditure from Dundee City Council and NHS Tayside recognises that debtors and creditors in respect of NHS Tayside and Dundee City Council with third parties (other than the Dundee Integration Board) but not yet settled in cash terms are offset against the funds they are holding on behalf of the IJB. This essentially requires that when consolidating its accounts the Dundee Integration Joints Board have consolidated the accrued net expenditure. Therefore only debtors and creditors between Dundee Integration Joint Board and its two constituent body are detailed in the IJB's final accounts. The only exception to this is Audit Scotland audit fees.

Annual Governance Statement

Introduction

The Annual Governance Statement explains Dundee City Integration Joint Board's governance arrangements and reports on the effectiveness of the Integration Joint Board's system of internal control.

Scope of Responsibility

Dundee City Integration Joint Board is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

To meet this responsibility, the Integration Joint Board has established arrangements for governance which includes a system of internal control. The system is intended to manage risk to support the achievement of the Integration Joint Board's policies, aims and objectives. Reliance is also placed on the NHS Tayside and Dundee City Council systems of internal control that support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the Integration Joint Board.

The system can only provide reasonable and not absolute assurance of effectiveness.

The Governance Framework and Internal Control System

Dundee City Integration Joint Board comprises six voting members, three nominated by Dundee City Council and three nominated by Tayside NHS Board, as well as non-voting members including a Chief Officer and Chief Finance Officer appointed by the Integration Joint Board. During 2017/18, the Integration Joint Board continued to develop and enhance its governance arrangements as it moved through its second year of being responsible for the strategic planning and operational delivery of integrated health and social care services. This included progressing areas highlighted as developments in the 2016/17 Annual Governance Statement.

The main features of the governance framework in existence during 2017/18 were:

- The Integration Scheme as the overarching agreement between the Integration Joint Board, NHS Tayside and Dundee City Council as to how the planning for and delivery of delegated health and social care services is to be achieved reflecting a range of governance arrangements required to support this arrangement.
- The senior leadership team consisting of the Chief Officer, Head of Finance and Strategic Planning (Chief Finance Officer) and Head of Health and Community Care. The Chief Finance Officer has overall responsibility for the Integration Joint Board's financial arrangements and is professionally qualified and suitably experienced to lead the Integration Joint Board's finance function and to direct staff accordingly.
- Monthly meetings of the senior leadership team.
- Standing Orders, Financial Regulations and a Code of Conduct including the publication of Register of Member's Interests and the nomination of the Clerk to the Integration Joint Board as Standards Officer were all in place during 2017/18.
- The Integration Joint Board met on eight occasions throughout the year to consider its business.
- The Integration Joint Board's Performance and Audit Committee met on five occasions throughout the year to enhance scrutiny of the performance of the Integration Joint Board and audit arrangements in line with regulations and good governance standards in the public sector.

- Internal Audit arrangements for 2017/18 were approved including the appointment of the Chief Internal Auditor of FTF Internal Audit and Management Services to the role of Chief Internal Auditor of the Integration Joint Board supported by Dundee City Council's Internal Audit Service. An Internal Audit Plan for 2017/18 was approved drawing on resources from both organisations.
- The assurances provided from internal audit through their independent review work of the Integration Joint Board's internal control systems.
- The Clinical, Care and Professional Governance Framework continued to evolve as an action identified as an area of improvement from the 2016/17 annual governance statement through the leadership of the Dundee Health and Social Care Clinical, Care and Professional Governance Forum (R2). An Internal Audit Review found these arrangements as being broadly satisfactory.
- The Integrated Strategic Planning Group met on three occasions during the year.
- The establishment of the Transformation Delivery Group, consisting of senior leaders from the health and social care partnership, the voluntary sector, staff side representation and Dundee City Council and NHS Tayside transformation leads to provide oversight and governance to the developing range of service redesign and transformation projects.
- The Chief Finance Officer complied fully with the five principles of the role of the Chief Finance Officer, as set out in CIPFA guidance.

The governance framework described operates on the foundation of internal controls, including management and financial information, financial regulations, administration, supervision and delegation. During 2017/18 this included the following:

- The enhancement of risk management arrangements through the clear identification of risks in relation to Integration Joint Board decisions reflected in reports presented to the Integration Joint Board and Performance and Audit Committee, subsequently included within the High Level Risk Register with regular reviews provided to the Performance and Audit Committee as an area of improvement identified within the 2016/17 Annual Governance Statement.
- The approval and progressing of the Annual Internal Audit Plan.
- Continued development of the performance management framework with a range of performance reports published and scrutinised by the Performance and Audit Committee throughout the year, including more detailed reviews of specific areas of concern as requested by the committee.
- A process of formal regular reporting of financial performance and monitoring to the Integration Joint Board was in place throughout 2017/18.
- The provision of regular budget development reports for 2018/19 to the Integration Joint Board.
- The provision of an assurance report from the chair of the Performance and Audit Committee outlining the key issues raised at the previous Performance and Audit Committee meeting to the following Integration Joint Board meeting.
- In-year reporting on issues relating to Clinical, Care and Professional Governance in line with the overarching strategy: Getting It Right for Everyone – A Clinical, Care and Professional Governance Framework with no major issues reported.
- The development of a process for issuing directions to NHS Tayside and Dundee City Council reflected in Integration Joint Board reports during the year.
- Regular reporting to the Performance & Audit Committee of external scrutiny reports relating to delegated services from scrutiny bodies such as the Care Inspectorate and Mental Welfare Commission and supporting subsequent action plans.
- Development and reporting of the Integration Joint Board's Complaint's Handling Procedure.
- Reliance on the procedures, processes and systems of NHS Tayside and Dundee City Council.

Continuous Improvement

The following areas for improvement have been identified through the self-assessment process and Annual Internal Audit Report. Progress against these will be monitored by the Performance and Audit Committee during 2018/19. Some of these are outstanding from the 2016/17 continuous improvement plan (marked as *) and have primarily been delayed due to resource capacity and the impact of other priorities across the wider partnership with NHS Tayside and the other Tayside Integration Joint Boards.

Area for Improvement	Lead Officer	Planned Completion Date
Development of Large Hospital Set Aside arrangements in conjunction with the Scottish Government, NHS Tayside and Angus and Perth and Kinross Integration Joint Boards	Chief Officer / Chief Finance Officer	December 2018
Implementation of an action points update to each meeting of the IJB and PAC in addition to an annual workplan to be agreed for both meetings	Chief Officer / Chief Finance Officer	October 2018
Development of improved Hosted Services arrangements around risk and performance management for hosted services*	Chief Officer / Chief Finance Officer	December 2018
Development of an overall Governance Action Plan to progress previous recommended areas for improvement	Chief Finance Officer	October 2018
Development of regular IJB and PAC member induction and development process	Chief Officer / Chief Finance Officer	December 2018
Further develop the Integration Joint Board's local Code of Governance*	Chief Officer / Chief Finance Officer	December 2018
Present the governance principles adopted by the Health and Social Care Integration Governance Working Group to the PAC to be taken forward by all parties (* reflects partial development from 2016/17)	Chief Finance Officer	September 2018
Development of multi-year financial plan as part of the review of the Strategic and Commissioning Plan	Chief Finance Officer	March 2019

Area for Improvement	Lead Officer	Planned Completion Date
Update the Integration Joint Board's Participation and Engagement Strategy*	Chief Officer / Chief Finance Officer	December 2018
Develop Scheme of further delegation in relation to delegated services to the Integration Joint Board*	Chief Officer / Chief Finance Officer	December 2018
Clarify responsibilities and accountabilities around the impact of General Data Protection Regulations (GDPR) legislation with partner bodies	Chief Finance Officer	October 2018
Update and enhance the IJB's Risk Management Strategy and further develop the IJB's operational risk register	Chief Finance Officer	December 2018

Dundee City Integration Joint Board complies in full with "The Role of the Head of Internal Audit in Public Organisations" (CIPFA) and operates in accordance with "Public Sector Internal Audit Standards" (CIPFA). The Head of Internal Audit reports directly to the Performance and Audit Committee with the right of access to the Chief Finance Officer, Chief Officer and Chair of the Performance and Audit Committee on any matter. The annual programme of internal audit work is based on a strategic risk assessment, and is approved by the Performance & Audit Committee.

Review of Adequacy and Effectiveness

Dundee City Integration Joint Board is required to conduct, at least annually, a review of the effectiveness of its governance framework including the system of internal control.

The review is informed by the work of the Senior Management Team (who have responsibility for the development and maintenance of the internal control framework environment), the work of the internal auditors and the Chief Internal Auditor's annual report, and reports from external auditors and other review agencies and inspectorates.

The review of Dundee City Integration Joint Board's governance framework is supported by a process of self-assessment and assurance certification by the Chief Officer. The Chief Officer completes a "Self-assessment Checklist" as evidence of review of key areas of the Integration Joint Board's internal control framework. The Senior Management Team has input to this process through the Chief Finance Officer. There were no significant internal control issues identified by the self-assessment review.

In addition, the review of the effectiveness of the governance arrangements and systems of internal control within the Health Board and Local Authority partners places reliance upon the individual bodies' management assurances in relation to the soundness of their systems of internal control. Due to ongoing concerns during 2017/18, NHS Tayside has been subject to a number of internal (e.g. Internal Audit) and external (e.g. Scottish Government) commissioned reviews. These reviews have reported back to NHS Tayside and the Scottish Government with a series of actions set out to address identified weaknesses. These actions will be monitored locally by NHS Tayside's new leadership team and through the Scottish Government. A number of the weaknesses identified may have an impact on the Integration Joint Board and its ability to deliver on its strategic objectives. In particular, the Integration Joint

Board is supported by NHS Tayside in relation to financial management and strategic planning capacity, with both of these regarded as weaknesses in NHS Tayside's own review of governance. The Integration Joint Board will continue to work in partnership with NHS Tayside to mitigate the impact of these issues.

In preparing the Annual Governance Statement, the Integration Joint Board gave consideration to both NHS Tayside and Dundee City Council's Annual Governance Statements. While recognising the issues noted above within NHS Tayside, there were no issues arising which require any further disclosure in the Integration Joint Board's Governance Statement.

Throughout the year, the Performance and Audit Committee has considered a range of issues which cover its core responsibilities in providing the Integration Joint Board with independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and governance arrangements. The Chair of the Performance and Audit Committee provides an update to the next available Integration Joint Board meeting on the issues raised and any areas of concern which the Integration Joint Board should be made aware of. Over the course of 2017/18, no such areas of concern were noted by the Chair of the Performance and Audit Committee.

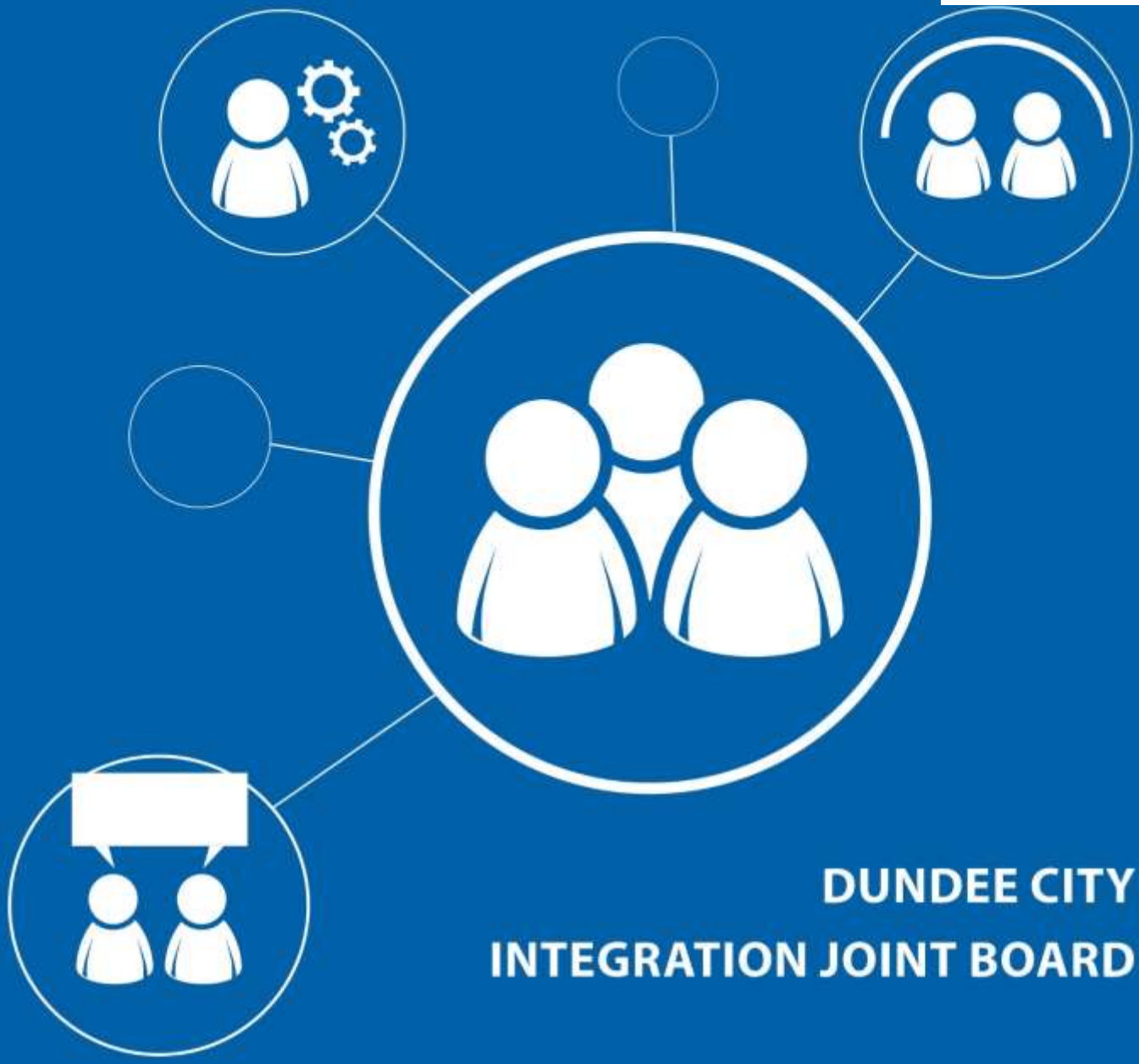
The review is subject to assessment and comment by Internal Audit who will reflect their findings and any recommendations in their Annual Internal Audit Report 2017/18 to be presented to the Performance and Audit Committee at its meeting on 31 July 2018. An action plan to meet any identified recommendations will be produced and agreed by the Performance and Audit Committee and will be incorporated into the above Annual Governance Statement to form the final Annual Accounts Statement.

Conclusion and Opinion on Assurance

While recognising that the above Annual Governance Statement is subject to Internal Audit assessment, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of Dundee City Integration Joint Board's governance arrangements.

We consider that the internal control environment provides reasonable and objective assurance that any significant risks impacting on the Integration Joint Board's principal objectives will be identified and actions taken to avoid or mitigate their impact.

Systems are in place to regularly review and improve the internal control environment.



DUNDEE CITY
INTEGRATION JOINT BOARD

ANNUAL ACCOUNTS
2017-18

Dundee
Health & Social Care
Partnership

Dundee City Integration Joint Board

Annual Accounts 2017-18

Contents

Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and received Royal Assent in April 2014. This established the framework for the integration of health and adult social care in Scotland, to be governed by Integration Joint Boards with responsibility for the strategic planning of the functions delegated to it and for ensuring the delivery of its functions through the locally agreed operational arrangements.

Following approval from Dundee City Council and NHS Tayside, the Dundee Integration Scheme, the formal legal partnership agreement between the two parent organisations, was submitted to the Scottish Ministers in August 2015. On 3 October 2015 Scottish Ministers legally established Dundee's Integration Joint Board as a body corporate by virtue of the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Amendment (No 3) Order 2015.

Dundee City Integration Joint Board formally became responsible for the operational management and oversight of delegated health and social care functions with effect from 1 April 2016.

This publication contains the financial statements for Dundee City Integration Joint Board for the year ended 31 March 2018. The Management Commentary highlights the key activities carried out to date and looks forward, outlining the anticipated financial outlook for the future and the challenges and risks facing health and social care services over the medium term.

Role and Remit of Dundee City Integration Joint Board

Dundee City Integration Joint Board has responsibility for providing defined health care and social care services for the residents of Dundee encompassing an area of 60 square kilometres and a population of 148,000. Like other parts of Scotland, Dundee is expected to see a significant rise in the number of older people with an increase of 45% in those over 75 anticipated over the next 20 years. Deprivation in Dundee is high with just over 29% of the population living in the 15% most deprived areas of Scotland. Overall Dundee is the third most deprived local authority area in Scotland, with only Glasgow and Inverclyde having higher deprivation. Dundee has the second lowest life expectancy in Scotland, with factors such as prevalence of substance misuse, mental health problems, smoking, and obesity all contributing to the reduced life expectancy. These factors highlight the scale of the challenges Dundee City Integration Joint Board faces over the coming years.

The voting membership of Dundee City Integration Joint Board is drawn from three elected members nominated by the Council and three non-executive members nominated by the Health Board.

The table below notes the membership of Dundee City Integration Joint Board in 2017/18:

Voting Members:

Role	Member
Nominated by Health Board	Doug Cross
Nominated by Health Board	Judith Golden
Nominated by Health Board	Munwar Hussain
Councillor Nominated by Dundee City Council	Councillor Ken Lynn
Councillor Nominated by Dundee City Council	Councillor David Bowes*
Councillor Nominated by Dundee City Council	Councillor Stewart Hunter**
Councillor Nominated by Dundee City Council	Bailie Helen Wright***
Councillor Nominated by Dundee City Council	Councillor Roisin Smith***

*Until 4 May 2017
**Until 22 May 2017
***From 22 May 2017

Non-voting members:

Role	Member
Chief Social Work Officer	Jane Martin (Dundee City Council)
Chief Officer	David W Lynch
Proper Officer Appointed under section 95 (Chief Finance Officer)	Dave Berry
Registered medical practitioner whose name is included in the list of primary medical performers prepared by the Health Board	Frank Weber
Registered nurse who is employed by the Health Board	Sarah Dickie (NHS Tayside)
Registered medical practitioner employed by the Health Board and not providing primary medical services	Cesar Rodriguez (NHS Tayside)
Staff of the constituent authorities engaged in the provision of services provided under integration functions	Raymond Marshall (NHS Tayside Staff Side Representative) Jim McFarlane (Dundee City Council Trade Union Representative)
Director of Public Health	Drew Walker (NHS Tayside)
Third Sector Representative	Christine Lowden (Dundee Voluntary Action)
Service user residing in the area of the local authority	Andrew Jack (Public Partner, NHS Tayside)
Persons providing unpaid care in the area of the local authority	Martyn Sloan (Carer, Dundee Carers Centre)

The Chair of Dundee City Integration Joint Board rotates on a two yearly basis with the current arrangements due to change in October 2018. Councillor Ken Lynn is the current Chair with Doug Cross acting as Vice Chair. Dundee City Integration Joint Board is supported through the appointment of the Chief Officer, the Head of Finance and Strategic Planning (as Chief Finance Officer) and the Head of Health and Community Care who provide the strategic leadership and management of delegated operational services.

Operations for the Year

2017/18 represents the second full financial year of Dundee City Integration Joint Board (commonly known as Dundee Health and Social Care Partnership) being formally responsible for planning and delivering community based health and social care services. The development and delivery of these services is in line with the Integration Joint Board's Strategic and Commissioning Plan which sets out the context within which integrated services in Dundee operates and is shaped around the Health and Social Care Partnership's vision that "Each Citizen of Dundee will have access to the information and support that they need to live a fulfilled life." Dundee Integration Joint Board's Strategic and Commissioning Plan for 2016-2021 can be found at:
https://www.dundeehscp.com/sites/default/files/publications/dhscp_strategic_and_commissioning_plan_0.pdf
The Strategic & Commissioning Plan focusses on delivering on the following eight strategic priorities:

These priorities are consistent with and support the Scottish Government nine National Health and Wellbeing Outcomes which apply across all health and social care services. These are:

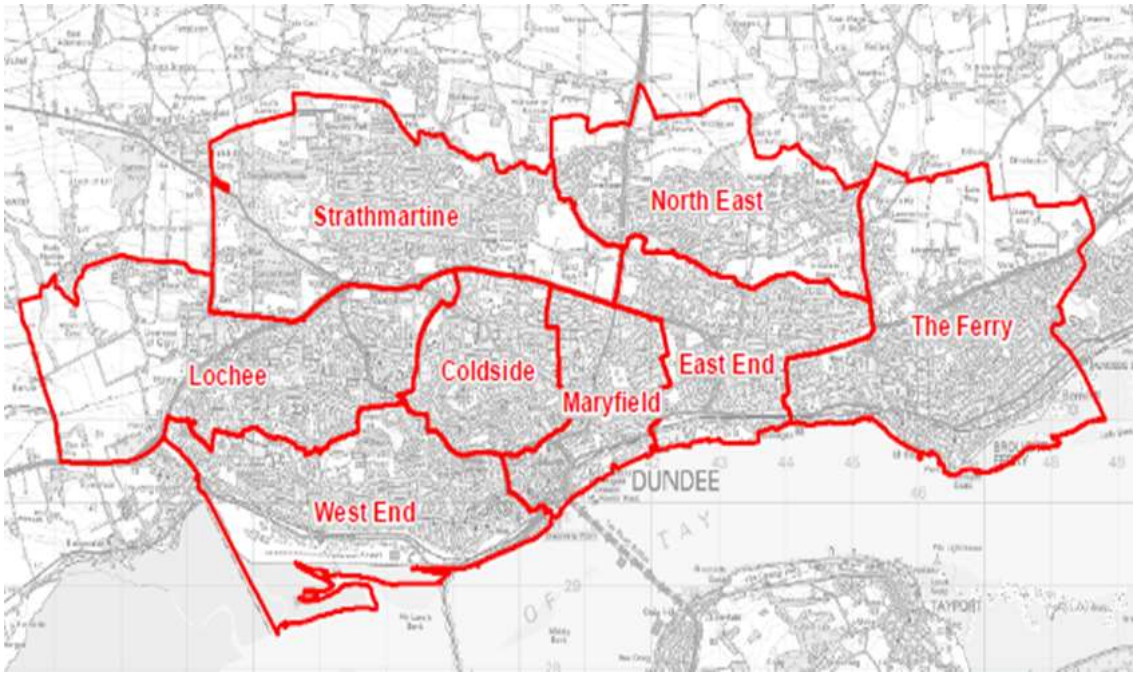
Table 1 National Outcomes

1. Healthier Living	People are able to look after and improve their own health and wellbeing and live in good health for longer
2. Independent Living	People, including those with disabilities, long term, conditions, or who are frail, are able to live as far as reasonably practicable, independently at home or in a homely setting in their community.
3. Positive Experiences and Outcomes	People who use health and social care services have positive experiences of those services and have their dignity respected.
4. Quality of Life	Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live.
5. Reduce Health Inequality	Health and social care services contribute to reducing health inequalities.
6. Carers are Supported	People who provide unpaid care are supported to look after their own health and wellbeing, and to reduce any negative impact of their caring role on their own health and wellbeing.
7. People are Safe	People who use health and social care services are safe from harm.
8. Engaged Workforce	People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.
9. Resources are used Efficiently and Effectively	Best Value is delivered and scarce resources are used effectively and efficiently in the provision of health and social care services.

Operational Delivery Model

During 2017/18, Dundee Health and Social Care Partnership continued to develop its operational delivery structure with a view to embedding a full locality based model of integrated health and social care services to support the delivery of the Integration Joint Board's strategic priorities. This structure is based around the eight Local Community Planning Partnership areas within the city as noted below.

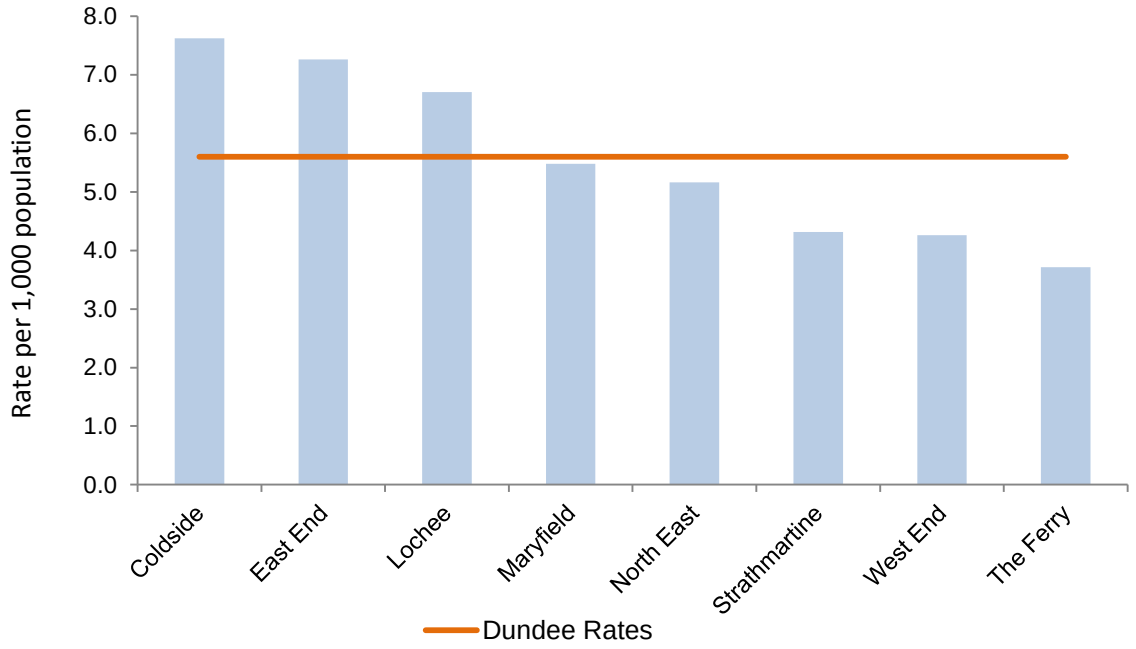
Map of Eight Local Community Planning Partnership Areas



Locality managers' portfolios currently include a combination of service specific responsibilities which are city wide (eg older people care at home, learning disabilities) as well as an overview of the needs of their locality areas as part of the transition to fully locality based integrated health and social care services.

One of the key challenges in delivering on the Integration Joint Board's Strategic Priorities and National Health and Wellbeing Outcomes is the high levels of inequalities which exist within the city with significant variances across locality areas, driven by high levels of deprivation and resultant impact on higher prevalence levels of health and multiple long term conditions. In addition to the frailty and ill health which is prevalent in the ageing population, many younger adults in Dundee are experiencing health conditions earlier in life as a result of deprivation and associated impact of substance misuse and mental health issues. In Dundee life expectancy is 77.6 years which is the second lowest in Scotland compared with an average of 79.1 years across the country. However the variance between localities within the city is considerable as highlighted in chart 1 below. The combined effects of these are evidenced by the increased demand and usage of health and social care services in Dundee.

Chart 1 Premature Mortality Age Standardised Rates per 1,000 Population <75 in 2015



Source: NHS Tayside

The Integration Joint Board's developing response to these challenges over 2017/18 include the following locality focussed initiatives:

- Development of a locality approach to carers in Coldside and Strathmartine
- Roll out of the Macmillan Improving the Cancer Journey in Coldside and Lochee
- The whole system approach to supporting children and families in Lochee
- An East End Health and Wellbeing drop in initiative offering a free service with a focus on wellbeing information, activities and support.

Scrutiny and Performance

The Integration Joint Board's Performance and Audit Committee (PAC) provides the opportunity for committee members to better understand the needs of communities and to monitor and scrutinise performance of delegated services against delivering the strategic priorities through a range of performance indicators and benchmarking. Throughout 2017/18, the Integration Joint Board's Performance and Audit Committee received regular performance reports which quantified Dundee's health and social care challenges in relation to the baseline data against a range of performance indicators, designed to capture the progress made under integration over time. This includes nationally and locally set indicators, a number of which are reflected at locality level to assist the Integration Joint Board in determining the areas of greatest need and to inform the targeting of resources. Dundee's 2017/18 performance against a range of national indicators is noted in Table 2 below. This shows good progress is being made in relation to reducing emergency bed days, hospital readmissions and delayed discharges from hospital however challenges still remain in relation to emergency admissions to hospital, readmissions and falls. These have been subject to further in-depth scrutiny through the PAC.

Table 2

National Indicator	Dundee 15/16 (Baseline Year)	Dundee 16/17	Dundee 17/18	Scotland 2017/18
Emergency admissions rate to hospital per 100,000 people aged 18+	12,154	12,411	12,790	11,959
Emergency bed days rate per 100,000 people aged 18+	142,407	136,059	131,673	115,518
Readmissions to acute hospital within 28 days of discharge rate per 1,000 population	121	125	123	97
Falls rate per 1,000 population aged 65+	25	26	28	22
Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (Delayed Discharge bed days)	832	755	347	772

Transforming Services

Through the Integration Joint Board's Transformation Programme, a range of service redesign initiatives have been developed in line with the priorities in the strategic plan which have improved patient and service user pathways in order to reduce hospital admissions and shorten hospital stays, including undertaking early intervention and prevention approaches. One of the most significant shifts in service provision commissioned by the Integration Joint Board over 2017/18 has been to re-design and reduce the bed base at Royal Victoria Hospital and re-invest the resources released into a multi-disciplinary, Enhanced Community Support model of care while contributing to efficiency savings and reducing cost pressures. An example of the outcomes of such an approach is reflected below:

EARLY INTERVENTION AND PREVENTION

75 year old lady living in a care home with complex needs being admitted to hospital as a result of frequent diabetic attacks.

Through the collaborative work of the General Nurse and Review Officer within the team and in conjunction with care home staff, GP and Specialist Diabetes Nurse they were able to devise an appropriate management plan; provide care home staff with training as well as updating her anticipatory care plan that allowed the care home to better support the lady and prevent further hospital admissions.

Developments such as this have had a positive impact in improving performance in some indicators such as a reduction in delayed discharges for Dundee service users. However as noted in Table 2 above there are a range of indicators where Dundee's position is among the lowest performing across Scotland.

The Integration Joint Board's Transformation Programme is key to the Integration Joint Board continuing to deliver change in the way in which health and social care services are provided and connects the overarching strategic priorities with service redesign opportunities. During 2017/18, a Transformation Delivery Group was established, consisting of a range of professionals, officers, the voluntary sector and staff side representation to provide oversight, governance and support to the delivery of the Transformation Programme. This group is also tasked with developing and bringing forward service change proposals to the Integration Joint Board for consideration. The challenge for the group is to be able to develop and sustain levels of change at scale and pace to meet the growing demographic needs with continuing financial restrictions.

A summary of the key achievements over 2017/18 is as follows:

- Achieving a further shift to locality working
- The redesign of Mental Health and Substance Misuse services
- Increased collaborative work with carers
- A continued focus on reducing health inequalities and expansion of services
- New resources secured around employability
- Continued improved performance around delayed discharge.

Financial Position at the End of March 2018

The impact of the overall financial position for integrated services in Dundee for 2017/18 has resulted in the level of reserves held by Dundee City Integration Joint Board decreasing to £4.560m at the year ended 31 March 2018 (as against £4.963m at the year ended 31 March 2017). The surplus generated throughout 2017/18 was significantly less than in 2016/17 mainly due to the Integration Joint Board setting out clear commitments against additional integration funding from the Scottish Government in line with its Strategic Plan.

Of the reserves, £2.459m has been committed by the Integration Joint Board to provide bridging finance to transition toward new models of care and support, further innovation and tests of change. A further £1.814m of these reserves have been allocated by Dundee City Integration Joint Board to offset budget shortfalls anticipated in 2018/19 as a result of challenging budgets, delegated to the Integration Joint Board from NHS Tayside and Dundee City Council. This non-recurring investment provides the opportunity for the Integration Joint Board to design, test and implement service changes which improve service user outcomes in a more efficient way.

While the position at the year ended 31 March 2018 results in the Integration Joint Board's reserves level being close to a level of reserve equating to 2% of the Integration Joint Board's net expenditure as set out within its reserves policy, given the commitments noted above, this is unlikely to be maintained at the end of the 2018/19 financial year.

It should be noted that Tayside NHS Board will release funding held on behalf of the three Tayside Integration Joint Boards during 2018/19, a small proportion of which is currently uncommitted, which will support the Integration Joint Board's activities in 2018/19 and beyond.

Key Risks and Uncertainties

Looking forward, the impact of Dundee's demographic growth with an increasingly frail population following evidence that Dundee citizens have poor health at an earlier age, the prevalence of disabilities and high numbers of people with substance misuse and mental health problems will continue to present risks that the availability of resources will not be able to meet that demand.

While service redesign and development will continue to provide opportunities to deliver services more effectively and efficiently with better outcomes for individuals, the continuing funding restrictions and cost pressures facing the Integration Joint Board will limit the ability to release and shift resources from traditional models of care for reinvestment. The impact of a flat cash budget settlement from Dundee City Council to Dundee City Integration Joint Board for 2018/19 and continued cost pressures around the GP Prescribing budget and In-Patient Mental Health services within the NHS delegated budget provide real risks that the Integration Joint Board will be unable to sustain current levels of activity in order to deliver a balanced budget.

The Integration Joint Board's budget efficiency plans for 2018/19 are reliant on a range of non-recurring interventions such as the use of uncommitted reserves to cover known expenditure pressures. There is a risk that the Integration Joint Board is unable to drive change at the scale and pace necessary to replace these with sustainable and recurring plans from 2019/20 onwards.

During 2017/18, the Integration Joint Board made a number of decisions around the use of its reserves in order to support transformational change through transition funding. The application of uncommitted reserves to balance the 2018/19 budget severely restricts the ability of the Integration Joint Board to support these in the future, or to meet unforeseen cost pressures.

The new GP Contract the Scottish Government has introduced from 2018/19 to develop a sustainable model of general practice, changes the demands and relationship between the NHS Board, Integration Joint Boards (as delegated services) and GP Practices. This will see the development of multi-disciplinary, community based support teams working in and around general practices to support areas previously the responsibility of GPs. To deliver this operational change new competencies and skills of the workforce would be required. However, there are challenges in that Dundee may not be able to recruit or develop the workforce to deliver all the expectations or create instability across other services as staff move to the new services.

There is a wider risk around the ability to develop and sustain the required workforce to deliver effective health and social care services given a profile of an ageing workforce, recruitment difficulties for particular professions such as nurses and competing demands within the traditional social care labour market through the projected growth in the hospitality sector in Dundee.

The impact of NHS Tayside's financial challenges in addition to recent leadership changes has created some uncertainty around the impact this will have on the Integration Joint Board over the coming year and beyond. However, through our Transformation Change Programme and the established Transformation Delivery Group we continue to review models of service

delivery to ensure we remain fit for the future and be able to meet the needs of the citizens of Dundee.

Analysis of Financial Statements

The Annual Accounts report the financial performance of Dundee City Integration Joint Board. Its main purpose is to demonstrate the stewardship of the public funds which have been entrusted to the Integration Joint Board for the delivery of its vision and its core objectives. The requirements governing the format and content of local authorities' annual accounts are contained in The Code of Practice on Local Authority Accounting in the United Kingdom (the Code). The 2017/18 Accounts have been prepared in accordance with this Code.

Integration Joint Boards need to account for their spending and income in a way which complies with our legislative responsibilities and supplementary Local Authority (Scotland) Accounts Advisory Committee (LASAAC) guidance.

The 2017/18 Annual Accounts comprise:-

a) Comprehensive Income and Expenditure Statement – This statement shows that Dundee City Integration Joint Board made an overall surplus of £29k in 2017/18 (£4,963k in 2016/17) on the total income of £262,184k (£263,784k in 2016/17). This overall underspend will be carried forward into 2018/19 through the Integration Joint Board's reserves.

b) Against Social Care budgets, an underlying underspend of £29k was reported (£4,963k in 2016/17). The Integration Scheme sets out that underspends will be retained by Dundee City Integration Joint Board as reserves following agreement with the partners.

c) Against health budgets an underlying overspend of £2,119k was reported (£3,462k in 2016/17). This consisted of an overspend of £2,407k in prescribing, £448k net effect of charges for hosted services, with an underspend of £533k on services directly managed by the Integration Joint Board and underspend of £203k in General Medical and Family Health Services. However in line with the risk sharing agreement agreed with NHS Tayside and Dundee City Council for the first two years of Dundee City Integration Joint Board, NHS Tayside devolved further non-recurring budget to the Integration Joint Board to balance income with expenditure.

d) Movement in Reserves – Dundee City Integration Joint Board has year-end reserves of £4,560k (£4,963k in 2016/17). These are held in line with the Integration Joint Board's reserves policy.

e) Balance Sheet – In terms of routine business Dundee City Integration Joint Board does not hold non-current assets, however the reserves noted above are reflected in the year-end balance sheet.

f) Notes - Comprising a summary of significant accounting policies, analysis of significant figures within the Annual Accounts and other explanatory information.

The Annual Accounts for 2017/18 do not include a Cash Flow Statement as Dundee City Integration Joint Board does not hold any cash or cash equivalents.

Conclusion

We are pleased to present the annual accounts for the year ended 31 March 2018 for Dundee City Integration Joint Board as the second full operational year of the Integration Joint Board. The accounts show that Dundee City Integration Joint Board has delivered its operational services in line with financial expectations set out during the year through the financial monitoring process and has established a level of reserves to support its remodelling activities over the short term.

Going forward, Dundee Integration Joint Board has a significant financial challenge ahead to deliver the Strategic & Commissioning Plan in a climate of growing demand and limited resources. In order to achieve this we must ensure this resource is used effectively, identifying, testing and implementing innovative ways to deliver more personalised and well co-ordinated services, building the resilience of people and their communities and reducing unnecessary hospital admissions and delayed discharges from hospital. This will require the confidence of professionals and the public, to further shift resources from intensive, high cost services to a focus on more preventative service provision to ensure best value for public funds.

Signed: **25 September 2018**

Dave Berry CPFA
Chief Finance Officer
Dundee City
Integration Joint Board

David W Lynch
Chief Officer
Dundee City
Integration Joint Board

Councillor Ken Lynn
Chair
Dundee City
Integration Joint Board

Responsibilities of the Integration Joint Board

The Integration Joint Board is required to:

- Make arrangements for the proper administration of its financial affairs and to secure that the proper officer of the Board has responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). For this Board, that officer is the Chief Finance Officer.
- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets.
- Ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland act 2003).
- Approve the Annual Accounts.

I confirm that these Annual Accounts were approved for signature at a meeting of the Integration Joint Board on 27 June 2018.

Signed on behalf of the Dundee City Integration Joint Board

Councillor Ken Lynn 25 September 2018
Chair
Dundee City Integration Joint Board

Responsibilities of the Chief Finance Officer

The Chief Finance Officer is responsible for the preparation of Dundee City Integration Joint Board's Annual Accounts in accordance with proper practices as required by legislation and as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom ("the Code of Practice").

In preparing the Annual Accounts, the Chief Finance Officer has:

- selected suitable accounting policies and then applied them consistently
- made judgements and estimates that were reasonable and prudent
- complied with legislation
- complied with the local authority Code (in so far as it is compatible with legislation).

The Chief Finance Officer has also:

- kept proper accounting records which were up to date
- taken reasonable steps for the prevention and detection of fraud and other irregularities.

I certify that the financial statements give a true and fair view of the financial position of the Dundee City Integration Joint Board as at 31 March 2018 and the transactions for the year then ended.

Dave Berry CPFA 27 June 2018
Chief Finance Officer
Dundee City Integration Joint Board

Introduction

This Remuneration Report is provided in accordance with the Local Authority Accounts (Scotland) Regulations 2014. It discloses information relating to the remuneration and pension benefits of specified Integration Joint Board members and staff.

The information in the tables below is subject to external audit. The explanatory text in the Remuneration Report is reviewed by the external auditors to ensure it is consistent with the financial statements.

Remuneration: Integration Joint Board Chair and Vice Chair

The voting members of Dundee City Integration Joint Board are appointed through nomination by Dundee City Council and Tayside NHS Board. Nomination of the Integration Joint Board Chair and Vice Chair post holders alternates between a Councillor and a Health Board representative.

Dundee City Integration Joint Board does not provide any additional remuneration to the Chair, Vice Chair or any other board members relating to their role on the Integration Joint Board. The Chair and Vice Chair are remunerated by their relevant Integration Joint Board partner organisation. Dundee City Integration Joint Board does not reimburse the relevant partner organisations for any voting board member costs borne by the partner. No taxable expenses were paid to the Chair or Vice Chair of the Integration Joint Board in 2017/18.

Dundee City Integration Joint Board does not have responsibilities, either in the current year or in future years, for funding any pension entitlements of voting Integration Joint Board members. Therefore no pension rights disclosures are provided for the Chair or Vice Chair.

Remuneration: Officers of Dundee City Integration Joint Board

Dundee City Integration Joint Board does not directly employ any staff in its own right, however specific post-holding officers are non-voting members of the Board.

Senior Employees

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the Integration Joint Board has to be appointed and the employing partner has to formally second the officer to the Integration Joint Board. The employment contract for the Chief Officer will adhere to the legislative and regulatory framework of the employing partner organisation. The remuneration terms of the Chief Officer's employment are approved by the Integration Joint Board. Other non-voting board members who meet the criteria for disclosure are included in the disclosures below. The Chief Officer and Chief Finance Officer are both employed by Dundee City Council.

Total 2016/17 £	Post	Senior Employees	Salary, Fees & Allowances 2017/18 £
96,040	Chief Officer	David Lynch	99,956
67,023	Chief Finance Officer	Dave Berry	69,874
163,063		**Total**	**169,830**

In respect of officers' pension benefits the statutory liability for any future contributions to be made rests with the relevant employing partner organisation. On this basis there is no pensions liability reflected on the Integration Joint Board balance sheet for the Chief Officer or any other officers.

Dundee City Integration Joint Board however has responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the Integration Joint Board. The following table shows the Integration Joint Board's funding during the year to support officers' pension benefits. The table also shows the total value of accrued pension benefits which may include benefits earned in other employment positions and from each officer's own contributions.

Senior Employee	In Year Pension Contributions		Accrued Pension Benefits		
	For Year to 31/03/17 £	For Year to 31/03/18 £		Difference from 31/03/17 £	As at 31/03/18 £
D Lynch	16,327	16,993	Pension	1,102	37,120
Chief Officer			Lump sum	(2,901)	96,449
D Berry	11,394	11,879	Pension	2,334	25,720
Chief Finance Officer			Lump sum	1,787	43,798
Total	**27,721**	**28,872**	**Pension**	**3,436**	**62,840**
			Lump Sum	**(1,114)**	**140,247**

Disclosure by Pay Bands

As required by the regulations, the following table shows the number of persons whose remuneration for the year was £50,000 or above, in bands of £5,000.

Number of Employees in Band 2016/ 17	Remuneration Band	Number of Employees in Band 2017/ 18
1	£65,000 - £69,999	1
1	£95,000 - £99,999	1
2	Total	2

Exit Packages

There were no exit packages payable during the financial year.

Councillor Ken Lynn
Chair
Dundee City Integration Joint Board

25 September 2018

David W Lynch
Chief Officer
Dundee City Integration Joint Board

25 September 2018

Introduction

The Annual Governance Statement explains Dundee City Integration Joint Board's governance arrangements and reports on the effectiveness of the Integration Joint Board's system of internal control.

Scope of Responsibility

Dundee City Integration Joint Board is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

To meet this responsibility, the Integration Joint Board has established arrangements for governance which includes a system of internal control. The system is intended to manage risk to support the achievement of the Integration Joint Board's policies, aims and objectives. Reliance is also placed on the NHS Tayside and Dundee City Council systems of internal control that support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the Integration Joint Board.

The system can only provide reasonable and not absolute assurance of effectiveness.

The Governance Framework and Internal Control System

Dundee City Integration Joint Board comprises six voting members, three nominated by Dundee City Council and three nominated by Tayside NHS Board, as well as non-voting members including a Chief Officer and Chief Finance Officer appointed by the Integration Joint Board. During 2017/18, the Integration Joint Board continued to develop and enhance its governance arrangements as it moved through its second year of being responsible for the strategic planning and operational delivery of integrated health and social care services. This included progressing areas highlighted as developments in the 2016/17 Annual Governance Statement.

The main features of the governance framework in existence during 2017/18 were:

- The Integration Scheme as the overarching agreement between the Integration Joint Board, NHS Tayside and Dundee City Council as to how the planning for and delivery of delegated health and social care services is to be achieved reflecting a range of governance arrangements required to support this arrangement.
- The senior leadership team consisting of the Chief Officer, Head of Finance and Strategic Planning (Chief Finance Officer) and Head of Health and Community Care. The Chief Finance Officer has overall responsibility for the Integration Joint Board's

financial arrangements and is professionally qualified and suitably experienced to lead the Integration Joint Board's finance function and to direct staff accordingly.

- Monthly meetings of the senior leadership team.
- Standing Orders, Financial Regulations and a Code of Conduct including the publication of Register of Member's Interests and the nomination of the Clerk to the Integration Joint Board as Standards Officer were all in place during 2017/18.
- The Integration Joint Board met on eight occasions throughout the year to consider its business.
- The Integration Joint Board's Performance and Audit Committee met on five occasions throughout the year to enhance scrutiny of the performance of the Integration Joint Board and audit arrangements in line with regulations and good governance standards in the public sector.
- Internal Audit arrangements for 2017/18 were approved including the appointment of the Chief Internal Auditor of FTF Internal Audit and Management Services to the role of Chief Internal Auditor of the Integration Joint Board supported by Dundee City Council's Internal Audit Service. An Internal Audit Plan for 2017/18 was approved drawing on resources from both organisations.
- The assurances provided from internal audit through their independent review work of the Integration Joint Board's internal control systems.
- The Clinical, Care and Professional Governance Framework continued to evolve as an action identified as an area of improvement from the 2016/17 annual governance statement through the leadership of the Dundee Health and Social Care Clinical, Care and Professional Governance Forum (R2). An Internal Audit Review found these arrangements as being broadly satisfactory.
- The Integrated Strategic Planning Group met on three occasions during the year.
- The establishment of the Transformation Delivery Group, consisting of senior leaders from the health and social care partnership, the voluntary sector, staff side representation and Dundee City Council and NHS Tayside transformation leads to provide oversight and governance to the developing range of service redesign and transformation projects.
- The Chief Finance Officer complied fully with the five principles of the role of the Chief Finance Officer, as set out in CIPFA guidance.

The governance framework described operates on the foundation of internal controls, including management and financial information, financial regulations, administration, supervision and delegation. During 2017/18 this included the following:

- The enhancement of risk management arrangements through the clear identification of risks in relation to Integration Joint Board decisions reflected in reports presented to the Integration Joint Board and Performance and Audit Committee, subsequently included within the High Level Risk Register with regular reviews provided to the Performance and Audit Committee as an area of improvement identified within the 2016/17 Annual Governance Statement.
- The approval and progressing of the Annual Internal Audit Plan.
- Continued development of the performance management framework with a range of performance reports published and scrutinised by the Performance and Audit Committee throughout the year, including more detailed reviews of specific areas of concern as requested by the committee.
- A process of formal regular reporting of financial performance and monitoring to the Integration Joint Board was in place throughout 2017/18.
- The provision of regular budget development reports for 2018/19 to the Integration Joint Board.

- The provision of an assurance report from the chair of the Performance and Audit Committee outlining the key issues raised at the previous Performance and Audit Committee meeting to the following Integration Joint Board meeting.
- In-year reporting on issues relating to Clinical, Care and Professional Governance in line with the overarching strategy: Getting It Right for Everyone – A Clinical, Care and Professional Governance Framework with no major issues reported.
- The development of a process for issuing directions to NHS Tayside and Dundee City Council reflected in Integration Joint Board reports during the year.
- Regular reporting to the Performance & Audit Committee of external scrutiny reports relating to delegated services from scrutiny bodies such as the Care Inspectorate and Mental Welfare Commission and supporting subsequent action plans.
- Development and reporting of the Integration Joint Board's Complaint's Handling Procedure.
- Reliance on the procedures, processes and systems of NHS Tayside and Dundee City Council.

Continuous Improvement

The following areas for improvement have been identified through the self-assessment process and Annual Internal Audit Report. Progress against these will be monitored by the Performance and Audit Committee during 2018/19. Some of these are outstanding from the 2016/17 continuous improvement plan (marked as *) and have primarily been delayed due to resource capacity and the impact of other priorities across the wider partnership with NHS Tayside and the other Tayside Integration Joint Boards.

Area for Improvement	Lead Officer	Planned Completion Date
Development of Large Hospital Set Aside arrangements in conjunction with the Scottish Government, NHS Tayside and Angus and Perth and Kinross Integration Joint Boards	Chief Officer / Chief Finance Officer	December 2018
Implementation of an action points update to each meeting of the IJB and PAC in addition to an annual workplan to be agreed for both meetings	Chief Officer / Chief Finance Officer	October 2018
Development of improved Hosted Services arrangements around risk and performance management for hosted services*	Chief Officer / Chief Finance Officer	December 2018
Development of an overall Governance Action Plan to progress previous recommended areas for improvement	Chief Finance Officer	October 2018

Area for Improvement	Lead Officer	Planned Completion Date
Development of regular IJB and PAC member induction and development process	Chief Officer / Chief Finance Officer	December 2018
Further develop the Integration Joint Board's local Code of Governance*	Chief Officer / Chief Finance Officer	December 2018
Present the governance principles adopted by the Health and Social Care Integration Governance Working Group to the PAC to be taken forward by all parties (* reflects partial development from 2016/17)	Chief Finance Officer	September 2018
Development of multi-year financial plan as part of the review of the Strategic and Commissioning Plan	Chief Finance Officer	March 2019
Update the Integration Joint Board's Participation and Engagement Strategy*	Chief Officer / Chief Finance Officer	December 2018
Develop Scheme of further delegation in relation to delegated services to the Integration Joint Board*	Chief Officer / Chief Finance Officer	December 2018
Clarify responsibilities and accountabilities around the impact of General Data Protection Regulations (GDPR) legislation with partner bodies	Chief Finance Officer	October 2018
Update and enhance the IJB's Risk Management Strategy and further develop the IJB's operational risk register	Chief Finance Officer	December 2018

Dundee City Integration Joint Board complies in full with "The Role of the Head of Internal Audit in Public Organisations" (CIPFA) and operates in accordance with "Public Sector Internal Audit Standards" (CIPFA). The Head of Internal Audit reports directly to the Performance and Audit Committee with the right of access to the Chief Finance Officer, Chief Officer and Chair of the Performance and Audit Committee on any matter. The annual programme of internal audit work is based on a strategic risk assessment, and is approved by the Performance & Audit Committee.

Review of Adequacy and Effectiveness

Dundee City Integration Joint Board is required to conduct, at least annually, a review of the effectiveness of its governance framework including the system of internal control.

The review is informed by the work of the Senior Management Team (who have responsibility for the development and maintenance of the internal control framework environment), the work of the internal auditors and the Chief Internal Auditor's annual report, and reports from external auditors and other review agencies and inspectorates.

The review of Dundee City Integration Joint Board's governance framework is supported by a process of self-assessment and assurance certification by the Chief Officer. The Chief Officer completes a "Self-assessment Checklist" as evidence of review of key areas of the Integration Joint Board's internal control framework. The Senior Management Team has input to this process through the Chief Finance Officer. There were no significant internal control issues identified by the self-assessment review.

In addition, the review of the effectiveness of the governance arrangements and systems of internal control within the Health Board and Local Authority partners places reliance upon the individual bodies' management assurances in relation to the soundness of their systems of internal control. Due to ongoing concerns during 2017/18, NHS Tayside has been subject to a number of internal (e.g. Internal Audit) and external (e.g. Scottish Government) commissioned reviews. These reviews have reported back to NHS Tayside and the Scottish Government with a series of actions set out to address identified weaknesses. These actions will be monitored locally by NHS Tayside's new leadership team and through the Scottish Government. A number of the weaknesses identified may have an impact on the Integration Joint Board and its ability to deliver on its strategic objectives. In particular, the Integration Joint Board is supported by NHS Tayside in relation to financial management and strategic planning capacity, with both of these regarded as weaknesses in NHS Tayside's own review of governance. The Integration Joint Board will continue to work in partnership with NHS Tayside to mitigate the impact of these issues.

In preparing the Annual Governance Statement, the Integration Joint Board gave consideration to both NHS Tayside and Dundee City Council's Annual Governance Statements. While recognising the issues noted above within NHS Tayside, there were no issues arising which require any further disclosure in the Integration Joint Board's Governance Statement.

Throughout the year, the Performance and Audit Committee has considered a range of issues which cover its core responsibilities in providing the Integration Joint Board with independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and governance arrangements. The Chair of the Performance and Audit Committee provides an update to the next available Integration Joint Board meeting on the issues raised and any areas of concern which the Integration Joint Board should be made aware of. Over the course of 2017/18, no such areas of concern were noted by the Chair of the Performance and Audit Committee.

The review is subject to assessment and comment by Internal Audit who will reflect their findings and any recommendations in their Annual Internal Audit Report 2017/18 to be presented to the Performance and Audit Committee at its meeting on 31 July 2018. An action plan to meet any identified recommendations will be produced and agreed by the Performance and Audit Committee and will be incorporated into the above Annual Governance Statement to form the final Annual Accounts Statement.

Conclusion and Opinion on Assurance

While recognising that the above Annual Governance Statement is subject to Internal Audit assessment, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of Dundee City Integration Joint Board's governance arrangements.

We consider that the internal control environment provides reasonable and objective assurance that any significant risks impacting on the Integration Joint Board's principal objectives will be identified and actions taken to avoid or mitigate their impact.

Systems are in place to regularly review and improve the internal control environment.

Councillor Ken Lynn
Chair
Dundee City Integration Joint Board

25 September 2018

David W Lynch
Chief Officer
Dundee City Integration Joint Board

25 September 2018

This statement shows the cost of providing services for the year according to accepted accounting practices. Where the impact on the General Fund is amended by statutory adjustments this is shown in both the Expenditure and Funding Analysis and the Movement in Reserves Statement. There were no statutory adjustments for 2017/18.

2016/17 Net Expenditure (Income) £000		2017/18 Net Expenditure (Income) £000
66,987	Older People Services	**71,201**
18,593	Mental Health	**18,996**
29,427	Learning Disability	**31,215**
7,433	Physical Disability	**8,923**
3,666	Substance Misuse	**3,945**
12,009	Community Nurse Services / AHP* / Other Adult Services	**12,412**
10,184	Community Services (Hosted)	**10,151**
4,851	Other Services / Support / Management	**5,799**
35,450	Prescribing	**35,818**
24,533	General Medical Services (FHS**)	**24,163**
20,048	FHS – Cash limited & Non Cash Limited	**17,155**
233,181	**Total of Costs Reported during 2016/17**	**239,778**
229	IJB Operational Costs	**267**
4,352	Central Support	**4,658**
21,059	Acute Large Hospitals	**17,452**
258,821	**Total Cost of Services**	**262,155**
(263,784)	Taxation and Non- Specific Grant Income (Note 6)	**(262,184)**
(4,963)	**(Surplus) or Deficit on Provision of Services**	**(29)**
(4,963)	**Total Comprehensive Income & Expenditure**	**(29)**

Notes
* AHP – Allied Health Professionals
** FHS – Family Health Services

Dundee City Integration Joint Board was established on 3 October 2015. Integrated delivery of health and care services did not commence until 1 April 2016. Consequently the 2017/18 financial year is the second fully operational financial year for the Integration Joint Board and the figures above reflect this.

Dundee City Integration Joint Board's Comprehensive Income and Expenditure Statement shows the net commissioning expenditure provided to partners to support services. It does not detail income received from service users as this remains the statutory responsibility of the partners.

This statement shows the movement in the year on the Dundee City Integration Joint Board's reserves. There are no material movements which arise due to statutory adjustments which affect the General Fund balance, which are separately identified from the movements due to accounting practices.

Movements in Reserves During 2017/18	General Fund Balance	Total Reserves
	£000	£000
Opening Balance at 31 March 2017	**4,963**	**4,963**
Reserves used during 2017/18 to fund operations	(432)	(432)
Total Comprehensive Income and Expenditure	29	29
Adjustments between Accounting basis and Funding Basis	0	0
Increase/(Decrease) in 2017/18	(403)	(403)
Closing Balance at 31 March 2018	**4,560**	**4,560**

The Balance Sheet shows the value as at the Balance Sheet date of the assets and liabilities recognised by Dundee City Integration Joint Board. The net assets of Dundee City Integration Joint Board (assets less liabilities) are matched by the reserves held by Dundee City Integration Joint Board. Reserves are reported in two categories. The first category is usable reserves, i.e. those that Dundee City Integration Joint Board may use to provide services, subject to the need to maintain a prudent level of reserves and any statutory limitations on their use. The second category is those that Dundee City Integration Joint Board is not able to use to provide services. This category includes reserves that hold unrealised gains and losses. At 31 March 2018 Dundee City Integration Joint Board had no unusable reserves.

31 March 2017 £000		Notes	31 March 2018 £000
4,975	Short Term Debtors	Note 7	4,596
4,975	**Current Assets**		**4,596**
(12)	Short Term Creditors	Note 8	(36)
(12)	**Current Liabilities**		**(36)**
4,963	**Net Assets**		**4,560**
4,963	Usable Reserves	Note 9	4,560
4,963	**Total Reserves**		**4,560**

The unaudited accounts were issued on 27 June 2018.

Dave Berry, CPFA 27 June 2018
Chief Finance Officer
Dundee City Integration Joint Board

1. Significant Accounting Policies

General Principles

The Financial Statements summarises Dundee City Integration Joint Board's transactions for the 2017/18 financial year and its position at the year-end of 31 March 2018. The Dundee City Integration Joint Board was established under the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a Section 106 body as defined in the Local Government (Scotland) Act 1973.

The Financial Statements are prepared in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2017/18, supported by International Financial Reporting Standards (IFRS), and statutory guidance issued under Section 12 of the 2003 Act.

The accounts are prepared on a going concern basis, which assumes that the Dundee City Integration Joint Board will continue in operational existence for the foreseeable future. The historical cost convention has been adopted.

Accruals of Income and Expenditure

Activity is accounted for in the year that it takes place, not simply when settlement in cash occurs. In particular:

- Expenditure is recognised when goods or services are received and their benefits are used by the Dundee City Integration Joint Board.
- Income is recognised when the Dundee City Integration Joint Board has a right to the income, for instance by meeting any terms and conditions required to earn the income, and receipt of the income is probable.
- Where income and expenditure have been recognised but settlement in cash has not taken place, a debtor or creditor is recorded in the Balance Sheet.
- Where debts may not be received, the balance of debtors is written down.

Funding

Dundee City Integration Joint Board is primarily funded through funding contributions from the statutory funding partners, Dundee City Council and NHS Tayside. Expenditure is incurred as the Integration Joint Board commission's specified health and social care services from the funding partners for the benefit of service recipients in the Dundee City Integration Joint Board area.

Cash and Cash Equivalents

Dundee City Integration Joint Board does not operate a bank account or hold cash. Transactions are settled on behalf of Dundee City Integration Joint Board by the funding partners. Consequently Dundee City Integration Joint Board does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to or from each funding partner as at 31 March 2018 is represented as a debtor or creditor on Dundee City Integration Joint Board's Balance Sheet.

Pension Liability

Dundee City Integration Joint Board does not directly employ staff. Staff are formally employed by the funding partners who retain the liability for pension benefits payable in the future. Dundee City Integration Joint Board therefore does not present a Pensions Liability on its Balance Sheet. Dundee City Integration Joint Board has a legal responsibility to appoint a Chief Officer. More details on the arrangements are provided in the Remuneration Report. The charges from the employing partner are treated as employee costs. Where material the Chief Officer's absence entitlement as at 31 March is accrued, for example in relation to annual leave earned but not yet taken. Charges from funding partners for other staff are treated as administration costs.

Changes in Accounting Policies and Estimates and Errors

Changes in accounting policies are only made when required by proper accounting practices or when the change provides more reliable or relevant information about the effect of transactions, other events and conditions on the Dundee City Integration Joint Board's financial position or financial performance. Where a change is made and it is material to the financial statements, it is applied retrospectively (unless stated otherwise) by adjusting opening balances and comparative amounts for the prior period as if the new policy had always been applied. Changes in accounting estimates are accounted for prospectively, i.e. in the current and future years affected by the change. Material errors discovered in prior period figures are corrected retrospectively by amending opening balances and comparative amounts for the prior period.

Charges to Revenue for Non-Current Assets

Dundee City Integration Joint Board does not hold non-current assets and therefore is not subject to direct depreciation charges. However Dundee City Integration Joint Board does receive a charge for property for the use of assets. These assets enable Dundee City Integration Joint Board to deliver their priorities. Contained within this recharge amongst other costs, is an element of depreciation associated with the assets that help support the Board's activities.

Provisions, Contingent Liabilities and Contingent Assets

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation as at 31 March 2018 due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March 2018, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in Dundee City Integration Joint Board's Balance Sheet, but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March 2018, whose existence will only be confirmed by later events. A contingent asset is not recognised in Dundee City Integration Joint Board's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

Accounting Standards that have been issued but not adopted

There were no relevant accounting standards that have been issued but are not yet adopted in the 2017/2018 Code of Practice on Local Authority Accounts in the United Kingdom.

Reserves

Reserves are created by appropriating amounts out of the General Fund Balance in the Movement in Reserves Statement. When expenditure to be financed from a reserve is incurred, it is charged to the appropriate service in that year to count against the Surplus/Deficit on the Provision of Services in the Comprehensive Income and Expenditure Statement. The reserve is then appropriated back into the General Fund Balance in the Movement in Reserves Statement.

Dundee City Integration Joint Board has a Useable Reserve. The balance of the Usable Reserve as at 31 March 2018 shows the extent of resources which the Integration Joint Board can use in later years to support service provision. Dundee City Integration Joint Board has no Unusable Reserve.

VAT

Due to its legal status Dundee City Integration Joint Board is not registered for VAT. As a result VAT payable is included as an expense as it is not recoverable from Her Majesty's Revenue and Customs. In addition where consideration is received by Dundee City Integration Joint Board for services provided income will include the associated VAT.

Indemnity Insurance

Dundee City Integration Joint Board has indemnity insurance for costs relating primarily to potential claim liabilities regarding Board member and officer responsibilities. NHS Tayside and Dundee City Council have responsibility for claims in respect of the services that they are statutorily responsible for and that they provide. Unlike NHS Boards, Dundee City Integration Joint Board does not have any 'shared risk' exposure from participation in CNORIS. Dundee City Integration Joint Board participation in the CNORIS scheme is therefore analogous to normal insurance arrangements.

Known claims are assessed as to the value and probability of settlement. Where it is material the overall expected value of known claims taking probability of settlement into consideration, is provided for in the Dundee City Integration Joint Board's Balance Sheet. The likelihood of receipt of an insurance settlement to cover any claims is separately assessed and, where material, presented as either a debtor or disclosed as a contingent asset.

2. Critical Judgements and Estimation Uncertainty

Critical Judgements in Applying Accounting Policies

In applying the accounting policies set out in Note 1, the Dundee City Integration Joint Board has had to make certain judgements about complex transactions or those involving uncertainty about future events. The critical judgements made in the Annual Accounts are:

There is a continuing high degree of uncertainty about future levels of funding for local government, particularly ahead of the Scottish Government's 2019-2020 Spending Review. However, the Dundee City Integration Joint Board has determined that this uncertainty is not yet sufficient to provide an indication that the assets of the constituent bodies, Dundee City Council and NHS Tayside, might be impaired as a result of a need to close facilities and reduce levels of service provision.

The value of the Hospital Acute Services "set aside" expenditure reported within the total Integration Joint Board expenditure of £17.452m is based on the most recently available activity levels for hospital inpatient and day case activity as provided by NHS Services Scotland's Information Services Division and direct cost information provided by NHS Tayside. This is a transitional arrangement for 2017/18 agreed locally between NHS Tayside and the three Tayside Integration Joint Boards and with the Scottish Government. Work is progressing at a national and local level to refine the methodology for calculating and planning the value of this in the future.

Assumptions Made About the Future and Other Major Sources of Estimation Uncertainty

The Annual Accounts contains estimated figures that are based on assumptions made by the Dundee City Integration Joint Board about the future or that are otherwise uncertain. Estimates are made taking into account historical experience, current trends and other relevant factors. However, because balances cannot be determined with certainty, actual results could be materially different from the assumptions and estimates.

3. Events after the Reporting Period

There were no events that occurred between 1 April 2018 and 27 June 2018 that would have an impact on the 2017/18 financial statements.

4. Expenditure and Funding Analysis

The objective of the Expenditure and Funding Analysis is to demonstrate how the funding available to Dundee City Integration Joint Board for the year has been used in providing services in comparison with those resources consumed or earned by Dundee City Integration Joint Board in accordance with generally accepted accounting practices. The Expenditure and Funding Analysis also shows how this expenditure is allocated for decision making purposes between Dundee City Integration Joint Board's services. Income and expenditure accounted for under generally accepted accounting practices is presented more fully in the Comprehensive Income and Expenditure Statement.

In respect of 2017/18 there was no material difference between the Comprehensive Income and Expenditure Statement and the net expenditure chargeable to the Dundee City Integration Joint Board.

5. Expenditure and Income Analysis by Nature

2016/17 £000	Description	2017/18 £000
160,924	Services commissioned from NHS Tayside	155,535
97,668	Services commissioned from Dundee City Council	106,353
212	Other IJB Operating Expenditure	244
17	Auditor Fee : External Audit Work	24
(179,717)	Partners Funding Contributions – NHS Tayside	(176,871)
(84,067)	Partners Funding Contributions – Dundee City Council	(85,314)
(4,963)	**Surplus or Deficit on the Provision of Services**	**(29)**

6. Taxation and Non-Specific Grant Income

2016/17 £000	Description	2017/18 £000
(179,717)	Funding Contribution from NHS Tayside	(176,871)
(84,067)	Funding Contribution from Dundee City Council	(85,314)
(263,784)	**Taxation and Non-Specific Grant Income**	**(262,185)**

The funding contribution from the NHS Board shown above includes £17.452m in respect of 'set aside' resources relating to acute hospital and other resources (Large Hospital Set Aside). Dundee City Integration Joint Board has responsibility for the strategic planning of the amount set aside based on the local population's consumption of these resources. NHS Tayside has the responsibility to manage the costs of providing these services. The value of the set aside noted above is based on activity information provided by the Scottish Governments Information Services Division, set against direct expenditure figures provided by NHS Tayside. The methodology of calculating future values of the Large Hospital Set Aside is being developed locally and nationally.

The funding contributions from the partners shown above exclude any funding which is ring-fenced for the provision of specific services. Such ring-fenced funding is presented as income in the Cost of Services in the Comprehensive Income and Expenditure Statement.

7. Debtors

2016/17 £000	Description	2017/18 £000
0	NHS Bodies :- NHS Tayside	0
4,975	Other Local Authorities :- Dundee City Council	4,596
4,975	**Total Debtors**	**4,596**

Amounts owed by the funding partners are stated on a net basis. Debtor balances relating to income yet to be received by the funding partners but not yet settled in cash terms are offset against the funds they are holding on behalf of the Integration Joint Board.

8. Creditors

2016/17 £000	Description	2017/18 £000
0	Other Local Authorities :- NHS Tayside	6
12	Other Bodies	30
12	**Total Creditors**	**36**

Amounts owed are stated on a net basis. Creditor balances relating to expenditure obligations incurred by the funding partners but not yet settled in cash terms are offset against the funds they are holding on behalf of the Integration Joint Board.

9. Usable Reserve: General Fund

Dundee City Integration Joint Board holds a balance on the General Fund for two main purposes:

- To earmark, or build up, funds which are to be used for specific purposes in the future, such as known or predicted future expenditure needs. This supports strategic financial management.
- To provide a contingency fund to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the Integration Joint Board's risk management framework.

2016/17	Balance at 1 April 2016 £000	Transfers Out 2016/17 £000	Transfers In 2016/17 £000	Balance at 31 March 2017 £000
Non Earmarked Reserves – General Fund	0	0	632	632
Non Earmarked Reserves Total	**0**	**0**	**632**	**632**
Earmarked Reserves – Integration Reserve	0	0	3,931	3,931
Earmarked Reserves – Transformation Reserve	0	0	400	400
Earmarked Reserves – Total	0	0	4,331	4,331
Total – General Fund Balances	**0**	**0**	**4,963**	**4,963**

2017/18	Balance at 1 April 2017 £000	Transfers Out 2017/18 £000	Transfers In 2017/2018 £000	Balance at 31 March 2018 £000
Non Earmarked Reserves – General Fund	632	(431)	29	230
Non Earmarked Reserves Total	632	(431)	29	230
Earmarked Reserves – Integration Reserve	3,931	(1)	0	3930
Earmarked Reserves – Transformation Reserve	400	0	0	400
Earmarked Reserves – Total	4,331	(1)	0	4,330
Total – General Fund Balances	**4,963**	**(432)**	**29**	**4,560**

Purpose of Earmarked Reserves:-

a) Integration Reserve - To assist in the integrating of Social Care and Health Service provisions.

b) Transformation Reserve - To assist in the development of service provisions to meet ongoing and future demand.

10. Related Party Transactions

The Dundee City Integration Joint Board has related party relationships with NHS Tayside and Dundee City Council. In particular the nature of the partnership means that the Dundee City Integration Joint Board may influence or be influenced by, its partners. The following transactions and balances included in Dundee City Integration Joint Board's accounts are presented to provide additional information on the relationships. Dundee City Integration Joint Board is required to disclose material transactions with related parties – bodies or individuals that have the potential to control or influence Dundee City Integration Joint Board or to be controlled or influenced by Dundee City Integration Joint Board. Related party relationships require to be disclosed where control exists, irrespective of whether there have been transactions between the related parties. Disclosure of these transactions allows readers to assess the extent to which the Dundee City Integration Joint Board may have been constrained in its ability to operate independently or might have secured the ability to limit another party's ability to bargain freely with Dundee City Integration Joint Board.

Dundee City Integration Joint Board Members

Board members of Dundee City Integration Joint Board have direct control over the Board's financial and operating policies. The Dundee City Integration Joint Board membership is detailed on page 4 of these statements. Board members have the responsibility to adhere to a Code of Conduct, which requires them to declare an interest in matters that directly or indirectly may influence, or be thought to influence their judgement or decisions taken during the course of their work. In terms of any relevant parties, board members with declarations of interest did not take part in any discussion or decisions relating to transactions with these parties.

Officers

Senior Officers have control over Dundee City Integration Joint Board's financial and operating policies. The total remuneration paid to senior officers is shown in the Remuneration Report. Officers have the responsibility to adhere to a Code of Conduct, which requires them to declare an interest in matters that directly or indirectly may influence, or be thought to influence their judgement or decisions taken during the course of their work. In terms of any relevant parties, officers with declarations of interest did not take part in any discussion or decisions relating to transactions with these parties.

Key Management Personnel

The Non-Voting Board members employed by Dundee City Council and recharged to the Dundee City Integration Joint Board include the Chief Officer and the Chief Finance Officer. Details of the remuneration for some specific post-holders is provided in the Remuneration Report.

Transactions with NHS Tayside

2016/17 £000	Description	2017/18 £000
179,717	Funding Contributions received from the NHS Tayside Board	176,871
(160,924)	Net Expenditure on Services Provided by the NHS Tayside Board	(155,535)
18,793	**Net Transactions with NHS Tayside**	**21,336**

Balances with NHS Tayside

2016/17 £000	Description	2017/18 £000
0	Debtor balances: Amounts due from the NHS Board	0
0	Creditor balances: Amounts due to the NHS Board	6
0	**Net Balance with the NHS Board**	**6**

Transactions with Dundee City Council

2016/17 £000	Description	2017/18 £000
84,067	Funding Contributions received from Dundee City Council	85,314
(93,316)	Net Expenditure on Services Provided by Dundee City Council	(101,695)
(4,352)	Support Services from Dundee City Council	(4,658)
(13,601)	**Net Transactions with Dundee City Council**	**(21,039)**

Balances with Dundee City Council

2016/17 £000	Description	2017/18 £000
4,975	Debtor balances: Amounts due from Dundee City Council	4,596
0	Creditor balances: Amounts due to Dundee City Council	0
4,975	**Net Balance with Dundee City Council**	**4,596**

11. Value Added Tax (VAT)

Non recoverable VAT is limited to costs incurred directly by Dundee City Integration Joint Board where these costs are outwith any special legal regime. The only incumbent special legal regime relates to the role of the Board's Chief Officer. All costs attributable to the special legal regime are outwith the scope of VAT.

The commissioning of services by Dundee City Integration Joint Board from the constituent bodies are outwith the scope of VAT.

The net expenditure incurred by the two constituted bodies in respect of services commissioned by Dundee City Integration Joint Board is subject to different VAT regimes as defined by Value Added Tax Act 1994.

Dundee City Council is classified as Section 33 body for VAT purposes and can recover VAT on taxable supplies (including zero-rated) in the course of the furtherance of business. In addition a Section 33 body can where appropriate, recover VAT on non-business activities and based on a prescribed limit, recover VAT on exempt business activities. In general terms a Section 33 body can recover VAT on most activities.

Where Dundee City Council is a provider of services commissioned by Dundee City Integration Joint Board the cost of the commissioned services will exclude VAT unless it is determined to be irrecoverable to the Council as a result of its status as a Section 33 body.

NHS Tayside is classified as Section 41 body for VAT purposes. This VAT status makes VAT recovery somewhat more restricted. VAT is only recoverable on a restricted list of activities. Where VAT is paid on activities outwith the prescribed list, VAT is irrecoverable and forms part of the service expenditure. This means that services commissioned by Dundee City Integration Joint Board from NHS Tayside will where appropriate include irrecoverable VAT.

12. Agency Income and Expenditure

On behalf of all Integration Joint Boards within the NHS Tayside area, the Dundee City Integration Joint Board acts as the lead manager for a variety of Community, Older People, Physical Disability, Mental Health and Learning Disability Services. It commissions services on behalf of the other Integration Joint Boards (Perth & Kinross and Angus) and reclaims the costs involved. The payments that are made on behalf of the other Integration Joint Boards, and the consequential reimbursement, are not included in the Comprehensive Income and Expenditure Statement (CIES) since the Dundee City Integration Joint Board is not acting as principal in these transactions.

The amount of expenditure and income relating to the agency arrangement is shown below**.**

2016/17 (£000)	Description	2017/18 (£000)
10,928	Expenditure on Agency Services	10,870
(10,928)	Reimbursement for Agency Services	(10,870)
0	**Net Agency Expenditure Excluded from CIES**	**0**

13. Provisions

Dundee City Integration Joint Board has currently made no provisions. This does not prohibit Dundee City Integration Joint Board making provisions in the future and will where necessary consider the needs for a provision based on the merits of the incumbent circumstances at a relevant future point.

Independent Auditor's Report

The Annual Accounts are subject to audit in accordance with the requirements of Part VII of the Local Government (Scotland) Act 1973.

The Auditor appointed for this purpose by the Accounts Commission for Scotland is:

Fiona Mitchell-Knight FCA
Assistant Director
Audit Scotland
4th Floor
The Athenaeum Building
8 Nelson Mandela Place
Glasgow
G2 1BT

While much of the terminology used in this document is intended to be self explanatory, the following additional definitions and interpretation of terms may be of assistance.

Accounting Period

The period of time covered by the accounts, normally a period of 12 months commencing on 1 April.

Asset

An asset is categorised as either current or non-current. A current asset will be consumed or cease to have material value within the next financial year (e.g. cash and stock). A non current asset will provide benefit for a period of more than one year. Whilst referred to in these accounts, the Dundee City Integration Joint Board is not allowed to hold non current assets.

Balance Sheet

This represents the overall financial position of the Dundee City Integration Joint Board at the end of the year. All inter-company balances between the Board and its constituent bodies have been eliminated in preparation of the balance sheet.

Comprehensive Income & Expenditure Statement (CIES)

This statement shows the accounting cost in the year of providing services in accordance with generally accepted accounting practices defined by the International Financial Reporting Standards (IFRS).

Constituent Bodies

The Dundee City Integration Joint Board has two constituent bodies which both fund the Board's activities and provide services to the Board. These are NHS Tayside and Dundee City Council.

Creditor

Amounts owed by the Dundee City Integration Joint Board for work done, goods received or services rendered within the accounting period, but for which payment has not been made by the end of that accounting period.

Debtor

Amount owed to the Dundee City Integration Joint Board for works done, goods received or services rendered within the accounting period, but for which payment has not been received by the end of that accounting period.

Entity

A body corporate, partnership, trust, unincorporated association or statutory body that is delivering a service or carrying on a trade or business with or without a view to profit. It should have a separate legal personality and is legally required to prepare its own single entity accounts.

Events after the Reporting Period

Events after the Reporting Period are those events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the Annual Accounts are authorised for issue. Should such events occur it may or may not be necessary to adjust the accounts. Guidelines are in place to determine whether an adjustment should be made to the accounts.

Events taking place after the accounts have been authorised are not reflected in the financial statements or notes.

General Fund

The General Fund encompasses all services areas and is funded mainly by the constituent bodies or the Scottish Government.

Government Grants

Grants made by the Government towards either revenue or capital expenditure in return for past or future compliance with certain conditions relating to the activities of the Dundee City Integration Joint Board. These grants may be specific to a particular scheme or may support the revenue spend of the Dundee City Integration Joint Board.

Gross Expenditure

This includes all expenditure attributable to the service and activity including employee costs, expenditure relating to premises and transport, supplies and services, third party payments, support services and capital charges.

Gross Income

This includes grant income and all charges to individuals and organisations for the direct use of the Board's services.

Inventories

Items of raw materials and stock that one or both of the constituent bodies (Dundee City Council /NHS Tayside) has procured and holds in expectation of future use. Examples are consumable stores, raw materials and products and services in intermediate stages of completion. Notably the Dundee City Integration Joint Board can hold inventories albeit this will be limited in nature.

Liability

A liability is where the Dundee City Integration Joint Board owes payment to an individual or another organisation. A current liability is an amount which will become payable or could be called in within the next accounting period e.g. creditors. A long term liability is an amount which by arrangement is payable beyond the next year at some point in the future or to be paid off by an annual sum over a period of time.

Movement in Reserves Statement

This statement shows the movement in the year on the different reserves held by the Board, analysed into usable reserves (i.e. those that can be applied to fund expenditure) and unusable reserves.

Net Expenditure

This relates to gross expenditure less gross income and is the amount that needs to be funded by the constituent bodies and the Scottish Government.

Notes to the Core Financial Statements

These are intended to give the reader further information which is not separately detailed in the financial statements.

Pension Reserve

A Pension Reserve arises from the IAS 19 account disclosures requirements for retirement benefits and recognises an organisation's share of actuarial gains and losses in an attributable pension fund and the change in the organisation's share of any such pension fund net liability chargeable to the organisation's Comprehensive Income and Expenditure Statement. Dundee City Integration Joint Board is not an employer and therefore does not operate a Pension Reserve.

Provision

An amount put aside in the accounts for future liabilities or losses which are certain or very likely to occur but the amounts or dates or when they will arise are uncertain.

Related Parties

Entities or individuals that have the potential to control or influence the Dundee City Integration Joint Board, or to be controlled or influenced by the Board.

Remuneration

All sums paid to or receivable by an employee and sums due by way of expenses allowances (as far as these sums are chargeable to UK income tax) and the money value of any other benefits received other than in cash.

Reserves

The accumulation of surpluses, deficits and appropriation over past years. Reserves can be either usable or unusable. Usable reserves can be used to fund expenditure. Unusable reserves are accounting adjustments which enable a true and fair view to be determined. Unusable reserves cannot be used to fund expenditure. Reserves of a revenue nature are available and can be spent or earmarked at the discretion of the Board.

Revenue Expenditure

The day-to-day running costs associated with the provision of services.

GET IN TOUCH:

Further information on the accounts can be obtained on the Dundee Health & Social Care Partnership website
www.dundeehscp.com

If you have any questions about the information contained in this document, please email:
dundeehscp@dundeecity.gov.uk

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

City Chambers
DUNDEE
DD1 3BY

20th June, 2018

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 the Council Chamber, City Chambers, City Square, Dundee on Wednesday, 27th June, 2018 at 10.30 am.

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 24th April, 2018 is attached for approval.

4 PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF MEETING OF 29TH MAY, 2018 **(page 5)**

(Copy attached for information).

(b) CHAIR'S ASSURANCE REPORT **(page 11)**

(Report No DIJB45-2018 by the Chair of the Peformance and Audit Committee, copy attached).

5 TAYSIDE PRIMARY CARE IMPROVEMENT PLAN (page 13)

(a) Joint Presentation by Shona Hyman, Senior Manager, Service Development and Primary Care, Dr David Shaw, Clinical Director and Andrew Thomson, Medical Secretary, Tayside General Practitioners' Sub-Committee.

(b) Report No DIJB26-2018 by the Chief Officer, copy attached.

6 STRATEGIC AND COMMISSIONING STATEMENT FOR PEOPLE WITH PHYSICAL DISABILITY 2018-2021 (page 108)

(Report No DIJB35-2018 by the Chief Officer, copy attached).

7 VETERANS FIRST POINT TAYSIDE (V1PT) (page 148)

(Report No DIJB32-2018 by the Chief Officer, copy attached).

8 RESHAPING NON-ACUTE CARE IN DUNDEE – UPDATE (page 230)

(Report No DIJB31-2018 by the Chief Officer, copy attached).

9 ANNUAL REPORT OF THE DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP AND CLINICAL, CARE AND PROFESSIONAL GOVERNANCE GROUP (page 234)

(Report No DIJB38-2018 by the Chief Officer, copy attached).

10 DUNDEE PRESCRIBING MANAGEMENT POSITION (page 244)

(Report No DIJB41-2018 by the Chief Officer, copy attached).

11 DRAFT ANNUAL ACCOUNTS 2017/18 AND ANNUAL GOVERNANCE STATEMENT

(Report No DIJB28-2018 by the Chief Finance Officer, copy to follow).

12 CONFIRMATION OF DUNDEE INTEGRATION JOINT BOARD BUDGET 2018/19 - DIJB37-2018

Dundee Integration Joint Board considered Report No DIJB17-2018, Dundee Integration Joint Board 2018/19 Budget, at its meeting held on 30th March, 2018. The IJB noted the indicative delegated budget from Tayside NHS Board for 2018/19 and instructed the Chief Finance Officer to report back to the IJB following receipt of formal notification from Tayside NHS Board of the budget offer with assocated recommendations including any implications of the finalisation of hosted services budgets and the Large Hospital Set Aside.

Tayside NHS Board is due to formally consider its budget at its meeting to be held on 28th June, 2018 therefore the implications of this will be presented to the next IJB meeting to be held on 28th August, 2018.

13 MEETINGS OF THE INTEGRATION JOINT BOARD 2018 – ATTENDANCES – DIJB43-2018 (page 260)

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

14 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, 28th August, 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	TBC*
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)	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 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

Dundee Health & Social Care Partnership

At a MEETING of the **DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 24th April, 2018.

Present:-

Members	**Role**
Ken LYNN *(Chairperson)*	Nominated by Dundee City Council (Elected Member)
Doug CROSS (*Vice Chairperson*)	Nominated by Health Board (Non-Executive Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
Cesar RODRIGUEZ	Registered Medical Practitioner (not providing primary medical services)
Frank WEBER	Registered Medical Practitioner (whose name is included in the list of primary medical performers)
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
Andrew JACK	Service User residing in the area of the local authority
Martin SLOAN	Person providing unpaid care in the area of the local authority

Also in attendance at the request of the Chief Officer:-

Dr David SHAW	Dundee Health and Social Care Partnership
Arlene HAY	Dundee Health and Social Care Partnership
Claire LEWIS-RICHARDSON	Dundee Health and Social Care Partnership
Shona HYMAN	Dundee Health and Social Care Partnership
Lucinda GODFREY	Dundee Health and Social Care Partnership
Alexis CHAPPELL	Dundee Health and Social Care Partnership
Joyce BARCLAY	Dundee Health and Social Care Partnership

Ken LYNN, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

Roisin Smith, Nominated by Dundee City Council (Elected Member), Judith Golden, Nominated by Health Board (Non-Executive Member), Munwar Hussain, Nominated by Health Board (Non-Executive Member), and Sarah Dickie, Registered Nurse.

II DECLARATIONS OF INTEREST

Martin Sloan declared a non financial interest in the items of business at Articles V and VI of this minute by virtue of having been involved in the developments.

Andrew Jack declared a non financial interest in the item of business at Article XI

III MINUTES OF PREVIOUS MEETINGS

(a) The minute of meeting of the Integration Joint Board held on 27th February, 2018 was submitted and approved.

(b) The minute of special meeting of the Integration Joint Board held on 30th March, 2018 was submitted and approved.

IV PERFORMANCE AND AUDIT COMMITTEE

(a) The minutes of meetings of the Performance and Audit Committee held on 13th February, 2018 and 27th March, 2018 were submitted and noted.

(b) Chair's Assurance Report

Doug Cross, Chair of the Performance and Audit Committee gave an overview summary of the business considered by the Performance and Audit Committee over the meetings of the Committee held on 13th February, 2018 and 27th March, 2018.

The Integration Joint Board agreed to note the overview summary as provided.

V AMENDMENT TO INTEGRATION SCHEME

(a) Integration Scheme – Amendment – Background

There was submitted Agenda Note DIJB24-2018 reporting that the Carers (Scotland) Act 2016 came into force on 1st April, 2018. The Act imposed new duties on Local Authorities and Health Boards which were to be delegated to Integration Joint Boards. In order to implement the Carers (Scotland) Act 2016 the Scottish Government amended those Regulations which identified the functions which were to be delegated by Local Authorities and Health Boards respectively to Integration Joint Boards. As a result of the changes to the Regulations, Local Authorities and Health Boards, working with Integration Joint Boards, were required to amend their Integration Schemes to take account of the new provisions.

The Integration Joint Board agreed:-

(i) to note that Dundee City Council and NHS Tayside had submitted a revised Integration Scheme to the Scottish Government on 2nd March, 2018;

(ii) to note that on 3rd April, 2018 the Scottish Government advised that the revised Dundee Integration Scheme had been approved; and

(iii) to note the content of the note and the Appendices to the Integration Scheme which contained the tracked changes which were submitted as DIJB25-2018.

VI DUNDEE ADULT CARERS ELIGIBILITY FRAMEWORK

There was submitted Report No DIJB22-2018 by the Chief Officer seeking approval of the Dundee Adult Carers Eligibility Framework including Local Eligibility Criteria and Eligibility Threshold.

Alexis Chappell and Lucinda Godfrey, Chief Executive Officer, Dundee Carers Centre, gave a presentation in supplement to the report.

The Integration Joint Board agreed:-

(i) to note the content of the presentation;

(ii) to note the duties and powers placed on local authorities through the Carers (Scotland) Act 2016 regarding Duty to Support Carers and the Dundee Adult Carers Eligibility Criteria outlined in the report;

(iii) to approve the Dundee Health and Social Care Partnership Workforce Policy: Dundee Adult Carer Support Eligibility Criteria which was attached to the report as Appendix 1; and

(iv) to approve the publication of Carers Fact Sheet 6 (Adult Carer Support Plan) and Carers Eligibility Criteria which were attached to the report as Appendices 2 and 3.

VII FINANCIAL MONITORING POSITION AS AT 28TH FEBRUARY, 2018

There was submitted Report No DIJB19-2018 by the Chief Finance Officer providing an update of the projected financial monitoring position for delegated health and social care services for 2017/18.

The Integration Joint Board agreed to note the content of the report including the overall projected financial position for delegated services to the 2017/18 financial year end as at 28th February, 2018.

VIII UPDATE ON GENERAL DATA PROTECTION REGULATIONS PREPARATIONS

There was submitted Report No DIJB18-2018 by the Chief Finance Officer informing of planned work in relation to the implementation of the General Data Protection Regulations on 25th May, 2018.

The Integration Joint Board agreed:-

(i) to note the preparations that were being undertaken by NHS Tayside and Dundee City Council for the implementation of General Data Protection Regulations; and

(ii) to note that discussions were ongoing between Data Protection Officers in NHS Tayside and Dundee City Council to identify a Data Protection Officer for the Integration Joint Board.

IX UPDATE ON DUTY OF CANDOUR PREPARATIONS

There was submitted Report No DIJB20-2018 by the Chief Finance Officer informing of ongoing and planned work in relation to the implementation of the Duty of Candour procedure which came into force on 1st April, 2018.

It was reported that the Health (Tobacco, Nicotine, etc and Care) (Scotland) Act 2016 received Royal Assent on 6th April, 2016 and introduced a new organisational duty of candour on health, care and social work services.

The Integration Joint Board agreed:-

(i) to note the preparations that were being undertaken by NHS Tayside and Dundee City Council for the implementation of the Duty of Candour (Scotland) Regulations 2018; and

(ii) to note that the responsibility for the reporting of the Duty of Candour events remained with the responsible person.

X DATE OF NEXT MEETING

The Integration Joint Board noted that the next meeting of the Integration Joint Board would be held in Committee Room 1, 14 City Square, Dundee on Thursday, 26th June, 2018 at 2.00 pm.

The Integration Joint Board resolved under Section 50(a)(4) of the Local Government (Scotland) Act 1973 that the press and public be excluded from the meeting for the undernoted item of business on the grounds that it involved the likely disclosure of exempt information as defined in paragraph 3, 6 and 9 of Part I of Schedule 7A of the Act.

XI GENERAL MEDICAL SERVICES

There was submitted Report No DIJB21-2018 by the Chief Officer outlining the current position with Practice providing general medical services and the options for ensuring continuity of care for those patients registered with the Practice.

The Integration Joint Board agreed to the recommendations as outlined in the report.

Ken LYNN, Chairperson

4

Dundee Health & Social Care Partnership

At a MEETING of the **PERFORMANCE AND AUDIT COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 29th May, 2018.

Present:-

Members	**Role**
Doug CROSS *(Chairperson)*	Nominated by Health Board (Non-Executive Member)
Roisin SMITH	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance officer
Cesar RODRIGUEZ	Registered Medical Practitioner (not providing primary medical services)
Raymond MARSHALL	Staff Partnership Representative

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

Tony GASKIN	Chief Internal Auditor
Arlene HAY	Dundee Health and Social Care Partnership
Diane McCULLOCH	Dundee Health and Social Care Partnership
Lynsey WEBSTER	Dundee Health and Social Care Partnership
Claire LEWIS-ROBERTSON	Dundee Health and Social Care Partnership
Arlene MITCHELL	Dundee Health and Social Care Partnership
Alexis CHAPPELL	Dundee Health and Social Care Partnership
Liz BALFOUR	Dundee Health and Social Care Partnership
Professor Kevin POWER	Dundee Health and Social Care Partnership
Linda GRAHAM	Dundee Health and Social Care Partnership

Doug Cross, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

Judith GOLDEN	Nominated by Health Board (Non-Executive Member)
Jane MARTIN	Chief Social Work Officer

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 March, 2018 was submitted and approved.

IV OUTCOME OF CARE INSPECTORATE NSPECTION – TURRIFF HOUSE

There was submitted Report No PAC25-2018 by the Chief Finance Officer advising of the outcome of the recent Care Inspectorate inspection of Turriff House Older People's Care Home.

The Committee agreed:-

(i) to note the content of the report and the content of the inspection report which was attached to the report as Appendix 1;

(ii) to note the one recommendation as detailed in paragraph 4.6 of the report and the action plan to address this which was attached to the report as Appendix 2; and

(iii) to note the grades awarded to the service, the strengths of the service, and the positive comments made by service users and carers as outlined in the report.

V ANNUAL RISK MANAGEMENT OVERVIEW

There was submitted Report No PAC28-2018 by the Chief Finance Officer providing an annual overview of Dundee Health and Social Care Partnership's Risk Management Strategy.

The Committee agreed:

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

(ii) to note the work being undertaken to formalise escalation protocols for specific risks to the Integration Joint Board and to partner bodies and future developments around Locality Operational Risk Management Plans and a Resilience Group as outlined in Paragraphs 4.4, 4.3 and 4.5 of the report.

VI DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP – ACTION PLAN IN RESPONSE TO THE SERVICES FOR OLDER PEOPLE (EDINBURGH) INSPECTION REPORT

Reference was made to Article XI of the minute of meeting of this Committee held on 28th November, 2017 wherein the report on the Inspection of Older People's Services within Edinburgh Health and Social Care Partnership and the potential learning points for the Dundee Health and Social Care Partnership was submitted and it was agreed that an action plan, setting out improvements for Dundee, be prepared and presented to the Performance and Audit Committee by May 2018. There was submitted Report No PAC29-2018 by the Chief Finance Officer providing the Performance and Audit Committee with the proposed action plan.

The Committee agreed to note the content of the report, the Dundee Health and Social Care improvement action plan which was attached to the report as Appendix 1 and the progress made to date.

VII DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – QUARTER 4

There was submitted Report No PAC30-2018 by the Chief Finance Officer updating the Performance and Audit Committee on Quarter 4 (Q4) 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 against the Measuring Performance Under Integration Interim Targets as outlined in Section 5 and Appendix 1 of the report; and

(iii) to note the performance of Dundee Health and Social Care Partnership against the National Health and Wellbeing Indicators as outlined in Section 6 of the report and Appendix 2 of the report.

VIII UNSCHEDULED CARE

There was submitted Report No PAC31-2018 by the Chief Finance Officer providing assurance to the Performance and Audit Committee that a comprehensive analysis of unscheduled care performance had been provided to relevant professionals and groups in order to support improvements.

The Committee agreed:-

(i) to note the content of the report and the analysis of unscheduled care as outlined Section 5 and Appendix 1 of the report;

(ii) to request the Unscheduled Care Board to consider the findings of the analysis with a view to informing operational decision making and improvement actions; and

(iii) to instruct the Chief Finance Officer to present a follow up paper to the Performance and Audit Committee, containing an action plan which described how the data would be used by practitioners and the Unscheduled Care Board to make continuous improvements, timescales for improvement actions and the anticipated impact of these actions.

IX FALLS PERFORMANCE

There was submitted Report No PAC32-2018 by the Chief Finance Officer providing assurance that an in-depth analysis of falls related hospital admissions in Dundee had been provided to relevant professionals and groups in order to support improvements.

The Committee agreed:-

(i) to note the contents of the report and the analysis of falls related hospital admissions as outlined in Section 5.0 and Appendix 1 of the report;

(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 as outlined in Section 6.0 of the report; and

(iii) to note the future priority areas as outlined in Section 8.0 of the report.

X PSYCHOLOGICAL THERAPIES WAITING TIMES

There was submitted Report No PAC33-2018 by the Chief Finance Officer briefing on those specialities within the hosted Psychological Therapies Service currently failing to meet Health Improvement, Efficiency, Access & Treatment (HEAT) targets and the actions being taken to address the same.

The Committee agreed:-

(i) to note the current position and reasons for certain specialities currently failing to meet HEAT targets as outlined at Sections 4.3, 4.4, 4.6, 4.7 and 4.8 of the report;

(ii) to note the actions already being taken within the Psychological Therapies Service to address the current waiting time challenges as outlined at Sections 4.12 of the report;

(iii) to note the intention of the service to adopt alternative means of providing planned cover arrangements given the demographic of the workforce and level of demand for psychological therapy services as outlined at Sections 4.8 and 4.9 of the report;

(iv) to note the intention of the service to review current psychology service models within General Adult Psychiatry Service as outlined at Section 4.7 of the report; and

(v) to note the requirement for more detailed modelling of demand, capacity and potential impact on future financial resources within Clinical Neuropsychology as outlined at Section 4.11 of the report.

XI DRUG AND ALCOHOL TREATMENT WAITING TIMES

There was submitted Report No PAC41-2018 by the Chief Finance Officer providing an update to the Performance and Audit Committee on Substance Misuse waiting times performance in Dundee.

The Committee agreed:-

(i) to note the current position in relation to Drug and Alcohol Treatment Waiting Times as outlined in Section 5.2 of and Appendix 1 of the report;

(ii) to note the improvement actions planned to respond to areas of pressure identified as outlined in Section 5.3 of the report;

(iii) to note the intention to develop a balanced scorecard as outlined in Section 4.2 of the report; and

(iv) that a further report be provided to the Committee outlining the Substance Misuse Improvement and Redesign Plan.

XII DISCHARGE MANAGEMENT PERFORMANCE UPDATE (INCLUDING CODE 9 ANALYSIS)

There was submitted Report No PAC34-2018 by the Chief Finance Officer providing an update to the Performance and Audit Committee on Discharge Management performance in Dundee.

The Committee agreed:-

(i) to note the content of the report and the current position in relation to Discharge Management Performance as outlined in Section 5.2 of the report and Appendix 1 (Sections 2.2 and 2.3);

(ii) to note the current position in relation to complex delays as outlined in Section 5.3 of this report and Appendix 1 (Section 2.4); and

(iii) to note the improvement actions planned to respond to areas of pressure identified as outlined in Section 5.2 and 5.4 of the report.

XIII NHS TAYSIDE – INTERIM EVALUATION OF INTERNAL CONTROL FRAMEWORK 2017/18

There was submitted Report No PAC40-2018 by the Chief Finance Officer sharing NHS Tayside's Interim Evaluation of Internal Control Framework 2017/18 report.

The Committee agreed:-

(i) to note the content of the report and the content of the NHS Tayside Internal Audit Service's Interim Evaluation of Internal Control Framework which was attached to the report as Appendix 1 including the recommendations and corresponding management actions as set out in the Appendix (page 30 onwards); and

(ii) to instruct the Chief Finance Officer to take into consideration the outcome of the review when developing Dundee Integration Joint Board's Annual Governance Statement 2017/18.

XIV DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT

There was submitted Report No PAC38-2018 by the Chief Finance Officer providing the Performance and Audit Committee with a progress update in relation to the current Internal Audit Plan.

The Committee agreed to note the progress of the current Internal Audit Plan as outlined in the report and the Appendix which was attached to the report.

XV AUDIT SCOTLAND ANNUAL REPORT 2016/17 – PROGRESS ON ACTION PLAN

There was submitted Report No PAC11-2018 by the Chief Finance Officer providing an update of progress of the actions identified and agreed as a response to the recommendations outlined by Audit Scotland in their Annual Review of Dundee Integration Joint Board 2016/17.

The Committee agreed:

(i) to note the contents of the report and progress of the actions agreed as part of Audit Scotland's Annual Review 2016/17 as set out in Appendix 1 of the report; and

(ii) to instruct the Chief Finance Officer to progress the outstanding actions to ensure the completion of the action plan prior to the completion of the 2017/18 Audit Scotland Annual Review.

XVI DATE OF NEXT MEETING

The Committee noted that the next meeting of the Committee would be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 31st July, 2018 at 2.00 pm.

Doug CROSS, Chairperson.

ITEM No …4(b)……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2018**

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

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

REPORT NO: **DIJB45-2018**

Instructions Issued by the Committee

The Performance and Audit Committee (PAC) issued the following instructions to the Chief Finance Officer:

- To present an action plan, with timescales, to the PAC detailing how the data provided on unscheduled care performance would be used by practitioners and the Unscheduled Care Board to make continuous improvements and the anticipated impact of these actions.

- To reflect the findings of the Internal Audit Interim Evaluation of Internal Control Framework 2017/18 in the Integration Joint Board's (IJB) 2017/18 Annual Governance Statement.

- To progress the outstanding actions from the Audit Scotland 2016/17 Annual report prior to the completion of the 2017/18 Audit Scotland Annual Review.

Performance Against Workplan

The Committee:

- Considered the outcome of the Care Inspectorate Inspection of Turriff House. This was a very good report which reflected the level of service provided, the strengths of the service and its staff and included a number of positive comments made by users and carers.
- Noted work was being undertaken to ensure processes were in place to share risks between Dundee Health & Social Care Partnership (DHSCP), Dundee City Council (DCC) and NHS Tayside and also partner IJBs and to ensure risks were escalated to and from the Partnership appropriately.
- Noted the action plan put in place in response to the Inspection of Older People's Services in Edinburgh.
- Scrutinised the Partnership's performance for quarter 4 of 2017/18.
- Noted the information on unscheduled care performance which is considered at the Unscheduled Care Board (UCB) and sought assurance that the UCB used this information to inform operational decision making. As previously highlighted the PAC instructed the Chief Finance Officer to provide further information on how this data would be used to make improvements.

- Considered a report in relation to Falls Performance following a request from PAC for more work to be done in understanding poor performance in this area.
- Were updated on the level of performance in Psychological Therapies Waiting Times and the challenges facing the service which were preventing it meeting HEAT targets. It was noted the service planned to review the current psychology service models; adopt alternative means of providing planned cover; and undertake more detailed modelling of demand, capacity and financial resources in an attempt to improve performance.
- Noted the current position in relation to Drug and Alcohol Treatment Waiting Times and the actions being taken to improve the position, including developing a balanced scorecard. A further progress report will be provided to the PAC.
- Considered a report in relation to Discharge Management following a request from PAC for more work to be done to make improvements in this area.
- Noted the issues raised within Internal Audit's Interim Evaluation of Internal Control Framework were being addressed. Progress against the action plan will be monitored by the PAC. As previously highlighted the Committee instructed the Chief Finance Officer to reflect the findings of the evaluation in the Board's Annual Governance Statement for 2017/18.
- Noted progress against the Board's Internal Audit Plan.
- Noted progress against the Audit Scotland Annual Report 2016/17. As previously highlighted the PAC instructed the Chief Finance Officer to ensure the action plan was completed prior to completion of the 2017/18 Audit Scotland Annual Review.

Any Other Major Issues to highlight to the Integration Joint Board

- The Committee recorded its gratitude to the management and staff of Turriff House for their diligence and professionalism in providing good quality services to residents and their carers.
- The Committee again raised concerns over areas of poor performance against the rest of Scotland and also levels of inequality within Local Community Planning Partnership (LCPP) areas with regard to performance against the Dundee average. The Committee were of the view that at this stage of the Partnership's development we should now be making further inroads into addressing these issues and sought assurance on how performance information would be used to improve the lives of people in Dundee.
- The Committee noted good work was being carried out to prevent falls and support those who had fallen but sought assurance that work would continue to improve the position further.
- While improvements have been made in reducing delayed discharges overall, complex cases continue to be challenging. The Committee heard previously of the significant improvements in "non-complex" cases and that significant efforts were being made to apply a similar analytical methodology to complex (Code 9) cases. This latest update indicates more work is required to improve performance in this area. This will continue to be monitored by the PAC.

Doug Cross
June 2018

ITEM No …5(b)…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2018**

REPORT ON: **TAYSIDE PRIMARY CARE IMPROVEMENT PLAN**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB26-2018**

1.0 PURPOSE OF REPORT

The purpose of this report is to detail the development of the Primary Care Improvement Plan and seek approval of the Plan.

2.0 RECOMMENDATIONS

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

2.1 Approves the Tayside Primary Care Improvement Plan (the Plan), which outlines the overall direction of travel and sets out the first year of delivery (attached as Appendix 1);

2.2 Notes the specific actions for Dundee Health & Social Care Partnership as described in Appendix 2;

2.3 Agrees to direct NHS Tayside to implement with immediate effect the specific actions relevant to them in Appendices 1 & 2;

2.4 Agrees to delegate the monitoring of the Primary Care Improvement Plan Fund (Dundee allocation) as detailed in paragraphs 3 and 4.4.1 of this report.

2.5 Instructs the Chief Officer to provide a further report to the IJB to be held on 28 August 2018 which will include a full financial framework for the Direction to NHS Tayside at 2.3 above;

2.6 Instructs the Chief Officer to provide a further report on progress made in the first year to a future IJB;

2.7 Notes that the Tayside Primary Care Improvement Plan will be submitted to the Scottish Government following approval of the Plan by the relevant parties by 1 July 2018.

3.0 FINANCIAL IMPLICATIONS

The development of the services and infrastructure to deliver the Plan outlined is significant. The Scottish Government has allocated £45.750m nationally through the Primary Care Improvement Fund and issued guidance on the financial allocation in May 2018. The Dundee share of the allocation is £1,355,476 for 2018-19 (subject to local agreement). The funding will increase year on year over the following three years, with these funding streams to be confirmed, although a notional allocation has been indicated. It is anticipated that the longer term funding implications to support the breadth of development required by the General Medical Services (GMS) contract will present financial challenges and the IJB will require to consider how it will support this work longer term. The financial management of the Primary Care Improvement Plan is delegated to the Chief Officer, Chief Finance Officer and Clinical

Director. However, it is proposed that the monitoring of this budget is overseen by the Dundee Primary Care Improvement Group.

4.0 MAIN TEXT

4.1 Context

4.1.1 The IJB has previously considered papers setting out the context and challenges within primary care (report number DIJB51-2017 presented at the meeting held on 19 December 2017) and the implications of the GMS contract and related memorandum of understanding (report number DIJB9-2018 presented at the meeting held on 27 February 2018). This paper builds on these previous papers by outlining how developments will be taken forward to support the changes required. Many of these developments build on work already underway in Dundee as part of the Strategic and Commissioning Plan. However, a number of areas are significantly different and less developed in terms of building blocks. The Plan requires approval by each Integration Authority, the Local Medical Committee (LMC) and NHS Board.

4.2 Requirements of the Plan

4.2.1 The GMS contract aims to develop a sustainable model of general practice through the development of a multi disciplinary support team working in and around general practice, enabling GPs to have more capacity to fulfil their role as Expert Medical Generalist.

4.2.2 All primary care development must accord with seven key principles:

- Safe
- Patient centred
- Equitable
- Outcome focused
- Effective
- Sustainable
- Affordability and value for money.

4.2.3 The key priority areas between 2018-21, the agreed implementation timeline for this contract, identified nationally are:

- The Vaccination Transformation Programme (VTP)
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care
- Additional professional roles - such as musculoskeletal focused physiotherapy services
- Community Link Workers (referred to as social prescribers).

4.2.4 A number of national documents provide further context regarding the national planning to support reform within health and social care. All are key enablers for delivery of the new GP contract:

- Premises - as outlined in the National Code of Practice for GP Premises, a new model for general practice premises is planned within 25 years, whereby GPs will no longer be expected to own their own premises.
- Information sharing arrangements - The Information Commissioners Office (ICO) now accepts that GPs are not the sole data controllers of the GP records but are joint data controllers along with their contracting NHS Board.
- Workforce - The National Health and Social Care Workforce Plan Part 3 - improving workforce planning for primary care in Scotland, provides guidance on workforce planning to support the reform of primary care.
- Mental Health - Action 15 of the Mental Health Strategy allocations have been announced bringing a further £11m nationally to improve availability of mental health workers in GP practices, police station custody suites, prisons and emergency departments.

4.2.5 The Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards, signed in November 2017 provided a statement of intent, recognising the statutory role of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist and the NHS Boards role in service delivery and as NHS staff employers and parties to General Medical Services.

4.2.6 The Memorandum of Understanding outlines the responsibilities of the Integration Authority as:

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the Health & Social Care Partnership (HSCP) Strategic & Commissioning Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective Multi-Disciplinary Team (MDT) model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.
- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that patient needs identified in care plans are met.

4.2.7 NHS Territorial Boards responsibilities are outlined as follows:

- Contracting for the provision of primary medical services for their respective NHS Board areas.
- Ensure that primary medical services meet the reasonable needs of their Board area as required under Section 2c of the NHS (Scotland) Act 1978.
- Delivering primary medical services as directed by HSCPs as service commissioners.
- Arrangements for local delivery of the new Scottish GMS contract via HSCPs.
- As employers, NHS Boards will be responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of the priority areas.

4.2.8 The Memorandum of Understanding outlines that the Primary Care Improvement Plan which should be determined based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. The expectation is that reconfigured services, as outlined above, continue to be delivered in or near GP practices.

4.2.9 The key requirements of the Primary Care Improvement Plan are outlined as follows:

- To be developed collaboratively with HSCPs, GPs, NHS Boards and wider stakeholders.
- To detail and plan the implementation of key priorities, with reference to agreed milestones over a three year time period.
- To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.
- To provide detail on available resources and spending plans (including workforce and infrastructure).

- To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.
- Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018.

4.3 Dundee Commitments

4.3.1 The Improvement Plan has been developed on a Tayside wide basis as many of the services are across Tayside. A principle of aiming to have core processes across Tayside has been adopted in developing the plan with local delivery models to suit local needs. Agreeing the plan has been challenging given the timescales to do so and some of the detail is yet to be developed. It is therefore seen as a dynamic document which will change with time, including regular reviews. The Tayside Plan outlines the overall direction of travel and sets out in detail the first year of delivery. In many cases year 2 and 3 will build on the learning of year 1 and so cannot at this stage be detailed. This has implications on the financial planning and management.

4.4 Dundee Governance

4.4.1 The Dundee Primary Care Improvement Group was established earlier this year with a remit to develop the Dundee Plan and take responsibility for implementation going forward. This Group has senior managers of the services where the primary care developments will be developed, as well as from a range of supporting services. The cluster leads are members of this group. Importantly the GP Sub Committee/LMC are also represented. It is proposed that this Group take responsibility for all aspects of governance, including financial monitoring, for the Dundee Primary Care Improvement Plan. This Group would report to the Integrated Strategic Planning Group, and then to the IJB. It will also link to Tayside groups including the GMS Implementation and Advisory Group and the Primary Care Board.

4.5 Dundee Priorities and Plan

4.5.1 Dundee HSCP are committed to delivering the overall Tayside Plan, recognising that the models developed and implemented in Dundee may vary from those in other parts of Tayside. This is to ensure that we reflect the priorities of Dundee and the four GP clusters. It will also reflect the needs and variation of local communities, the assets and infrastructure we have and what is felt realistic to deliver locally. Some of the high level key commitments for year one locally are noted in the attached appendix (Appendix 2). Costs have not been fully developed for all of these areas. However, given that these are all priority areas we are mandated to ensure that these are implemented as early as possible. There is a risk we may not get the balance of these priorities completely correct at this stage, so different aspects will need to develop in tandem and be adjusted as the developments all gain learning. A degree of risk is involved in this but the risk of waiting until the overall aspects are all clearer is that we fail to deliver these key priorities.

4.6 Next Steps

4.6.1 As highlighted in the plan we are building on a lot of work which is already underway, both driven through the wider integration agenda, work that has been developed from necessity due to issues with GP recruitment, or proactive planning for the anticipated changes. The Dundee Primary Care Improvement Group must ensure that the work outlined is developed with some pace, and recognising that there is a need to scale this up across Dundee within the three year period of the initial phase of the contract changes. There is a recognition nationally as well as locally that no Board or HSCP will have fully implemented all aspects of the services required, but that there will have been significant progress towards that, across all areas of delivery.

5.0 POLICY IMPLICATIONS

Each area of the plan will require to have an ongoing assessment of EQIA. This paper has been screened and there are no significant implications of the paper.

6.0 RISK ASSESSMENT

The following key high level risks have been identified. Risks will be identified and managed within each service in more detail and managed by the Dundee Primary Care Improvement Group.

Risk 1 Description	There is a significant risk that Dundee may not recruit or develop the workforce to deliver all of the commitments in this plan given the scale and breadth of the plan. This applies across a number of professions, including pharmacy, nursing and Allied Health Professionals (AHPs). This will directly impact on the delivery of services described.
Risk Category	Workforce, operational
Inherent Risk Level	Likelihood (5) x Impact (4) = Risk Scoring 20
Mitigating Actions (including timescales and resources)	All services are planning with this risk at the forefront and looking to maximise skill mix as much as possible to reduce this. Longer term national work to provide increased undergraduate training will support this but not within the timescales of the 3 year plan.
Residual Risk Level	Likelihood (4) x Impact (4) = Risk Scoring 16
Planned Risk Level	Likelihood (4) x Impact (4) = Risk Scoring 16
Approval recommendation	This risk should be accepted.

Risk 2 Description	There is a risk that we will have inadequate infrastructure to support the delivery of the Plan, both in terms of IT infrastructure and systems, and buildings/premises.
Risk Category	Technological, Environmental, Financial
Inherent Risk Level	Likelihood (5) x Impact (4) = Risk Scoring 20
Mitigating Actions (including timescales and resources)	Investment in year 1 for IT infrastructure and systems need to be prioritised to allow dependant aspects of delivery to progress. Some services may need to be delivered from practice premises. Consideration needs to be given to where premises are required and capital bids may be required to progress any gaps.
Residual Risk Level	Likelihood (4) x Impact (4) = Risk Scoring 16
Planned Risk Level	Likelihood (3) x Impact (3) = Risk Scoring 9
Approval recommendation	This risk should be accepted.

Risk 3 Description	There is a risk that the finance allocated via the primary care improvement fund will not adequately meet all the costs to implement the plan, and that resource will have to be identified from other sources. This will impact the scale and pace of roll out of services across the city.
Risk Category	Financial
Inherent Risk Level	Likelihood (5) x Impact (4) = Risk Scoring 20
Mitigating Actions (including timescales and resources)	Other sources of funding will be identified as opportunities arise. Finance is a key component of planning and ensuring the most cost effective models are progressed. Where models with variation in costs are tested in different parts of Tayside there will be a judgement made as to cost effectiveness of these models prior to roll out.
Residual Risk Level	Likelihood (5) x Impact (4) = Risk Scoring 20
Planned Risk Level	Likelihood (4) x Impact (4) = Risk Scoring 16
Approval recommendation	This risk should be accepted.

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report. A significant number of groups have informed and been involved in the development of both the Tayside Plan and the local plans that are emerging. This includes:

- Practice staff at a protected learning event
- Dundee cluster/LMC meeting
- Individual cluster meetings
- Practice managers' meeting
- A number of service/team meetings
- Integrated Strategic Planning Group,(ISPG)
- Mental Health and Wellbeing SPG (sub-group)
- Frailty SPG
- Dundee H&SCP Staff Forum.

There has been no direct public consultation on the Plan to date but going forward there will be significant engagement with communities as part of the wider development of the Plan, particularly to inform local models of delivery.

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.

David W Lynch
Chief Officer

DATE: 14 June 2018

Shona Hyman
Senior Manager
Service Development & Primary Care

David Shaw
Clinical Director

Appendix 1

Tayside Primary Care Improvement Plan

2018 to 2021

Authors
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Version 17
13th June 2018

CONTENTS

Foreword

We are delighted to present our Primary Care Improvement Plan. This plan has been developed collaboratively between by Angus, Dundee and Perth and Kinross Health and Social Care Partnerships, NHS Tayside Board and GP Subcommittee.

The plan describes our commitment to support and deliver primary care services which meet the needs of the communities we serve both now and for the future. It represents an ambitious programme of change which places people at the heart of service delivery.

The Primary Care Improvement Plan does not sit in isolation. It is a living document that is a critical element of to the rich clinical context of strategic and transformative change taking place across Tayside and is integral to the delivery of the Integrated Clinical Strategy.

Dr David Shaw
Clinical Director
Dundee HSCP
June 2018

Dr Andrew Thomson
Medical Secretary
Tayside GP Subcommittee

Introduction

An effective primary care system is critical to sustaining high quality universal healthcare and is vital if we are to realise Scotland's ambition of improving the health of our population and reducing the burden of health inequalities that rests upon it. As a nation we require a strong and thriving general practice at the heart of our primary care system if we are to succeed in these goals.

The vast majority of healthcare interactions for our population start and end within primary care, with General Practices acting as a necessary and efficient gateway to decisions about referral, admission and prescribing. These decisions have a direct impact on the entire health and social care system with immense consequential resource implications.

This document describes a three year investment programme of unprecedented scale that aims to support the moving of patient care and resources into the community, the improving of quality and efficiency of healthcare delivery and the addressing of the Realistic Medicine agenda. This will ensure that we have a general practice and a primary care system that delivers high quality, effective and responsive care for our patients in the communities in which they live.

This Plan is a commitment to provide better care for our population. An effective, vibrant and fully functional primary care is essential for NHS Tayside and for the Health and Social Care Partnerships, who commission that care. It is also essential for the professions and services that deliver it. The spirit of collaboration and co-production runs through this plan and are essential to ensure its effective implementation.

National Background and Context

General practice has experienced a prolonged and unprecedented level of challenge across the UK. A sustained period of real terms decline in resource coupled with a negative portrayal of General Practice has resulted in a recruitment crisis with GP Practices; unable to match recruitment to the service with departures from it.

This challenge is set against a background of increasing demand for access through changes in societal values, an ageing demography and an increasing disease burden. Practices have not only struggled to attract sufficient doctors but also to recruit other healthcare professionals to deliver the service at the level to which they aspire. The result of this 'perfect storm' across Scotland is a wave of practices restricting their lists through closure, tightening boundaries and increasingly having to surrender their contracts due to insurmountable difficulties.

Development of the 2018 Scottish GMS contract

Recognising the severity of the situation, the Scottish Government in close collaboration with the Scottish General Practitioners Committee, developed the 2018 Scottish General Medical Services (GMS) contract. This contract seeks to both re-invigorate general practice and through fundamental service re-design create positive effects throughout Primary Care as a whole.

The 2018 GMS contract builds on re-energised core values, developing the GP as the expert medical generalist at the heart of the community multidisciplinary team. The aims of the contract are to create a dynamic and positive career for GPs; a resilient and responsive wider primary care with opportunities for all healthcare professionals to flourish; and an assurance that patients will continue to have accessible, high quality general medical services.

Scope of the Contract and supporting documents

The new contract is supported by a Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards. This MoU requires every area in Scotland to develop a Primary Care Improvement Plan (PCIP) as a collaborative process between the NHS Board, Health and Social Care Partnerships (HSCPs) and GP Subcommittee of the Area Medical Committee (GP Sub). Specific agreement is also required by the Local Medical Committee in relation to contract implementation.

The MoU identifies six key priority areas which must be included in the PCIP:

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care Services (advanced practitioners)
- Community Link Workers
- Additional Professional Clinical and Non-clinical services including
    - Acute musculoskeletal physiotherapy services
    - Community Mental Health Services

The MoU represents a statement of intent recognising the roles of the Integration Authorities and NHS Boards in commissioning and delivering primary care services. Primary care service redesign and development will be in the context of delivery of the new GMS contract and accord with seven key principles:

- Safe
- Person Centred
- Equitable
- Outcome Focussed
- Effective
- Sustainable
- Affordability and Value for Money

Further key enablers for change identified are:

- **Premises** – a shift over 25 years to a new model for GP premises in which GPs will no longer be expected to provide their own premises
- **Information sharing arrangements** – reducing risk to GPs by moving to a system where GPs and their contracting Health Boards have joint data controller processing responsibilities towards to the GP patient record
- **Workforce** – a national workforce plan has been published setting out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team

The MoU covers the 3 year period, from 1 April 2018 to 31 March 2021 to which this implementation plan relates.

Aims of the Tayside Primary Care Improvement Plan

The Tayside Primary Care Improvement Plan takes the principles detailed within the GMS contract and MoU; describing how they will be embraced and implemented by creating a better functioning, patient centred primary care that allows other healthcare professions to grow and develop while easing pressure within General Practice. This is not just to increase the sustainability of the profession, but also to release the time required for GPs to take a full part in shaping a reinvigorated primary healthcare system.

The changes that our Improvement Plan describes are the single greatest alteration to the shape of primary care in a generation. Each of the workstreams that lie within the plan is a major project in its own right. The improvements within the plan represent an opportunity for the whole of the Primary health and social care team to reshape itself; becoming more rewarding, attractive and sustainable. This will act as a catalyst for change which will reshape, refresh and re-invigorate the entire healthcare system so that our population will have timely access to the right person within their community delivering the highest quality achievable.

The PCIP will be interwoven within the Strategic Plan for each Health and Social Care Partnership (HSCP) and, to ensure the continued delivery of high quality, safe, person centred care, the transition to full implementation will happen over a period of three years.

A regional plan, locally owned

The three Tayside HSCPs (Dundee, Perth & Kinross and Angus), NHS Tayside and the GP Sub agreed to formulate a joint plan for Tayside. A single shared plan allows services to be planned at scale; to be integrated with the other major strategic changes occurring across the region's health and social care services; and assists in the aspiration of an equal standard of service across the population.

A single plan does not prevent or restrict but facilitates individual HSCPs in finding differing solutions that address the local needs of Tayside's disparate population. We strongly support an equality of outcome across Tayside that is supported by locally owned and designed solutions with regional support.

A description of how the PCIP was developed, how it will be implemented and how it will be monitored is included in the Governance section of this paper.

A Plan for General Practice

General Practice within Tayside is experiencing the same difficulties as elsewhere in Scotland. Three practices are already operated by NHS Tayside, as they were unable to sustain themselves as independent practices. Many others are struggling, particularly due to problems with recruiting new GPs. As a result many practices have, closed their lists, reduced their boundaries or reduced the scale of the services that they offer.

The PCIP aims to improve the resilience of our Tayside practices. It will do so in part by moving work and services more appropriately provided by others away from the responsibility of General Practitioners and in some cases practices.

The PCIP also aims to attract more doctors to the profession by creating a more fulfilling role for those working in it. The proposed new role for the profession is described below in the following extract from the 2018 GP Contract offer document:

"GPs are expert medical generalists who provide the first point of contact with the NHS for most people in their communities. They may deal with any medical problem, 'from cradle to grave', and by providing continuity of care to their patients, families, and communities, they contribute hugely to keeping the nation healthy.

General practice is a unique discipline. Rigorous scientific and clinical medical training and the ability to apply the evidence appropriately in community settings, places general practice at the centre of the NHS. This knowledge and skill set – when combined with the discipline's holistic, relationship based philosophy and broad generalist practice, distinguish the discipline in large measure from other medical disciplines."

The aspiration of this change in focus is that it makes General Practice a more attractive specialty to work in. The effect of this change should be to offer greater opportunities for the development of additional skills for other healthcare professions; and to make the care of patients central to an entire healthcare team working together.

The document goes on to outline the following aspiration for the new contract:

To enable and empower GPs to function as expert medical generalists, non-expert medical generalist workload needs to be redistributed to the wider primary care multi-disciplinary team, ensuring that patients have the benefit of the range of expert advice needed for high quality care.

Through delivery of this Primary Care Improvement Plan, which is interwoven with HSCP Strategic Plans, future service will be protected. This will ensure the delivery of sustainable services required to ensure our population's health and social care needs continue to be delivered.

A Plan for Our Patients - designed with our population

Throughout the development of the PCIP it has been critical to ensure that our Plan is suitable for the needs of our local populations and that the improvements it brings address the challenges our population face.

The most obvious of the many challenges that we face are those created by the shifting demographics of the population. An ever greater proportion of our community are living longer, resulting in an aging population. This brings with it an inevitable and growing burden of chronic disease accompanied by a relative decrease in the working age population. Addressing these pressures through the mobilisation of community assets and infrastructure is a priority.

Health inequality is, and will remain, a priority for NHS Tayside. We have pockets of both significant deprivation and geographic isolation within Tayside and the delivery of services to help tackle these will have to be sensitive to local needs that will vary between local populations.

Some of the priority workstreams such as Link Workers offer a vital tool in helping to address and mitigate these societal challenges that directly impact on wellbeing and the use of health resource. Delivery of enhanced and proactive care will be facilitated by freeing up GP time and through enhanced delivery within the community such as in Care and Treatment Centres.

Stakeholder Engagement

The successful delivery of the PCIP relies on it being seen as clinically necessary, clinically led and good for patients.

In implementing this plan, we place those responsible for delivering the services and the patients that they care for at its heart. Those services which are key to the implementation of the plan, along with each HSCP and GP locality clusters, are charged with ensuring that the needs and views of patients are integrated with the delivery and further evolution of the plan; and that our workforce is informed, supported and consulted in the necessary changes that must be made.

There has already been a broad focus on engagement seen throughout Tayside, both in terms of gathering and developing the views of professionals, and also facilitating local dialogue about principals and priorities for implementation. Each HSCP has undertaken surveys to help inform them of GP practice priorities for implementation of the contractual elements and this has been reflected within the priorities set within the following chapters. Implementation will be guided by local priorities with new services being made available to patients of every practice and locality at a roughly even rate with an expectation of full and universal provision by 2021.

Ongoing stakeholder engagement will be critical to successful delivery and we intend to expand further on our engagement with the public around service development as the route-map to implementation becomes clearer. Their views and experiences will guide our conversations and decisions, informing our choices for the development and prioritisation of services. We have a good track record of successful co-production which we envisage expanding upon during the implementation of the PCIP.

Tayside's population – Understanding Health Inequalities

Introduction

Understanding our population's demography is important if we are to provide for their current and predicted health and social care demands. Many illnesses, conditions and health related behaviours are associated with age, gender or other demographic characteristics. An awareness of population distributions and attributes can help identify those likely to experience health inequalities. This will enable us to plan the most efficient and effective services for the future.

Tayside currently has 64 GP practices providing care to a population of approximately 416,000 registered patients. Over a third of our population have been diagnosed with at least one chronic disease and for a growing number they suffer from multi-morbidity. These patients often require significant numbers of clinical attendances, are on multiple medications and may require significant social care support.

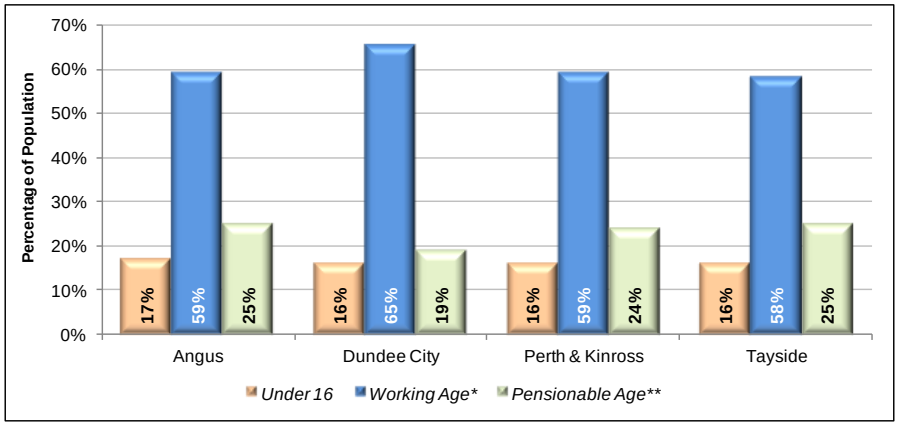
With an aging population (Fig: 1), health and social care demand is set to continue to increase and, without change, would outstrip our current capacity. This improvement plan uses the information we know about our population in developing and prioritising new approaches to the provision of health and social care to ensure our ability to continue the high quality provision for our population now and in the future.

Population Structure

The estimated population of Tayside on 30th June 2016 was 415,470, an increase of 430 (0.1%) from 2015. The gender distribution was similar to previous years, with males comprising 48.6% of the population and females 51.4%

Tayside's population is distributed across three local authority areas, in 2016 there were 116,520 residents [28.0% of the Tayside population] in Angus, 148,270 in Dundee [35.7%] and 150,680 in Perth & Kinross [36.3%]. Figure 1 displays the age structure of the Tayside population and its three local authority areas for 2016.

Figure 1. Age Structure of the Tayside Resident Population, as at 30th June 2016



The proportions in each age category across the three local authority areas are relatively similar. However, Dundee City has a higher proportion of the population who are of working age and a lower proportion of those who are pensionable in comparison to its Tayside counterparts.

Minority Ethnic Population

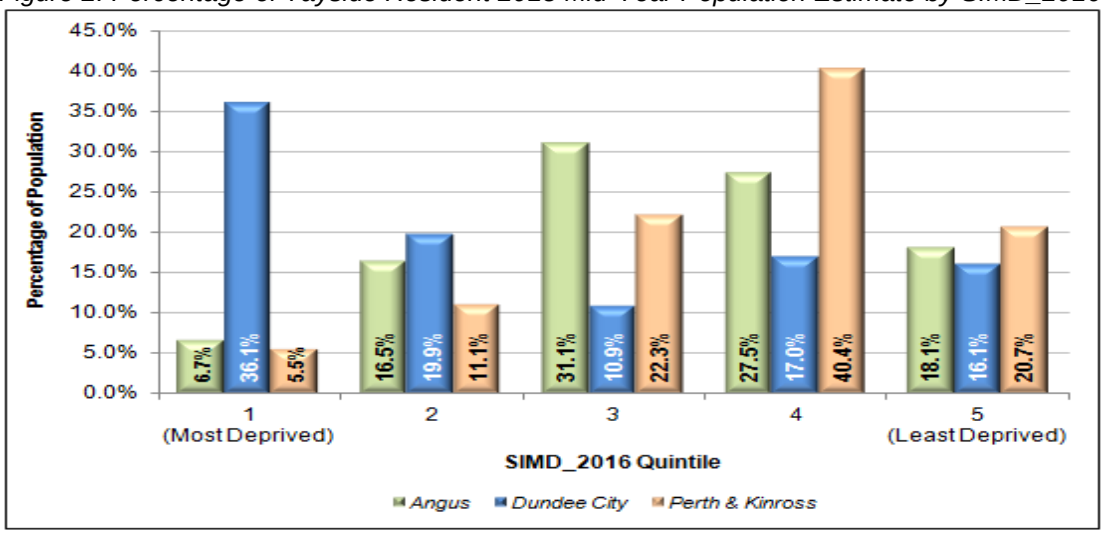
The 2011 Census reported that 3.2% (13,111 individuals) of the Tayside population were of non-white ethnicity. This varied across the region with the corresponding proportions in Angus, Dundee City and Perth & Kinross being 1.3%, 6.0% and 2.1% respectively.

Deprivation

The Scottish Index of Multiple Deprivation (SIMD1) is an area-based measure of deprivation, identifying small area concentrations of multiple deprivation in a comparative manner. It combines the domains of income, employment, health, education, skills and training, housing, geographic access and crime based on a ranking system from most to least deprived. These ranks can be grouped into categories, most commonly quintiles.

While in a standard population, 20% of the population would be expected to live within each quintile, across Tayside there are large variations between the differing levels of deprivation. Figure 2 displays the population proportions residing in each deprivation quintile for all three of Tayside's local authority areas.

Figure 2. Percentage of Tayside Resident 2015 Mid-Year Population Estimate by SIMD_2016 Quintile

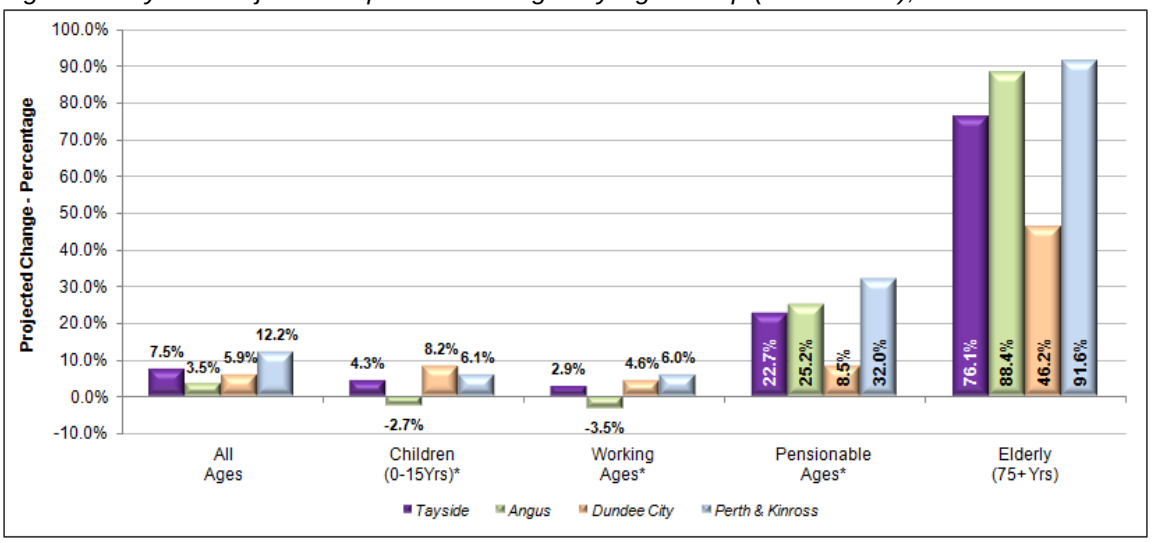


Dundee City has the greatest proportion of their residents living within the most deprived areas (SIMD Quintiles 1 and 2). 36.1% of the Dundee City population resided in the most deprived area, more than five times that compared to its Tayside counterparts.

Population Projections

The total Tayside population is projected to increase by 7.5% (N=444,763) by 2039 (2014 population estimate based). Displayed in figure 3 are the projected changes in the Tayside population, showing the variations in the differing age groups across the three local authority areas.

Figure 3. Tayside Projected Population Changes by Age Group (All Persons), 2014 and 2039



Perth & Kinross is expected to represent the largest projected population change by 2039, an increase of 12.2% (N=167,087) from the baseline estimate of 2014[2]. The other two areas are also projected to increase in total population by 2039, however by considerably less. (Angus - 3.5% (N=120,799), Dundee City - 5.9% (N=156,877)).

Of those age groups encompassed within the population of Tayside, those of pensionable age, and especially those aged 75+ years, are projected to display the greatest increase in population size by 2039 from the 2014 baseline estimate. Over the next twenty-five years, the most elderly age band, those aged 85+ years, are projected to increase by 128.7%. Of Tayside's three local authority areas, both Angus and Perth & Kinross are predicted to show the greatest increases in these elderly age groups.

Ill health

Many patterns of disease and conditions demonstrate inequalities between gender, age or geographical area. It is estimated that one in four adults (aged 16+ years) report some form of long term condition (LTC), health problem or disability and by the age of 65 nearly two thirds will have developed a LTC. Examples of common LTCs include diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD).

Understanding health inequality

Inequalities in health are a major challenge both for the NHS in Scotland and for Tayside. Despite improvements in many other health outcomes, there has been little improvement in relative inequalities with evidence of some areas where it is increasing.

Deprived socioeconomic groups suffer lower life expectancy, higher morbidity, and much lower healthy life expectancy than their more affluent peers. Male mortality exceeds that of women; those with physical or learning disability die earlier than those without; those with mental health issues have greater morbidity and mortality than those who don't. Some rural populations with limited access to patient service suffer greater ill health than more urban communities. The reduction of inequalities is a challenging priority at national, regional and local level. This is reflected in a number of strategies and plans in Tayside and is embedded in the Strategic and Commissioning Plan of each HSCP. NHS Tayside is committed the aim of achieving health equity within a generation.

Life Expectancy and Disease expectation

Life expectancy in Tayside overall is similar to the rest of Scotland. However there is significant variation. A baby boy in Dundee can expect to live to 75.1 years, while a baby girl in Perth and Kinross can look forward to surviving an additional 7.5 years. (Figure 4)

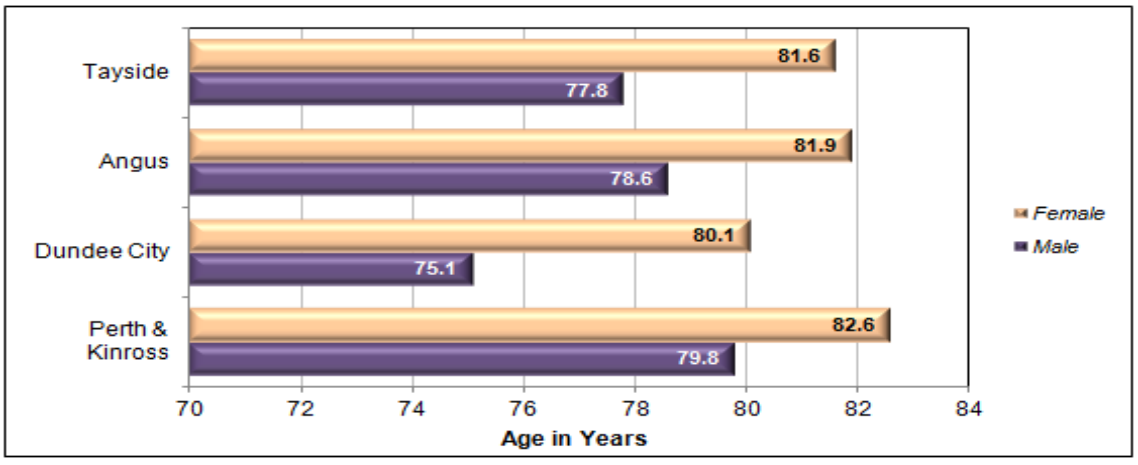


Figure 4. *Tayside Residents 'Life Expectancy at Birth' by Gender, 2013-2015*

These figures mask an even wider variation at locality level, with those in areas associated with higher levels of deprivation, having poorer outcomes across virtually all indicators of health. (Figure 5 and 6)

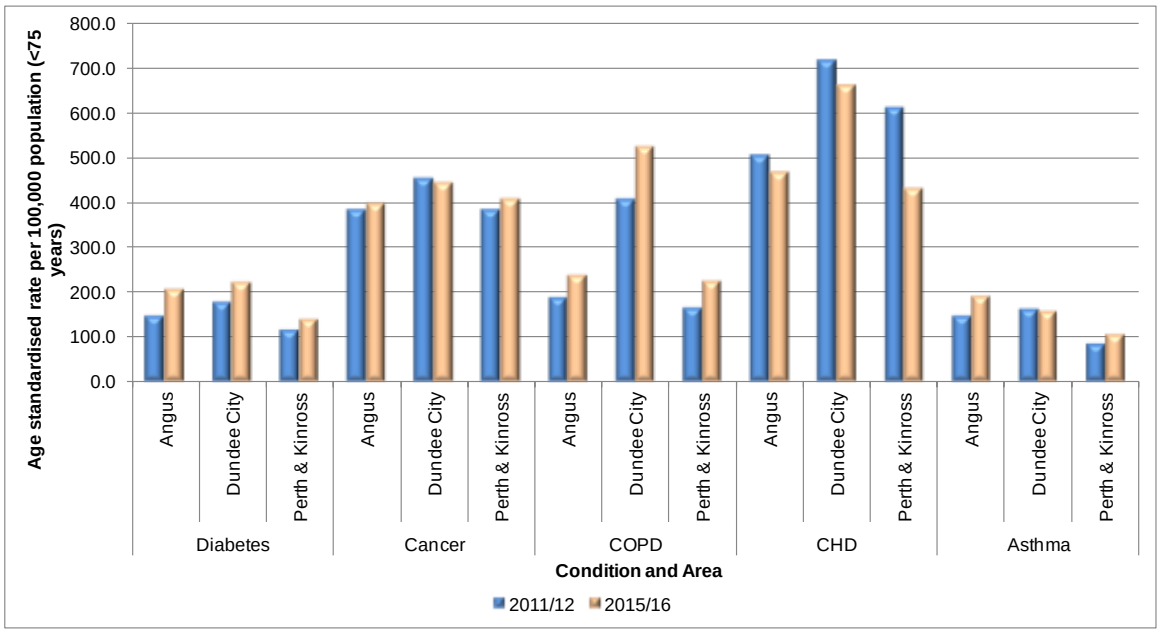


Figure 5. *Age standardised rates for those aged under 75 years for selected conditions across Tayside 2011/12 and 2015/16 (cancer registrations compare calendar years 2011 and 2015)*

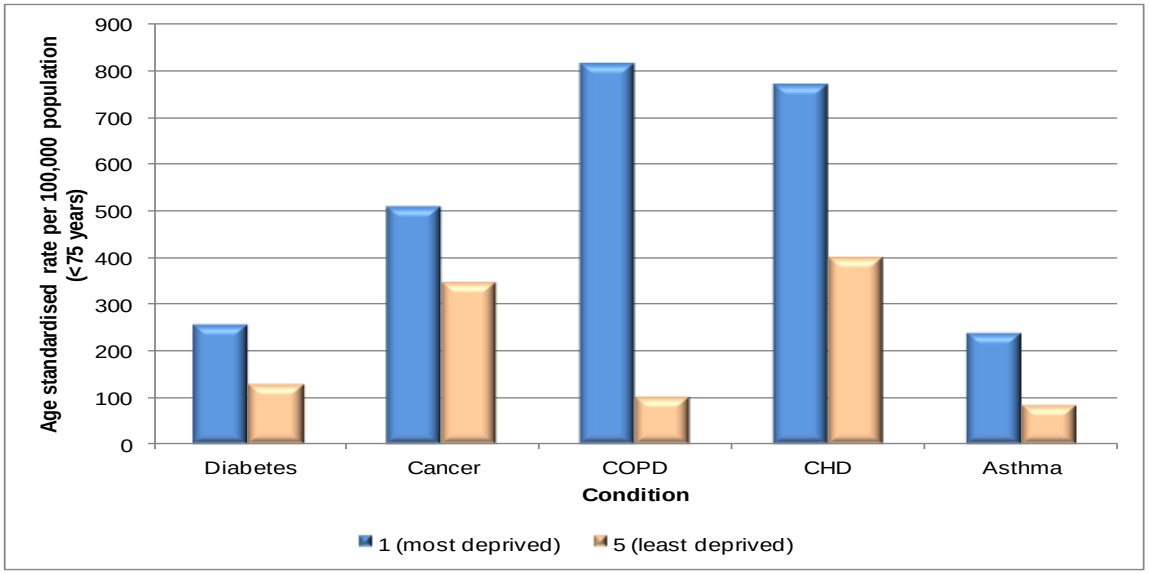


Figure 6. *Comparison of age standardised rates for the most and least deprived areas in Tayside for selected conditions 2015/16 (2015 for cancer registrations)*

Comprehensive evidence suggests that poverty causes harm through the chronic stress it causes. Unhealthy lifestyles, such as substance misuse, which help people cope with this stress, are passed on at very early ages. Teenage pregnancy is both a product of this cycle and an accelerant.

The lifestyle and socioeconomic factors which lead to ill health are interrelated. For example someone who has lost their job and income may have chronic stress and anxiety, with this impact on their mental wellbeing having a further negative impact on their physical health, and leading to longer term unemployment due to ill health. Breaking the cycle of deprivation leading to ill health early is therefore vital for future generations.

Having a sense of worth, aspiration and confidence can protect people from such harm and gives them resilience. We will build on existing confidence, promote resilience, and rebuild aspiration within communities. This is a very different goal than just aiming for faster or closer services.

Achieving Improvement

Through improving and innovating as detailed in this plan, there is an aim to reduce the avoidable differences dramatically; reducing the years of life lost annually to poverty in Tayside. This goal requires a fundamentally different approach to health and social care, starting with embedding improvements within Primary Care.

We will promote community resilience and support co-production; helping people to plan services and to take back elements of services which do not need to be delivered by health professionals. Engaged communities, with a caring and connected society will promote patient and community enablement, not more dependency on the NHS.

Our effort will need to be tailored to the needs of local populations within Tayside to reflect the problems and supports these communities possess. We will encourage cultural change to help communities become stronger and healthier. This will happen not just within our HSCPs but through inclusion of the voluntary and third sector.

Impact on and role of Primary Care teams

The impact on practices that have populations who predominantly reside in areas of higher deprivation is well documented including by the work of the “Deep End” practices. Socioeconomic deprivation has the greatest impact in Dundee where 33% live in the most deprived 20% of the population. The resulting workload impact on supporting those with multi-morbidity from a relatively early age is hugely demanding. There has been evidence for a number of years that practices in more deprived areas should have longer appointment times but this has not been achievable. Longer term as the workload in practices shifts as a result of the investment that the PCIP brings, it is anticipated that the duration of appointment times could be increased.

General practice and the wider primary care team, as described in the new contract, is core to achieving this ambition. As the key service which supports the whole population, General Practice has a critical role from pre-conception to palliative care. The aspiration of GPs as expert medical generalists at the core of a locality based

MDT within a local community will support identifying and planning for local health needs in a way that reflects the ambitions of the Health Equity Strategy.

Tayside already has a strong infrastructure to support this approach, with well established, GP led cluster groups, actively involved in considering quality improvement work for their local population. As capacity is released within general practice there will be the ability for GP teams to become more involved in the broader aspects of planning services around communities and community needs.

Inequality is also linked to rurality, with a number of contributory factors, particularly access to services, and low incomes. By its nature, the rural aspect of this issue makes it challenging but General practice is often unique in being part of the local community. An important aim of the contract is to ensure that services are provided as locally as possible. The role of technology to provide support is a key part of that solution, and with increasing rural connectivity, is more achievable now than it has been in the past.

Supporting Primary Care

A number of roles may support practices to interrupt the cycle of health inequality. The link worker role is one component of this, but wider social prescribing support can also add value. Where practitioners can easily refer to other agencies and groups, particularly where there is supported access when required, this can impact positively on all aspects of people's lives.

Examples of work undertaken in Tayside to develop this include:

- The use of **web based information systems** to support both self referral and professional referral based on ALISS infrastructure in Angus and Perth and Kinross.
- Dundee has funded the **co-location of welfare rights officers in practices** allowing clinicians to book patients directly to see the welfare rights officer. The officer has access to relevant medical information, with the person's consent, simplifying processes for a range of financial benefits, including PIP and DSA. This work has been evaluated very positively including a reduced impact on clinician time.
- The role of **link workers**, well evaluated nationally, with a well established model in Dundee. There is a social prescribing model that is currently operating in Angus practices with developing work within Perth & Kinross. These roles will be expanded across Tayside, using a range of models which fit local needs, as one of the priority areas of this improvement plan.

The positioning of care and treatment services locally within communities will also assist by providing better and more local access to care which can be augmented by embedding other community services such as social prescribing within the same location.

Tackling inequality

Through the improvements described within this plan, as well as NHS Tayside and HSCP strategic plans, we will:

- Encourage and support a more flexible appointment length for practice appointments for those with complex, socioeconomic or disability issues
- Increase the amount of social prescribing undertaken at practice level
- Continue to develop social prescribing support through a number of teams, including link worker models, wider social prescribing support, welfare rights and volunteering opportunities
- Continue to develop mental health resources within the community supported by the resources associated with Action 15, ensuring that it is tailored to meet the needs of our deprived and vulnerable populations to improve their resilience
- Develop the links established through local planning groups, ensure we work in a coordinated way to meet local health needs
- Build in Equality Impact Assessment in to all our developments
- Promote prevention at as early a stage
- Work with local people to promote a culture of proactive community support, to improve resilience and reduce social isolation.
- Encourage GP clusters to consider how they plan for, evaluate and address inequalities for their local population.
- Actively adopt technologies which increase accessibility and affordability of services. e.g. Florence or Attend Anywhere.
- Make better use of the information available at Tayside and HSCP levels to ensure that we are targeting our resources at those most in need.

An element of the investment supporting these goals will come through existing work planned by HSCPs, local authorities and NHS Tayside. A further element will come through the investment in community link workers associated with this PCIP and the additional funds linked to the Action 15 funding stream for mental health services described in the finance section below.

However, if we are to see the greatest impact on reducing the health and social care burdens associated with inequality we need to embed the cultural changes referred to above throughout all the workstreams described within this document.

Barriers and Opportunities

This PCIP describes a radically different future for primary care from the present in which we now live. It describes an expanded workforce that does not currently exist, with competencies that we have not yet fully described, working in part from premises that have not yet been built or developed, with an IT infrastructure that is not yet readily available. Funding information is relatively limited in extent and is being released at a time that NHS Tayside is encountering significant financial strain and requirements for contraction of spend. Funding sources for the PCIP will need clearly defined with appropriate staff and resources moved across the health and social care system as services are delivered within the community in new and innovative ways. There is an opportunity for greater efficiency of resource usage through innovation and close working between clinicians and managers in a clinically led and directed service.

An additional external pressure within Tayside relates to the early adoption of the link worker scheme within Dundee. This scheme was initially funded separately by Scottish Government but is now expected to come from the resources allocated to the implementing the PCIP. The Government recognised when they made that choice that this might disproportionately impact on HSCPs that had successfully applied to this scheme and therefore gave authority to HSCPs to work jointly to manage this.

The Government have directed that HSCPs and Boards should take note that the continuation of the early adoption of the link worker scheme should be considered to be a priority, whilst leaving it up to HSCPs to decide whether there is a need to change the scope, oversight, employer or lead responsibility for these posts. Discussions regarding how this scheme will develop are ongoing.

This PCIP seeks to coordinate the activities of our 3 HSCPs, the Health Board and an array of services hosted, managed and reporting to a variety of locations across NHS Tayside in a complex reshaping of care clinically led by 13 different GP clusters with a requirement to take into account the needs and views of the 416,000 patients we all serve. The scale of the challenges we face should not be underestimated and the efficiency and speed of decision making and progress should not be fettered by blunt instruments designed for a previous era of healthcare delivery.

We have an opportunity to develop systems of care that enable patients to have access to services close to their home and to be flexible to deal with patients that may live across either Board or HSCP boundaries in a way that ensures the patient is the focus.

The HSCPs and NHS Tayside have a responsibility to monitor, evaluate and report on the impact of the plan to Scottish Government whilst the Government's reporting requirements continue to evolve.

It is almost inevitable that the outcome we will see in 2021 at the culmination of Improvement Plan will differ in part from that which we are seeking to describe in 2018.

The key opportunity this PCIP brings is a massive catalyst for change and development. Whilst envisaged as a means to improve the sustainability of General Practice, it also offers a tremendous chance for other professions to develop into new, enhanced, and more rewarding roles. It allows those in existing roles to be facilitated to develop further having their skills recognised and utilised appropriately.

The changes, and possible redeployment opportunities, arising as part of NHS Tayside's financial recovery, offers the prospect of the release of an already highly skilled workforce, largely based within Secondary Care, into the new services described within this plan. This has potential to provide us with some of the capacity to meet our new and emergent needs.

The release of General Practitioner time to develop into the role of expert medical generalist allows both health and social care services to tap into an additional clinical resource that can support our evolving multidisciplinary teams to provide better care for patients. The GP Clusters will have increasing opportunity and responsibility to shape the quality of service delivered in their locality and will be facilitated by accurate, timely and relevant information delivered through comprehensive IT and data service support, both locally and nationally.

The improvements in IT infrastructure which this plan describes represent an opportunity to ensure better, safer and more efficient communication between primary and secondary care; more local care for patients; and for more coherent specialist clinical management of complex patients by those who have the expert knowledge to do so.

There will be an opportunity to focus on ensuring the principal of 'single entry' delivering appropriate sharing for clinical and care recording reducing and eliminating the risks identified through data transcription that exists currently.

Finance and Resourcing Principles

The changes described in this Primary Care Improvement Plan offer an opportunity to reshape our local healthcare system. The development of Care and Treatment Services; enabling an efficient and safe local IT infrastructure; and the augmentation to the nursing, pharmacy, physiotherapy and other healthcare services described are a catalyst to further improve services not covered directly within the Plan but reflected in the Strategic Plans of each IJB. There is a real opportunity, over time, to move services currently delivered in hospital settings closer to where people live; and to augment social care services by linking them more intimately with healthcare provision.

While the Primary Care Improvement Fund is designed as a facilitator to enable and accelerate change with the intention to provide direct support to General Practice. This funding stream can be, and may need to be, broadened by extended local re-modelling of other services to deliver the broader strategic plan for Primary Care.

The programme of investment and improvement outlined in the Primary Care Improvement Plan will be supported by funding made available by the Scottish Government as part of the Scottish Government's overall commitment to increase Primary Care Funding by £250m by 2021/22. The General Medical Services contract document is clear in stating that the funding streams agreed with the profession are for the direct support of general practice.

Primary Care Improvement Funding has been made available at an IJB level and, while funding has only been confirmed for 2018/19, overall national funding is planned to increase from c£46m in 2018/19 to £155m in 2021/22. The funding available locally is assumed to be as follows:-

	2018/19	2019/20	2020/21	2021/22
	£k	£k	£k	£k
Angus	986	1185	2370	3340
Dundee	1355	1630	3259	4592
Perth	1249	1502	3004	4232
Tayside	3591	4317	8633	12165
Scotland	45750	55000	110000	155000

While funding has been made available at an IJB level based on NRAC weightings, locally it is acknowledged that much of the investment will provide direct support to General Practices and therefore differential weightings may be required. It is also recognised that IJB's have the ability to collaborate where appropriate at a regional level and examples of this would naturally include areas where it is acknowledged that regional development is both necessary and an efficient use of funding (e.g. development of a core process for use of Care and Treatment services or engagement of appropriate levels of professional advisory and project management support).

At this stage in the development of local plans, allocations to specific outcomes have not yet been agreed and this will remain under development and subject to local prioritisation and approval. Scottish Government have stipulated that they require a progress report, including financial details, which must be submitted by September 2018. These will include Local Medical Committee approval in relation to monies provided for direct support of general practice and the implementation of the GMS 2018 contract provisions. Costings mentioned within the workstreams should therefore be regarded as indicative rather than as confirmed.

Within overall plans issues such as impact on premises, IT and other support will be considered along with the impact of existing local commitments (e.g. “early adopter” link workers) and the cumulative impact of inflation. Specific requirements of this funding stream including it not being subject to savings measures or being used to address wider funding pressures will be adhered too.

While in the first year of the Primary Care Improvement Plan overall investment will be dependent on early clarification of plans and ability to quickly recruit to any new posts, in the longer term it will remain challenging to deliver the overall plan within available funding.

However, there is also recognition within the Primary Care Improvement Plan that additional sources of funding may also be available to provide further support including:-

- Mental Health Strategy : Action 15 funding , to improve access in settings such as Accident & Emergency, General Practice, Police custody settings and Prisons.
- GP Out of Hours Funding
- GP Recruitment and Retention Funding.

Tayside	2018/19	2019/20	2020/21	2021/22
	£k	£k	£k	£k
Mental Health (Action 15)	863	1334	1884	2511
GP OOH Funding	392	392	392	392
Recruitment & Retention	TBC	TBC	TBC	TBC

Governance

The ethos behind the Primary Care Improvement Plan (PCIP) is that it should be locally owned, reviewed and implemented whilst being regionally approved and nationally monitored.

Integrated Joint Boards are responsible for commissioning the PCIP and must be confident that it is fit for their local population and that it is being implemented equitably and effectively. All three Tayside HSCPs are committed to working together to deliver the best PCIP for the people living within NHS Tayside. The GP Sub is similarly committed to ensuring that the PCIP fosters a stronger, more sustainable primary care system for our patients.

The delivery of the PCIP will be embedded within the strategic development and improvement plans of the HSCPs and of NHS Tayside. This is essential to maximise the whole system improvement that the 2018 GMS contract offers.

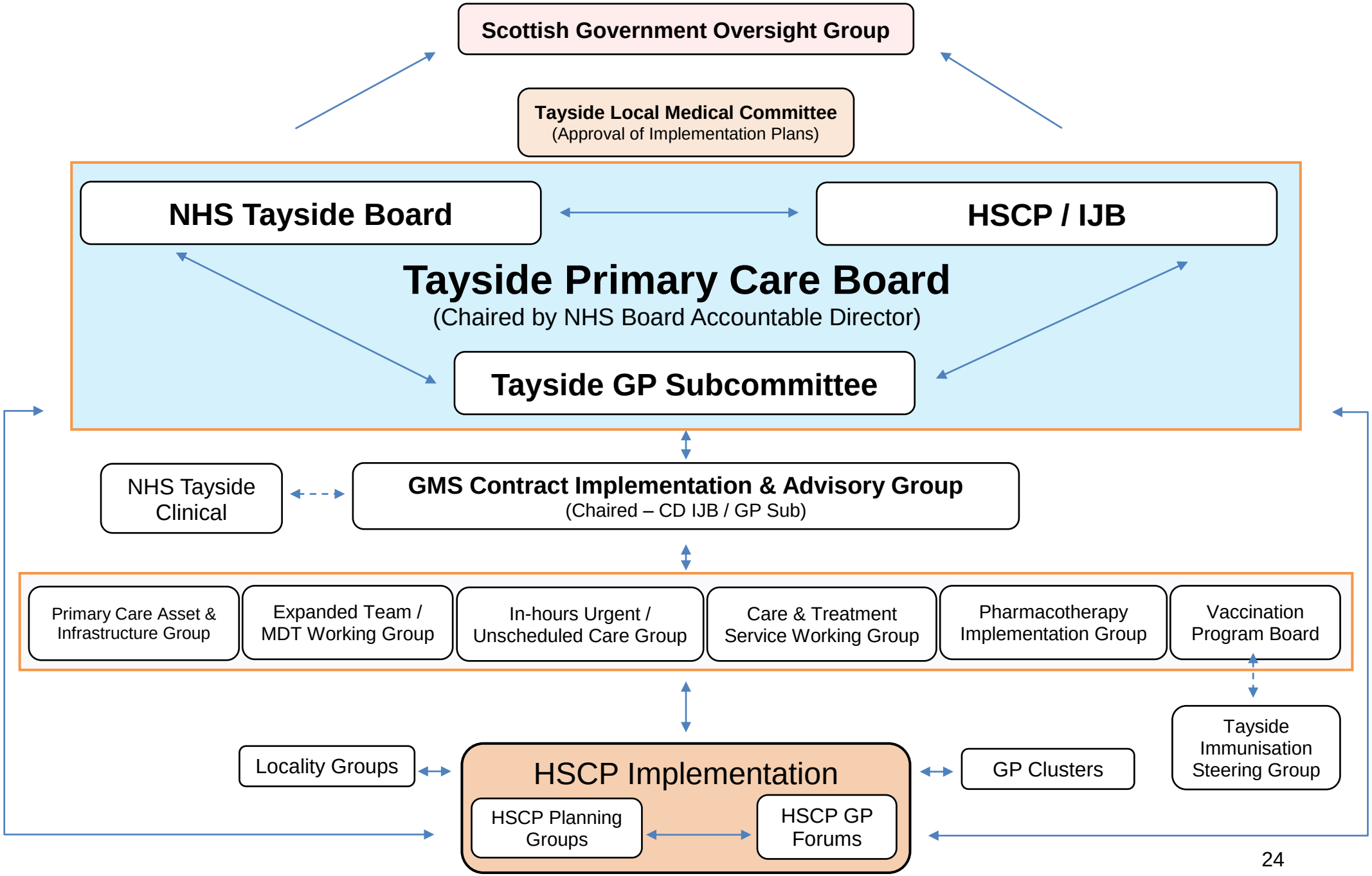
Development of the Plan

Each of the different work streams outlined in the following sections was developed on a regional basis with inputs from each HSCP, NHS Tayside and with Clinical Expert support and GP Sub collaboration. A group entitled the GMS Contract Implementation & Advisory Group (GMS CIAG) was set up for this purpose. This ensured efficient use of resource and an improved ability to generate common understanding of challenges and achieve expeditious solutions.

Ongoing national and regional monitoring of the PCIP

GMS CIAG's role is not confined to the generation of the PCIP. It has an ongoing role in monitoring and evaluating the outputs of the PCIP. Each regional work stream will continue to report to GMS CIAG. GMS CIAG's membership comprises healthcare professionals and service leads; representatives of the GP subcommittee; managers and clinical directors from the Health and Social Care Partnerships; and the Associate Medical Director for Primary Care and Primary Care Department Managers. GMS CIAG should act to facilitate communication between multidisciplinary teams, ensuring that all are supporting each other through the challenge of implementing the PCIP. GMS CIAG reports on progress and barriers to progress to the Tayside Primary Care Board. Quarterly funding status reports must be brought to the Primary Care Board with funding approved also by the LMC. The Governance flow diagram below presents this structure graphically.

Updates on the PCIP's progress must be sent in periodically to the National Oversight Group. This national group is comprised of representatives from the Scottish Government; the SGPC; Integration Authorities (HSCPs) and NHS Boards. It is responsible for overseeing implementation of both the GMS 2018 Contract by NHS Boards and Primary Care Improvement Plans by HSCPs. This will include focus on delivery of clear milestones for the redistribution of GP workload and the development of effective MDT working, including with non-clinical staff.


Scottish Government Oversight Group
Tayside Local Medical Committee
(Approval of Implementation Plans)
NHS Tayside Board
HSCP / IJB
Tayside Primary Care Board
(Chaired by NHS Board Accountable Director)
Tayside GP Subcommittee
NHS Tayside Clinical
GMS Contract Implementation & Advisory Group
(Chaired – CD IJB / GP Sub)
Primary Care Asset & Infrastructure Group
Expanded Team / MDT Working Group
In-hours Urgent / Unscheduled Care Group
Care & Treatment Service Working Group
Pharmacotherapy Implementation Group
Vaccination Program Board
Tayside Immunisation Steering Group
Locality Groups
HSCP Implementation
HSCP Planning Groups
HSCP GP Forums
GP Clusters

Local implementation and monitoring of the PCIP

Each Health and Social Care Partnership owns its own Improvement Plan and monitors it locally, reporting back to its Integrated Joint Board, and holding councils and health board to account in ensuring the timely implementation.

Professional and Care Governance is critical to the protection and improvement of high quality service delivery. Local and regional governance structures will be refreshed to ensure that they are clinically focussed providing guidance to the emergent new landscape of primary Care Delivery.

As workstreams are delivered at local level many of them will have and develop interdependencies with other services that will vary according to local circumstances. It will therefore be necessary to work with GP clusters, patients and other stakeholders in ensuring that robust, locally owned plans are developed, approved and implemented.

Cluster role in implementing and guiding the PCIP

Each HSCP has aligned its structures into locality units. Each of these has a grouping of General Practices forming a 'Cluster'. GP clusters, with identified quality leads from each GP practice (PQLs), have a clear role in quality planning, quality improvement and quality assurance. Their core functions include an intrinsic focus to improve clinical care quality for their practice populations through peer led review whilst also providing meaningful influence the local system on service function and quality. Quarterly service provision reports will be made available for review by clusters to ensure quality and consistency and reassure of service development across all areas.

Each Cluster has an identified lead GP. These Cluster quality leads are an integral part of locality improvement groups which, in turn, feed into HSCP Strategic Planning Groups responsible for service commissioning. GP clusters also feed into the local Clinical, Care and Professional Governance Forums which report to both the Integrated Joint Boards, and through the Clinical Quality Forum to NHS Tayside Board.

This model of engaging GPs within clusters, and cluster leads within HSCP structures is consistent with the contract's call for GPs to become expert clinical generalists playing a clinical leadership role in the design of services along with other professional colleagues.

Interface Issues

The PCIP is being implemented at a time when there is a wider set of changes to flows of work across Primary and Secondary systems. Inevitably without good communication across these systems we will not be able to achieve the best outcomes for our patients. A new Primary : Secondary Care interface group is being developed to address these issues.

This is supported at NHS Tayside level with the appropriate recognition and authority to influence pathways of care for patients across the Generalist / Specialist and Community / Hospital interfaces. This will assist in turn the realisation of the Primary Care Improvement Plan's core aim of maintaining and improving the quality, efficiency and effectiveness of the care delivered to our population.

Future of the PCIP

The Improvement Plan is a living document. As services develop, new staff are employed, new premises and new ways of working are developed, it is inevitable that the Plan will change. At each stage of this development, further engagement will be required, including sharing ideas and working in partnership with various staff side and professional bodies. Although this Improvement Plan is for a three year time period, it will be reviewed many times over that period, ensuring it is on track and adapting as necessary. In keeping with that ethos, the Scottish Government has mandated that there will be at least annual formal review of the Plan. Within Tayside HSCPs, NHS Tayside and the Local Medical Committee are committed to ensuring that our PCIP is current, effective and responsive to the changing needs that will emerge over this time.

Evaluation & Monitoring

We will require a robust evaluation of the implementation of the PCIP across its three year lifespan. This is partly to identify the benefits that it will bring; partly to identify where a change in priority or direction is required and partly to identify where investment needs to be focused differently.

There will need to be tests of change and pilots as part of scoping for new services. These will require review and evaluation to ensure that they are capable of being scaled up, and that adequate information is available to ensure efficient and effective development and delivery of services.

Each priority area will identify a set of 'SMART' measures and hard objectives with which to monitor progress towards implementation and drive further improvement and development.

Evaluation will involve community and staff consultation in addition to quantitative and qualitative analyses.

There is a need to provide a suitable, timely and robust project and programme management resource to each HSCP area with the allocation of adequate business development and change management resource to allow for the initiation, monitoring and evaluation of local projects.

There will need to be a fundamental bolstering of resource to support HSCPs, primary care managers, and other workstream teams through this period of implementation to allow them to adequately support the clinically led delivery of the Plan.

As identified in the MoU and further clarified in the Funding Allocation letter, there must be a commitment to adequately resource this support as well as the required professional advice and support of the GP Sub and work of the Cluster GP leads in driving forward quality improvement at local level.

Workforce

Introduction

The PCIP describes fundamental change in Primary Care. It describes change in how healthcare is delivered, who delivers it, where it is delivered and how that care is organised, communicated and contracted for.

This change in how Primary Care is provided means that there will be a necessary requirement to change the primary care workforce that we currently have into the one that we will need for the future. Our future workforce will require new and differing competencies and skills to do the new and interesting tasks that are new to how we have worked before within Tayside.

Requirement for a comprehensive workforce plan

We need a Tayside wide workforce plan that takes us from where we are to where we need to be. This necessary transition requires the development of a robust workforce development programme. This programme must ensure that we possess within our workforce the competencies, skills and scale of workforce to deliver our new future.

There is a need to develop and enhance the existing skill sets of almost all staff involved in the care of our community, from Advanced Nurse Practitioners to Paramedics, Physiotherapists to Administration team. New skills and job descriptions that have yet to be defined will undoubtedly emerge as we implement this challenging but achievable Implementation Agenda.

To support this development there is commitment to break down barriers in recruitment, facilitate the streamlining and efficiency of grading processes and develop and invest in the necessary training resources required to develop our future workforce.

Employment arrangements of our workforce

There is a separate challenge as tasks previously performed by GP contractor employed staff become the responsibility of Board and HSCP employed staff, while aspects of necessary day to day clinical direction of the workforce remains with the GP. While this presents a new operational challenge, it is nonetheless critical to the risk reduction promises within the new GMS contract for independent contractor GPs.

Development of the wider workforce

The workforce development plan, as it develops, will outline a set of developments over a wide set of professional groupings. The Improvement Plan describes fundamental changes in scale, skills, and competencies within the nursing, pharmacy, physiotherapy and paramedic professions. If that is to be delivered within the ambitious time targets we have set ourselves, then we must not only describe how we address recruitment and training; but also address the contractual, trade

union and other employment issues that will inevitably follow from the new roles, new means of employment and new skills needed from our workforce.

Developing the workforce plan: identifying the existing workforce

Recruiting, developing and retaining our workforce against a backdrop of vacancies across Tayside, retraction occurring within secondary care, demographic pressure within the workforce itself and pre-existing pressure within the healthcare environment to develop new skills and roles is challenging. This is even before we consider the new roles and needs that the PCIP will bring.

We have at present only partial knowledge of our total current workforce, with only limited information about those employed by GP practices. At present we do not have central clear current knowledge of the head count, whole time equivalents, grades or competencies of those employed within practices across Tayside
In order to plan the transformation of this workforce it is essential that we possess baseline information on the current state position. This needs to cover:

- Current roles and numbers.
- Current skills and skill gaps.
- Required staffing models for primary care based on population differences and need.

One of the first actions in planning our future workforce therefore must be finding out the attributes and disposition of our current one. This should then allow us to identify where gaps are likely to exist, and allow us to plan how to recruit and train so that we can progress towards the workforce we require. In order to do this, we plan to survey both GP practices and existing primary care services over the 2018-19 period to establish a comprehensive picture of our current state.

Developing the workforce: identifying the future need

The needs of our future workforce are necessarily dependent on the following factors:

- the scale of the services that we plan to offer
- the locations at which are staff are employed
- the models chosen of how we employ our staff
- the models chosen of how we operate our services
- the models chosen of how our services will work together
- the availability of staff
- the new needs and skills our staff require to perform their roles
- the need to recruit and retain staff
- the opportunities to use staff more flexibly across services
- the financial envelope available

In recognition of the scale of the challenge we face, GMS CIAG has set up an expert led, professionally supported working group to collate and review these factors to produce early recommendations of where change or investment is required. There will be direct input into this group from the service areas impacted upon by the PCIG. Recommendations from this group will be sent to the Primary Care Board, the HSCPs and NHS Tayside for review, consideration and necessary action and approval.

Premises

Introduction

The work performed under the new Improvement Plan will require workplaces suited to the needs of patients and staff, with IT links that support the delivery of that care, and which operate within structures that provide for the safe communication of the results of that care into the patient record and back to those who have requested that care be performed.

While there are existing premises that are owned or managed by NHS Tayside and our local councils, there will be an increasing need to provide workplaces within local communities to perform work previously done within practices. With limited capital funding we will need to make the best use of those premises we have, consider where it is practical to use space within practices, and consider where new buildings are needed.

The PCIP recognises that the provision of appropriately located and designed premises linked by an effective IT infrastructure is critical to the development and delivery of improvement of Primary Care within our communities.

GP practice estate

The new GP contract recognises that asking GPs to own their own premises or to hold a lease that may commit the practice to paying rent for decades into the future places significant risks on General Practitioners and may discourage new partners from joining the practice when older GPs approach retirement. The contract therefore states that the ownership of leases and of premises should move from GPs to Health Boards. The effect of this change will be a substantial reduction in risk for GP partners in Scotland, which should lead to a substantial increase in practice sustainability and hence result in better care for patients.

GP Owned Premises

New interest-free sustainability loans will be made available, supported by £30 million investment over the next three years. GP contractors have been informed of the priority categories for applications and requested to provide notes of interest by 25 May. The District Valuer has provided refreshed estimates of the existing-use value of GP owned premises and the intention is that these will be provided to GP contractors before the scheme opens.

The GP Premises Implementation Group have met and agreed broad principles for the loan documents. There will be discussions with BMA and NHS representatives on the detail of the loan documents with a view to all parties reaching agreement. The plan is to open the scheme once the detail of the loan documents has been agreed.

GP Premises Survey

Health Facilities Scotland has prepared the High Level Information Pack for bidders for the survey contract and an assessment panel is being identified. Health Boards have been asked to confirm that the list of properties to be surveyed is correct.

GP Leased Premises

The Scottish Government's long term strategy is that no GP contractor will need to enter a lease with a private landlord for GP practice premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises. NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions.

There are three ways in which NHS Boards can take on the responsibility of providing a GP contractor with practice premises. These are:

- negotiating a new lease for the GP contractor's current premises, with the NHS Board as the tenant
- accepting assignation of the GP contractor's current lease
- providing alternative accommodation for the GP contractor when its current lease expires

If a lease expires before 1 April 2023, the most likely course of action is for the NHS Board to negotiate a new lease or provide alternative accommodation.
If the lease expires after 1 April 2023, NHS Boards will take on the existing lease from GPs where:

- The practice has ensured that its premises are suitable for the delivery of primary care services and are sufficient to meet the reasonable needs of its patients
- The practice has met its statutory obligations regarding the premises
- The practice has provided all relevant information to its NHS Board
- The practice has given sufficient notice to its NHS Board of its need for assistance
- The practice has registered the lease with the NHS Board
- The practice has the agreement of the landlord to the assignation of the lease (and the other necessary conditions)
- The practice has complied with its obligations under its existing lease
- The rent represents value for money

Current GP Premises Portfolio for Service Provision

GP practices currently operate a range of premises models in Tayside. The models vary in form and include large teams operating from independently leased purpose built facilities using private sector funding, wholly owned premises or mortgaged by the independent contractor, through to Board owned / leased premises.

There are 64 GP practices operating their main surgeries from 54 sites across Angus, Dundee and Perth & Kinross. With respect to sites these sites:-

- 13 are Board owned / leased premises sites
- 24 are premises leased from third party developers (including PFI)/ private landlords
- 17 are owner occupied premises

In addition to this GP practice estate there are a number of Board owned or leased premises, such as community hospitals and community care centres, embedded in the community which may be able to support delivery of the new services, specifically where there location facilitates local access for patient.

At present NHS Tayside occupy space within 37 practices supporting the delivery of community nursing services and anticoagulation clinics.

Planning for the future non-GP Primary Care estate

This Improvement Plan also describes a shift of work from General Practitioners to other healthcare professionals, many of whom will be located outside of General Practices. The Plan describes new services that will be developed; and existing services that will be enhanced. This section therefore also describes how we will ensure that we have premises fit for these new services and these new workers.

Although the Improvement Plan comes with significant resource aimed at shifting work from GPs to other healthcare professionals, it does not come with a capital allocation for the development of new premises for our new workforce to work in.

NHS Tayside has established an Assets and Infrastructure Programme Board with the purpose of developing, implementing and reviewing the regional primary care strategy for assets and infrastructure. This will pull together both national and local strands to develop a coherent strategy that provides the necessary infrastructure and premises to meet the needs identified by each of the Health & Social Care Partnerships.

NHS Tayside and our local councils own or manage a range of existing premises. However, it is recognised that the current premises portfolio is not designed to meet the needs of GMS 2018 or those of the extended multidisciplinary teams that will be

developed both within GP Practices and their localities. Premises provision has to date developed individually at a local level to meet local needs and has not been seen as part of a strategic plan.

There will be an increasing need to provide workplaces within local communities to perform work previously done within practices. With limited capital funding we will need to make the best use of those premises we have, consider where it is practical to use space within practices, and consider where new buildings are needed. It is important to realise that premises will not be replaced on a like for like basis.

There is a need for additional premises to support delivery of the services within each HSCP's improvement plan, in particular to provide locality hubs and care and treatment centres. The strategy will recognise HSCP priorities arising as a result of each of the phases in their three year implementation plans with initial delivery likely to be from existing facilities. Premises milestones will be mapped out for each phase and element during implementation of the plan.

The implementation of NHS Tayside's premises strategy will be underpinned by the national perspective which recognises that that the general practice estate needs to be considered as an integral part of the local care estates and planned for and invested accordingly, recognising that it is unrealistic to expect GP practices to fund new primary care premises.

Actions

NHS Tayside will be required to:

- Implement a detailed work programme to inform their strategy.
- Quantify the premises requirement and seek to establish optimum locations to meet the needs of the service.
- Develop a complete register of the estate available both within Health and within Social Care
- Prioritise the development of existing premises and the development of new premises to meet the needs of the Health & Social Care Partnerships

There are significant funding challenges attached to the development and implementation of the premises strategy to support delivery of services including; the need for capital investment, revenue funding to support function, space and quality surveys across GP Practices and funding to support lease transfers.

IT Infrastructure

Introduction

This PCIP describes a future where work is moved from General Practitioners and from GP practices to other healthcare professionals who may be working in other locations. This cannot proceed safely without IT systems that capture that work into the patient's core GP record.

Our IT systems need to be able to connect and communicate across primary care, and into secondary care. We need systems that can allow both primary and secondary care clinicians to appoint patients where and when they need to be seen. We need IT processes that return necessary clinical information about test results and procedures to those who have requested them.

Most medical error takes place when communication fails, and the future we are constructing will only work if our communications structure is robust. It is essential therefore that we develop safe and effective communication links that operate within safe, effective and well understood processes that work for both primary and secondary care.

This section describes the work that we are doing and the work we need to undertake to make sure that our population receives the safe, efficient and high quality healthcare it requires in the future described within this Improvement Plan.

Tayside's eHealth Programme

Tayside's eHealth programme recognises the role that technology will have in enabling the changes required to support the implementation of the GMS Contract, the NHS Tayside Improvement Plans and assist in the deliver for Primary care Transformation.

This support will cover the 6 key service areas identified in the GMS Contract:

- vaccination services,
- pharmacotherapy services,
- community treatment and care services,
- urgent care in hours services
- additional professional roles (MSK, Mental Health)
- community link worker services

The strategic aims of the national eHealth strategy remain in support of this work and are to:-

- enhance the **availability of appropriate information** for healthcare workers and the tools to use and communicate that information effectively to improve quality
- support people to communicate with NHS Scotland, **manage their own health and wellbeing**, and to become more active participants in the care and services they receive
- contribute to care integration and to support people with long term conditions
- improve the **safety of people taking medicines** and their effective use.
- provide clinical and other local managers across the health and social care spectrum with the **timely management information** they need to inform their decisions on service quality, performance and delivery
- maximise **efficient working practices, minimise wasteful variation**, bring about measurable savings and ensure value for money
- contribute to innovation occurring through the Health innovation Partnerships, the research community and suppliers, including the small and medium enterprise (SME) Sector

Key Principles

The following key principles will be used to evaluate and support implementation for the services in scope. These guiding principles, while apparent, are worth stating and include:-

- The need to provide services with access to an appropriate electronic health record to ensure relevant information is available at the point of care to aid clinical decision making.
- The solutions and systems will be prioritised against those already invested in by NHS Tayside, the North of Scotland region and nationally.
- The intention is to capture data once, but make it available for viewing and use at multiple stages in the provision of 6 key service areas – providing efficiency
- The design and build of the services should be applied consistently for Tayside, where clinically safe to do so. Variation will cause complication and result in difficulties in implementing solutions/systems and ensuring continuous improvement.
- The ability to refer and commission the services in scope of GMS contract will be phase through Primary, Secondary and Community care and likely Local Authority MDT Personnel and contractors, with Primary Care being the priority. Implied in this is Secondary and Community care will maintain an as

is position for accessing these services during the delivery of the primary care phase.

- Solutions and systems need to be clear, easy to use and have a simple ability to ensure patients are safely referred into and transferred across services. Having a consistent model for the service delivery model across Tayside will be a determining factor for this.
  Already at this early stage it is apparent that the technology to support business process will need to be provided by multiple systems. All stakeholders and users will require to directly engage with these systems.
- The ability to remain agile and flexible to emerging requirements is essential during the period of implementation and will require assessment when considering any 3rd Party providing support.

Out of Scope

Infrastructure Items – It is expected that the Primary Care Assets and Infrastructure group, will be responsible for the implementation of any infrastructure changes required to support the full GMS Implementation Programme. For the eHealth element this would be expected, where assessed necessary, items such as network capacity and coverage and End Point availability.

Current Priorities

There are five priorities for the eHealth Programme:

Priority 1 – to understand and document the business processes required to support the Tayside plan.
Priority 2 – consider the delivery model proposed by the different
Priority 3 – develop a joint mapping process to formally assess existing systems and solutions to map their ability (current and future) to support the implementation.
Priority 4 - carry out an assessment of capability or improvement necessary to support the implementation.
Priority 5 – carry out prioritised work-packages to realise changes to support delivery of solution/systems to the services in scope.

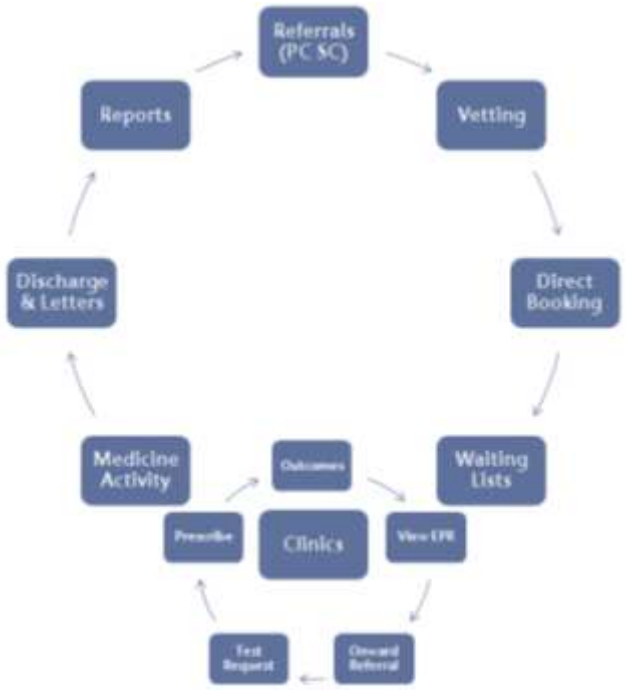
A proposed categorisation is as follows:-

Red	Supplier has no formal plan to provide this functionality in their product – i.e. not on a published roadmap
Amber	The supplier has a plan to provide this functionality or is running a test of change to help its development. Should also include functionality that is in use in other markets but has not been used in Scotland. That test of change could be in place in NHS Tayside/Scotland
Green	The supplier has the functionality in their current product set and this is working/functioning in live sites in NHS Scotland
Blue	NHS Tayside are currently using this functionality at present

Aims of Solutions and System

As well as their support of the guiding principles the solutions will be required to cover the range of high level processes detailed in *Figure 7 – High Level Business Processes*. These processes will be considered for every service level and require a significant investment in resource to understand the requirements. The processes need to be capable of being initiated by Primary Care (Phase 1) followed by Secondary and Community Care (Phase 2) and likely Local Authority MDT Personnel and contractors (Phase 3)

Figure 7 - High Level Business Processes



Current Projects and Early Milestones

Project Name	Project Description	Benefits	Current Status
Letham Federated Working	A solution was required to support a hub model agreed to provide MDT services to the population of Letham	• Ability to present patient details from multiple practices in a single view • Ability to record clinical updates in a system • Ability to provide these updates within the practice system in a timely manner • Presentation on the costs model associated with this working method • Information Governance model for sharing • Evaluation of benefits for this project	Test of Change **Closure**
Lochee Health Centre	The development of a 2c Practice and the merging of solutions and infrastructure to support a more modern delivery of hosted solutions, similar to a future GP IT Re-provisioning model	• Supports multi-agency working and health and social care agenda. • a blueprint for future primary care premises supporting GP IT Re-provisioning and new GP contract.	**Initiation**
Technology Care Fund	Through the national funding route for Primary Care Digital Funding. Practices are implementing, through choice, a range of technologies. These are:- **Clinical Coding** **Patient Text Reminder** **Mobile**	• assess the ability to reduce time spend coding and filing within the existing systems • Assess the impact on reducing waste through reduction in DNA's and releasing valuable clinical time. • Ability to provide offline working and update clinical records in a timely manner	**On Hold** **Execution** **Execution**

	WiFi **Patient Online Services** **Patient Portal**	• Provide a limited WiFi canopy in GP practices for use by MDT teams and for Patient Services • Provide ability to patient to make appointment and request repeat prescriptions, without the involvement of practice staff • Provide further access to self care management information	**Execution** **On Hold** **On Hold**
South West Angus	Test federated approach with 2 Angus practices in a virtual care and treatment centre	• Ability to present patient details from both practices in a single view • Ability to share appointments books • Ascertain solution suitability	Test of Change Request **Registration**
18/18 Care and Treatment	Requirements gathering and solution matching for Care And Treatment Services.	• Supporting access to and recording of relevant information within Care and Treatment Services in line with new GP Contract.	Test of Change **Initiation**

Other Active Projects that have dependencies

Project Name	Project Description	Benefits	Status
18/12 Extend Clinical Portal to all Pharmacies	17/92 community Pharmacies currently have pharmacists able to access clinical portal in them. This request is to roll this out fully and give access to clinical portal in the other 75 Community	• Ability to access Test results to support Pharmacy First and patients on drugs requiring monitoring eg. lithium • Ability to access Electronic discharge documentation (EDD): ▪ To support patients discharged from hospital	Initiation

	Pharmacy premises and their pharmacists.	who receive compliance devices from their pharmacy, ▪ In NHS crisis times where bed pressures exist to help with early supported discharge from hospital for medicines (required on discharge) to be dispensed through community pharmacy ▪ Support medication review of patients in care homes ▪ Emergency supply of medication required after hospital discharge as per community pharmacy unscheduled care PGD v 23 • Ability to Access to ECS – where necessary to facilitate an emergency supply of medication under community pharmacy unscheduled care PGD v 23	

18/06 Corporate CP Access to Staffnet	Provide access to staffnet in Community Pharmacy	To enable 18/12 Extend Clinical Portal to all Pharmacies	Initiation
17/40 Chronic Medication Service	Rollout of CMS to all Tayside GP/CP	The Chronic Medication Service aims to encourage joint working between GPs and community pharmacists to improve patient care by: • Identifying and Prioritising risk from medicines • Minimising adverse drug reactions • Address existing and prevent potential problems with medicines • Provide structured follow-up and interventions where necessary	Execution
18/67 Chronic Medication Service National Review Recommendations/Refresh	Refresh of CMS project		Request Registration
18/15 PCTP Assets and Infrastructure Dataset	Develop a comprehensive data set of information about all community based premises and their associated resources.	• Provide a solid base of comprehensive and accurate information on all aspects of GP premises and will underpin decision making process going forward.	Execution
17/139 AP Rollout (130 AP's) General Practice	Infrastructure Project to facilitate WiFI in General Practice	• To enable PC Digital WiFi Project	Execution

Enablers

The key enablers to support the implementation process mentioned below could be considered as deliverables for the Tayside Primary Care Board.

Information Governance – a data sharing arrangement needs to be put in place for the handling and control of patients' data currently retained by GPs but made available to NHS Tayside for use in clinical systems. The change required to enable this is defined in the following statement:-

> "*Both General Practitioners and Tayside NHS Board ("the Board") are Data Controllers in their own rights. For data that has been agreed for share and viewable in Clinical Portal or other Board clinical IT systems, General Practitioners and the Board will be Data Controllers in Common. The responsibility for "legitimate access" to the shared data will therefore rest with the employer of staff."*

Primary Care Assets and Infrastructure Group - this group is collating a data set that could be used to confirm locality approaches to providing services and solutions from the locations identified. It is also consider that this group, following review of their data set, would be in a position to recommend and implement infrastructure improvements in order to enable the provision of services and solutions as required by the plans. Examples of this would include Network connectivity for provision of solutions, patient video conferencing, Unified Communication platforms.

GP IT Re-provisioning

The deliverables through the GP IT Re-provisioning should be considered prerequisites and need to be controlled to ensure they support the delivery of the overarching work-packages that are key to the programs objectives. The timeline for this delivery will require NHS Tayside to adopt the services offered through the GP IT Re-provisioning programme during the three year programme.

It is also critical to successful delivery that NHS Tayside seeks to adopt single system coverage within GP Practices. Any movement from the current model will impact on timescales and budgets and will require resources to be diverted to providing the solutions necessary for the GMS implementation and will put at risk the ability to deliver this agenda.

The requirement from the GP IT re-provision must therefore be set to minimise the work associated with adopting the new model and minimise the degree of re-work associated with the test of change/current implementations. The potential scale of this work, available to be implemented from 2019, could divert significant resource and is a significant risk to all programmes of work in the scope of the GMS Contract implementation group.

Early discussion with the Primary Care IT Group, has confirmed this as a risk. A move towards a single system should be the considered as the key enabler to support the GMS implementation and reduce the risk of patient data not being available to clinical staff via electronic means.

Potential Risks

Resources – there is a risk that competing organisational priorities will result in resources having to be utilised in other projects or programmes during the 3 year period of implementation. Given the size and scale of many national programmes due to impact systems and solutions during 2018 – 2021, the risk is currently a likely (4) and would have a major (4) impact on the programme. This gives an inherent risk quantification of 16 High.

The mitigation to this is for the programme to procure dedicated programme and project management resource ensuring these resources are ring fenced for the duration of the programme. It is expected that the resourcing requirements will reduce during the 3 year period as the solutions commissioned move into a Business as Usual support model.

Dependencies – given the complexity of this programme and the number of dependencies and enablers are significant in number. Some, but not all of the dependencies are detailed in this paper, while others will be discovered as the programme moves through initiation. Key items mentioned are Data Sharing arrangements, Infrastructure Requirements, GP IT Re-provisioning etc. Given the number the likelihood of this happening is likely (4) and the impact, depending on the dependency, is moderate to major (3 – 4). This gives and inherent risk quantification of 12–16 High.

The mitigation to this is for the programme to ensure active management of the dependencies, to be clear with the responsible officers the criticality of these and to seek support of the Primary Care Transformation Board when escalation is necessary.

Supplier Management and System Maturity – there is a risk that the systems provisioned in recent periods within NHS Tayside either directly or through National Frameworks, were not specified to the requirements to be detailed as part of the GMS Contract. In addition, the agility of suppliers in the Healthcare sector to adapt and change their software has been limited either through resource challenges internal to the 3rd Party or a result of the solution being managed nationally. That said they are Healthcare system and so the likelihood of some business functionality not being available is possible (3) and the consequence moderate (3). This gives an inherent risk quantification of (9) or Medium.

The mitigation to this is to build on existing supplier relationships, leverage active procurement activities nationally, regionally and locally and provide regional pressure to suppliers where appropriate to adapt and tailor their software to the requirements. With this in mind the business requirements gather has been focussed on areas where there is suspected business process gaps e.g. Pharmacotherapy.

Financial Risk – there is a risk that suitable funding for solutions/systems is not available to provide the needs of the services. The risk if further enhanced given that the requirements is still to be understood and translated into licencing, implementation and support costs. In addition many of the systems will go through contract re-negotiation during the period of implementation. The likelihood of this risk occurring is considered possible (3) and the consequence to provide efficient electronic working practice is major (4) – given a risk exposure of high (12)

The mitigation to this is to move through the requirement process as quickly as possible so funding can be profiled and secured.

Governance

The design, testing and implementation of solutions (systems) and infrastructure serviced by eHealth will require clear guidance and decision making from within the governance structure. This structure is set out in NHS Tayside's *Delivering Primary Care Transformation & GMS 2018 Implementation* document and is assisted by a number of specific sub groups working with operational personnel responsible for the service improvement plans.

Funding

Additional funding will need to be provided to support implementation, licensing, integration and resources to support implementation.

The detailed funding model will require refinement as the service plans are translated to a system delivery stages, so are likely to be phased over the 3 year period. An early estimate is detailed below but subject to change.

The expected funding requirements are:-

Funding Item	Nature One Off/Recurring	Description	Estimate
System Licences	One Off?	Provision of system licencing costs and use	Unable to estimate
System Implementation Costs	One Off	Provision of 3rd Party implementation services	Unable to estimate
System Integration Costs	One Off	Provision of interfacing of data item to multiple systems	Unable to estimate
Activity Reporting Development	One Off	1x Reporting Consultant	£55k
Implementation Resources	On Off	1x Programme Manager 2 x Project Manager/Business Analysts 1 x Project Administrator	£450k
System support costs	Recurring	Annual Support and Maintenance Costs	Unable to estimate

Vaccination Transformation Programme

As part of a commitment to reduce GP workload Scottish Government and SGPC agreed vaccinations will move in stages from a model based on GP delivery to one that is NHS Board delivered through the development of multi-disciplinary teams. By 2021 almost all vaccinations previously undertaken in General Practice will be delivered this way.

In NHS Tayside we have been delivering most childhood vaccinations since 2016. The changes introduced by the new GMS contract provide us with the opportunity to extend our vaccination programme, to work collaboratively with other parts of the system to design models that increase the opportunities available for our workforce by developing attractive roles and build sustainability.

Introduction

The Vaccination Transformation Programme (VTP) is a 3-year Scottish Government led programme running from April 2018 to April 2021. The VTP forms one of a number of priority work-streams within the Government's programmes for Primary Care transformation.

The VTP seeks to develop and transform vaccination administration throughout Scotland. The main drivers for the VTP include the increasing number of vaccinations and complexity of schedules, transformation of school nursing and health visiting roles, re-establishing the role of general practitioners as expert medical generalists, and re-configuration of health and social care services including the formation of Integrated Joint Boards (IJBs) and Health and Social Care Partnerships (HSCPs).

Current Position

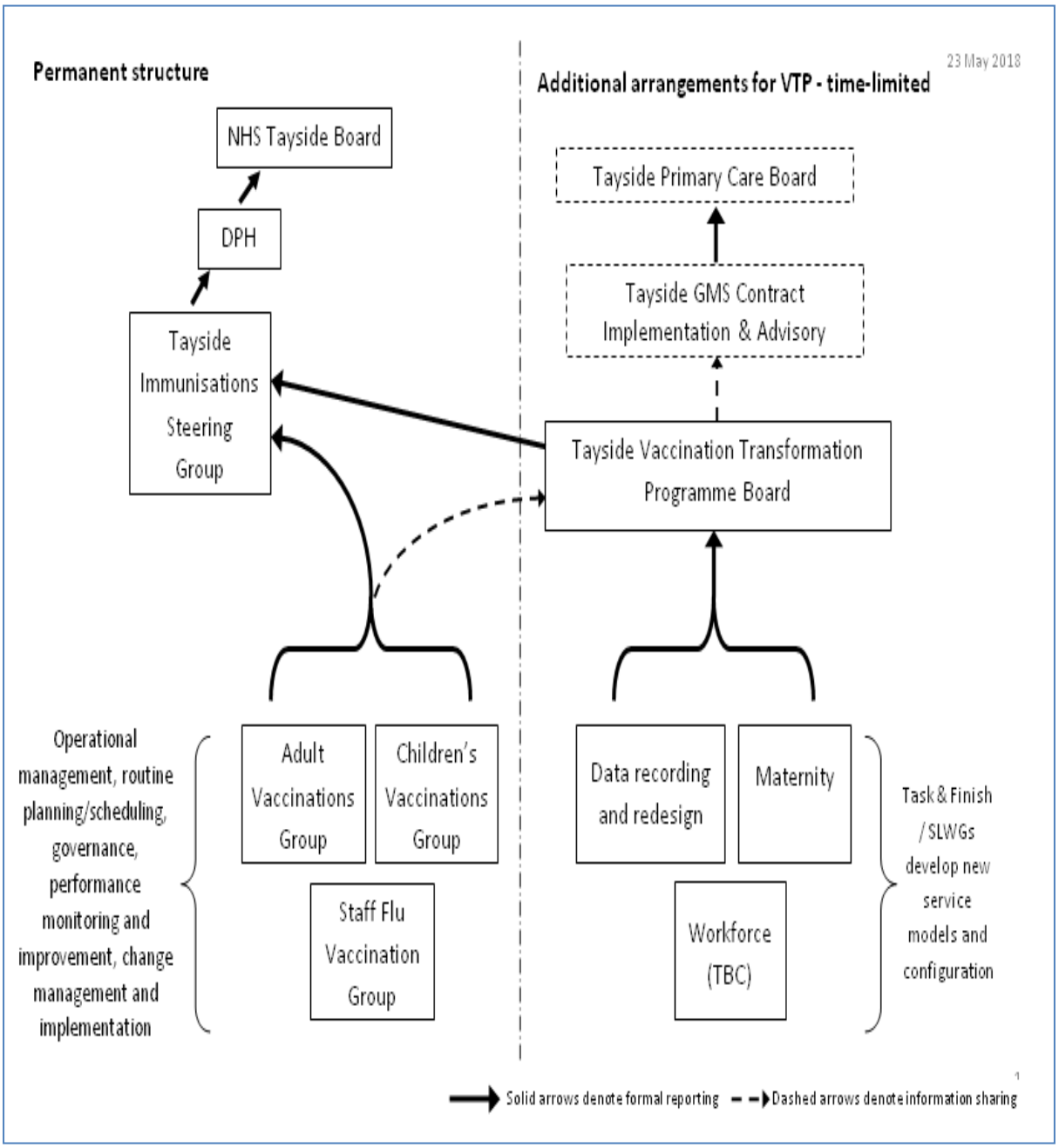
An NHS Tayside Children's Immunisation Service was formed in 2016, becoming operational in October 2016. The service delivers routine pre-school and school age primary immunisation programmes previously delivered by general practice, health visitors and school nurses. A recent review of the service and workforce identified positive benefits achieved and identified a number of challenges and areas for development. These include recommendations around workforce (staffing, cover, retention and career development); induction, CPD, supervision; clinical practice and travel/travel costs. Routine adult immunisations some catch up/mop up vaccines for children and selective children's and adult vaccinations are administered by a range of services in primary care, community pharmacy, specialist services and private providers.

Redesign Work already underway

Members of the VT Programme met with stakeholders throughout November and March to map out and agree a potential model for future vaccine delivery in Tayside and to develop the VT programme governance structure.

Governance & Monitoring

A multi-disciplinary Steering Group oversees immunisation governance, development and service delivery. The diagram below sets out the suggested synergy between current working groups and governance structures, the newly established VTP Board, and additional new working groups that may be required.



Future Vision

Following consultation, the agreed Tayside vision, is for an integrated comprehensive locality-based adults and children's vaccination service, integrated within HSCPs, operating within a single Tayside management structure. In line with IJB transformational plans, by 2021 this service should be coordinated around existing GP clusters, but with NHS directly employed staff and integrated within HSCP Care & Treatment Services (locality hubs) as part of the new model for primary care delivery.

This model provides opportunity for flexible roles, integrated service provision across primary and community care, and facilitates career development within the locality and services. Within immunisation therefore, individual staff roles may be flexible and negotiable, from dedicated child or adult vaccinators, to vaccinators for all programmes, to staff who deliver vaccines as part of a wider role. Other services and providers, including maternity, paediatrics and community pharmacies, will also have roles in delivering and contributing to specific vaccines and programmes.

Successful integration and future delivery of the VTP is dependent upon a number of factors being in place. These include integrated workforce planning between nursing, AHPs, Pharmacy and HSCPs, sufficient funding, additional resource, robust and integrated IT systems and premises.

Milestones

Year one of this Programme seeks to build on existing work undertaken within children's service delivery (0-19), with Years two & three seeking to take an integrated approach to service and workforce development in partnership with all HSCPs, GP and practice nurse services, Pharmaceutical, AHP and Nursing workforce plans therefore ensuring integrated service delivery within locality, primary care and treatment services.

The table below sets out an initial transition programme for vaccines in Tayside.

Year 1 (2018/19)	• Build resilience of the current Children's Immunisation Team and ensure that routine pre-school and school vaccines are provided in a safe and timely fashion. • Expand the remit of the Children's Immunisation Service to cover all children's vaccinations, including catch-up and mop-up doses for children with incomplete or unknown immunisation status; missed school age vaccines; children new to the UK; and immunisations of children with underlying medical conditions not routinely provided by a specialist service. Provision of adolescent booster mop-ups through community pharmacy may be considered as an interim arrangement. Pre-school influenza, travel vaccines, and those provided routinely by specialist services are specifically excluded from transitioning in Year 1.

	• Operational management of Children's Immunisation Service to remain with Children, Young People & Families Directorate. Begin to develop plans for redesign and integration within locality models and structures. • Begin to shift the responsibility for delivery of individual adult immunisations programmes away from General Practice e.g. vaccinations in pregnancy. • Expand community pharmacy administration of vaccinations for residents in Care Homes (e.g. influenza, pneumococcal, shingles) • Provide additional strategic Consultant PH leadership and project management to lead and develop and oversee the three year VTP programme. Seek to clarify any additional workforce implications within PH vaccination team.

There is less certainty as to the priorities for Years 2 and 3, as this will be shaped by Tayside VTP Board discussions, resource allocation, and the implementation of the PCIP in Tayside, as well as national progress and direction for specific vaccination programmes (e.g. Travel vaccinations and travel health advice).

Year 2 (2019/20)	• Pre-school influenza • Build on adult's service e.g. selective immunisations for at risk groups and individuals with underlying medical conditions or immunosuppression.
Year 3 (2020/21)	• Age related adult programmes (e.g. pneumococcal, shingles and influenza) • Travel N.B During the 3 year programme when it is safe and appropriate to do so, responsibility for the delivery of the majority of immunisation programmes will be transferred to IJBs.

Resource Requirements & Finance

A detailed costing of Year one of the programme has been developed and is currently being prepared for wider consultation. The cost of the first year of the programme is projected at £411k, divided between additional resource to deliver immunisations; administrative and managerial support to co-ordinate and manage the programme; and clinical input to guide it.

Barriers and Opportunities

The changes proposed for the delivery of the vaccination programme offer the opportunity for us to deliver services differently. We have the opportunity to build new and exciting roles for the team, away from purely being vaccinators. This development and broadening of the roles should help us meet some of the current difficulties and challenges we have been experiencing in the recruitment and

retention of staff. We will also have the opportunity to build the service around the newly formed care and treatment centres, which again should help to alleviate some of the challenges around staff travel and attracting staff to the role. In order to manage the complexity of the programme and the scale of the work detailed within the workstream there needs to be significant investment in clinical leadership and programme management support.

Evaluation of the programme

The VTP board is developing a range of evaluation measures as part of the implementation phase. These will include:

- Vaccination roles for specific vaccination strands
- Measures for staff such as recruitment &retention progress
- Staff experience
- Patient and Carers satisfaction
- Prediction of vaccination wastage and error rates

Pharmacotherapy

Introduction

The GMS Contract describes how by 2021 every practice will receive support from a new sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. This will allow GPs to focus on their role as expert medical generalists, improve clinical outcomes and support prescribing improvement work. This is in line with the professional aspirations of the Achieving Excellence in Pharmaceutical Care Strategy to integrate pharmacists with advanced clinical skills and pharmacy technicians in GP Practices to improve pharmaceutical care and contribute to the multidisciplinary team.

From April 2018, the pharmacotherapy service will evolve over a three year period with the aim that at the end of year three pharmacy teams will be integral to the core practice clinical teams delivering a consistent sustainable service. This timeline will provide an opportunity to test and refine the best way to do this, and to allow for new pharmacists and pharmacy technicians to be recruited and trained.

Over the three year implementation period, pharmacy teams will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

The table below set out in the new GMS Contract describes the service that NHS Tayside will have to develop by 2021.

Core And Additional Pharmacotherapy Services		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	• Authorising/actioning all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits

	includes/authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • instalment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	
Level two (additional - advanced)	• Medication review (more than 5 medicines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries
Level three (additional - specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicines reconciliation • Telephone triage

Current Position

Currently in Tayside medications are dealt with by a mixture of professionals within GP practices including GPs, practice admin staff and by dedicated pharmacy support. The existing locality pharmacy service is already delivering elements of the pharmacotherapy service, mainly in Levels 2 and 3 (see table below). These level 2 and 3 services will continue to be delivered over the three year implementation period.

Additional Advanced Level 2 Services

Role	**Activities**	**Pharmacy Team Member**		
		Senior Locality Pharmacist	**Locality Pharmacist**	**Senior Pharmacy Technician**
Level 2 (additional advanced)	Medication review (more than 5 medicines) Polypharmacy / medication reviews for specified groups of patients at both levels 2 and 3, either in their own home, care homes or in the practice, focusing on the priorities of NHS Tayside e.g. patients identified through DQIP2, chronic pain, older people, new patients registered to practice if complex. This may involve managing caseloads of patients on an	✓	✓	

	ongoing basis, developing referral pathways and using Independent Prescribing when appropriate			
	Resolving high risk medicine problems	✓	✓	
	Non-clinical medication review			✓
	Medicines shortages			✓
	Pharmaceutical queries			✓

Additional Specialist Level 3 Service

Role	**Activities**	**Pharmacy Team Member**		
		Senior Locality Pharmacist	**Locality Pharmacist**	**Senior Pharmacy Technician**
Level 3 (specialist advanced)	Polypharmacy reviews: pharmacy contribution to complex care	✓	✓	
	Specialist clinics (e.g. chronic pain, heart failure)	✓	✓	
	Medicines reconciliation			✓
	Telephone triage			✓

In addition pharmacy teams are delivering locally agreed activities as detailed below, depending on resourcing and skill mix within GP clusters. These services need to be maintained over the 3 year implementation phase to promote and maintain safe, efficacious and high quality prescribing.

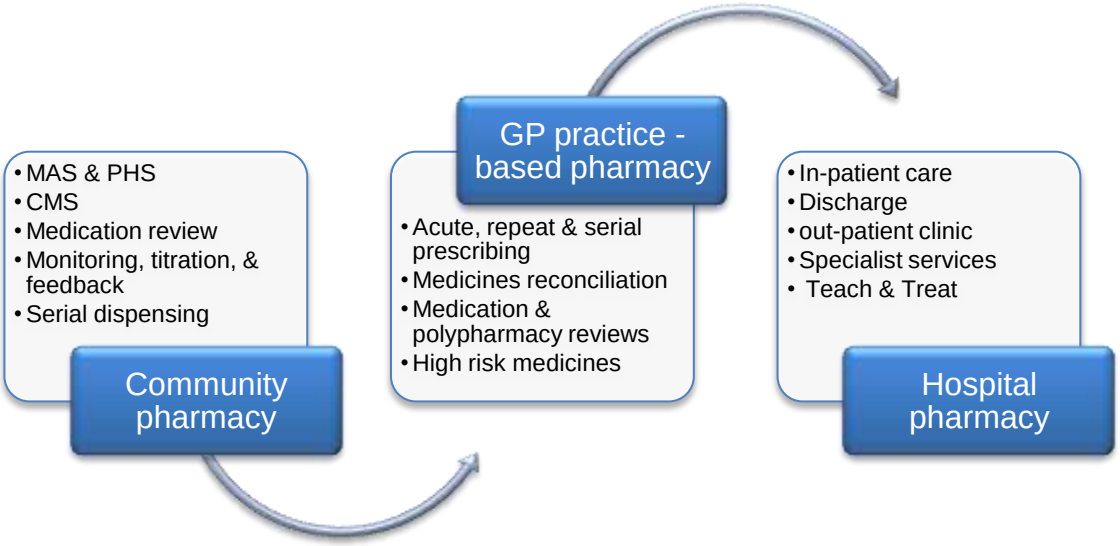
Tayside Locally agreed General Practice Pharmacy Services

Role	Activities	Pharmacy Team Member		
		Senior Locality Pharmacist	**Locality Pharmacist**	**Senior Pharmacy Technician**
Medicines Safety and Governance	Provide advice on local prescribing status of medicines e.g. shared care agreements/IPTRs	✓	✓	
	Advice on actioning MHRA warnings	✓	✓	✓
	Contribution to Significant Events, IR1s, Datix, Large Scale Investigations (Care Homes), Medication Complaints, Care at Home	✓	✓	✓
	Antimicrobial Stewardship	✓	✓	✓
	Controlled Drugs Governance	✓	✓	✓
Teaching and Training	Teaching of other pharmacists and pharmacy technicians in training and foundation posts	✓	✓	✓
	GP Education on Medicines related topics	✓	✓	✓
	Mentoring of others (nurses, pharmacists and AHPs) undertaking Independent Prescriber Training	✓	✓	
	Support and train practice staff to undertake non clinical medication reviews (NCMRs) as part of the repeat prescribing system			✓
	Job Shadowing for Medical Students in GP training practices	✓	✓	✓
Facilitating Prescribing Improvement	Prescribing Support Meetings with practices to discuss prescribing data and reports, and current prescribing priorities	✓	✓	✓
	Meetings with IJBs/clusters to discuss relevant prescribing data	✓		
	Supporting Organisational Prescribing Priorities	✓	✓	✓
	Facilitating and/or undertaking prescribing audits and quality prescribing projects	✓	✓	✓
	Simple PRISMS queries			✓
	Dealing with queries from projects e.g. from patients/carers		✓	✓
General	Clinical input into Practice Meetings	✓	✓	
	Service Development e.g. Teach and Treat, ECS and Care Homes	✓	✓	✓

The current service is delivered by 28 WTE Locality Pharmacists and 10 WTE Pharmacy Technicians in primary care across Tayside covering between 1-8 sessions per week (1x session= 0.5 day in line with GPs). There are an additional 10 WTE staff affiliated with the locality teams e.g. the ECS Pharmacy Technicians but they do not currently deliver sessions in GP practices.

Future Vision

In conjunction with the range of services to be delivered by 2021 (referenced in the introduction of this section), the GMS Contract describes the future Pharmacotherapy Service to be delivered in all regions by 2021:



This means that over the three year implementation period, all pharmacy staff, regardless of funding source will become part of an integrated team.

Milestones

In order to continue to progress the Pharmacotherapy service, the first priority will be to undertake a Test of Change (TOC) commencing in August 2018 to scope the workload resulting from level one service and estimate the resource and skill mix required to deliver the service consistently, taking into account other drivers in addition to list size such as deprivation and demographics. The results from the test of change will inform the three year implementation programme in terms of developing the level one activities that can be delivered consistently in year one. Other level one activities will be added in years 2 and 3 as staffing resource allows with full implementation of level one service required by year 3. Arrangements for this are now underway.

Work is also underway to make arrangements with community pharmacists to work directly with GPs to deliver patient facing care as per the requirements of PCA (P) (2017) 4. A successful pilot is currently in place in South Angus with the Monifieth, Carnoustie and Arbroath practices. The intention is to provide an arrangement of 2 days a week for each HSCP. This model has also been used in other Health Boards via Service Level Agreements. The capacity to deliver this approach at scale will need to be scoped further.

Good links will be established between the pharmacotherapy service and local community pharmacies to make full use of the clinical capacity within the chronic medication service (CMS). Community Pharmacists can carry out an annual medication review, as well regular monitoring and feedback to the GP practice for patients registered for this service. Making full use of the clinical capacity within community pharmacy can improve the pace and efficiency of delivery of the pharmacotherapy service in GP Practices.

GP Practice teams will also make full use of the other NHS Services available through local community pharmacies, such as self care advice, access to minor ailments service and Pharmacy First (currently restricted to UTI and impetigo). Further common conditions work is developing.

Resources and funding required

Funding of £922,100 was made available in 2017-18. This provided access to Pharmacists for all practices. It also provided an initial baseline of Pharmacists to support the delivery of the most appropriate skill mix, to enhance the service to the priority areas and provide pharmacists with advanced clinical skills. The funding has allowed an increase in pharmacy technicians, as well as of pharmacists within practices.

However, further funding is required to secure the required levels of staff to deliver the Pharmacotherapy Service. Guidance for pharmacy staffing in the National Health Service and Social Care Workforce Plan part 3 – Improving workforce planning for primary care in Scotland equates this to an additional 59 WTE pharmacy posts during the 3 year contract implementation period, to deliver a 52 week per year service, providing cover for annual leave and sickness.

For year 1 2018-19 this means we will be looking to recruit 11.6 WTE pharmacy posts at a cost ranging from £395-£697K depending on the preferred skill mix of post following the Test of Change evaluation (range between Band5 – Band 8a).

The table below breaks this down to individual HSCP

Total Year 1 Indicative Funding Required for additional Pharmacy Staff

HSCP	**Funding Required 2018-19** (dependent upon banding)
Angus	£92K-£161K
Dundee	£166K- £293K
Perth & Kinross	£136K- £239K

Currently the administration of medicines in General Practice is undertaken by practice employed admin staff. If the Tayside service were to employ all these administration staff to deliver appropriate roles with the pharmacotherapy service, this additional resource required would equate to an additional 104 WTE band 4 staff (based on 1WTE per 5000 patients). This would amount to a total cost of £2.9Million at the end of year 3, with year 1 costs of £574K. This reflects the true hidden costs of this work. However, it is recognised that further discussion and negotiation is required to ascertain how best this area is addressed.

Total Year 1 Indicative Funding Required for Administration Staff:

HSCP	Funding Required
Angus	£148k
Dundee	£230k
Perth & Kinross	£195K

Risks and Issues

The ability to fund and recruit additional pharmacy staff including administrative support is critical to the success of the programme. Recruitment for both pharmacists and pharmacy technicians is an increasing problem. The Scottish Government target of an additional 140 Pharmacists for Primary Care in the last 2 year period has resulted in vacancies and increasing challenges to recruit to this number of posts in such a short period of time. Consideration is also currently being given to recruiting to additional foundation pharmacist posts at Band 6 to build capacity for the future within Primary Care.

There is a real risk that there is not currently the specialised workforce available in order to carry out the roles as described within the new GMS Contract and that this will not be available by 2021. Other concerns are in relation to funding and having adequate funding to develop and implement a robust and efficient Pharmacotherapy Service in Tayside within the timescales allocated. There is a risk around availability of suitable and accessible premises, space and infrastructure to deliver a Pharmacotherapy service. Other practical concerns relate to IT infrastructure and that suitable IT systems will not be available to allow the communication required between the MDT, the Pharmacotherapy service and community pharmacy.

There is a risk that if a professionally satisfying pharmacotherapy service cannot be designed it will fail to attract and retain a suitable and motivated work force. We also need to be mindful of the fact that if highly skilled clinical pharmacists have to deliver Level 1 services routinely, staff may disengage. We need to think about these issues and how we make both the service and the roles within it professionally rewarding and satisfying. The market place for pharmacy staff will be competitive and we need to ensure that Tayside is an attractive place to work. There will be substantial requirements for training and mentorship, as well as for educational and clinical

supervision. We will need to ensure that sufficient staff are available to supervise education and training placements. We also need to explore what level of risk Pharmacists are willing/able to accept when issuing prescriptions, an area still to be explored.
Amongst some other potential unintended consequences that we must be mindful of is that if we use a greater proportion of the existing locality pharmacy resource to deliver the pharmacotherapy service, we may lose focus on prescribing efficiencies work. This may then place NHS Tayside at a potential financial risk. These practical issues will be worked through as we move through the implementation period, but it should be recognised that building a fully integrated Pharmacotherapy Service whilst providing many positive benefits to patients and staff, is not without significant challenges and difficulties which will have to be overcome in order to achieve the vision laid out by Scottish Government within the contract offer.

Engagement & Governance

A pharmacotherapy implementation group has already been established, with representation from all of the key stakeholders. This working group will feed into the GMS CIAG, which will report to the Primary Care Board.

Regular engagement with the GP Sub-committee will be essential throughout the implementation period. In view of this, they are represented on the Pharmacotherapy Implementation Group. Project support and improvement support has already been established. We also recognise that developing the Pharmacotherapy Service will require substantial staff engagement, across all sectors with workforce colleagues and staff side representatives. Patients and their interests are at the heart of everything we do. Patient engagement and public involvement both for this work stream and wider in terms of the plan overall will be a central feature of how we progress this work over the next three years.

Community Treatment and Care Services

Introduction

Community Treatment and Care Services provide an opportunity to deliver high quality care that is located within the community where patients live.

The types of services which may be provided include:

- management of minor injuries and dressings
- phlebotomy (suggested in the contract that this is a priority in year 1)
- ear syringing
- suture removal
- chronic disease monitoring

The responsibility for providing these services will move from General Practice to HSCPs over the next three years.

This is an ambitious programme of re-design representing one of the greatest opportunities to get things right for patients so that they are seen by the right person, at the right time and in the right location. It also presents an area where we can get it right for the professionals who work in primary care by creating rewarding and satisfying careers. The Scottish Government has committed HSCPs to developing care and treatment services for patients local to where they live. By necessity Partnerships are required to meet the distinct needs of their local populations whilst at the same time recognising that a number of core principles for the redesign of services require to be retained.

Community Treatment and Care services have been designed for use by primary care. They should also be available for secondary care referrals if they would otherwise have been work load for GPs. Where Care and Treatment Services are used by secondary care, they will require funding that is in addition to that which is outlined here in the PCIP.

Current Service Provision

These services are currently delivered in a number of different ways including:

- In Practice by GPs and Practice employed staff
- Partly funded by Local Enhanced Funding streams
- In community hospitals, treatment rooms and Minor Injury and Illness Units by HSCP staff
- Elements of care and treatment services work performed in secondary care

Future Vision

By 2021 these services will be commissioned by HSCPs and delivered in collaboration with NHS Boards who will employ and manage appropriate nursing and healthcare assistant staff.

Local circumstances and demand will determine where it is most appropriate to safely situate services. In some circumstances, services may still be carried out in the Practice environment, in others the NHS Board may decide to operate these services from separate facilities. Where a separate facility is developed, this offers an opportunity to co-locate other health, social and third sector services as part of a larger community hub delivering a broad range of complementary services to the entire community.

The key aim is to allow patients convenient and comprehensive access to community treatment and care services. Where it is agreed locally that practices will continue to deliver care and treatment services then support will be provided in the form of payment of staff expenses or in the direct provision of NHS employed staff.

These changes offer a radically different future for primary care from the one in which we now live. We cannot under estimate the scale and complexity of what is required, as we design services with a workforce that currently does not exist, with competencies that we have not yet fully worked out, working from differing premises.

Core Principles

In Tayside we have agreed upon a number of core principles that are required in the future redesign of and provision of care and treatment services:

Principle 1:

- A single system facing towards secondary care

Rationale:

Secondary care does not have the flexibility or resource to identify the specific delivery mechanism in each locality area. A single system that allows tests or procedures to be ordered in a set, common fashion will have a lower error rate and a higher adoption rate.

Principle 2:

- Room for differing local implementation in different HSCP areas depending on the available resource

Rationale:

There are three main ways in which a secondary care request might be satisfied:

- Delivery of the service in a locality centre or community hospital
- Delivery of the service by NHS employed staff in a local GP practice
- Delivery of the service by a local practice at an agreed tariff

The choice of which is the preferred route will be dependent on what resources the locality possesses. Some localities will already have staffed community hospitals or centres that can fulfil secondary requests. Some localities will not have any appropriate NHS owned resource near enough for the local community to be useful and will not have sufficient GP contractor capacity to deliver such a service from a GP practice. Local practices may however have sufficient room to embed an NHS employed staff member to deliver the service. The anticoagulant monitoring service has used this model in some practices with periodic clinics held in GP managed premises by NHS employed staff. In some localities where there is spare practice nursing capacity within practices it may be reasonable to consider either a bulk contract or item of service contract model of employing GP managed staff to deliver this service.

Principle 3:

- Diagnostic tests ordered by a clinician should return to that clinician regardless of whether they are based within primary or secondary care

Rationale:

The aim of the contract is to free up GP time in order to allow GPs to fulfil their role as “expert medical generalists”. It is therefore necessary that secondary care requests are returned to secondary care for interpretation and action. The movement of work from nursing and HCA staff out of General Practice whilst retaining the responsibility of interpreting and managing the result does nothing to deliver on this objective and runs contrary to the GMC view that the ordering clinician should be responsible for interpreting the result of the test they have ordered.

Engagement and Consultation

Each HSCP has undertaken significant consultation with general practices given the need to consider local circumstances in development of services to ensure convenient and safe patient services. Results are summarised below.

Whilst scoring systems used varied considering all responses priority afforded was as follows. (1 being of highest priority and 7 being of lowest)

Task	Dundee	Perth & Kinross	Angus
Leg ulcer care	1	2	1
Wound care	2	1	2
Phlebotomy	3	5	4 =
Minor injuries	6	4	3
Ear Syringing	5	6	4 =
Suture removal	4	3	6
Chronic disease monitoring & related data collection	7	7	7

Significant planning work has taken place within each HSCPs in relation to contract delivery and the wider implementation of local strategic plans. Regional planning around IT requirements has started. Each HSCP has established a local working group to oversee the implementation of Community Care & Treatment Services.
Whilst we recognise that phlebotomy has been identified by Scottish Government as the priority area for 2018-19, we will also be reflecting the viewpoints of our local practices and clusters.

Progress to date in each HSCP is as follows:
Dundee:

1. Complex leg ulcer clinics in place for 2 clusters with further roll-out planned.
2. Job descriptions developed and submitted to AFC to support expansion of teams.
3. Planning initiated to develop Lochee HC as a care and treatment centre.

Perth & Kinross:

1. Currently scoping phlebotomy services, leg ulcer and catheter clinics
2. Proposed service developments Aug 2018-Feb 2019 include lithium/ECG, anticoagulation, phlebotomy service introduction and pre-operative surgical assessment

Angus:

1. Initial planning progressed within Angus Care Model conversation and planning.
2. MIIU service model approved and will be implemented in 2018/19
3. Proposed service developments for 2018/19 and the 2021 vision for Care & Treatment Services in Angus available in draft pending local approval

Barriers and Opportunities

There are a number of general and specific risks presented by this complex area of redesign. Many of these services are already managed well within general practice where care is already delivered close to the patient. HSCPs will have to make decisions on the number, locations and how services will be delivered in their areas. Perth & Kinross and Angus have community hospitals that may provide possible locations for these services, but this work will need to take place in conjunction with the other complex review and change programmes taking place. Dundee has no community hospitals. This makes finding specific locations more challenging. However, there is flexibility in how we provide this model with services being delivered in a variety of different ways. Along with the changes in premises introduced by the new GMS contract, there is opportunity to do things very differently. It will be for HSCPs to consider this in their planning and implement what best suits their specific needs and local populations.

The roles of staff in supporting this work, the capacity of staff to absorb the work and the various professional standards required and how they are contracted is still to be worked out. The changes to roles will result in additional training, supervision and development of standard operating procedures. The detail of this will require input from the Nursing Directorate and will need to be negotiated with HSCPs, NHS Boards and GPs.

The intent behind establishing the care and treatment service is to relieve pressure on primary care. The service also presents opportunities to move secondary care services closer to the communities where the people who need those services live. Care and treatment services might also act as care hubs around which other community and third sector services might be constructed. The PCIP does not bring funding for either of these desirable goals and they would therefore need to be resourced from outside of this plan.

IT is one of the greatest challenges to the care and treatment service. We require IT systems that are fit for purpose and which can communicate across services, primary and secondary care and with GP practices. Safe systems that can perform this function need to be developed and rolled out. If we cannot achieve this we will not meet the intended aim of these services in providing safe, seamless care for patients and it will not result in a shift in workload from GP practices.

Urgent Care Services (in hours)

Introduction

A significant amount of GP time is used in visiting patients at home who could have their needs effectively dealt with by other health professionals. The new GMS contract and MoU describe a future model with advanced practitioners providing support as first responders for certain urgent unscheduled care presentations and home visits. The aim of this model is to free up GP time so it can be reinvested in the model of GP as expert medical generalist.

Current model

Currently almost all home visits are made by GPs. In certain circumstances nurses and advanced nurse practitioners may visit as part of enhanced community support, nursing home support or other project teams but this is very much the minority. Paramedics employed by Scottish Ambulance Service (SAS) visit and assess patients who have accessed them directly through the 999 service and may deal with some of these presentations within the community without GP involvement. However, this presents a tiny fraction of the overall workload.

Future Model

By 2021 in collaboration with NHS Boards there will be a sustainable advance practitioner service in all HSCP areas, based on an appropriate local design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

Redesign already underway

There are two strands to our approach in Tayside for providing advanced practitioners as first responders undertaking home visits. The first is to develop and enhance the nursing teams that already have some input into visiting in the community and the second is to work with SAS to progress and grow the Specialist Paramedic Practitioner role.

Paramedics

There is real potential to further maximise the contribution paramedics and specialist paramedics make as a member of the community based multi disciplinary team. This approach is outlined in *Towards 2020: Taking Care to the Patient- A Strategic Framework for 2015-2020*. As part of the SAS national strategy, 21 specialist paramedics will be appointed to Tayside, with the first cohort already in training.
In line with this workstream, in 2018/19 it is proposed that SAS will appoint 2 wte paramedics to support tests of change to inform future modelling. This will allow the testing of service models to further develop the service. This will ensure that this test is ‘ringfenced’ and thus avoid any negative impact on core service provision.

Within Angus it is proposed that a paramedic will be included, as a test of change, within the enhanced community service of one Angus cluster. That will provide the potential for the paramedic to support both home visits and in practice patient reviews for patients, following an initial practice based triage. This will provide additional information regarding the effectiveness of this model of care.

Evaluation

A robust evaluation process will be detailed upon approval. This will include:

1. Qualitative data such as:
- Profile of patients seen by paramedics as part of the practice MDT response
- Place of care delivery (home/practice/clinic)
- Patient outcomes
- Impact of SAS rates of low acuity calls
- Emergency admission rates
2. Quantitative data such as:
- Patient satisfaction
- Staff satisfaction within MDT

A multidisciplinary, multiprofessional group will monitor the outcomes of these tests of change and report back to GMS CIAG, the Primary Care Board and the HSCPs.

Barriers and Opportunities

Recruitment of sufficient workforce may prove challenging. There is a concern that current paramedics may not wish to progress to these new specialist paramedic posts. GPs have expressed concern that the development of these roles may impact adversely on the current provision of SAS services.

Many practices have worked hard over a number of years to manage demand for house calls by actively supporting and encouraging attendance to the practice. Patients able to attend GP practices are seen in better conditions with better information than those at home. Introducing a responsive home visiting service may drive up demand as a more convenient option for some who could attend their practice but choose not to.

House calls are often made to the sickest and most vulnerable in society. As these patients may be medically very complex they may be better served by continuing to see the GP as the expert medical clinician who is more appropriate to deal with complex undifferentiated illness. An effective urgent visiting service needs to be able to recognise those cases that require GP input; it cannot be seen as a substitute for all GP visiting. It is vital that a GP who knows the patient is available for clinical direction and input to the visiting service if the service is to function safely.

We will require robust clinical IT systems that can provide appropriate access to the patient clinical record both to determine the clinical requirements of the patient and

to document and communicate back to practices what has been done. We also require administrative IT systems which can manage referral bookings from a range of sources.

Support is required from practices and specialist services to develop and implement new protocols and pathways. Without access to suitable training and in particular the commitment for the provision of mentorship support from the GP community whilst these staff are in training, they will not be able to progress in the competencies they will need to do their work with patients safely.

Next Steps

In addition to the national monies provided directly to SAS to support training of specialist paramedics and increase workforce for the long term, an initial short term funding of 2wte Band 6 paramedics, at a cost of £85k, will support a test of change within each HSCP area in 2018/19. This will enable models to be tested and developed with view to roll out in 2019/21.

Developing the nursing model

A further strand in providing advanced practitioners to support urgent unscheduled care presentation in hours is to augment the existing peripatetic nursing home service and the current enhanced community nursing model to visit housebound and care home patients who are not currently covered by these services.

Redesign work already underway

Within Angus, Advanced Nurse Practitioners based within the Medicine for the Elderly service have supported community nursing teams and practices within Enhanced Community Services to support complex care coordination and same day assessment in the deteriorating patient. This model has also been tested supporting triage of same day demand, including house calls, within practices.
Dundee HSCP is developing their existing nursing teams with a view to undertaking house calls and have identified four types of patients requiring acute home visiting:

Type 1: Care Home residents

Type 2: Minor illness cases

Type: 3 Acute Undifferentiated illness and long term conditions

Type: 4 Palliative patients

In year 1 they will test and develop a model that supports and enhances the existing care home team to undertake dealing with urgent/acute care of care home residents across Dundee. At the same time the existing ECS team will be trained and supported to take on acute visiting of minor illness of conditions such as urine and chest infections and falls within the elderly. This will be tested in one cluster initially. As part of the testing, a framework for ANP/specialist nurse role in GP Practice settings will be developed along with models of good practice to support people with palliative care needs.

In Year 2 all Type 1 acute visiting will be directed to the Care Home team. There will be a roll out of Type 2 visits to all clusters and localities.

In year 3 an acute visiting team made up of advanced nurse and paramedic practitioners will start to review Type 3 presentations. This testing will be phased so to ensure that any roll out is performed safely.

Additional Professional Roles

The new GMS Contract sets out a vision that by 2021 additional specialist professionals will be working as part of an extended Multi-Disciplinary Team seeing patients as a first point of contact. Not only does this free up GP time and work load, it ensures that patients see the most appropriate professional for their needs in a timely manner. We support patients receiving the right care, at the right time in the right location and believe this provides the best care and most cost effective outcomes.

In Tayside the areas where we see potential for providing additional specialist roles as part of an extended multi-disciplinary team are MSK Physiotherapy and Mental Health.

MSK Physiotherapy

Introduction

Musculoskeletal problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. An estimated 85% of GP's musculoskeletal caseload can be safely and effectively be seen by a physiotherapist without the need for a GP referral. Presentations perhaps better dealt by MSK physiotherapy account for up to 30% of GP consultations. Dealing with these entirely within the MSK service offers the potential to improve efficiency and productivity across the health and social care pathways and systems, improve outcomes for patients and have a positive impact upon the health economy.

Current Service

Across Tayside MSK services are provided via the Physiotherapy Service with specialist input from occupational therapy, orthotics and podiatry with access routes through the Musculoskeletal and Advice Triage Service (MATs), GPs, Consultants and other health care professionals. The musculoskeletal physiotherapy services are operated from mainstream outpatient departments across Tayside with small numbers of clinics on satellite sites.

Future Service

We propose in Tayside a future service which sees first contact clinics for MSK services provided on a cluster basis across the region. Patients will use MATs or be signposted by practice staff to an Advanced Physiotherapy Practitioner who will be working as an integral member of the primary care multi-disciplinary team, there will be no need for patients to see the GP first, if at all for MSK presentations.

Redesign work already underway

Angus Model

We have already made progress in looking at how we can deliver MSK differently and support General practice. In Angus a test of change is running in Brechin Health Centre. This model, started in response to a shortage of GPs, has an Advanced Physiotherapist Practitioner embedded in the health centre team, working directly in the practice.

A number of positives have been identified by this model. These include closer working with GPs and the primary care team; participation in the MDT huddle; opportunities for joint training and sharing good practice. In common with tests that have taken place in other parts of the country we have seen that earlier intervention avoids the development of chronicity of conditions and decreases referrals to secondary care.

Crieff Model

This model is similar to the Brechin model but differs slightly in that a nurse triages patients to physiotherapy and patients are then appointed into clinics set within the GP surgery. As with the Brechin model the benefits are broadly similar in that the model provides the opportunity for closer working with GPs and the other members of the primary care team. There are opportunities for joint training, sharing good practice and early intervention. It has evidenced a similar decrease in the development of chronicity which impacts positively on secondary care referrals.

Milestones

During year 1, we plan to build on the redesign work in place and roll out the MSK model to one cluster per Partnership across Tayside. This will be rolled out further to include all clusters within Tayside by the end of 2021.

Governance

A working group lead by the Director of AHP has been established and a detailed project plan is being developed to include how this programme will be taken forward over the next 3 years. This work stream reports to the GMS CIAG, Primary Care and HSCP Boards.

A number of evaluation measures have been identified:

- Numbers seen by physiotherapist
- Impact on GP capacity
- Numbers referred to MSK services for therapy
- Onward referrals to secondary care
- Re-referral or attendance for same condition
- Prescribing
- Patient satisfaction and PROM (patient reported outcome measures)

Finance and Resources Required

In year 1 additional funding will be needed for an initial 5.0 wte Band 7 physiotherapy posts, an approximate cost of £260k. We believe that this is achievable and realistic; we need to ensure that we attract external interest in these posts, as adopting a purely internal recruitment process would adversely affect our ability to sustain services in other areas.

Total Year 1 Staffing required for additional Physiotherapy Staff

HSCP	Staffing Required 2018-19
Angus	1.5wte
Dundee	2.0wte
Perth & Kinross	1.5wte

By 2021 we estimate that we will require approximately an additional 12 wte Physiotherapists at a cost of approximately £612k (subject to how the model continues to evolve throughout the 3 year period).

Barriers and Opportunities

By its very nature, this is an evolving programme of work. Year 1 will allow data gathering which can then inform what is required in subsequent years. It is recognised that service redesign requires us to think differently about how services are configured and that it is not simply a question of introducing additional staff to do the same. Equitable and sustainable models must be built whilst recognising the challenges around workforce and the national shortage of physiotherapists in Scotland.

In implementing the model we will have to address issues such as premises and accommodation and work these out with relevant parties and stakeholders recognising that one size may not fit all and that some of this requires to be tailored to the specific circumstances of a locality or cluster group. The ability to communicate effectively between IT systems in common with the redesign of other services related to this improvement plan will be a major issue to be addressed.

Mental Health

Introduction

Mental health and wellbeing affects and influences the lives of individuals, families, and communities. Mental health problems are managed mainly in primary care by general practitioners who have access to specialist expertise in a range of secondary care services.

The contract states that:
'*Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice, will work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input.*'

The Scottish Mental Health Strategy (2017) supports health and wellbeing in Primary Care:

Action 15 of this strategy commits the Government to increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years there will be an additional investment of £35 million for 800 additional mental health workers in those key settings. The funding for Action 15 comes from a separate funding pot, as described in the finance section.

Action 23: Test and evaluate describes the development of effective and sustainable models of **supporting mental health in primary care,** by 2019.

Current Service

In many cases those who have a mental health or wellbeing issue will present to their GP, and much GP time involves consultations with a mental health aspect, even if this is not the primary presentation. After assessment the GP will often refer to a wide range of services within the health and voluntary sector, and can also encourage self care or signpost to online resources. A number of practices in Tayside will use link workers or the listening service to provide additional support. Navigating the options in terms of onward referral can be complex for a range of reasons, including waiting times and charges for some services.

Future Service

The future aim would be for all NHS Tayside Practices to have access to a Mental Health and Well being Service, whether Practice based or located elsewhere (e.g. within a Care and Treatment Centre). The model should be able to support people at universal level with clear pathways or routes into targeted services and onwards into specialist services for those in greatest need.

Health and Wellbeing model

Angus HSCP has tested two Health and Wellbeing models in two separate burghs over the past 18 months. Each consists of 2 part time qualified band 6-7 experienced Registered Mental Health Nurses (RMN) seconded from Community Mental Health Teams in the same locality. This ensures a good interface, sharing of local knowledge and provides supervision and support for the workers.

The workers deal with all requests from adult patients connected with:

- Distress- A better response by services to individuals in distress is seen as a key component in supporting people at risk of non-fatal self-harm, future suicide prevention and mental health services.
- Substance misuse – Trained to deliver evidence based Alcohol Brief Interventions
- Mental illness

The Pilot pathway summary (subject to some variation across the two practices):

1. The worker identifies available patient's slots each day. Receptionist and/or clinical triage allocates consenting patients to the worker instead of a GP. Nurse accesses VISION notes as well as MIDIS.

2. Worker provides a timely connection with patient to identify of immediate presenting issues. Nurse carries out first level mental health assessment, and record findings on VISION.

3. Disposal: signpost to self help, including Beating the Blues, General Practitioner, Level 1/ social prescribing, examples include Talking Services in practice, Long Term Conditions Group, WRAP Groups, Insight Counselling, Adult Psychological Therapies Service, Substance Misuse Services, Adult Community Mental Health Team or Older Peoples Community Mental Health Team.

4. The worker does not deliver any ongoing interventions themselves but can offer one follow up appointment if patients needs time to consider options available which will also test patient's motivation to change. Patient should be equipped to make ongoing referral themselves although worker can refer into services, thus reducing need for further screening. Statutory services need to accept experienced nurse referral.

Worker will record outcome of assessment and follow up within VISION.
53% of GP practices have access to 'Do You Need To Talk' delivered by NHS Tayside Spiritual Care Department. Based in Health and Social Care contexts, the Do You Need to Talk service promotes wellbeing by offering an active listening service. The service helps people explore their deepest hurts and draw strength from their own inner resources and those of the communities of support around them.

The service is a short term, early intervention model of person-centred, assets based listening with the aim of promoting personal and communal wellbeing.

Primary Care transformation funding supported a staff wellbeing project for staff in general practice, aiming to improve wellbeing and increase resilience. The findings of this are positive.
The link worker role described in the next section is also an important aspect of supporting wider mental health and wellbeing.

Funding and Resources Required

Tayside's share of the Mental Health allocation is £863,306 in 2018/19 rising to just over £2.5 m by 2021/22.

Based on the findings of the Angus pilot work we estimate that to replicate the model across Tayside by 2021 will cost in the region of £1.9 m. However, there are variations in how each IJB sees this work progressing. Dundee propose to test a model with initial psychology assessment, rather than nursing. As learning develops the model and skill mix can be reviewed across Tayside. Depending on the findings of these tests the costs may vary quite significantly from the figure noted.

Do You Need to Talk is a key service in some but not all practices in Tayside. To support the integration of this across Tayside a further £65k would be required.

Wider redesign of services will be reviewed alongside these developments, recognising the evolving pathways and capacity issues this work both support and creates. Local planning infrastructures for mental health in each HSCP will incorporate this in to their planning processes.

Development of resources to support staff in GP Practices

Transformation funding was used to support the wellbeing of our own staff through developing the services offered through the Tayside Spiritual care Team. The funding tested the concept of and impact of a network of care for staff in the community supported by staff from the Well Being Centre. Over the test period, teams were introduced to and had access to support for resilience and wellbeing through the use of support and supervision, incorporating group Values Based Reflective Practice, Mindfulness concepts and practices, and one to one confidential support.

Workforce recruitment and retention is a key challenge for all practitioners and services delivering GP and primary care services; providing a sustainable resource to support staff would add to the attraction of Tayside as a place to work whilst supporting our existing workforce.

Based on the resource package for the test phase, this model could be supported across Tayside with £40k investment. The model implemented would enable growth and roll out of the current model and be sustainable across all 3 partnerships.

Barriers and Opportunities

Workforce availability is the main risk to this development. In Tayside particularly in its more rural areas there are significant challenges in attracting staff. Having the availability of appropriate staff with the necessary skills and attributes may take time to develop. Recruiting from within the current workforce could leave other areas depleted which could be detrimental to mental health services overall.

A major review of Mental Health Services is currently taking place within Tayside, this may provide an opportunity to meet some of the future staffing requirements for primary care mental health services.

Accommodation and IT requirements as described elsewhere in this plan apply equally to developing mental health primary care services that are integrated and part of the extended MDT.

Opportunities are available through working more closely and investing in the community based third sector and universal services as well as the digital options and choices. Governance arrangements would need to be embedded within the models and local structures.

Community Link Workers

Introduction

Social Prescribing is a term used to describe a spectrum of approaches to support clients, community members and service users to access services and activities that can help them to deal with their life circumstances. A non medical model that provides community solutions to life problems can empower patients who would otherwise have their problems medicalised with little benefit to them.

Community Link workers are non-medical practitioners aligned to practices within GP clusters. They work directly with patients to help them navigate and engage with a full range of health, social care and third sector services. They often serve socio-economically deprived communities or assist patients because of the complexity of their conditions, rurality or a need for assistance with welfare issues.

Current Service

Each locality in the region has its own specific model in place. All localities have link workers based within GP practices already and/or working closely with practice staff, albeit to different scales with Dundee being the most significant service for now.

All localities regard social prescribing as a strategic priority and work in partnership with the third sector. In Dundee, link workers are employed by NHS Tayside and are sited within the Health and Social Care Partnership whereas in P&K and Angus, staff are employed within either the local authority or Third Sector. Each service has referral mechanisms in place and is monitoring and evaluating outputs and outcomes.

Future Service

The Government is clear that each HSCP as part of their Improvement plan is required to assess the local need and develop link worker roles in every area, in line with the manifesto commitment of delivering 250 link worker roles in the life of this Parliament.

Issues and Risks

Each locality has a model that works for them. There is an opportunity to use the Primary Care Improvement Fund to scale up the work in each area, taking into consideration the HSCPs Strategic plans and own local based need assessments.

Dundee Health & Care Partnership was an early adopter for the national link worker programme and received significant resources to scale up the previous pilot. The initial pilot in 2011 ran in one practice, this was extended to a further three in 2014. Over time this has increased and following external evaluation in 2017 the service was extended further and is now available in 16 Practices.

The funding letter of 23 May spells out that the link workers already in post should be seen as a priority, however, it makes reference to HSCPs working jointly to resource early adopter link workers and that flexibility around the scope oversight, employer or

lead responsibility. Further clarification nationally is being sought and further local discussion will be required.

Angus

Community link workers, known locally as social prescribers, are sited within the third sector and embedded within general practices, working closely with the wider multi-agency team and supporting care models, such as enhanced community support. Whilst social prescribing has been available in a number of practices in Angus for some years, the model has had the opportunity to develop and undergo significant evaluation as part of the new models of care programme in two practices in Forfar since 2016. A development event is planned for August to finalise Angus service modelling for planned roll-out in 2019/21.

Perth

A partnership group has been formed to support the development of social prescribing led by the HSCP with representation from the third sector interface and the local authority. Mapping is underway at present to identify the nature and breadth or social prescribing activity in the locality

Conclusion

This PCIP describes a comprehensive reshaping of primary care that is ambitious in scope and transformative in scale. This will be delivered over a challenging three year time scale. It offers a future for our population of better quality, better co-ordinated health care, developed with the people receiving it and delivered closer to the communities in which they live.

The PCIP has been developed in partnership across the three HSCPs in Tayside and with NHS Tayside in collaboration with the services and professions that will deliver that healthcare.

The PCIP is a beginning. It represents a vision, and it is now necessary to implement that vision. The PCIP was written in collaboration and it shall be implemented in the same way. The PCIP has been designed to improve the health of our population and it must be co-produced with our population. The next phase of developing the outline plans into fully costed programmes that can be rolled out across our population has already begun.

This will require significant work from all of the partner organisations that have contributed to the PCIP. We are confident that they are fully committed to this in accordance with the MoU. It will require the evolution of new finance and accountability structures; and the rapid and effective evaluation of the new care models that are being developed and rolled out. IJBs have a key scrutiny role in discharging their role of managing the commissioning of the services described within the plan.

Inevitably there will be changes made to the plan. It is a living document, and as time goes on it will change from being an aspirational statement of the better services we aim to provide for our population to a fully realised description of a more ambitious, more resilient, more sustainable thriving primary care assisted by a vibrant general practice at its heart.

Appendix 1- Contributors

Sheila Allan	Dundee HSCP
Karen Anderson	Director Allied Health Professionals
Sandy Berry	Chief Finance Officer, Angus HSCP
Alison Clement	Clinical Director, Angus HSCP
Jim Devine	Primary Care Manager, Perth HSCP
Hamish Dougall	Clinical Director, Perth HSCP
Julia Egan	Consultant in Public Health Nursing
Kenny Freeburn	Head of Ambulance Services
Russell Goldsmith	Health Intelligence Officer
Alistair Graham	Head of Service eHealth
Rhona Guild	Primary Care Manager, Angus HSCP
Jane Haskett	General Manager, Primary Care
Shona Hymen	Primary Care Manager, Dundee HSCP
Christopher Jolly	Programme Manager, Perth HSCP
Fiona Lornie	Lead Nurse
Gail McLure	Quality and Services Manager Primary Care Dept
Jill Nowell	Head of Prescribing Support Unit
Frances Rooney	Director of Pharmacy
Bill Troup	Head of Mental Health Services, Angus HSCP
Michelle Watts	Associate Medical Director
Joan Wilson	Associate Nurse Director

Appendix 2

Dundee Primary Care Improvement Plan – additional information

1. Vaccination transformation programme (VTP)

Dundee Health & Social Care Partnership (H&SCP) support the NHS Tayside commitments and funding will be top sliced to support this.

2. Pharmacotherapy Service

Dundee H&SCP support the NHS Tayside commitments and funding will be top sliced to support this.

3. Musculoskeletal (MSK) services

Dundee H&SCP support the NHS Tayside commitments. In year 1 a model will be tested in a small number of practices. This, or an alternative model based on comparison with other models in Tayside, will be rolled out across Dundee based on this learning, over the following two years, aiming to provide a service to all practices/patients by the end of year 3.

4. Mental Health services

Dundee H&SCP support the NHS Tayside commitments in year 1. A model will be tested which provides initial assessment and triage for patients presenting with mental health issues, (although not children or older people initially). As part of this work pathways of care will be reviewed and how referrals across the system are made to try to streamline and simplify where we can, increasing the access to the right services first time. This will be compared with alternative models in the other areas and based on this broader perspective the model will be rolled out across other practices/clusters. There is likely to be a significant challenge for workforce development/recruitment of this aspect of delivery, regardless of the professional who does the initial assessment. We are therefore unable to commit to full roll out in 3 years.

5. Link workers/social prescribing.

Dundee H&SCP support the NHS Tayside commitments. In year one we will embed the link workers who have already been recruited as part of an early adopter programme into practices and review the model to ensure it is the best fit for the change in focus with the Primary Care Improvement work. As part of this we will consider skill mix and links across sectors, as well as scoping wider social prescribing initiatives in Dundee and how we maximise the impact across the system.

6. Urgent care

Dundee H&SCP support the NHS Tayside commitments. We will work with colleagues across Tayside to scope the role of advanced practitioners in supporting urgent care, and plan a test for year 2 linked to this. This will be closely linked to out of hours urgent care and the Scottish Ambulance Service. It may be feasible to test a paramedic model in year 1.

In year 1 we will build on the redesigned care homes team to increase the nursing component of assessment when residents are unwell. This includes training and up skilling of the current nursing team to develop their knowledge and skills around clinical assessment and diagnosis. This will work towards a nursing assessment being the first contact for all care home visit requests in the longer term (where appropriate to do so.)

In year 1 the current Enhanced Community Support (ECS) and Enhanced Community Support Acute (ECSA) models will be reviewed to assess how to best support patient pathways when patients deteriorate, and where different roles best support that pathway. This review will inform developments going forward. However in year 1 the Advanced Nurse Practitioner (ANP) role in the team will be enhanced to start to develop supporting frameworks and clinical tests.

7. Care and treatment centres

Dundee H&SCP support the NHS Tayside commitments. The current team who support leg ulcer work are short term funded. The team is being integrated with anti coagulant and catheter care, to start to provide a more unified team. Clinical priorities to move work from general practice teams include further leg ulcer work, wound care, such as pilonidal sinuses, and starting to test phlebotomy. Some of these developments are closely linked to the development of information systems, and governance linked to that. Training of the team is required.

There are issues around delivering this model to capacity with the current community and primary care premises we have. So work will be undertaken in year 1 to scope what capacity we have. This will inform how the model progresses, and if it can be rolled out on a community/cluster basis.

Given this will be a fairly sizeable service longer term it is proposed to front load some posts for this in year 1 (time limited) to ensure focus and drive for this, and a senior nurse role to manage the team going forward. We need to ensure the clinical development of the team and management of the care is planned well from the start.

8. Premises, infrastructure and IT systems

A number of pieces of work are being progressed on a Tayside wide basis which will inform planning within Dundee for this aspect of delivery. This includes plans to undertake a comprehensive review of all GP premises to assess suitability and sustainability. This will inform longer term

planning of sites going forward, particularly as we look to develop new models of care in communities. We will also utilise this as an opportunity to assess if we have underutilised space which could be used differently.

In terms of information developments and management there is a recognition of the significant change culturally and we will look at how we use technology to support different ways of working. So mobile devices will be utilised and data shared as much as is practical to support patient care and delivery. Systems we use are not currently suited to the new models of working being proposed and will need to be developed, along with hardware required for this.

9. Workforce planning and development

Recruitment and retention of GPs is being led at a Tayside level but we need to adopt a flexible approach to GP recruitment given the issues currently faced. Much of the focus of the plan is on roles which can work alongside GPs, across a wide range of professional groups. This is clearly detailed in the Tayside plan. However, we need to consider how this works alongside wider developments, especially for our local workforce, in Dundee. We need to plan across services both within the primary care context, but it goes across our whole system given the breadth and range of services being considered.

10. Sustainability/scalability

Developments need to be both sustainable and achievable at scale. This is challenging for some aspects of the workforce in particular. However, if we do not set off with a vision we will never achieve the degree of progress we require to support care in the most effective way longer term. The approach taken should include taking a risk that things may not work, but by testing it we will establish that, and we will refine how we deliver.

11. Practice staff development (in general practice)

- Practice admin role to support a range of the above work streams
- Development of nursing roles around advanced practice, disease management etc, including ANP
- Unclear if will sit with direct practice funding or centrally.

12. Evaluation

Monitoring of the developments to assess progress, and evaluating their impact, is critical to the progress of the plan. However we do not want to create hugely complex systems to do this. It needs to be achievable as part of routine data collection required for clinical purposes as much as possible. The LIST team will support this work, especially where things are focused at cluster level.

13. Communication and engagement

Communication and engagement is key to the success of much of the change being proposed, alongside involving our local communities in shaping our plans. Key messages will be developed on a Tayside basis for public messaging around the culture change required for accessing services. More detailed plans will be developed around communication and engagement for each part of the development as more detailed plans are progressed, to ensure that how the plan is delivered is co-produced.

Commitment	Actions (in addition to Tayside wide actions in plan)	Lead Officer
1 VTP	• As per Tayside plan. • Integrate into care and treatment services longer term and as premises are identified to deliver a community model. • Work to identify which practices have space if required.	Julia Egan Danny Chandler
2 Pharmacotherapy services	• As per Tayside plan.	Jill Nowell/ Elaine Thomson
3 MSK services	• As per Tayside plan. • Test pilot in Dundee in one cluster in year 1, 2 further year 2, final cluster year 3 (= 2, then 4 then 5 staff in total). • Train staff esp in year one to start to create capacity. • Backfill (staff) for NMP course required and may be a limiting factor.	Janice McNee/ Matthew Kendall
4. Mental Health services	• As per Tayside plan. • Test assessment for first contact by MH team (clinical psychologist) as pilot • Roll out skill mix/model. • Develop new ways of working across pathways. • Develop linked roles to direct to most appropriate person from first contact. • Ensure close working with development of link worker posts. • Ensure we have Listening service/Do You Need To Talk in all Dundee practices.	Arlene Mitchell/Linda Graham Alan Gibbon
5. Link workers/social prescribing	• As per Tayside plan. • Link workers are already in post due to the early adopter nature of Dundee for this work. • Establish these roles fully and ensure maximising the impact of these roles on practice workload and patient outcomes, across a spectrum of conditions. • Develop streamlined processes for recording, monitoring and evaluation • Develop model (processes) to support wider social prescribing in practices, building on the training programme delivered to date. • Develop practice teams ability to refer directly where feasible to other agencies.	Sheila Allan

Commitment	Actions (in addition to Tayside wide actions in plan)	Lead Officer
	• Develop information systems to support this referral and signposting service, both for professionals, the public and patients /carers. • Embed welfare rights workers in teams which support clusters.	Clare Lewis-Robertson Craig Mason
6. Urgent care	• As per Tayside plan. • Review ECS and ECSA to consider how to maximise the initial assessment of frail/older people when unwell/deteriorate. • Develop the integrated care home team to be more responsive to supporting varying needs of those in care homes. This includes upskilling of current nursing team to take on a more advanced role, and developing a greater skill mix in the team. • Work with colleagues across Tayside to develop a model of advanced practitioners supporting urgent care. Plan to test this in year 2 with subsequent roll out. This will involve development of new nursing and paramedic roles for Tayside.	Shawkat Hassan/ Jenny Hill
7. Care and treatment services	• As per Tayside plan. • Develop a nursing team who can deliver the range of services (as defined in Tayside Plan) required in care and treatment centre in a range of settings, both community based and practice based. • Link this with work to develop community hubs in Dundee with a wide range of coordinated services across sectors. • Identify gaps in service provision partly around premises, and link this to property strategy, progressing plans for further development of premises when required. • Utilise the opportunity of the Lochee development to test this model in year 2.	Beth Hamilton/Alison Carnegie
8. Premises, infrastructure and IT systems	• As per Tayside plan. • Work with colleagues in NHS Tayside and Dundee City Council to develop a plan for future development of primary care sites, including general practice and community hubs, based on the premises survey to be undertaken. • Work with clusters to consider boundaries for general practice to ensure all areas of city have adequate access to general practice and care and treatment services, recognising that teams are increasingly geographically based.	Tracey Wyness/ Arnot Tippet

Commitment	Actions (in addition to Tayside wide actions in plan)	Lead Officer
	• Continue to look for opportunities locally to maximise the use of technology, particularly around supporting health e.g. roll out Attend Anywhere videoconferencing consultations. • Work with colleagues in E-Health to develop information systems to support these new ways of working. • Undertake test of change for care and treatment services in Lochee.	
9. Workforce planning and development	• As per Tayside plan. • Work with lead nurses to progress how develop the nursing workforce in particular for new and expanded roles, both in primary care teams and general practice settings. • Work across professional groups around this agenda, and agree a more detailed local workforce plan. • Staff need to be fully engaged and we will work with HR and staff side colleagues to ensure that staff are fully involved in developments.	TBA
10. Sustainability /scalability	• The primary care improvement plan is about long term sustainable change which can be delivered at scale across Dundee. The approach taken will be to test new ways of working and build on learning of these models. Developing at a reasonable pace to fit with the 3 year time frame will be challenging. It requires dedicated time to ensure the programme is coordinated and managed as a whole. • Consideration of how services can be redesigned, or additional resource identified, to deliver this at scale.	All/ Shona Hyman
11. Practice staff development	• Practice admin roles are key to many of the changes in the contract, including pharmacotherapy, link workers and many of the linked roles where patients will need assessed and redirected from GP appointments. • A programme of development for admin staff will be progressed, based on national findings or work elsewhere, to progress this role.	TBA
12. Evaluation	• Evaluation and monitoring will be coordinated as much as possible at a Tayside level. • We will work with the LIST team in particular to support this work going forward, as well as internally from NHST.	TBA

Commitment	Actions (in addition to Tayside wide actions in plan)	Lead Officer
13. Communication and engagement	• There has been limited public engagement in the initial development of the plan but going forward the detail of each aspect will be proactively planned with a wide range of key stakeholders, including patients, carers and the public. • Key messages around the range of services we provide, and how and where these are provided will need to be shared widely, including how we change the culture of the GP as the first point of contact by default.	Communications team

ITEM No …6……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2018**

REPORT ON: **STRATEGIC AND COMMISSIONING STATEMENT FOR PEOPLE WITH PHYSICAL DISABILITY 2018-2021**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB35-2018**

1.0 PURPOSE OF REPORT

To seek approval for the Strategic and Commissioning Statement for People with Physical Disability 2018 – 2021.

2.0 RECOMMENDATIONS

It is recommended that the IJB:

2.1 Notes the contents of this report.

2.2 Notes the breadth of service provision covered within this Statement and the engagement work undertaken over the last two years to ensure that the direction and language of this Statement reflects the needs and wishes of people with physical disability in Dundee.

2.3 Approves the Strategic and Commissioning Statement for People with Physical Disability (attached as Appendix 1) as the vehicle for the planning and development of services over the next three years.

3.0 FINANCIAL IMPLICATIONS

This Statement sets out the intentions for the existing budgetary allocations for people with physical disability and any future new funding streams.

4.0 MAIN TEXT

4.1 Within the context of the Strategic Planning framework, a need was identified for a specific Strategic Planning Group (SPG) to bring together the range of experience and needs of people with physical disability across the City. The creation of the Strategic and Commissioning Statement for People with Physical Disability began in 2016 and has been completed this year taking into account the need for a co-ordinated and collaborative approach to the delivery of quality services across Dundee.

4.2 A Strategic Needs Assessment was carried out and identified a range of issues that required to be addressed:

- People in Dundee have a lower life expectancy than the Scottish average.
- Dundee has a high level of deprivation.
- There is a link between getting older and having a physical disability.
- People who live in more deprived areas have a higher rate of physical disability.
- Barriers to people with a physical disability taking up education and employment opportunities.
- Access to housing, public spaces and services for people with a physical disability.
- Preventative approaches that improve and maintain health and wellbeing are key in reducing the impact of physical disability.

4.3 Members of the SPG, which includes people who use services and key people delivering those services, have contributed to the development of the key actions and priorities and will measure performance against these key actions.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. An EQIA is attached as Appendix 2. It supports the Scottish Government's A Fairer Scotland for Disabled People delivery plan (A Fairer Scotland for Disabled People: Scottish Government, December 2016).

6.0 RISK ASSESSMENT

Risk 1 Description	Services may be delivered by disparate organisations around their own priorities and not the identified needs of the community as identified in the Strategic Needs Assessment resulting in duplication and disjointed services.
Risk Category	Operational
Inherent Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (which is a high Risk Level)
Mitigating Actions (including timescales and resources)	The SPG and this strategic statement provide the structure and key stakeholders to mitigate this risk.
Residual Risk Level	Likelihood 1 x Impact 3 = Risk Scoring 3 (which is a low Risk Level)
Planned Risk Level	Likelihood 1 x Impact 3 = Risk Scoring 3 (which is a low Risk Level)
Approval recommendation	Given the low level of planned risk, the risk is deemed to be manageable.

Risk 2 Description	There is a risk that future financial resources will not be sufficient to deliver this plan particularly around the delivery of accessible homes and services delivered in people's own homes which can be significantly more expensive than placements in care homes.
Risk Category	Operational/Financial
Inherent Risk Level	Likelihood 4 x Impact 4 = Risk Scoring 16 (which is an extreme Risk Level)
Mitigating Actions (including timescales and resources)	• The SPG will work with the Chief Finance Officer and local providers to ensure that resources are community focussed, enabling people with physical disability to live in their own homes where this is their preferred option. • The Locality Manager, Resource Manager and Chief Finance Officer will work together to project the level of resource required over each financial year to assist with the IJB's financial planning process. • The Resource Manager and Contracts Officers will deliver a range of services that are commissioned in partnership to be innovative and creative in meeting the needs of people.
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	This risk is deemed to be acceptable on the basis that the mitigating actions will support the best possible outcomes for people and the most effective use of resource.

7.0 CONSULTATIONS

The Strategic Statement was devised following a significant period of consultation across Dundee with all stakeholders. The Chief Finance Officer and the Clerk were consulted in the preparation of the 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.

David W Lynch
Chief Officer

DATE: 12 April 2018

Alison Bavidge
Resource Manager (Physical Disability and Sensory Services)
Health & Social Care Partnership

Beth Hamilton
Locality Manager (Coldside and West End)
Health & Social Care Partnershi

Appendix 1

Dundee
Health & Social Care
Partnership

Strategic and Commissioning Statement for Adults with a Physical Disability 2018 – 2021

Table of Contents

Introduction

This is the Strategic and Commissioning Statement for Services and Supports for People with a Physical Disability in Dundee (the Statement). This Statement has been developed from the Dundee Health and Social Care Partnership Strategic and Commissioning Plan (2016 – 2021) (DHSCP Strategic Plan). It sets out the direction of travel for supporting people with physical disability to live longer, more fulfilled lives. It recognises the skills, knowledge, connections and experience of people with a physical disability and the need to build on this resource to promote healthy, active and integrated communities. Whether people are born with a physical disability or acquire disability at some point in their lives, the social and physical environment is likely to present barriers to them leading fulfilled lives[1]; getting around, finding employment, having a home that meets their needs and accessing the information they need. This results in health and financial inequalities that reduce life opportunities and wellbeing for people with disability and their families.

In its Strategic Plan, the Dundee Health and Social Care Partnership sets out the priorities for using available resources to improve the wellbeing of people who use health and social care services, in particular those whose needs are complex and who require support from both health and social care at the same time. The strategic priorities identified in the plan are:

1 Health Inequalities
We know that people who live in areas of deprivation have poorer health and live shorter lives. We will take positive steps to improve health equity in the localities in Dundee where there are the most people with the greatest needs.

2 Early Intervention and Prevention
By working with people earlier, we can reduce the impact of health and social care needs on the people experiencing them and target our resources more effectively. We will focus on self-management of long-term conditions to allow people to manage their lives and conditions as independently as possible and secondary prevention which aims to reduce the likelihood that having one or more long term condition results in a person being more likely to develop others. Anticipatory Care Planning promotes the idea that we should think ahead and ensure that we have put in place some contingency plans, information for family and others.

3 Person Centred Care and Support
We need 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.

[1] Scope and the Social Model of Disability

4 Carers
We will invest in the role that carers play in supporting friends and family ensuring that their rights and well-being are actively promoted. There is a specific Strategic Planning Group for Carers.

5 Localities and Engaging with Communities
Dundee has a wide range of people with diverse needs across different parts of the city. We will invest in an infrastructure to support the development of locality planning and allocate resources to implement locality plans.

6 Building Capacity
We will optimise people's opportunities to contribute to their families, their community and to the City. We will support individuals to maximise their financial situation through work, access to learning and access to the benefits they are entitled to. We will build stronger relationships with employers and educational institutions and build capacity within the third sector to identify and meet needs in our communities that stop people living full and healthy lives.

7 Models of Support, Pathways of Care
We want 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 need more targeted and specialised residential resources and to invest in accommodation with support and day opportunities. We need to maximise the telehealth and telecare supports available to help people live more independently for longer.

8 Managing our resources effectively
We will develop our workforce to support the integration and development of new models of care and invest in co-located, integrated models of care and support aligned to localities and deliver better outcomes for people.

You can find background information about why the Dundee Health and Social Care Partnership (DHSCP) has been created, the national and local outcomes and the Partnership's strategic action plan in the DHSCP Plan.

The Scottish Government recently published A Fairer Scotland for Disabled People which includes a national delivery plan based on five ambitions which we must also take into account:

1. Support services that meet disabled people's needs
2. Decent incomes and fairer working lives
3. Places that are accessible to everyone
4. Protected rights
5. Active participation

The DHSCP Plan explains that we need to achieve significant shifts in how services are prioritised, accessed, organised and delivered. This will involve investing in some areas of service and disinvesting in others in order to deliver a more preventative and integrated community based approach.

The Strategic Planning Groups (SPGs) are groups representing people who use services and the key people delivering those services. The SPGs will influence and shape the priorities and actions of the Health and Social Care Partnership in addressing the specific issues and support required.

In Dundee, the Partnership currently has the following SPGs:

• Frailty (including People with Dementia)
• Learning Disability and/or Autism
• Physical Disability
• Sensory Services
• Mental Health and Wellbeing
• Carers
• Homelessness
• Substance Misuse

The diagram at Appendix 1 shows how the SPG for People with a Physical Disability (SPG PPD) fits into the overall structure.

This Strategic and Commissioning Statement for People with a Physical Disability has been developed as the next stage to the DHSCP Strategic Plan. It focuses on the needs of people who:

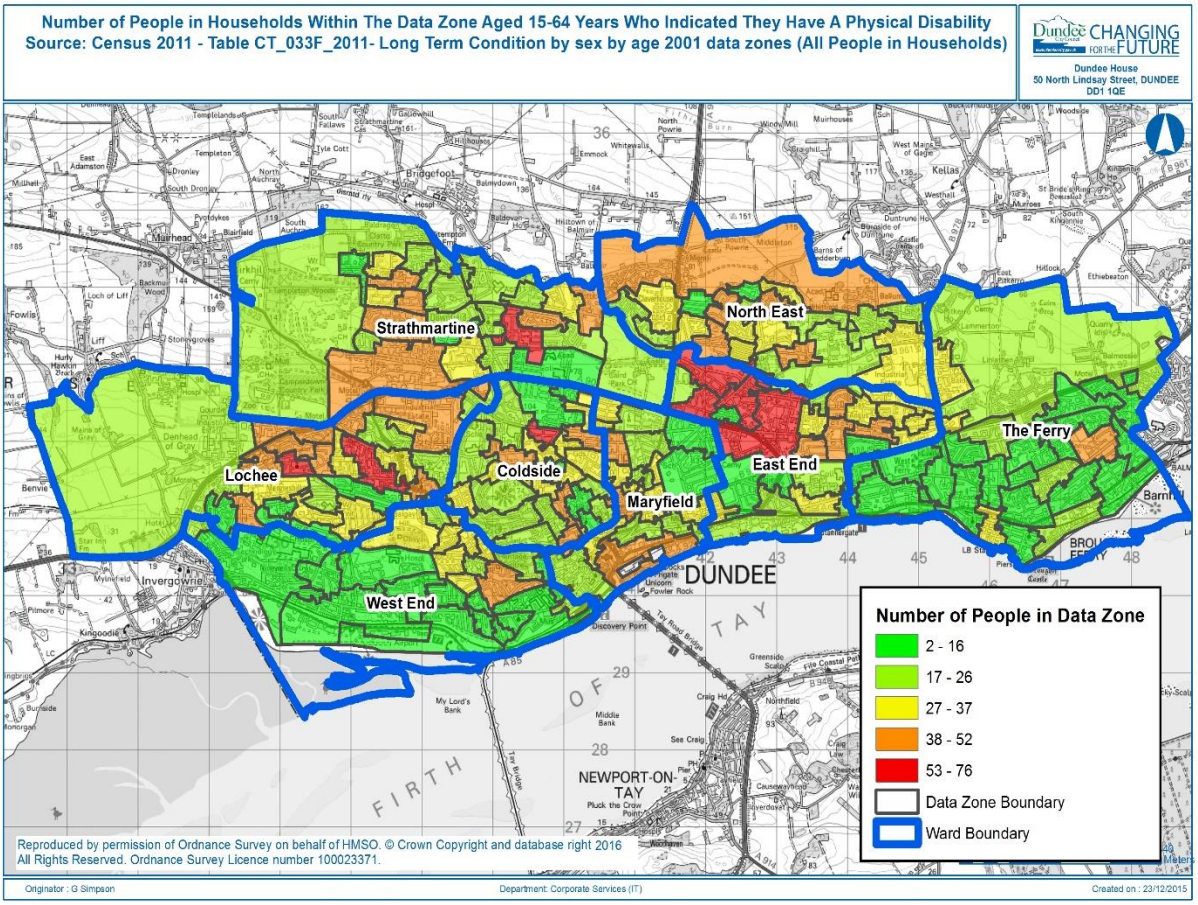
- are adults (over 16 years of age),
- have a enduring physical impairment or long-term condition; and
- are unable to independently undertake activities of daily living, or who experience significant restrictions when doing so.

We used a wide range of data to inform this statement. The data was collated and then developed into a Physical Disability Strategic Needs Assessment. There is summary of this in Appendix 2. The Physical Disability Needs Assessment provides a demographic and geographical profile of adults with physical disability who live in Dundee. It helps to plan for future needs and the demand for health, social care and community services. It has been difficult to accurately define the number of people with physical disability due to wide-ranging differences in the ways that this is reported. Therefore, our plans must be designed so we can respond quickly to changes in information and needs and that we take the likelihood of change into account in the way we monitor and review our action plans.

The key issues identified in the Needs Assessment include:

- People in Dundee have a lower life expectancy than the Scottish average
- Dundee has a high level of deprivation
- There is a link between getting older and having a physical disability

- That people who live in more deprived areas have a higher rate of physical disability
- There appear to be barriers to people with a physical disability taking up education and employment opportunities
- Access to housing, public spaces and services for people with a physical disability
- Confirmation that preventative approaches that improve and maintain health and wellbeing are key in reducing the impact of physical disability



In order to take our work forward, the SPG PPD will review the current provision, design tests of change and implement successful change projects more widely. The SPG PPD is responsible for ensuring that all our improvement work is clearly defined and monitored, for ensuring the work supports the overarching DHSCP Strategic Plan and that we engage fully and in a coordinated way with all stakeholders.

The DHSCP Plan notes that all the SPGs have some common pressures to address, including:

• An increase in demand for community health and social care including general practice, community nursing and care at home services
• An increase in the number of people with complex needs seeking support
• Increasing pressure on hospital inpatient services from unscheduled admissions and delays in discharging to home
• Requirement for more housing options, both with and without support

• More flexible services to meet variable need across extended days and overnight
• More personalised supports
• Support for carers

SPG PPD members consulted over an 18 month period to ensure that the key areas for action in this statement will deliver the greatest improvement to people using our services. The SPG PPD will meets every three months (or more often)and will use the action plan arising from this Statement to monitor and report on progress in improving outcomes for people with physical disability in Dundee.

Where do we want to be?

We want to live in a Dundee where:

1. everybody is able to access responsive and individualised health and social care services in order to live fulfilled lives

2. people with a physical disability lead healthy, independent, connected lives

3. people who need support experience dignity, respect and compassion from health and social care services across the public, private and voluntary sectors

4. people who need support can access local community amenities, public areas and housing that meets their needs and those of their families and carers.

Areas for Action

Key Action 1: Improving health and social care support

The development of this Statement is taking place against one of the most significant organisational redevelopments for people with health and social care needs. For the first time ever, one organisation, Dundee Health and Social Care Partnership, is responsible for the provision of both adult social care and community health services. This means we need to think about how our integrated health and social care services are planned, organised, delivered and managed.

One of the strategic priorities set out in the DHSCP Strategic Plan is around models of support and pathways of care. People want to live as independently as possible at home or in a homely setting. In order to meet the growing numbers of people living with long term health conditions, we need to ensure that support is anticipatory, well planned, and offers choice and smooth transitions between services. We need to deliver more preventative community based support to help people to manage their own conditions, get help earlier and to get people the right care at the right time in the right place. This approach will help prevent people developing conditions, deteriorating and possibly reaching crisis point.

Significant factors in achieving this include:

- ensuring that integrated, coordinated, planned processes (pathways) are in place to facilitate person-centred, flexible care planning
- delivering support close to home making full use of technological advances
- co-locating services in localities and develop single points of access, shared information and systems
- ensuring that transitions from children's to adult's services are smooth and well planned.

Work so far

- ✓ The Brain Injury Pathway: We have developed a care pathway for people in Dundee who have experienced a brain injury to support people through their rehabilitation through the Centre for Brain Injury Rehabilitation (CBIR) and the Mackinnon Centre. This allows people to learn and regain skills without them remaining in acute hospital settings longer than they need.
- ✓ The CBIR and The Corner have worked together for a number of years raising awareness of Brain Injury with young people across Dundee. Staff at The Corner and the CBIR worked together to produce a film entitled "Keeping (a) Head" and a set of resources entitled "Puzzled about the Brain" which were launched in March 2017. These resources were developed in partnership with the staff and a patient and family at the

CBIR, young people and supported by Dundee City Council's Youth Work Department. This launch in March celebrated the joint work of young people and professionals involved in the development of these resources, and provided an opportunity for workers from across the DHSCP to see the potential of these resources with young people. Work is now ongoing across high schools in Dundee using the resources to raise awareness and once this has been evaluated further development work is planned.

Example of need

This case example shows the types of needs and challenges that some people with physical disability in Dundee can face. It is not necessarily a case study of best practice.

Bridget

Bridget suffered a stroke which has left her with a weakness on one side of her body, heart problems, epilepsy and communication issues which means she needs to write down what she says. After her stroke, Bridget needed rehabilitation which helped her to learn how to manage the symptoms of her stroke and allowed her time for her adjust to her disability.

However, then poor blood flow resulted in her having a leg amputated. After a short stay in a care home, Bridget continued her rehabilitation on a new care pathway which enables people recovering from strokes and acquired brain injury to move from acute medical care, through the Centre for Brain Injury Rehabilitation to the Mackinnon Centre which has temporary accommodation and support available for people who have had a brain injury.

As well as classes in gardening, cookery and art, the Centre provides daily support for physiotherapy and people are able to develop their independent living skills and practise with the aids and adaptations they may need in preparation for going back home or moving to a new home if their previous home is no longer suitable.

A new wheelchair adapted home has been found for Bridget. Her husband, who will be her main carer at home, has been able to learn from staff at the Centre about how best to help and support his wife.

Key Action 1 Priorities

By making use of the opportunities for integrated working in Dundee Health and Social Care Partnership and working closely with partners in the independent sector, we will:

Key Action Area 1 Health and Social Care Support		Local Measures in addition to the SPG report against its action plan	National Health and Wellbeing Outcomes	National Health and Wellbeing Indicators	A Fairer Scotland Five Ambitions
1.1	Further develop discharge planning arrangements and new models of service delivery to ensure that people who need housing and community support are able to move on from hospital based services as soon as they are ready. This will include improving the Brain Injury Pathway to ensure transitions are as smooth as possible and to consider how the Dundee model aligns with the Tayside wide brain injury work in Angus and Perth and Kinross and investing in resources which support assessment for 24 hour care taking place at home or home like settings	Delayed discharge figures Days in step down accommodation due to the need for suitable housing and/or care package.	**Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer **Outcome 2:** 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 **Outcome 3.** People who use health and social care	1. Percentage of adults able to look after their health very well or quite well. 2. Percentage of adults supported at home who agree that they are supported to live as independently as possible. 3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. 4. Percentage of adults supported at home who agree that their health and care services	1. Support services that meet disabled people's needs 5. Active participation
1.3	Build preventative approaches into our work across health and social care so that we deliver more proactive assessments and support to reduce long term conditions and physical disability. This will include aligning services more closely with preventative community based and primary care support and making better use of community	We will work with a range of teams to identify measures to evidence improvements.			

	resources such as libraries and community pharmacies to promote health and wellbeing, including a social prescribing role, as a point of contact with people. Prioritise and invest in models of support that help to support life style changes which improve outcomes for people with a physical disability.		services have positive experiences of those services, and have their dignity respected **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those	seemed to be well co-ordinated. 5. Percentage of adults receiving any care or support who rate it as excellent or good 7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. 9. Percentage of adults supported at home who agree they felt safe.	
1.4	Support the move toward locality work based in communities where we make it easier for people to access the range of services they need. This will include building workforce capability and the capacity to deliver models of care which promote health, self-management and address inequalities.	We will work with a range of teams to identify measures to evidence improvements.			
1.5	Develop our approach to the transition from children's services to adults to ensure that the transition is smooth and that young peoples' aspirations and goals are fully incorporated into their outcome plans.	Survey of people who have transitioned to adults services. Case file audit			
	Enhance support to improve mental wellbeing of people with physical disability, focussing on those who live in areas which experience greater health inequalities	We will work with a range of teams to identify measures to evidence improvements.			

Key Action 2: Having somewhere to live and the support to live there.

The Strategic Planning Group acknowledges the important role that the Housing Sector plays in delivering the city`s health and social care accommodation and support outcomes. People who have or develop physical disability often require housing to meet their specific needs. The ability of people to leave hospital or step down care and accommodation relies on the availability of suitable homes. As a result, we are committed to working with our housing partners to develop a variety of community based housing and support choices in the city for adults with physical disabilities.

Social Rented Sector: Wheelchair Adapted Housing

Dundee currently has 352 social rented wheelchair adapted houses. In general, between 2009 and 2014 the number of social rented wheelchair housing provision in the city met waiting list demand. However, since 2015 Dundee has experienced a significant rise in demand for social rented wheelchair adapted housing. For example, in 2015 the number of waiting list applicants stood at 55; as at November 2017 it was 111. This represents a 68% increase over the 2015 - 2017 period. In addition to the rising wheelchair adapted housing waiting list demand, the PPD SPG has identified fifteen individuals with physical disabilities requiring new-build, wheelchair adapted supported housing. Their housing requirements and the requirements of applicants on the social rented wheelchair adapted housing waiting list are reflected in the Dundee Strategic Housing Investment Plan`s (SHIP) particular needs housing targets, 2019 – 2022, under categories 3 and 4 respectively.

Around 1 % (242[2]) of children (aged 0-15) in Dundee have a physical disability. As young people grow up and become more independent, they need housing to meet their needs. Our strategic planning must anticipate this future need.

Table 1. Provides a breakdown of Dundee`s social rented wheelchair adapted housing provision.
Table 2. Outlines the city`s particular needs housing targets over 2019 - 2022.

Table 1. Dundee Social Rented Sector, Wheelchair Adapted Housing Provision

Local Authority	Housing Association	Total
169 (48%)	**183 (52%)**	**352 (100%)**

Source: Dundee City Council, Neighbourhood Services, November 2017

[2] 2011 Census

Table 2. Dundee, Particular Needs Housing SHIP Commissioning Targets, 2019 - 2022

	Year	2019/20	2020/21	2021/22	2019-22
	Service Area	Housing Targets	Housing Targets	Housing Targets	Total
1.	Learning Disabilities	10	10	6	**26**
2.	Mental Health	4	4	4	**12**
3.	Physical Disabilities	9	6	❖	**15**
4.	Waiting List Wheelchair Housing	4	5	5	**14**
5.	Young Persons	❖	❖	❖	❖
	Total	**27**	**25**	**15**	**67**

Sources 1 - 3 Dundee Health and Social Care Partnership, November, 2017
4 Dundee City Council, Neighbourhood Services, November, 2017
5 Dundee City Council, Children and Families Services, November, 2017

N.B. Year: Reflects the housing target commissioning date; not the completion date
❖ When figures become available, they will be reflected in the housing targets

Work so far

In partnership with our housing partners, we now have:

Housing with Support

- ✓ Delivered three step-down supported houses to enable people to leave hospital as soon as they are medically able
- ✓ Identified care and support revenue funding for an additional step-down supported house

New-Build Housing

- ✓ Delivered six technology enabled care wheelchair adapted houses
- ✓ A target to commission fourteen wheelchair adapted houses to meet the housing needs of people on Dundee`s social rented wheelchair adapted housing waiting List

Example of Need

This case example shows the types of needs and challenges that some people with physical disability in Dundee can face. It is not necessarily a case study of best practice.

Richard

Richard and his partner had a long history of alcohol addiction and self-neglect. Richard started using a wheelchair after he got one of his legs amputated from the knee due to complications from his high level of drinking. When his partner died suddenly in the flat, it was for four days before Richard

informed Housing concierge who then notified the Police and the Health and Social Care Partnership.

Richard was offered emergency care and accommodation at a centre for people with physical disability whilst his partner's body was removed from their home. After this, the flat was assessed as uninhabitable and workers found out that Richard had not been able to get into the shower or the bath. The flat was then all redecorated and furnished so that Richard could return to the flat on a short term basis until housing could be found which would meet his health and social needs.

After 4 months, Richard was offered a supported placement at a facility for people who have difficulties with maintaining their tenancies as a consequence of substance misuse.

Richard said he really loved living at this facility and enjoyed building relationships with fellow residents and the staff who supported him. He thrived as he was receiving regular meals and got help to register with a GP so his health and wellbeing all greatly improved.

Unfortunately, Richard was diagnosed with advanced throat cancer and he died 7 months after this diagnosis. However, he would regularly say that the last year of his life was the best he ever had. He would say he 'had peace of mind' and as, his alcohol intake greatly decreased, he felt more in control.

Therefore, over the period of our Strategic and Commissioning Statement we will work in partnership with our housing partners to support:

Housing with Support

- The development of appropriate models of housing which include a high level of care or support to enable people to live independently.

Housing Adaptations

- Where safe installation allows, adaptations to individuals` existing homes, thereby improving accessibility. For example, assistive technology, level access, fitting of handrails, converting kitchens and bathrooms.

New Build Housing

- The development of new-build, wheelchair adapted social rented housing.

Existing Social Rented Housing

- The best use of existing mainstream and wheelchair adapted housing stock.

Key Action 2 Priorities

In partnership with our housing partners, we will identify people with physical disabilities living in accommodation that is inappropriate for their needs, develop alternative housing and support options for them and ensure that suitable accommodation is available for our integrated health and social care pathways. We will:

Key Action Area 2 **Health and Social Care Support**		**Local Measures in addition to the SPG report against its action plan**	**National Health and Wellbeing Outcomes**	**National Health and Wellbeing Indicators**	**A Fairer Scotland Five Ambitions**
2.1	Deliver three supported wheelchair adapted houses by the end of 2018	Increase in the stock of supported wheelchair housing.	**Outcome 2:** 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	2. Percentage of adults supported at home who agree that they are supported to live as independently as possible. receiving care at home. 18. Percentage of adults with intensive needs 19. Number of days people spend in hospital when they are ready to be discharged. 21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home. 22. Percentage of people who are discharged from hospital within 72 hours of being ready.	3. Places that are accessible to everyone 4. Protected rights
2.2	Understand our existing housing stock to identify properties that could be enhanced and adapted	Number of people under 65 with physical disability living in care homes.			
2.3	Identify potential care, support, and capital funding sources to progress the development of supported wheelchair adapted houses over the period of the plan.	Number of people on wheelchair houses waiting list decreases.			
2.4	Develop Best Practice Guide to Managing Social Rented Wheelchair Adapted Housing Tenancies	People with Physical Disability using Housing Support Services			

Key Action 3: Learning and working.

Work is a significant part of most people's lives and brings with it higher standards of living, social engagement, learning opportunities and for many people a sense of pride and achievement. The Physical Disabilities strategic needs assessment highlights the issue of low numbers of people with a physical disability who are employed within Dundee.

In Dundee 78% of people aged 16-64 are employed or in education. Only 30% of people with a physical disability in the same age group are working or studying.

In Dundee 7% of people aged 16-64 are long-term sick or disabled. 58% of people with physical disabilities are long-term sick or recorded as not working due to a disability.

It is important that people a with physical disability are supported to access appropriate welfare rights support and advice in order to support their daily living expenses, quality of life and their access to work or meaningful activity like volunteering or study.

Along with other agencies in Dundee's Employment Pipeline, the Dundee Health and Social Care Partnership Employment Support Service helps people with disabilities, health problems and other significant barriers to find and sustain employment. There is no 'one best way' to help a person to find employment because a person's skills, abilities, motivation and domestic circumstances are unique to them so the Employment Support Service tailors the service to meet individual service user's needs whether they are already in employment or whether they are looking for employment. This includes:

- Job Club to assist service users to look for employment
- Work Experience Placements to enable service users to develop their skills
- Support Team providing on-going support to people with significant barriers to employment
- Consultancy and Advisory Service to local employers, voluntary organisations and people who have disabilities and health problems regarding good employment practice

Work so far

- ✓ Dundee City Council Welfare Rights Advisers implemented a pilot scheme in 5 GP practices which has been extended across the city. By linking in early with people when illness or disability strikes, the advisers have successfully used access to medical records to secure more than £2.1 million in extra income for individuals since January 2015.

- ✓ In 2016 the DD4 network was set up to target people furthest from the labour market. This operates from 2 local venues which are accessible not only because they are based in the communities they support but are also based in wheelchair friendly buildings. Disability was one of the

most common barriers expressed by participants. Although it is still relatively new the community -based, integrated model is recognised as potentially improving the journey to employment for local people. This approach has yielded positive outcomes for clients with complex needs.

Example of need

This case example shows the types of needs and challenges that some people with physical disability in Dundee can face. It is not necessarily a case study of best practice.

Claire

Claire suffered a stroke in June 2014 aged 55. This resulted in difficulties with concentration, information processing, memory and fatigue. Her communication skills were also affected and she found it difficult to find words. In 2015 Claire started attending a skills centre for people with a physical disability. She identified some outcomes she was determined to achieve

- *Move forward after stroke and identify new identity*
- *Be constructive with her time*
- *Rediscover her creative talents*
- *To develop skills in using a sewing machine*
- *Complete some therapeutic activities.*
- *For guidance and support to complete projects started at home.*
- *Exploring other media and techniques.*

Additionally Claire was supported to ensure she was getting the welfare benefits she was entitled to. Soon, Claire realised she wanted to move onto a college course and identified a course at a local college in Contemporary Art Practice. She started this course in August 2017.
"I've benefitted greatly from attending the Centre in terms of improving my confidence and developing my skills. I've achieved my outcomes and I'm ready to move on."

Key Action 3 Priorities

We need to ensure that local people with physical disabilities have access to suitable employment opportunities in line with those available to all local people. This must include access to vocational education and training. We need to work with local employers, local partners and statutory services to increase knowledge and awareness of employment issues so as to remove or reduce current barriers to employment and identify and prevent any future barriers arising.

Key Action Area 3 Learning and Working		**Local Measures in addition to the SPG report against its action plan**	**A Fairer Scotland Five Ambitions**
3.1	Engage with people with physical disability to explore their experiences of employment and education, identify their need for support, and to review existing sources of local and national information about employment support needs.	Percentage of people with physical disability who are in education volunteering or work. Number of people with physical disability supported by the Employment Support Service Number of people whose income we help to maximise We will work with a range of teams to identify other measures to evidence improvements	1. Support services that meet disabled people's needs 2. Decent incomes and fairer working lives 3. Places that are accessible to everyone 4. Protected rights 5. Active participation
3.2	Review the skill development opportunities currently available for people with physical disability		
3.3	Work with partner agencies to ensure that income is maximised for people with disabilities across the city		
3.4	Work with partner agencies and employers across Dundee to help facilitate access to employment for people with a physical disability		
3.5	Secure the provision of education/training in partnership with local further education institutions and through employment focused social enterprises.		
3.6	Promote an approach to employment support in line with the findings of the Dundee Partnership Employability Review.		

NOTE: The National Health and Wellbeing Outcomes and Indicators do not directly link to this Key Action Area

Key Action 4: Having a life

In order to live a fulfilled life most of us expect not only to have somewhere to live and be able to meet our health and care needs but to be a part of the community in the place that we live, have hobbies and to be able to make and maintain relationships. Feeling part of families and the wider community is key to our mental health and well-being. Promoting inclusion for people from a diversity of backgrounds and with diverse needs promotes their wellbeing and enables them to contribute to their communities. But also, when a wide range of people are visible and engaged as part of our communities, we are more likely to develop groups and services that reflect the full range of needs and experiences.

People with disability are part of families and relationships. Whilst sometimes they are cared for by family and friends, they may themselves be carers for parents, siblings, friends and children. Services for people with physical disability must reflect the lives, sometimes complex, that people live and take their relationships and life stage into account. We need to ensure that the right support is available to mitigate some of the issues that are faced by people with a disability who might be parents and carers for others. We also need to consider young and adult carers of people with a disability and will do this in collaboration with the work of Dundee Carers Partnership Strategic Plans.

There are many barriers that can result in people with a disability not accessing community groups, activities, buildings and services. These include poor transport, buildings that are not accessible to people who use a wheelchair or have difficulty walking and attitudes or lack of knowledge from staff in public places. These barriers then may lead to people becoming less confident in going out and being part of their local community.

Work so far

- ✓ All Leisure and Culture Dundee activities are designed to be inclusive and open to everyone. For further information and contact numbers please visit Leisure and Culture Dundee's website or see Appendix 3
- ✓ Leisure and Culture Dundee provides a range of groups specifically for people with a physical disability: Carpet bowls; swimming, powerchair and more (see Appendix 3)
- ✓ There are a number of independent Clubs for people with disability including: Discovery Swimming Club, Dundee Dragons Sports Club, Tayside Dynamo Powerchair Football and Dundee Boccia Club (see Appendix 3).
- ✓ Tayside Healthcare Arts Trust develops the role of the arts in healthcare across Tayside, working to improve the health and wellbeing of people with a variety of Long Term Conditions and enhance the quality of healthcare environments. Work has included:
    - **Singing with Chronic Obstructive Pulmonary Disease**
    - **Dancing with Dementia**

- **DCA Printmaking Summerschools**

✓ Core exercise programmes including activity and advice are offered to people who have suffered a stroke, have heart failure and other conditions as part of the rehabilitative process. The level of the programme depends on the person, and whether they have exercised before or would prefer an agreed home exercise programme.

✓ The Dundee Stroke Exercise Club offers open weekly exercise classes in two locations across the city.

Example of Need

This case example shows the types of needs and challenges that some people with physical disability in Dundee can face. It is not necessarily a case study of best practice.

Diana

Diana suffered muscle and nerve damage to her spine following a virus. After surgery she also experienced damage to her bowel. She uses a wheelchair to get around and can very occasionally use crutches. Before the virus, Diana had a full-time job working with young people but had to give up her employment due to the deterioration in her health. She has a husband and a young family.

During the early days of her condition Diana felt embarrassed to go out and spent most days in her house, feeling very low emotionally and not motivated to do anything. The family had to move into rented accommodation as the home that they owned was not suitable for Diana's wheelchair. Diana's disability affected everyone as she now needed to be cared for as well as needing to care for her own family. House moves can mean that children need to move school and changes around work and finances can cause real problems for families when someone acquires a disability. Diana's teenage children now began to care for her rather than the other way around which affected their relationship and Diana vs sense of self and mental wellbeing.. Diana knew that she wasn't being the parent and the partner she wanted to be and reluctantly agreed to try some activities suggested by her care manager. She found it difficult to view herself as having a disability but decided that she would try some classes at a centre for people with a physical disability. This felt as though it would be a good place to start in a safe environment where others were in similar positions before attempting more mainstream activities. Here, Diana felt encouraged and supported. She also decided to take up some respite care in a residential centre to give her caring family an occasional break. "I loved it"

The opportunity to get out of the house, learn new things and make friends has reduced stress and improved family relationships. "I don't feel sorry for myself now and I'm able to be a supportive mother and partner. I'm the chair of the Service Users Group, organising events and getting people involved. My family have noticed a big difference in me and I'm happier and more relaxed".

Key Action 4 Priorities

The SPG PPD is responsible for ensuring that Dundee has a good range of formal and informal services and supports that are designed to cater for everybody. We will work across the Partnership to advise, develop, promote and commission services that support people with physical disability to have live their lives fully. We will:

Key Action Area 4 **Having a Life**		**Local Measures in addition to the SPG report against its action plan**	**National Health and Wellbeing Outcomes**	**National Health and Wellbeing Indicators**	**A Fairer Scotland Five Ambitions**
4.1	Build on current engagement methods to identify community need and initiatives. Listen to what people in Dundee with physical disabilities tell us about how accessible community activities are to them. Develop an action plan with a range of partners across all sectors to remove barriers that takes into account individual locality needs	Use of Disabled go website for information about accessible places Local Engagement and Communications Group data Links to National Health and Wellbeing Survey, Health and Social Care Experience Survey and the Dundee Citizen Survey We will also work with a range of teams to identify measures to evidence improvements.	**Outcome 6.** 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 well-being	7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. 8. Percentage of carers who feel supported to continue in their caring role.	3. Places that are accessible to everyone 5. Protected rights **6.** 5. Active participation
4.2	Work with current community facilities to develop a range of leisure and social activities for people with disability needs Use a co-productive approach to promote opportunities that delivers support closer to where individuals live.				
4.3	Work with the transport strategy to ensure accessible community transport				
4.4	Review building based day opportunities for people with physical disability.				

4.5	Review current models of respite support and remodel in line with findings.				
4.6	Prepare for and implement the Carers legislation when enacted and promote the approaches in the Strategic Commissioning Statement for Carers with input/ involvement from carers' groups and carers' partnerships and implement this.				
4.7	Co-locate activities to allow carers and those they care for to pursue their interests and activities in the same place at the same time.				
4.8	Continue to develop and increase the capacity of volunteers.				
4.9	Support health and social care staff to identify community resources and to sign post/support individuals to access these resources. Further develop community health resources to maintain people living in their own neighbourhoods.				

Key Action 5: Keeping safe and taking risks

Everybody wants to live safely, free from abuse, living the life that they choose and making their own decisions. In taking a human rights approach, the PPD SPG aims to create an environment where people with disability are deciding about what matters to them and are able to make their own life choices, taking risks in the same way that people without disability are expected to.

However, people with care and support needs, such as older people or people with disabilities, are more likely to be abused or neglected. [3] They may be seen as an easy target and may be less likely to identify abuse themselves or to report it. People with communication difficulties can be particularly at risk because they may not be able to alert others. Sometimes people may not even be aware that they are being abused, and this is especially likely if they have a cognitive impairment. Abusers may try to prevent access to the person they abuse and signs of abuse can often be difficult to detect.

Types of abuse include:

- Physical abuse
- Domestic violence or abuse
- Sexual abuse
- Psychological or emotional abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational or institutional abuse
- Neglect or acts of omission
- Self-neglect

Disabled people are significantly more likely to experience domestic abuse. That experience is likely to be more severe, long-lasting and include particular forms of abuse, such as ridiculing an impairment or withholding personal care. Disabled people may have increased risk factors for domestic abuse related to their impairment, reliance and isolation, or wider risk factors, including exclusion from education, employment and income. Disabled people experiencing domestic abuse may also encounter significant barriers to accessing services.[4]

[3] SCIE
[4] Disability and Domestic Abuse, Public Health England, 2015

Work so far

- ✓ In 2016 the Dundee Adult Support and Protection Committee actively supported the national 'Take Five' campaign. https://takefive-stopfraud.org.uk/resources/campaign-materials/
  - The aims are to engage, empower and educate on how best to protect against financial fraud. Its main message is 'take five minutes - stop and think'. In addition the multi-agency Financial Harm Group initiate ongoing work around financial harm and work closely with the Dundee Community Safety Partnership, Trading Standards and Money Advice services to set up awareness raising events for the public, staff within services and elected members.

- ✓ 'Keep Safe' Places works in partnership with Dundee Safe Place Initiative, Police Scotland and a network of local businesses to create 'Keep Safe' places for disabled, vulnerable, and older people when out and about in the community. Currently in Dundee there are 18 Keep Safe places which are recognisable by the Dundee Keep Safe logo on their window. If in distress or assistance members of the public can access a Keep Safe place and show their Keep Safe card. The card holds the person's name, health, communication needs and emergency contacts. The local scheme is managed by Advocating Together Dundee who visit local groups to hand out Keep Safe cards and explain Keep Safe to local disabled people.

Example of Need

This case example shows the types of needs and challenges that some people with physical disability in Dundee can face. It is not necessarily a case study of best practice.

Paul

Paul was in a very bad way physically, weighing only 4st and living with lice and scabies. He was living in his own home but there were concerns that some of his family were using his property for drug related purposes and abusing him financially. A placement in a rehabilitation unit resulted in medical treatment and improved nutrition. After this, he was discharged to alternative housing with care. Paul's family continued to visit him but measures were put in place in order to ensure his medication and finances were kept secure. This allowed Paul to keep contact with people who were important to him whilst reducing any risk to him.

Key Action 5 Priorities

The SPG PPD has a responsibility to ensure that the health and care services that are delivered to people with physical disability address the issues of abuse, ensuring that Adult Support and Protection guidance and procedures are fully understood by staff and embedded in services and that anyone in Dundee who experiences abuse is able to access someone who can help. We will:

Key Action Area 5 **Keeping Safe and Taking Risks**		**Local Measures in addition to the SPG report against its action plan**	**National Health and Wellbeing Outcomes**	**National Health and Wellbeing Indicators**	**A Fairer Scotland Five Ambitions**
5.1	Continue to work closely with Dundee Protecting People services, recognising that people who have a disability are more likely to experience all forms of abuse whilst ensuring that people with a disability are able to make decisions and take risks in keeping with a human rights approach.	Numbers of people with physical disability referred to Adult Support and Protection Number of these dealt within and outwith the formal Adults Protection process	**Outcome 7** People using health and social care services are safe from harm	9. Percentage of adults supported at home who agree they felt safe.	4. Protected rights 5. Active participation
5.2	Promote “Keep Safe” cards across services and supports for people with a physical disability.	Number of card in use. Number of business offering a safe place.			

Conclusion

Current Situation

The strategic needs assessment indicates that, with improved healthcare ensuring that people born with or who acquire a disability live longer and a growing population of older people in Dundee, the overall number of people with a physical disability and long-term conditions will increase in the future. Partnership services will need to work closely together to ensure that people with a physical disability are enabled and supported throughout their lives.

Supporting people with physical disability and long-term conditions is about embracing a model of care that recognises the principal issues faced by people with physical disabilities are often not predominantly medical. Rather, they are around the wider barriers faced by people; the inability to access housing, employment, or community resources. Like all people, people with physical disability hold personal and social experience and wisdom which can drive improvement and builder stronger and healthier communities. Through engagement and real involvement, this plan will use these assets to deliver the improvements in the key actions.

Future Actions

This strategy has set out how the SPG PPD intends to support adults with a physical disability in the future.

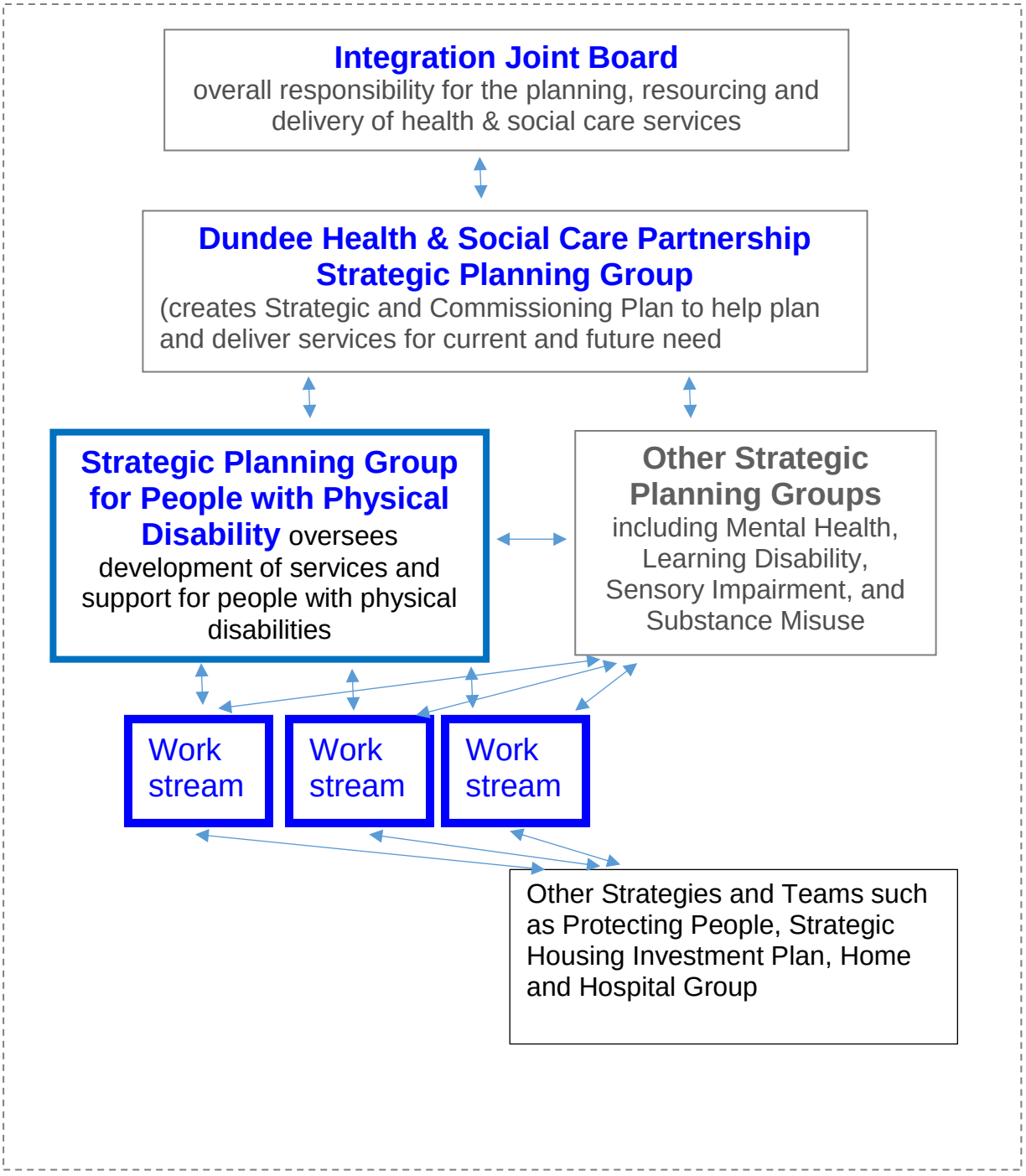
- We will facilitate a strategic shift based on a human rights approach towards self-management and greater independence for adults with a physical disability.
- We will develop new models of service delivery in order to meet current and future challenges. This will include a focus on developing integrated effective discharge pathways and ensuring a range of accessible, available and effective housing options.
- In addressing deprivation and inequalities across Dundee, we will include specific work to help develop and support access to volunteering and employment.
- We will engage with a wide range of people with a physical disability and their carers, in order to ensure that changes to services are focussed on improving the things that matter most to people.

This Statement lays out the direction that the SPG PPD will take over the years 2018-2021. The group will develop the key action priorities from each section in this Statement into a detailed action plan with timelines to ensure we can monitor and report on how well we are achieving our aims. The SPG PPD will report quarterly to the Dundee Health and Social Care Partnership Strategic and Commissioning Planning Group on progress. This statement will be reviewed on an annual basis to ensure that we continue to address the key priorities for people in Dundee to ensure people with a physical disability and long-term

conditions in Dundee live fulfilled lives where they can live independently in the community of their choosing and access the health, social care and community services that they need.

Appendix 1: Structure of Dundee Health and Social Care Partnership

Structure of Dundee Health & Social Care Partnership



Appendix 2: Strategic Needs Assessment – Summary

You can request the full Strategic Needs Assessment for People with a Physical Disability from the Strategy and Performance Team (01382 434000 or spssInformationTeam@Dundeecity.gov.uk).

Data about people with a physical disability

- According to most recent census (in 2011), 10,590 people in Dundee identified themselves as having a physical disability. Of these, 4,943 (47%) are between the ages of 16 and 64.
- According to the current census figures, Dundee has a slightly higher proportion of people with a physical disability than the Scottish average. The Scottish average rate for people aged 16 to 64 is 47.2 people per 1,000 population, but the Dundee average is 49.9.
- The biggest different is in the 50-64 age range where Dundee has 113 people per 1,000 population, compared to a Scottish average of 96 people per 1,000 population.
- There is a strong correlation between age and the likelihood of having a physical disability. Over 60% of people aged 16 to 64 who identified themselves in the census has having a physical disability were in the 50-64 age range. Of the people currently receiving support from Social Work teams, 55% are in the 50-64 age range.
- Dundee appears to have a higher prevalence of Chronic Obstructive Pulmonary Disease (COPD), diabetes, heart failure, peripheral arterial disease and stroke than the Scottish average.
- Many people with a physical disability who are receiving support from social work teams also have other conditions as well. 28% have a learning disability, 14% have mental health issues, and 10% have substance misuse issues.

Deprivation and Inequalities

- There is a strong correlation between deprivation and prevalence of physical disabilities.
- Of the eight Local Community Planning Partnership (LCPP) areas in Dundee, six are above-average levels of deprivation. Five have a higher average of people in the 16-64 age group with physical disabilities in comparison to the Scottish and Dundee average.
- The LCPP areas with the highest rate of 16-64 with physical disabilities is East End with 72.9 per 1,000 population, followed by Lochee with 66.4 per 1,000 population. West End had the lowest with 26.6 per 1,000 population.

- People with a physical disability are considerably less likely to be employed or in education, and are more likely to be recorded as long-term sick or disabled than the average population.

Appendix 3: Exercise and Sports for people with Physical Disability in Dundee

Groups
At the time of writing**,** Leisure and Culture Dundee provides the following opportunities for people with a physical disability. The groups run weekly during term time.

- Carpet Bowls Monday & Thursday @ Douglas SC 10am – 11.30am - Adults with a disability
- Active Adults Thursday @ Douglas SC 10am -11.30am - Adults with a Disability
- Swimming Friday mornings @ Lochee Leisure Centre 11am – 12noon - Adults with a Disability
- Powerchair Football - Any age, must be powerchair user.

In addition to the above all Leisure and Culture activities are inclusive and open to everyone. For further information and contact numbers please visit Leisure and Culture Dundee's website. This page lists all Leisure and Culture Dundee's Sports and leisure opportunities and facilities.
http://www.leisureandculturedundee.com/leisure-sport-0

Clubs:
- Discovery Swimming Club – Wednesday 7:30 – 8.30 Olympia Leisure Centre.
- Dundee Dragons Sports Club - https://dundeedragons.net/
- Tayside Dynamo Powerchair Football - http://taysidedynamos.org/
- Dundee Boccia Club – Contact Network Manager for further information.

Dundee Stroke Exercise Club
Douglas Sports Centre
- Monday 11.00am - 12.00 mid-day
- Monday 12.00 mid-day - 1.00pm (Low Intensity/seated)
- Wednesday 9.30am - 10.30am
- Wednesday 10.30am - 11.15am
- Thursday 15.30 - 16.30pm

Olympia
- Wednesday 3.00pm - 4.00pm
- Saturday 12.45pm - 1.45pm (low Intensity/seated)

For further information please contact Network Manager on Tel 01382 436963/ 01382 436962Appendix 4: What We Will do

Integrated Impact Assessment Report.

Appendix 2

Committee Report No:

Document Title: Strategic Statement for People with Physical Disability

Document Type: Strategy

New/Existing: New

Period Covered: 01/04/2018 - 31/03/2021

Document Description:
The Strategic and Commissioning Statement for services and supports for adults with a Physical Disability in Dundee has been developed from the Dundee Health and Social Care Partnership Strategic and Commissioning Plan. It sets out the direction of travel for supporting people with physical disability to live longer, more fulfilled lives. It recognises the skills, knowledge, connections and experience of people with a physical disability and the need to build on this resource to promote healthy, active and integrated communities. Whether people are born with a physical disability or acquire disability at some point in their lives, the social and physical environment is likely to present barriers to them leading fulfilled lives; getting around, finding employment, having a home that meets their needs, accessing the information they need. This results in health and financial inequalities that reduce life opportunities and wellbeing for people with disability and their families.

Intended Outcome:
As above

How will the proposal be monitored?
Through the appropriate SPG and the Integrated Strategic Planning Group of Dundee Health and Social Care Partnership. There is an action plan and a performance measure plan to support this strategy.

Author Responsible:

Name: Alison Bavidge

Title: Resource Manager

Department: Health and Social Care Partnership

E-Mail: alison.bavidge@dundeecity.gov.uk

Telephone: 01382 438303

Address: Claverhouse

Director Responsible:

Name: David Lynch

Title: Chief Executive

Department: Health and Social Care Partnership

E-Mail: david.lynch@dundeecity.gov.uk

Telephone: 01382 434000

Address: Dundee House

A. Equality and Diversity Impacts:

Age:	Positive
Disability:	Positive
Gender Reassignment:	No Impact
Marriage and Civil Partnership:	No Impact
Pregnancy and Maternity:	No Impact
Race/Ethnicity:	No Impact
Religion or Belief:	No Impact
Sex:	No Impact
Sexual Orientation:	No Impact

Equality and diversity Implications:
This strategic statement primarily focusses on the well-being of people with physical disability. It does not specifically address the needs of people from protected characteristics. However, no negative impact has been identified and, if the Strategic Planning Group highlights specific issues, this will be incorporated into the action plan.

Proposed Mitigating Actions:
Not applicable

Is the proposal subject to a full EQIA? : No

This strategic statement primarily focusses on the well-being of people with physical disability. It does not specifically address the needs of people from protected characteristics. However, no negative impact has been identified and, if the Strategic Planning Group highlights specific issues, this will be incorporated into the action plan.

B. Fairness and Poverty Impacts:

Geography

Strathmartine (Ardler, St Mary's and Kirkton):	Positive
Lochee(Lochee/Beechwood, Charleston and Menzieshill):	Positive
Coldside(Hilltown, Fairmuir and Coldside):	Positive
Maryfield(Stobswell and City Centre):	Positive
North East(Whitfield, Fintry and Mill O' Mains):	Positive
East End(Mid Craigie, Linlathen and Douglas):	Positive
The Ferry:	Positive
West End:	Positive

Household Group

Lone Parent Families:	Positive
Greater Number of children and/or Young Children:	Positive
Pensioners - Single/Couple:	Positive

Single female households with children:	Positive
Unskilled workers or unemployed:	Positive
Serious and enduring mental health problems:	Positive
Homeless:	Positive
Drug and/or alcohol problems:	Positive
Offenders and Ex-offenders:	Positive
Looked after children and care leavers:	Positive
Carers:	Positive

Significant Impact

Employment:	Positive
Education and Skills:	Positive
Benefit Advice/Income Maximisation:	Positive
Childcare:	No Impact
Affordability and Accessibility of services:	Positive

Fairness and Poverty Implications:
The strategy will impact positively on all people with a physical disability regardless of age or locality. The SPG will prioritise health inequalities and fairness issues in implementing the strategy. The locality focus on Dundee Health and Social Care Partnership means that each of the listed localities will be viewed form a needs and outcomes perspective.

Proposed Mitigating Actions:
As above

C. Environmental Impacts

Climate Change

Mitigating greenhouse gases:	No Impact
Adapting to the effects of climate change:	No Impact

Resource Use

Energy efficiency and consumption:	No Impact
Prevention, reduction, re-use, recovery or recycling waste:	No Impact
Sustainable Procurement:	No Impact

Transport

Accessible transport provision:	No Impact
Sustainable modes of transport:	No Impact

Natural Environment

Air, land and water quality:	No Impact
Biodiversity:	No Impact
Open and green spaces:	No Impact

Built Environment

Built Heritage:	No Impact
Housing:	Positive

Is the proposal subject to Strategic Environmental Assessment?

No further action is required as it does not qualify as a Plan, Programme or Strategy as defined by the Environment Assessment (Scotland) Act 2005.

Proposed Mitigating Actions:

Not applicable

Environmental Implications:

The SPG will work with Dundee City Housing Department to address shortfalls in accessible and wheelchair houses.

D. Corporate Risk Impacts

Corporate Risk Implications:
The risk implications associated with the subject matter of this report are 'business as normal' risks. The subject matter is routine and has happened many times before without significant loss. There is comfort that the risks inherent within the activity are either transferred to another party, shared equally and fairly between the Council and another party or are negligible.

Corporate Risk Mitigating Actions:
Not applicable

ITEM No …7……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2018**

REPORT ON: **VETERANS FIRST POINT TAYSIDE (V1PT)**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB32-2018**

1.0 PURPOSE OF REPORT

To provide Dundee Integration Joint Board with information about the hosted Veterans First Point Tayside (V1PT) service, which has been delivering welfare and specialist mental health services to veterans and their family members since 2015.

2.0 RECOMMENDATIONS

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

2.1 Acknowledges the very positive work of V1PT in operationalising the Armed Forces Covenant (as referred to in paragraph 4.1.1 of this report) across Dundee, Perth and Angus, ensuring better access to NHS services, including pathways for ensuring priority treatment for those veterans who should receive early treatment for health problems that have resulted from military service.

2.2 Acknowledges the steps that are being taken as outlined in paragraphs 5.4.1 – 5.4.3 of this report to determine the future model and financial framework for the service.

2.3 Notes the content of the Scottish Veterans Commissioner's report; Veterans' Health & Wellbeing (attached as Appendix 1).

2.4 Remits to the Chief Officer to bring forward a further report, once future service modelling is complete, by April 2019.

3.0 FINANCIAL IMPLICATIONS

3.1 The Scottish Government has provided 50% matched funding for the V1P service over the next two financial years with £81,661 available in 2018/19 and a further £82,478 provided in 2019/20. Resources have been identified within Dundee Health and Social Care Partnership's delegated budget to the same value each year to provide total investment of £163,322 in 2018/19 and £164,956 in 2019/20.

3.2 The Scottish Government and V1P are working nationally to identify options to secure the future financial sustainability of the local services network.

4.0 BACKGROUND AND CONTEXT

4.1 Developing V1P services in Scotland

4.1.1 The Armed Forces Covenant is about fair treatment and sets out the relationship between the nation, the government and the Armed Forces. It recognises that the whole nation has a

moral obligation to members of the Armed Forces and their families and it establishes how they should expect to be treated. The Covenant's two principles are that:

- the Armed Forces community should not be disadvantaged compared to other citizens in the provision of public and commercial services in the area where they live;
- special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

All local authorities have pledged to uphold the Armed Forces Covenant.

4.1.2 The initial V1P Centre was set up in 2009 by NHS Lothian. The model aims to provide:

- Information and Signposting
- Understanding and Listening
- Support and Social Networking
- Health and Wellbeing - including a comprehensive mental health service delivered by a multi –professional team on site.

4.1.3 Funding was secured from the Mental Health and Protection of Rights Division of the Scottish Government (£200,000) and NHS Lothian Strategic Programme Budget for Mental Health and Wellbeing (£60,000). The success of V1P Lothian was recognised by the UK Military and Civilian Health Partnership Awards as a double award winner in 2011 and single award winner in 2013. A strength and key component of the V1P model has been the employment of veterans as peer workers. V1P psychological therapists deliver a range of quality evidence based care, treatment and support to veterans and their families. This includes the delivery of evidence based therapies.

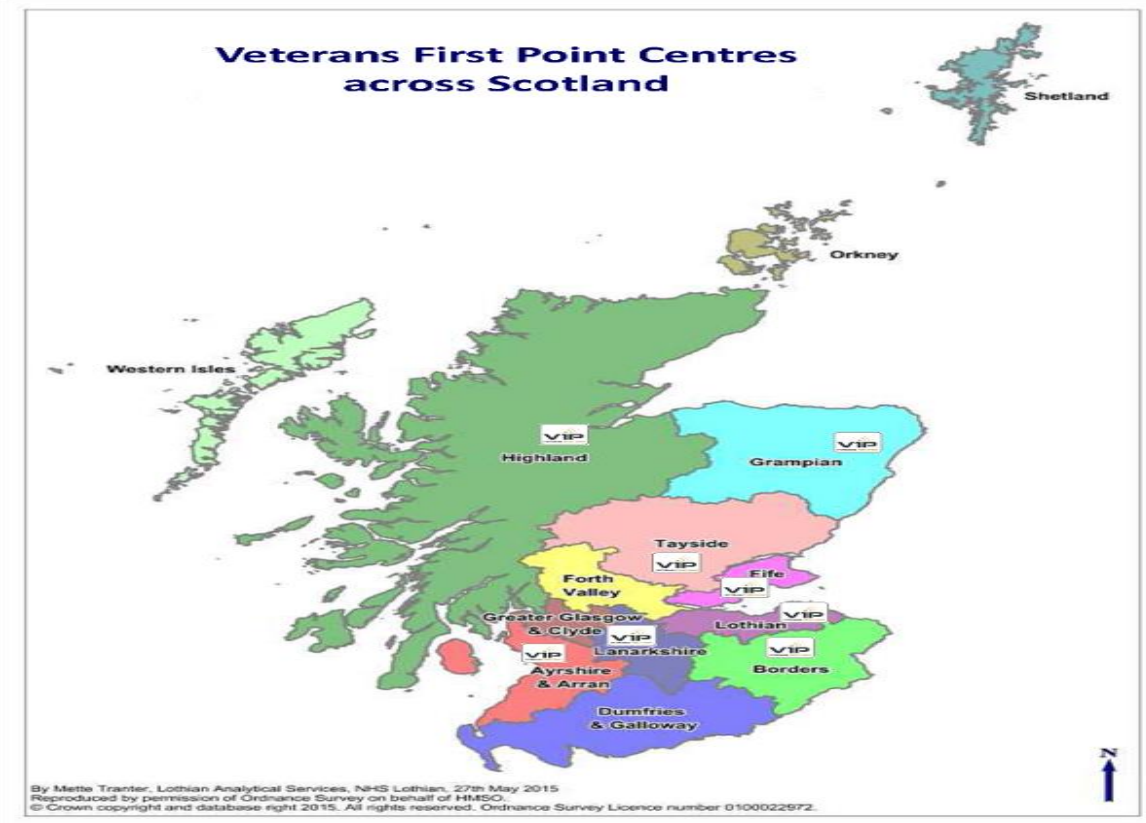
4.2 The UK Government Funding (LIBOR Fund)

4.2.1 Building on the success of V1P Lothian, a comprehensive proposal was submitted to the LIBOR fund in October 2012. The stated objective was to "*work in partnership to deliver high quality evidence based care, treatment and support for veterans and their families across Scotland".* The proposal set out how a hub and spoke model – supported by a small development team, would establish a further three centres in Tayside, Highland and Grampian. The proposal was successful and £2,560,586 was awarded to NHS Lothian to develop and deliver this model.

4.3 What has been achieved?

4.3.1 The V1P Scotland development has surpassed the original intent to develop an additional three centres. Instead, due to the commitment to partnership working and relationship building, a total of eight centres were established with the support of the V1P Scotland team (see Figure 1). Six of the eight centres were sustained beyond the initial LIBOR fund period (March 2017). Highland and Grampian services were disbanded in 2017 when 100% external funding was discontinued.

Figure 1:V1P Centres across Scotland



5.0 MAIN TEXT

5.1 *An Overview Of V1P Tayside*

5.1.1 The remaining six V1P Centres reflect the local needs, priorities, service landscape and partnerships and are therefore quite different in their staff composition, premises and partnership arrangements. However, the three core principles of the V1P model are: Creditability, Accessibility and Coordination.

5.1.2 Historically within Tayside, veterans were able to access assessment, treatment and support for mental health issues from a range of services including general adult psychiatry, psychotherapy, psychology and substance misuse services. Veterans also accessed inpatient treatment from *Combat Stress* - a nationally funded Veterans' charity. Welfare support was available from a range of resources such as SAFFA, Armed Services Advice Project (ASAP), Veterans UK and the local Veterans charity based in Dundee – the Tayforth Veterans Project (now disbanded).

5.1.3 In 2009 the NHS in Scotland were issued with guidance (CEL 3 2009 – UK VETERANS) which detailed the rights of veterans and their families to have priority treatment. All Health Records Departments in NHS Tayside were issued with the guidance and provided with a central, confidential email address to provide information on veterans and their families, to allow priority treatment to be arranged where appropriate. Explicit links were established to the Tayside Referral Governance Manager, allowing all services referred to, to be overseen to ensure there are no barriers to veterans accessing primary or secondary care services. This role has recently been re-allocated to the Assistant Health Records Manager. In addition, all local protocols in SCI-Gateway (National referring tool for Scotland) were redesigned to allow veterans data to be provided electronically.

5.1.4 Extensive consultation with local stakeholders confirmed the need for the development of health services for veterans, and emphasised the importance of joint working and co-ordination with other services (statutory and voluntary). The Stakeholders supported a model combining integration into generic care for most Veterans and specialist intervention for those unable or unwilling to engage.

5.1.5 In 2015, under the corporate leadership of the NHS Veterans Champion - Professor Andrew Russell (Medical Director), the V1P Tayside service was created. NHS Tayside entered into a Memorandum of Understanding (MoU) with V1P Scotland and the local veterans' charity - Tayforth Veterans Project (TVP). The V1P Tayside service was awarded £302,000 in LIBOR funding to provide a service between July 2015 and March 2017.

5.1.6 A decision was reached to 'nest' the V1P Tayside Service within the Multi-disciplinary Adult Psychotherapy Service (MAPS). In other words, having the clinical staff work in both services and thus supporting assertive brokerage between V1P Tayside and other psychiatric and psychological therapy services and enhancing access to a range of psychotherapies.

The team was comprised as follows:-

Clinical Service Lead – 0.4 whole time equivalent (wte)
Mental Health Practitioner/Adult Psychotherapist (Band 7) – 0.5 wte
Senior Adult Psychotherapist (Band 8a) - 0.2 wte
Veteran Peer Support Workers (Band 3) - 2 wte
Service Administrator (Band 4) -1.0 wte.

5.1.7 The service was designed so V1P Tayside and TVP were co-located in the existing TVP premises based at City Quay in central Dundee. V1P Tayside has encountered some operational challenges which have necessitated an alteration of the service model from that originally agreed. The service has been without dedicated psychiatric input. The clinical leadership and service management of the service has therefore been assigned to the service leader for MAPS (on a 0.1-0.3 wte basis). In addition, TVP experienced significant difficulties in recruiting and retaining sufficient volunteers to sustain the charity. Following support and guidance from the Office of the Scottish Charity Regulator (OSCR), TVP was disbanded in September 2015. V1P Tayside continued to operate and in consultation with veteran service-users, a decision was reached in 2017 to move to an NHS premise – The Cottage, within the grounds of Kings Cross Hospital.

5.1.8 Veterans seeking support from V1P Tayside meet a peer support worker to register with the service and identify the supports required. This may include welfare, mental health, physical health or a combination of presenting needs. Initial mental health assessments are the responsibility of the mental health practitioner, a dual qualified mental health nurse and Cognitive Behavioural Therapy psychotherapist. She is also able to devote some time to the delivery of psychological treatment. The 8a senior adult psychotherapist is also dual trained as a mental health nurse and accredited psychotherapist/Eye Movement Desensitisation and Reprocessing (evidence based psychotherapy for trauma) practitioner. Her role is largely dedicated to the delivery of clinical treatment. The clinical service lead is also able to offer a small clinical service to those who present with complex mental health needs as well as offering leadership support to the team.

5.2 *V1P Tayside: Who Have We Supported So Far?*

5.2.1 V1P Tayside became operational on 1st September 2015. Since then we have supported over 230 veterans and their family members. 28%, the majority, have self-referred to V1P services. 70% of self-referring veterans are encouraged to do so by forces charities/regimental associations. 42% are aged 45 yrs to 59 yrs. 97% consider themselves White Scottish or White British. 90% are male and 91% have been in regular services. 80% were in the Army. 35% served for between six and 12 years, with 21% discharged on medical grounds. The most common deployments are Northern Ireland, Iraq and Afghanistan.

5.2.2 The social circumstances of veterans who access V1P Tayside indicate 40% live in areas which are defined as in the 20% most deprived areas of multiple deprivation; whereas only 8% live in areas which are defined as in the 20% least deprived areas of multiple deprivation. Housing and homelessness is a significant issue with 41% having experienced homelessness and 27% considering their current living situation unstable.

5.2.3 In terms of relationships, 42% are married, in civil partnerships or co-habiting; the remaining 58% are single, divorced, separated or widowed. 79% have children. 44% live alone.

5.2.4 In terms of educational attainment and employability, 68% of veterans are educated to high school standard (10% did not complete school). Only 3% have attained degree level qualification (bachelor, masters or doctorate). 37% are in employment (full time and part time); while 34% are currently unemployed.

5.2.5 In terms of mental health and wellbeing, 91% of the veterans who access V1P Tayside report some degree of problem with anxiety or depression. 50% report severe or extreme problems, including those who endorse symptoms of post traumatic stress disorder.

5.2.6 Physical health issues are also significant. Chronic pain is a reported difficulty for 44% of veterans accessing V1P Tayside. 79% report pain interfered with carrying out daily activities to some degree, with 33% of reporting pain extremely interfered with daily routines.

5.3 ***How Do We Know We Are Making A Difference? - V1P Scotland Evaluation***

5.3.1 Queen Margaret University were commissioned to conduct the evaluation of Veterans First Point Scotland. The V1P Centres began accepting referrals at different times and all have contributed to the evaluation. The report will be published in the coming weeks. In reviewing activity to date, each Centre is building up substantial numbers of veterans who they are activity working with and the number of veteran contacts is steadily increasing as the Centres become established. The total number within the data set is **n=692**.

5.3.2 Three clinical measures used in the evaluation have all demonstrated improvements over time. In relation to depression, distress and functional impairment improvements are clinically significant and reliable. The V1P Scotland service is therefore a credible provider of psychological therapies to veterans. While these improvements are clear, it should be noted that Veterans presentations are complex. Initial assessment scores often meet the severe criteria for clinical assessments at engagement with services. However, the improvements veterans experience, while significant and reliable, continue to meet the criteria for moderate distress or depression. Veterans are therefore likely to need ongoing support and monitoring. Additionally, it is important to acknowledge that greater improvements are seen over time, increasing with duration of engagement with therapy. Mainstream services, in order to meet pressure of demand, often prescribe a time limited period of psychotherapy. Veterans seem to be one population group who appear to benefit from intervention of a longer duration.

5.4 ***Next Steps***

5.4.1 Since V1P Tayside was developed in 2015, it has demonstrated the Dundee IJB's commitment to the Armed Forces Covenant, ensuring that veterans – and particularly those with the most enduring health and welfare difficulties are able to access priority care and treatment from mainstream and specialist services.

5.4.2 Although a small service, V1P Tayside has delivered care and treatment to over 230 veterans and their family members living across Dundee, Perth and Angus. The service has been independently evaluated and demonstrates clinically significant outcomes. The credibility, accessibility and coordination of care has resulted in high levels of service user satisfaction through a cost effective service structure.

5.4.3 Following the recent independent evaluation by Queen Margaret University, the V1P network of Centres are now focussed on a range of initiatives over the next 12 months to ensure V1P

services are accessible across all tiers of service delivery, while maintaining a focus on those affected by the most severe, enduring and life changing difficulties. We aim to undertake local and Tayside wide service development in partnership with stakeholders across health, social care and third sector stakeholders; develop and refine clinical pathways for identified areas of need and clarify the optimal workforce plan to ensure the service continues to deliver safe and effective care. We envisage this work will conclude by April 2019 and a proposal about future service delivery will be presented to Dundee IJB.

6.0 POLICY IMPLICATIONS

6.1.1 The Scottish Government restated their commitment to recognising and valuing the Armed Forces community as a true asset and in 2016 renewed their commitments to support them and pledge to make Scotland the most attractive destination for the Armed Forces, Service leavers and their families.

6.1.2 This report highlights that Scotland has demonstrated great strengths in mental and physical healthcare provision, and states that this will continue to be a fundamental priority to support particularly in terms of improving awareness of long-term clinical needs and transfer of data.

6.1.3 The published Force in Mind report - Ca*ll to Mind: Scotland / Findings from the review of veterans' and their families' mental and related health needs in Scotland*. (2016) states that Scotland has one of the most robust mental health and related health provision for veterans in the UK, with a thriving specialist statutory and voluntary sector that has been supported and resourced by the Scottish Government.

6.1.4 Scotland's Veterans Commissioner recently published report (attached as Appendix 1) – *Veterans' Health and Wellbeing: A Distinctive Scottish Approach,* (April 2018) set out his ambition for veteran services in Scotland – "To see mainstream and specialist provision for veterans protected and enhanced, especially for those with the most severe and life-changing conditions; and to ensure veterans' healthcare is a properly planned and embedded feature of the new health and social care landscape in Scotland" (page 4).

6.1.5 In relation to V1P services, he added - "Veterans in Scotland have been able to access a number of key specialist services... including Veterans First Point teams. I have seen for myself during visits to these establishments, and heard first-hand just how vital and valued they are" (page 13). In terms of sustainability he suggests - "The recent experience of sustaining V1P has demonstrated that funding from time-limited, non-core sources can lead to uncertainty and insecurity, which will undoubtedly worry those who rely on such support" (page 15).

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

7.0 RISK ASSESSMENT

An assessment has not been undertaken at this stage as there are no imminent risks to the delivery of the service.

8.0 CONSULTATIONS

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

9.0 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	

10.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 30 May 2018

Arlene Mitchell
Locality Manager

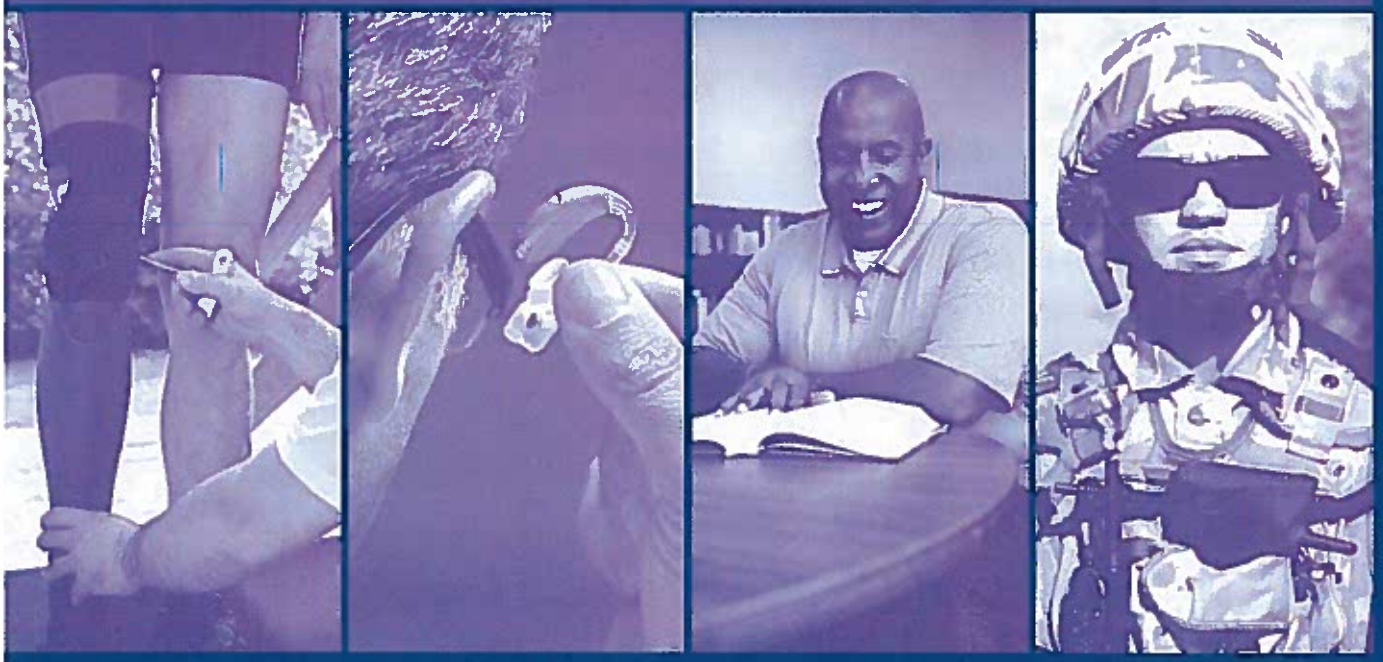
Michelle Ramage
Service Lead/Senior Adult Psychotherapist for MAPS
And Veterans First Point Tayside

Appendix 1

SVC SCOTTISH VETERANS COMMISSIONER

Veterans' Health & Wellbeing

A Distinctive Scottish Approach



APRIL 2018

Contents

Foreword




Foreword

Last year I published a paper entitled *Veterans' Health & Wellbeing in Scotland – Are We Getting it Right?* This set the scene on veterans' health matters and offered my first impressions on the main issues that strike to the heart of whether Scotland is providing the best possible treatment and care for its ex-Service community.

Since then my team and I have looked in significant detail at the topics raised in that initial report and others, setting ourselves the task of finding answers to the four fundamental questions we posed at the very start of this study, namely:

- are health outcomes of our veterans population as good as they can be?
- do veterans face any disadvantages when accessing health and social care provision?
- does our health system properly fulfil our obligation to veterans with the most severe and enduring illnesses and injuries acquired as a result of their military service?
- are the needs of our veterans population properly understood and considered by those who work in health and social care?

Our assessment of where things currently stand and what the future might hold can be found throughout this report, alongside findings and recommendations aimed at the Scottish Government, NHS Scotland and their partners. My ambition is two-fold: firstly, to see the mainstream and specialist provision for veterans protected and enhanced, especially for those with the most severe and life-changing conditions; and, secondly, to ensure veterans' healthcare is a properly planned and embedded feature of the new health and social care landscape in Scotland.

When embarking on this project I quickly recognised that there is much we can be proud of in terms of the support provided to our veterans by statutory services and the many charities working in this field. However, I was also aware of concerns within the community – reinforced by several health professionals and officials – that veterans' health and wellbeing is no longer attracting the same levels of attention, innovation or ambition as had been seen previously. There appears to be less enthusiasm for new ideas, some hesitation in seizing fully those opportunities offered by recent transformations in healthcare, and a degree of stagnation within a sector which has typically enjoyed a well-earned reputation for the quality and accessibility of the care provided.

My hope in writing this report is to re-focus and re-energise Scotland's approach to looking after its ex-Service men and women and to faithfully represent the views of as many of them as possible. Most importantly, I want to offer both an ambitious and realistic vision of health and social care for Scotland's veterans. This should be one that the entire nation can support, champion and ultimately be proud of.

Eric Fraser CBE
Scottish Veterans Commissioner

Introduction

In my initial paper, the main focus was on the mercifully small group of ex-Service men and women with severe and enduring health conditions acquired as a result of military service. Some had been wounded in action while others either suffered serious injuries or had been affected by life changing illness while serving their country. In every case these are the people who have sacrificed the most and will live with permanent conditions for the rest of their lives.

This paper set out the compelling moral case for these men and women to receive the very best medical treatment and social care that Scotland has to offer. Anything less, I suggested, would be a betrayal of the promises made in the Armed Forces Covenant and by the Scottish Government in its *Renewing Our Commitments* strategy.

It has been reassuring that in every conversation and interaction since publishing that paper, there has not been a single person who has disagreed with or questioned that argument. Put simply, this group of veterans has earned the right to be considered a strategic priority for politicians and all who provide support within our health and social care sector. Ultimately, this is the central and recurring theme throughout most of this report.

In highlighting this cohort, however, it is also important that we don't overlook the wider veterans community and their health needs. Theirs will not necessarily fall into the most serious category of severe and enduring injuries or conditions but they still deserve as good treatment as possible with an appreciation that their condition might be attributed, in some way, to their military service. This group will be typically treated by mainstream services within the NHS but, even here, their unique background and common experiences need to be recognised if the best outcomes are to be achieved.

Structure of Report

My original intention when scoping this subject had been to produce separate papers that focussed, in turn, on veterans suffering from severe and enduring conditions, followed by a later one on the broader health needs of our wider ex-Service community. Since then my team and I have come to realise that so many of the issues across these groups are intertwined and have, therefore, decided that there is greater merit in publishing a single report that covers the full range.

Chapters 1 and 2 cover subjects that are relevant to the health of all veterans but with a particular emphasis on those who suffer from the most severe and enduring injuries and conditions. The first culminates in a proposal for a distinctive approach to veterans' health in Scotland, and the second considers the main challenges as to how that approach might be delivered.

Chapters 3 and 4 concentrate, in turn, on the mental and physical health of this same group who will need dedicated mainstream and specialist support over many years.

Chapter 5 is more wide-ranging and considers the general health of the veterans community and where there might be opportunities to improve health and wellbeing outcomes for all.

Chapter 6 comprises my conclusions having spent many months investigating the issues. I hope this provides a useful summary of a complex and challenging agenda.

The full list of my recommendations can be found at **Annex 1**. As in previous reports, extracts and quotes from case studies are included throughout. These offer a fascinating insight into the subject matter and I am extremely grateful to the contributors for providing such candid and meaningful material. **Annex 2** contains these case studies in full.

'Severe and Enduring' Explained

The term 'severe and enduring' is a phrase used throughout this report to describe the most serious and life-changing injuries and conditions faced by veterans. For some in the military community this equates to those who are 'wounded, injured or sick' (WIS), but for the wider population the term severe and enduring provides a more recognisable description. It may, though, leave the reader begging the question exactly which injuries and conditions fall into this category and which do not. This is never going to be an easy question to answer.

I want to be clear that it is not my place to define, prescribe or list what constitutes this type of injury or illness. It would also be wrong for me to direct the medical profession when trying to determine how contingent such conditions might be on previous military service. These are decisions that must be left to experts.

I do, though, recognise that making such decisions can sometimes be far from straightforward – a view that has been crystallised during discussions with a range of medical and allied health professionals. There will always be grey areas where the severity of the illness or injury, and its unequivocal link to military service, divide opinion or are difficult to establish.

It is, therefore, imperative that those professionals who are being asked to make such decisions have as good an understanding of veterans' health issues as possible and are provided with advice and support where necessary. Ultimately, verdicts about whether a veteran who presents with particular injuries or illness falls into the category of severe and enduring – and therefore has access to 'special' care over and above that typically provided by mainstream services – will never be an exact science. I would, however, urge those involved to err on the side of the veteran in borderline cases. These individuals have already served their country and now struggle with conditions that may be wholly, or partly, the result of this service.

Chapter 1

A Distinctive Scottish Approach to Veterans' Health

A Distinctive Scottish Approach to Veterans' Health

This chapter covers a range of issues that relate to the delivery of health and social care to veterans and considers how the current system might be strengthened or adapted to improve outcomes for all in this community. It includes discussion about the commitments made in the Armed Forces Covenant (the 'Covenant') and the Scottish Government's *Renewing Our Commitments* strategy, priority treatment, funding arrangements and the structure of current services.

The fact is that the provision of healthcare for veterans in Scotland has always contrasted with other parts of the UK, just as for the wider population. Different structures, funding arrangements, governance and, in some cases, delivery models have led to a national health service which varies from those found in England, Northern Ireland and Wales. For veterans this also extends to the specialist care that is provided for those with serious and life-changing injuries or illnesses that have resulted from their military service. These bespoke services, some of which were set up in response to a series of reports by Dr Andrew Murrison MP, provide a level of support which goes beyond that typically offered by NHS Scotland (NHS(S)) and local Councils. They are also recognised by Lord Ashcroft in his various reports about veterans and fulfil a significant part of the promises laid out in the Covenant and in *Renewing Our Commitments*.

The combination of mainstream and specialist services has established a robust package of support that meets the needs of most veterans. This has been particularly so for the thankfully small number of those whose military careers have left them with the most severe and debilitating conditions. The impressive work at the start of this decade in establishing 'specialist' physical and mental health services in Scotland has had a significant impact over subsequent years and has rightly attracted considerable attention and praise. We still see the benefits of this today.

However, despite there still being a significant number of men and women in our communities who struggle with Service-related injuries and conditions, it is obvious that the levels of ambition and innovation which characterised this work have waned in recent years. This may be understandable given the pressures on the health system, but it is also disappointing that the health of veterans no longer attracts the same level of attention it once did. Discussions with senior decision-makers indicate a strong desire to check this trend, rekindle the spark that set up the current structures and invest in future long-term planning. This is encouraging.

Having examined the provision of healthcare over many months, it has become apparent to me that there is merit in now adopting a distinct strategic approach that ensures veterans' health sits squarely at the heart of current and future models of service provision in Scotland. Furthermore, this approach should aim to present a realistic and practical means of embedding the specific needs of veterans within mainstream services, ensuring current specialist care is protected and improving planning for long-term support.

Of course, veterans' issues do not sit in isolation within Scotland's healthcare system. The fast-paced, transformational nature of this landscape can be expected to have a significant impact in the years ahead and it will be crucial that veterans are part of, and benefit from, recent Scottish Government and NHS(S) policies in this field. Of these, I recognise the importance of the integration of health and social care services, an increasing role for allied health professionals within Primary Care settings, the Chief Medical Officer's proposals for *Realistic Medicine* and national strategies covering healthcare quality and mental health. Each has had considerable influence on this report and informed many of my recommendations.

In order to maximise the opportunities presented by these initiatives the following sections set out my thinking on what a new approach should seek to achieve and go on to discuss some of the key factors relevant to making it a reality.

Rethinking Priority Treatment

Before exploring some of the ideas behind this approach, I believe it important to address the prominent subject of 'priority treatment' for veterans from the outset. This was first introduced in the 1950s, is currently a significant feature of the Covenant and continues to be the most controversial and contested issue in terms of providing healthcare for this community. Its central premise is that veterans should receive early treatment for health problems that have resulted from military service, unless there is an emergency or another case that demands clinical priority. This is laudable, but as stated in my previous paper, the concept is flawed, often misunderstood and occasionally ignored by a number of health professionals and veterans – whether unwittingly or, in some cases, quite deliberately.

These views have been emboldened in recent months by feedback received from many individuals and organisations. This has reinforced the fundamental point that care within the NHS is based on **clinical need** and not on the background, occupation or category of a patient. As a consequence, the promise of priority treatment for veterans is a largely meaningless concept that rarely has any direct impact on individuals. Like many, I also have a growing conviction that an emphasis on waiting time lists, while never irrelevant, is no longer as important as it used to be. Instead, I sense an increasing demand – certainly in NHS(S) – for greater focus on the principles of excellence, accessibility and sustainable treatment for all veterans.

Frankly, the current confusion about what priority treatment means and its impact serves nobody well, especially if it results in unrealistic expectations which cannot be matched. It is clear to me that the time is right for a fresh and bolder vision, which will be especially important for those with the most severe and enduring injuries and conditions.

But in suggesting any alternative, I recognise there is a great deal of political and public support for these veterans receiving 'special' treatment and I am determined there must be no hint of any reduction in the level of support that has been hard-won over many years. Notwithstanding, there is a definite need for greater clarity about what veterans can expect from the health and social care system.

Addressing this aspect of treatment and care is, however, only the start. I am convinced that those in charge of healthcare in Scotland should go even further by taking a refreshed approach to all aspects of veterans' health. Recent transformational changes in the sector – more on which later – and a growing appetite for adapting to changing needs, offer a unique opportunity to develop a more innovative, focused and relevant approach to veterans' healthcare. Within this, priority treatment will be just one aspect.

Principles of a Scottish Approach to Veterans' Health

It is with this in mind – together with the need to refocus efforts within the Scottish Government, NHS(S), Health Boards and local Councils – that I am proposing a distinct Scottish Approach to Veterans' Health. This needs to provide the impetus and framework that protects and enhances Scotland's reputation for supporting its veterans while ensuring we place particular emphasis on those coping with the most severe and enduring conditions. It should also seek to promote the wider ex-Service community as a unique cohort whose health and wellbeing can benefit from the changes currently being seen across the health and social care sector in Scotland.

In particular, the unambiguous focus and priority placed on the small group of veterans with the most serious and life-changing conditions will send the strongest possible message of compassion and appreciation from Scotland's citizens. These are, after all, the people who have made the greatest sacrifices, suffered the most challenging consequences and are, therefore, in need of specialist and sustained support. Even more important than the message it sends, the prioritisation and long-term commitment to this group will provide the clarity and reassurance that their medical and social care needs will be met properly, now and in the future.

As a first step to establishing this fresh approach, it will be important that the Scottish Government, NHS(S) and their partners can agree a set of principles to provide strategic direction and guidance for those individuals and organisations responsible for planning and delivering day-to-day support. Many ideas have emerged during the past few months since the publication of my initial paper. The following set of proposed principles reflect the key priorities of the many health professionals, veterans, charities and officials that I have engaged with over that time.

Guiding Principles

Generally...

> Veterans, like the rest of the Scottish population, have the right to the highest possible standards of health and live longer, healthier lives.

> Veterans never suffer disadvantage and instead benefit from efforts to reduce health inequalities caused or exacerbated by military service.

> Veterans' specific characteristics and needs are recognised and well understood, shaping the design and delivery of their health and social care.

Exceptionally...

> Individuals with severe and enduring conditions caused by military service are the most important and deserving group within the veterans community and are the focus of efforts and resources.

> The treatment and care for these veterans is based on the best possible mainstream and specialist services, both in the statutory and third sectors, that is available no matter their circumstances or where they live.

> These veterans can be confident that this support – across the health and social care sector – is available whenever required and for the rest of their lives.

These principles are not intended to be either prescriptive or exhaustive. The Scottish Government and NHS(S) may wish to adapt or add to them now and in the future but I believe that in their current form, they offer a coherent and ambitious framework that will help raise the profile of veterans while ensuring they get the support they need and deserve. They also offer the chance for those in positions of leadership to make a public commitment to support our ex-Service community and satisfy their health needs over the long term.

Recommendation 1 – A Distinctive Scottish Approach to Veterans' Health

The Scottish Government and NHS(S) should commit to establishing a distinctive Scottish Approach to Veterans' Health at a strategic level, accept or adapt the guiding principles of this approach and work with their partners to embed it at an operational level.

Chapter 2

‘Making It Happen’

Over the course of the many visits and discussions undertaken in preparing this report, I was struck by the evident dedication and determination of professionals and others to ensure veterans in Scotland are given the best possible treatment, care and support. It was equally impressive that so many in the sector, from those in positions of leadership and practitioners through to volunteers, expressed a desire to do even more to improve health outcomes. In these times of stretched public finances and constantly competing demands, this commitment is not one to be underestimated.

Allied to this powerful sense of goodwill and resolve is a strong track record of providing impressive specialist and mainstream health services to veterans. This is something which is important to acknowledge. That said, we cannot afford to allow complacency to compromise that record nor see veterans' health take lower priority. To do so would put Scotland's hard earned and deserved reputation for supporting and valuing its veterans community at a degree of risk. Now is, therefore, an opportune time to protect the best practice that already exists, build on it with improvements wherever possible – in terms of practice, policy and governance – and prepare for the future. It is intended that the distinctive Scottish Approach to Veterans' Health should provide the strategic framework to drive that ambitious agenda.

The next sections set out the key issues that need to be addressed if this approach is to transition from a worthy set of high-level principles into day-to-day practical measures that will impact positively on the lives of our veterans now and for years to come.

Protecting Specialist Services

Over the past decade or so, veterans in Scotland have been able to access a number of key specialist services that include dedicated prosthetics clinics, a network of Veterans First Point (V1P) teams and Combat Stress' Hollybush House. I have seen for myself during visits to these establishments, and heard first-hand just how vital and valued they are.

This specialist provision is an important and well-established feature of how healthcare is delivered for veterans in Scotland today, especially those with severe and enduring conditions. It complements mainstream services very well, provides additional support and is seen as a model of care that deserves to be protected for current and future generations. As part of the Scottish Approach to Veterans' Health I believe the Scottish Government and NHS(S) should reaffirm their commitment to protecting this level of specialism.

That said, a responsible and responsive health system must adapt to changing needs and demands over time; just because a service has been provided or structured in a particular way does not mean it should always continue in the same form. In the case of the specialist services mentioned above, I anticipate these having to evolve and this should not be seen as a backward step or reduction in the levels of support. Indeed, in the case of Hollybush House, Combat Stress has recently proposed adjusting its delivery model from an exclusively residential course to one that includes community based modules that fit around a veteran's work and family life. This reflects changes across the wider health sector and it will be important to monitor its impact given the organisation's prominent role in supporting veterans with severe mental health issues.

In other words, we should never lose sight of making sure our veterans are cared for and supported in the best possible way – whatever that 'way' may be. The ultimate aim should be to ensure Scotland is a place where treatment – both in the mainstream and specialist sectors – is dynamic and responsive to the needs of the ex-Service community.

Finding 1:

Specialist physical and mental health services are a vital and valued part of supporting our veterans with the most severe and enduring injuries and conditions. While their exact make-up and models of delivery will inevitably change and adapt over time, it is imperative that the availability of specialist services – and the outcomes they support – are protected for current and future generations.

Improving Collaboration and Partnership

While the proposed Scottish Approach to Veterans' Health will see distinct planning, resourcing and delivery in Scotland, there remains much to be gained from engaging regularly with health and defence colleagues from other parts of the United Kingdom and beyond. By doing so there will be an opportunity to share our expertise and experience of supporting veterans while also improving our awareness of good practice, and increasing involvement in new health initiatives elsewhere.

Over the past few months, my team and I have had a number of informative meetings with colleagues in the MOD and NHS England, including the Director of Veterans Commissioning. These have alerted us to several projects that encompass new mental health services, a complex trauma service, and the Veterans Covenant Hospital Alliance scheme that accredits 'Veteran Aware' hospitals across the UK. The 'Step into Health' initiative is also interesting given its potential for seeing more veterans employed within the NHS.

I am aware there used to be active networks and dialogue linking health officials from across the United Kingdom but some of that has been lost in recent times. This is relatively easy to correct and should be done with some urgency. It has also been apparent that the Military Medical Liaison Officer (MMLO) to the Scottish Government has fewer opportunities to engage and influence the Government on its relationship with the MOD. This is largely because the role is now part-time and an additional responsibility for an already busy NHS(S) senior consultant and Reservist. As a result we are missing opportunities to benefit our veterans community and the health system in Scotland.

I would particularly advocate regular participation in the MOD's high-level Partnership Board, chaired by the Surgeon General and DG Health, and attendance at the relevant Clinical Reference Groups run by NHS England which tackle practical issues affecting Service personnel, veterans and their families.

Recommendation 2 – Improving Collaboration and Partnership

The Scottish Government should reinvigorate senior participation in cross-border networks with a view to improved information sharing and increased involvement in collaborative working and initiatives.

Finally in this section, it is important to highlight the key role that charities play in supporting veterans' health. The expertise and variety of treatments and projects that they offer complement and, in many instances, enhance those provided by the statutory sector. The partnership between these sectors is a vital feature of veterans' healthcare and must be nurtured and protected over the long-term.

Securing Funding

In my initial paper I state that, "*I do not anticipate that protecting the best of the current specialist services requires a large investment of new resource. I do, though, think it is crucial to ensure that this provision is protected in the medium to long-term and that the evolving needs of this group of veterans [with severe and enduring injuries and conditions] is part of a strategic plan*". Key to this will be a review of the way parts of these specialist services are funded.

I have been careful to recognise the good levels of specialist health provision for veterans throughout this report. There is, though, a remaining concern about the consistency and longer-term sustainability in some instances.

Current funding arrangements, in part, lack cohesion and can appear *ad hoc*. For example, the prosthetics clinics are commissioned, performance managed and, crucially, funded by a specialist part of NHS(S) called the National Services Division (NSD). The NSD receives top-sliced, ring-fenced funding directly from the Scottish Government, which means that the services it funds enjoy a degree of security and certainty that doesn't necessarily apply elsewhere.

The V1P services, on the other hand, were established and have been sustained using a combination of Scottish Government and Armed Forces Covenant (LIBOR) Fund money. The former directly funded the first V1P service in the Lothians in 2009 and thanks to on-going LIBOR money it was later expanded to eight locations across Scotland. However, last year when the Fund closed, V1P had to resort to a combination of funding directly from Government, individual NHS Boards and other partners. Matched funds from the Scottish Government will allow most of those services to continue to 2020, at which point Boards and partners will become fully liable. This process has caused an element of turmoil and posed serious questions about the long-term future of services in certain areas.

However, I do not believe that specialist services need to be delivered in exactly the same way forever without close review. For example, NHS Grampian and NHS Highland have decided to discontinue the V1P service in its current form and made alternative arrangements for providing mental health treatment and support to their veterans communities. I am aware that NHS Highland was awarded an additional LIBOR grant in 2017 to continue mental health support in partnership with Poppyscotland. Notwithstanding that welcome development, the recent experience of sustaining V1P has demonstrated that funding from time-limited, non-core sources can lead to uncertainty and insecurity, which will undoubtedly worry those who rely on such support.

Finding 2:

Funding for specialist mental and physical health services for veterans is disjointed and in some cases ad hoc. This results in a degree of uncertainty and raised questions about the sustainability of some of these services, which is a worry for those who rely on and value them. It is an issue that needs addressed as a priority.

Integrating health and social care

I have made much of a widely held desire to see the health and social care needs of veterans properly planned and co-ordinated over the longer-term. This is central to providing holistic and co-ordinated support as they age and their needs change, especially for those with severe and enduring conditions. In Scotland we are fortunate to already have an advanced and progressive approach to the integration of these services across the entire population; one which ought to lend itself to fulfilling this ambition for the ex-Service community.

Health and Social Care Partnerships (HSCP) were launched in 2016, bringing together local health and social care services. Partnerships are overseen by 31 Integrated Joint Boards (IJBs), also known as Integration Authorities, who are responsible – and carry the budget – for planning, innovating and working with professionals, communities and the third sector to deliver a range of services locally.

The creation of these partnerships and IJBs marks a fundamental shift in the way in which health and social care is delivered. It also changes the levers of control and accountability. As the budgets and responsibility for delivery are delegated to an increasingly more localised level then so must the focus of those interested in veterans' health. The idea of a centralised system of command and control is now outdated and will have little impact in this new environment.

The HSCPs provide the vehicle for ensuring that long-term planning of veterans' health and social care services is embedded in mainstream structures and budgets. Although they are still in their infancy and will no doubt evolve as they become a more established part of the system, it is still striking that only one IJB mentions veterans within their current strategic plans. I would anticipate this changing over time.

Their existence also offers an opportunity to plan and co-ordinate services across a wider range of areas, extending beyond the fields of health and social care. For example, I heard from Glasgow's Chief Officer about how his HSCP also has responsibility for children and families, homelessness and criminal justice services. All of which can be relevant to the veterans community.

Finding 3:

The integration of health and social care services in Scotland provides a unique opportunity to ensure the longer-term needs of veterans are properly planned and met. The new structure of IJBs and HSCPs is the vehicle for delivering this ambition. They must play a central role in decision-making about veterans' health and wellbeing and the delivery of both mainstream and specialist services.

Leadership, Planning & Governance

Strong and visible leadership will be critical in delivering the high standards envisaged throughout this report. It will also be required to make the most of the opportunities offered by a changing landscape and to maximise the evident desire to do the best by our veterans. Most will naturally look to the Scottish Government and NHS(S) but in order for veterans services to be consistently at their best over the long-term, leadership and ambition will be required from many others at different levels.

The obvious means for bringing together senior decision-makers and providing national leadership is via the Armed Forces and Veterans Health Joint Group. It was formed back in 2009 and includes representatives from, amongst others, NHS(S), Scottish Government, Armed Forces, veterans' organisations, charities and academia. It is chaired by Director-General Health and Social Care/Chief Executive NHS(S) and sits annually.

In the past this group has been responsible for overseeing the delivery of innovative support, that has included several successful pieces of work. For example, in 2012 a Sub-Working Group implemented recommendations from Dr Andrew Murrison's report *A Better Deal for Military Amputees in Scotland*, which led directly to the formation of the national prosthetics clinics. This was an impressive achievement but my strong sense is that the group has now become unwieldy in number, lost much of its original purpose and has, as a result, been far less impactful than it was in its earlier days.

In recent times, much of that loss of purpose can be attributed to the changing landscape across health and social care, which means that the group no longer sufficiently reflects current models of delivery. A new structure of oversight and governance of veterans' health that accords with the current system of greater local responsibility and accountability is, therefore, overdue.

That said, there is still a need for a national group that can provide high-level leadership across the health, social care and veterans sectors. The Joint Group should still fulfil that role but will undoubtedly require a refresh – both of membership and remit. It would need to 'own' the Scottish Approach to Veterans' Health at a national level and in doing so provide strategic direction and ideas to those tackling the issues set out in this report on a day-to-day basis. Its membership also needs to reflect the new environment of integrated environment and draw on a smaller senior cohort who can drive the veterans health and wellbeing agenda. It would also benefit from meeting more regularly.

Recommendation 3 – Leadership and Governance

The Armed Forces and Veterans Health Joint Group should refresh its membership and remit in order to provide the vital strategic leadership that will deliver the Scottish Approach to Veterans' Health

Alongside this, there is a need to introduce a mechanism at an operational level to develop further national thinking, tackle the issues highlighted in this report, and oversee the delivery of veterans' health. This is a challenging remit that demands a dynamic, innovative and effective body, under strong leadership that can influence and instigate change within a complex structure.

With this in mind, I heard recently from the CEO of the Mental Welfare Commission about a structure which provides an interesting example of how veterans' health issues could be considered. Its work on perinatal mental health of mothers and infants culminated in the establishment of a National Managed Clinical Network (NMCN).

There are a number of different National Managed Clinical Networks (NMCNs) in operation in Scotland. They are funded by the NHS(S) National Services Division and bring together those involved in providing specialist care for particular groups of patients with the most complex healthcare needs – health and other professionals, patients, carers, families and voluntary groups. Each network designs pathways of care that ensure patients and their families have equal access to the highest standards, regardless of where they live in Scotland. Networks focus on issues such as service planning and delivery, education, collating data to measure and improve quality of care, and engaging key stakeholders.

A new NMCN, or similar group, focussed on veterans' health would have responsibility for considering the issues highlighted in this report and others it regards as relevant. It would need to draw on a wide range of stakeholders with an interest in the health and wellbeing of veterans; including representatives from statutory services, charities, academia, carers organisations and, of course, veterans themselves. I would also anticipate the network drawing on the experience and knowledge of individuals like the MMLO and organisations like the Health and Social Care Alliance. The network's key responsibilities would be:

Network on Veterans' Health

> Advise, influence and monitor the planning and delivery of mainstream and specialist services for veterans based on the principles of the Scottish Approach to Veterans' Health.

> Lead on improving awareness, knowledge and understanding of veterans' needs and characteristics.

> Produce a Mental Health Action Plan and influence its delivery at a national and local level. (See Chapter 3)

> Identify and address health inequalities for veterans, using those set out in this report as a starting point. (See Chapter 5)

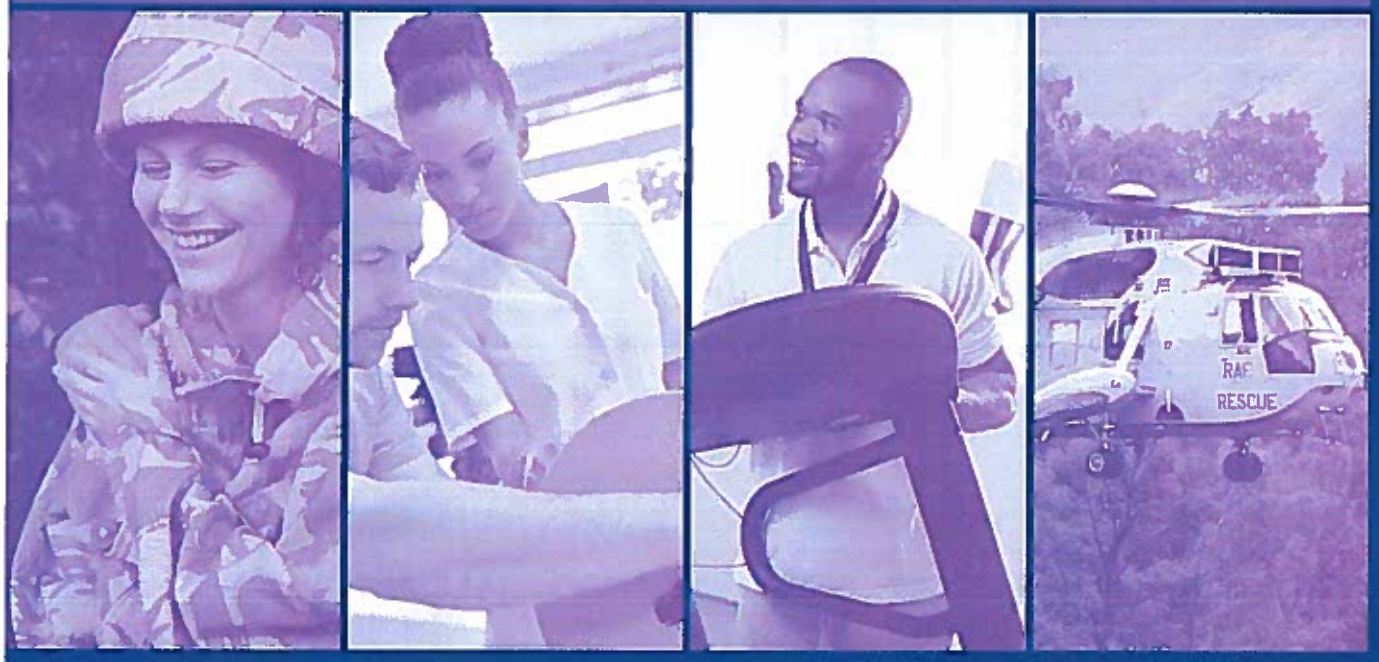
While issues of planning and governance may not seem particularly exciting, or directly relevant to the day-to-day lives of veterans, they are in fact crucial to ensuring that the Scottish Approach to Veterans' Health underpins the delivery of services and support. Those in positions of leadership have an opportunity – perhaps even a duty – to 'make it happen' and play their part in improving the health and wellbeing of our veterans community.

Recommendation 4 – National Managed Clinical Network

The Scottish Government and NHS(S) should establish a network on veterans' health. The network will have oversight of delivering the Scottish Approach to Veterans' Health, and will consider the key issues raised in this report and others it deems relevant. It should reflect current structures in the health and social care sector in its membership and approach.

Chapter 3

Mental Health



Scotland's role in treating those suffering from the mental effects of combat dates back to WWI when Craiglockhart War Hospital cared for 'shell-shocked' men struggling with their experiences on the Western Front. Many, including famous war poets Wilfred Owen and Siegfried Sassoon, were given radical and sometimes controversial new treatments to address the devastating effects of extreme trauma and constant bombardment. The display at Edinburgh Napier University provides a fascinating record of this work and Scotland's contribution in an important field.

Over the following decades the military recognised high risk groups within their ranks and worked hard to return affected individuals to duty whenever possible. However, amongst the general public there largely remained a reluctance to discuss mental health issues and as a consequence there were veterans who never sought or received the treatment and care they needed. It was only during recent conflicts in Iraq and Afghanistan that the impact of combat on the mental health of those who served was fully recognised. Thankfully, we now see far more extensive and effective support, less associated stigma and a growing acceptance that these wounds of war are no less debilitating than the physical ones.

It is, therefore, only right that in this report I acknowledge the significantly improved support for those suffering mental ill health after time spent in the Armed Forces. In recent years, veterans have been able to access a number of specialist – as well as mainstream – projects and services introduced to address their specific needs. Scotland has been in the vanguard in many instances. That said, many of the experts in this field that I have spoken to say there is still work to be done. This has been one of the main factors that motivated me to produce this report.

This chapter details some of the vital work being done in this area by both the statutory and charitable sectors, and then focuses on the future needs of veterans with serious mental health issues. It covers some of the key topics relevant to ensuring that Scotland maintains – and enhances – its well-earned reputation for innovative and compassionate care of its Service men and women, stretching all the way back to Craiglockhart Hospital in 1916.

Background

As I highlighted in a previous report, the vast majority of those leaving the military do so without severe mental health problems and cope well with the transition to civilian life. When problems occur they are most likely to be the same ones that can affect anyone in the wider population, such as depression, general anxiety or stress related disorders. The majority will be treated by local mainstream NHS services – typically through their GP – and it has been reassuring to hear consistently positive stories about the support received and the good outcomes achieved. There are, though, a number of individuals with serious, life-changing and distressing mental health problems after a career in the Armed Forces. It is only right they are the focus of medical efforts and are given the best treatment and support available; but it is equally important to counter exaggeration of the numbers of those seriously affected and not to allow myths to subsume the facts.

As this chapter focuses on those with the most complex and serious mental health conditions, I am reassured to note that they are able to access a number of impressive specialist services in Scotland. These deliver the type of 'special' treatment promised as part of the Covenant and *Renewing Our Commitments*. Such services should be cherished and never taken for granted.

Current Provision

Based on what I've observed in nearly four years as Commissioner and specifically on what my team and I have taken from our months of research and engagement on this topic, I support the finding from the 2016 Forces in Mind Trust *Call to Mind: Scotland* report, which stated:

"Arguably, Scotland has one of the most robust mental health and related provision for veterans in the UK, with a thriving specialist statutory and voluntary sector that has been supported and resourced by the Scottish Government"

This is a heartening assessment of the set-up in Scotland and one that has been borne out in the many conversations I have had about veterans and their mental health. The authors of that report and I have separately identified areas where more could – and should – be done to maintain or enhance this level of provision. It is, after all, important that we never stand still and allow our reputation to slip. Notwithstanding those opportunities for improvement, we ought not to lose sight of the overall positive position. It is evident that we have much good practice to protect for current and future generations and I would argue that the Scottish Approach to Veterans' Health is intended to do exactly that.

The treatment and care for veterans with severe and enduring mental health conditions is delivered by a mixture of statutory sector providers, under the responsibility of Integration Authorities, and third sector providers. Some services sit within the mainstream and others are specialist.

Veterans in several parts of the country are able to access the network of NHS-led Veterans First Point (V1P) services. In addition, the Scottish Government currently funds, through an arrangement with NHS Ayrshire and Arran, nationally available specialist treatment at Combat Stress' Hollybush House. I also heard from NHS Greater Glasgow and Clyde's Head of Mental Health about how their veterans are treated within the range of mainstream services. Just one of these is the Anchor Centre in Govan which brings together specialist resources from different disciplines to treat those with complex mental traumas.

Alongside that key provision, there are a number of third sector organisations offering support. Legion Scotland and Poppyscotland are two of the most widely identifiable charities that work with veterans, complementing support provided by the statutory sector. Other smaller, but no less important examples, include the work of Horseback UK and Bravehound, both of which use animals to help veterans cope with their mental health problems. Beyond the traditional Service charities, organisations such as the Scottish Association for Mental Health (SAMH) and Support in Mind Scotland provide help for veterans and others suffering from the widest range of mental health conditions. There are others besides. The Mental Welfare Commission for Scotland acts as 'watchdog' and ensures quality standards for care provision.

This mixture of provision – for both those suffering the most severe and enduring conditions, and more widely – adds up to a highly valued network for the veterans community.

Looking Ahead

Lest we get complacent about the level of support available to those struggling with mental illnesses, it is vital that we never forget the devastating impact that such conditions can have on individuals and their families. *Both the Call to Mind: Scotland* report and my own findings suggest that while Scotland has a range of services that have served the veterans community well, there are concerns that this support can be piecemeal on occasions and often quite limited for those with the most complex and difficult conditions.

Aidan Stephen, an ex-Army Major who served in Northern Ireland, Bosnia, Kosovo and Iraq over a 17 year career provides a graphic reminder of this. His testimony starts in 2003 and highlights the personal nature of these illnesses, the depths to which they can drag an otherwise fit and healthy individual, and the risks of unsuitable treatment. His is a traumatic story that reinforces the need for that 'special' level of support for those affected. Thankfully, Aidan has gone on to make a remarkable recovery, a testament to his own resolve and resilience, and to the help and support he received from many individuals and organisations. His full account can be read on page 63.

Aidan Stephen – Former Army Major

"A few months after returning from Iraq, I attempted suicide and spent five days in a coma. When I woke up, I was admitted to a military psychiatric facility in Germany. Most patients were relatives of soldiers, and the support I received wasn't suitable to my needs.

"I returned to Scotland where my wife and I separated and I ended up living alone, isolated with little family support. I was still in the Army at this point and they were trying to figure out what to do with me. I was sent to the Priory in Glasgow, a civilian mental health unit which treats people with addictions and eating disorders. This was one of the worst decisions made. None of the staff were trained to deal with patients from a military background and none of my fellow clients shared my experiences, yet I had to participate in group therapy with them.

"One day, one of the patients said she was feeling low because she had eaten loads of chocolate cake. Whilst acknowledging that seemingly minor issues such as this can have a much deeper psychological root for some, I was suffering from night terrors and traumatic flashbacks to my time in the Army, and comments like this only increased the distance I felt between myself and everyone else at the facility, leaving me feeling even more isolated.

"In 2006 I was discharged and was in the care of civilian rather than military doctors. I returned to Edinburgh and continued to spiral, culminating in an incident where I threatened to kill myself and self-harmed in public. I was arrested and ended up on remand. A doctor I spoke with while there told me to get in touch when I was out and he made me aware of veteran-specific support services that he thought would help.

"This is where things finally started to turn around...."

Crucially, both the UK and Scottish Governments remain committed to the idea of 'special' consideration for veterans such as Aidan, who suffer mental ill health following military service. That commitment is one of the cornerstones of how healthcare is delivered in Scotland.

I also welcome the fact the Scottish Government acknowledges veterans as a distinct group, albeit briefly, in its 10-year Mental Health Strategy which was published in 2017. This states: *"Armed Forces veterans, including those who have experienced trauma, may benefit from particular models such as peer support, combined with mainstream treatment. The Scottish Government will support efforts to meet the needs of veterans and their families, and local partnerships will want to consider how best to provide services locally for them."*

The Scottish Approach to Veterans' Health is intended to take matters further still. Its guiding principles provide a framework for ensuring that the best of specialist and mainstream provision is protected and the long-term needs of those with severe mental health conditions are properly planned and met. Resolving issues such as security of funding, equality of access and long-term planning are critical to living up to the commitments made. Most importantly, doing so will offer reassurance to veterans who currently or will in the future rely on bespoke mental health services.

A Long-Term Action Plan

The Government's Mental Health Strategy and *Renewing Our Commitments* provide an important statement of intent. However, given the specific commitments to, and sometimes unique needs of, veterans with severe mental health conditions, I believe there is a strong case for the creation of a separate Action Plan for the delivery of services.

The network proposed in recommendation 4 can provide the necessary expertise and governance to deliver such a plan, either as part of its core work or separately by a sub-group dedicated to mental health. The Action Plan would need to complement the Scottish Government's national strategy and address the key topics set out in chapter 2 'Making it Happen' and the ones that follow here. Ultimately, it should provide an articulation of how excellent, dedicated and sustained treatment will be delivered over the long-term, at a national level and locally by Integration Authorities. Quick referrals and early interventions should remain a central feature of that provision.

The following considerations – both structural and clinical – are the ones that featured most regularly during conversations with veterans and health professionals. Neither set is exhaustive but I hope they provide a useful starting point for those who may be responsible for delivering a long-term Action Plan. It will also be important that it reflects new issues and changing needs as they emerge.

Recommendation 5 – Mental Health Action Plan

The Scottish Government and NHS(S), through the network on veterans health (see recommendation 4), should produce a Mental Health Action Plan for the long-term delivery of services and support. Systemic issues of funding, collaboration, leadership, planning, governance and training of staff will be key.

Structural Considerations

The topics covered in detail in chapter 2 'Making it Happen' will be central to any plan for mental health provision for veterans. They include, protecting and funding specialist services, collaborating with others, demonstrating leadership, embedding long-term planning, and providing governance. I don't intend repeating any of that material but aspects are worthy of additional mention in this section as they apply to mental health care.

Funding

I say earlier that funding for specialist services is "disjointed and in some cases ad hoc". This is particularly evident in the field of mental health, as demonstrated by the experience of V1P and Combat Stress which is indicative of the short-term and insecure nature of funding. This is in sharp contrast to arrangements for some physical health provision, particularly prosthetics clinics, and demonstrate a clear anomaly that demands an urgent review. I would expect the proposed network to consider this as a priority as failure to do so will only leave a worrying degree of anxiety amongst veterans and dedicated providers, while increasing uncertainty for a number of our most important services.

Geographical Inequalities

There is also a need for separate consideration of how specialist mental health services are delivered across different parts of Scotland. I have consistently argued that veterans and others should see no threat in the fact that services will vary across the country, depending on factors such as rurality and remoteness, population density and demand. This is a consequence of the system of local delivery and accountability that underpins health and social care provision in Scotland.

What I don't consider inevitable or acceptable, though, is if the needs of all veterans with severe and enduring mental health conditions are not properly met. Should that be due to a lack of availability or delays in access then there is a clear question of inequality or disadvantage, which needs to be addressed.

Understanding of Veterans

Finally in this section, I would like to mention a recurring theme from veterans which suggest that health practitioners within the mainstream NHS do not always understand their specific needs and experiences. The implication is that those providing treatment and care are not as well equipped as they could be. Sharon Fegan, a psychological therapist, and Lauren Anderson, an occupational therapist, both from V1P Lothian, expand on this and their words are illuminating:

Sharon Fegan – Psychological and Occupational Therapist

"We have occupational therapist trainees who come to V1P for placements, so at a very early stage in their career they are learning how those from an ex-Service background might differ from civilian clients, and the best ways to approach this. Considering ways in which this increased awareness could be replicated across all positions in the NHS would be a really positive step towards improving engagement with veterans".

Lauren Anderson – Occupational Therapist

"Language is a hugely important aspect of treating the ex-Service community. Since I began working at V1P, I've picked up a great deal of military terminology which I previously didn't know. Building a good relationship with veterans in a therapy context involves showing appreciation and respect for their background, and acknowledging that there are aspects of Service life you don't know about, but which you hope to learn from them."

While parts of the health system are clearly well attuned to veterans' specific mental health needs there remains much to be gained from raising awareness, and increasing understanding, amongst as wide a network as possible, including GPs, mental health and allied health professionals.

Clinical Considerations

There are also a number of clinical considerations that will need to be incorporated into the Action Plan. Once again, this list is neither comprehensive nor exclusive but the topics are of sufficient importance to merit separate consideration and, in some cases, specific recommendations.

Post Traumatic Stress Disorder (PTSD)

Discussions about PTSD often elicit strong responses amongst an Armed Forces and veterans community that can sometimes appear critical of the attitudes and support provided by the MOD and statutory services. Many believe the number of veterans suffering from PTSD is significantly under-estimated and there has been insufficient investment in their treatment and care over several years.

Academics at institutions like Kings College London and University of Glasgow have conducted numerous studies over the past 10 years or so to assess the incidence, impact and treatment of PTSD amongst serving personnel and veterans. These have provided an impressive statistical evidence base for policy-makers and have shown that rates of PTSD in military personnel are similar to the wider population, although there is a modest increase in risk amongst combat troops and deployed reservists. Their specific findings have sometimes been at odds with some of the anecdotal evidence provided by those who struggle daily with the condition or offer direct support to the veterans community. This has led to debate and understandably caused a degree of confusion amongst the general public.

Over the past few years there has been a growing recognition by politicians, officials and health professionals of the need for effective and more accessible treatment for any who have served in the military and subsequently present with PTSD. The result has been a much greater willingness to see them as deserving 'special' support and an increasing number of initiatives that provide relief to individuals and their families. In Scotland this treatment is provided by a combination of NHS(S) mainstream services, V1P and Combat Stress. These must be protected now and over the long-term.

Although the overall number of veterans who suffer from PTSD in Scotland is relatively small, it is still vital that a national Action Plan considers the needs of those most at risk. It should also take account of the current move away from residential programmes towards an increased emphasis on community-based treatment and support. This will shape future provision of care for a vulnerable and deserving group. The severe and long-lasting impact of the illness, its link with other physical and mental conditions, and the levels of public interest reinforce these points on many levels.

Suicide Risk

Without doubt, the most poignant and thought-provoking conversations I've had during my time as Commissioner were with June Black. Her words laid bare the challenges her son, Aaron, faced when he returned from Afghanistan in 2009 that ultimately led to him taking his life in 2011. Matthew Green, in his book *Aftershock*, tells Aaron's story in the most moving way, leaving the reader to reflect on the sad and tragic loss of a young man.

We owe it to Aaron's memory to redouble efforts to support current and former Service personnel struggling with their mental health to such a worrying degree that suicide feels like the only escape. It is also essential that family and friends who are affected by suicide receive appropriate bereavement support.

In that respect, it is heartening to note some of the MOD's recent work, including the establishment of a 24hr Military Mental Health Helpline, and the publication of the Defence Mental Health and Wellbeing Strategy 2017-22. I have also been interested in NHS England's Transition, Intervention and Liaison (TIL) pilot, which seeks to improve mental health care for veterans and Armed Forces personnel approaching discharge. I believe NHS(S) should consider this latter initiative and work closely with organisations who have already invested time and resources in identifying and supporting those at increased risk of suicide.

NHS England's Transition, Intervention and Liaison (TIL) Mental Health service was set up in 2017 for veterans and those Armed Forces personnel about to leave the military who might have mental health difficulties.

The three elements that make up TIL are:

- A **Transition** service that is targeted at those about to leave the Armed Forces who may need continuity of mental health care during the transition process.
- An **Intervention** service that provides an assessment within two weeks of a referral which determines whether an individual has complex needs and, if so, provides an appointment with a clinician who has an expert understanding of Armed Forces life and culture. Veterans may also be supported by a care coordinator who can liaise with other services and organisations to ensure a coherent approach to their care.
- A **Liaison** function that supports those who do not have complex presentations yet would benefit from NHS care. They will be referred into local mainstream NHS mental health services where they will receive treatment and support.

Also of note, the Scottish Government intends to publish a Suicide Prevention Action Plan later this year. I have submitted a response to the consultation, highlighting veterans and their particular circumstances. An important aspect of identifying veterans within this plan will be the opportunity to extend the knowledge and understanding of the medical community on the challenges faced by some of our most vulnerable ex-Service men and women.

Finding 4:

The publication of the Suicide Prevention Action Plan by the Scottish Government later this year is a welcome step in ensuring everything possible is done to help anyone struggling with mental ill health. Vulnerable veterans, and their particular circumstances, will be an important consideration as the plan is developed.

Substance Misuse

All three Services are historically associated with a culture of heavy drinking and, while much has been done within the military to shift behaviours, alcohol misuse is still significantly higher than amongst the general population. Inevitably that culture extends into the veterans community which also reflects a national trend that has seen alcohol consumption increase significantly over the past few decades. This is a problem which the Scottish Government and others within the veterans community have done much to tackle nationally in recent years.

Alcohol misuse is often linked to poor mental health, with Combat Stress suggesting that almost 70% of veterans with PTSD also have drink-related problems. This organisation is currently piloting a Veterans' Substance Misuse Case Management Service, which helps veterans access the most appropriate services to support their abstinence and prevent relapse. I will watch with interest as this scheme develops.

The misuse of powerful painkillers, including opioids and other synthetic drugs, amongst veterans has received significant attention in the USA. There is, however, a growing sense that self-medication using both prescription and non-prescription drugs amongst UK veterans is also on the rise. This parallels trends in the wider community.

To date, there is minimal research on the subject but my conversations with senior medical professionals and practitioners working for Help for Heroes have left me in no doubt that this could be a serious concern. Given the tendency in the UK to follow US trends, and the devastating effect of drugs misuse, I believe it is important that we quickly determine the scale and nature of the problem in Scotland. The Action Plan should include details about how this will be done and initiate measures to counter this worrying trend.

Recommendation 6 – Drugs Misuse

The Scottish Government and NHS(S) should assess the scale and nature of drugs misuse – especially prescription and non-prescription painkillers – amongst the veterans community in Scotland and introduce remedial measures. This should be taken forward by the Joint Group and network, and included as part of the Mental Health Action Plan.

Stigma, awareness and other barriers

Mental health problems can be hard for anyone to cope with but it is made worse by having to deal with stigma, ignorance and discrimination from others. There is a widely held perception that the stigma associated with admitting to struggles with mental health is a major factor in veterans being reluctant to seek treatment and support. However, it seems the reality is more complicated than this.

A 2017 report by King's Centre for Military Health Research, *Stigma and Barriers to Care in Service Leavers with Mental Health Problems*, proposes that stigma is not a singular influence that prevents ex-Service personnel from seeking help for mental health problems. Failure to recognise that they have a mental health problem in the first instance, making the decision to seek help, and difficulty accessing and then maintaining support are all also contributing factors. This can be compounded when veterans live alone or have no-one to push them into seeking treatment. A recent study by Dr Margaret Bowes also identifies that the inherent culture of the Armed Forces may protect personnel from mental ill health during combat but then impede good recovery amongst veterans; in other words, the coping strategies required for good mental health may be at odds with the sort of resilience required to cope in battlefield situations.

Work has been undertaken in recent years by the MOD to overcome the challenges identified above. As attitudes in the military, amongst the veterans community and wider society have shifted, it has become evident that serving members of the Armed Forces and veterans now feel far more able to raise and discuss issues about their mental health. The increasing use of peer support workers by organisations like V1P and Help for Heroes has undoubtedly encouraged this and is widely regarded as good practice.

Nevertheless, for some, particularly those who served in less enlightened times, there may still be feelings of stigma attached to being mentally ill. I would like to make particular mention of the national programme *See Me*, funded by Scottish Government and Comic Relief and managed by SAMH and the Mental Health Foundation, which is aimed at changing negative attitudes and ending discrimination against all those with mental health problems. This work is important and I would expect an Action Plan to reflect this approach. I would also encourage any veteran who may be reluctant to seek help, to find out more about this programme and how it might benefit them.

During the past few years there have also been a number of initiatives aimed at improving awareness and understanding of the specific mental health challenges faced by some veterans. These have included education and information material produced by the Royal College of General Practitioners, NHS(S) and several charities. This has had an impact but I sense there is now need to refresh some of the content and renew efforts to disseminate it amongst as wide an audience as possible, including GPs, mental health specialists and allied health professionals.

This will be of particular importance to the 800 additional mental health workers that the Scottish Government has committed to funding over the next four years.

Recommendation 7 – Barriers to Accessing Services

The Scottish Government and NHS(S) should build on existing work aimed at reducing barriers to veterans accessing mental health services. This will include measures to address issues of stigma, seeking help, and improving awareness and understanding within the medical profession. This should be taken forward by the Joint Group and network, and included as part of the Mental Health Action Plan.

Conclusion

Throughout this chapter I have sought to emphasise that there are, thankfully, relatively few veterans who will experience severe mental health problems following their time in the Armed Forces. Furthermore, these problems are not always attributable to military service, with a proportion having been affected by adverse life experiences such as abuse, financial or relationship problems or as a victim of crime. Unfortunately for some, their time in the Services may have compounded their situation.

For those veterans who do suffer, there is no doubt that their lives can be devastated, sometimes for many years. Prompt access to the best possible treatment and support is vital in helping them to recover, and lead happy and fulfilling lives. We can be proud of the specialist and mainstream mental health services in Scotland and the role this plays in helping these individuals – and their families – achieve that aim.

We must, though, never allow complacency or lack of interest to compromise that level of provision and instead work to protect it for current and future generations. In that respect, I have concerns about the long-term sustainability of some of these services and the ability of some veterans to access them.

That is why I have called on the Scottish Government, NHS(S), local delivery organisations and partners to develop an Action Plan for the protection and long-term delivery of mental health services for veterans, especially those with severe and enduring conditions. In this chapter I have highlighted just some of the topics which should be considered and addressed as part of the creation of such a plan. There may be others that are worthy of inclusion, now and into the future as both services and needs evolve.

Chapter 4

Physical Health

"After the guns have fallen silent, and the din of battle quietened, the real fight begins" – Prince Harry

The image of a wounded veteran is the most stark reminder possible that the men and women of the UK Armed Forces, both regulars and reserves, are often called on to put themselves in harm's way on our behalf. Some end up paying a heavy price and it is only right that our health and social care system provides the best possible treatment and support for these individuals for the rest of their lives. More widely, it should be recognised that a career in the Armed Forces is nearly always physically demanding, often dangerous and can put a severe strain on the human body.

Combat operations obviously expose individuals to a significant risk of death or being seriously wounded. There are, however, those who suffer life-changing injuries and chronic conditions due to the physical nature of their job or as the result of training or other accidents experienced in military service. All will have to live with severe and enduring conditions for many years, and may need – and deserve – specialist treatment and care over and above that typically provided by NHS(S) and local Councils.

In this chapter I explore some of the most challenging physical conditions that veterans may experience. Most injuries will be obvious and demand immediate treatment although some may not present for many years. Others will change over time as physical demands and age take their toll.

I should stress that what follows is by no means an exhaustive list. Rather, it reflects the priorities and concerns expressed by veterans, their families and members of the health and social care professions. My aim is to highlight some of the good practices already in place and to identify improvements that will help protect and enhance the care Scotland provides to its veterans community. Ultimately we want all veterans, especially the most seriously injured, to have the care that allows them to look forward to enjoyable and productive lives after time spent in the Armed Forces.

Protect and Prepare – The Challenges To Be Faced

Two of the principles of the Scottish Approach to Veterans' Health are, firstly, to protect vital specialist services currently required by veterans with severe and enduring conditions, and secondly, to plan for their long term care. In my time as Commissioner, I have consistently heard concerns expressed by veterans, charities and other organisations that the first-rate medical treatment provided will not always continue for the long-term. This is a fear of many coping with life-changing injuries who worry that their needs will not be properly met as they get older and struggle with a number of related conditions.

The good news is that Scotland's overall approach to looking after our veterans, the broad support provided across all sectors and recent changes in healthcare – especially the integration of health and social care services – provide a solid foundation on which to address many of these concerns.

However, in order to make a real difference and provide reassurance to veterans, effective planning and a sustained commitment of public resources will be critically important as their needs change over time. The entire health and social care system will require to be well informed, co-ordinated and responsive if these individuals are to be properly supported. I cannot stress too highly that as the impact of the injuries sustained will be with them for the rest of their lives, so must the care and support.

An example of needs changing over time comes from Andy McIntosh, who served as an Army Corporal for 15 years in Bosnia, Northern Ireland and the Falklands. Whilst at work in 2008, a persistent kidney pain worsened and he collapsed. He was taken to hospital and it was discovered that he had very serious vascular problems stemming from his time in uniform.

Andy McIntosh – SSAFA Lanarkshire Branch Secretary

"I had been in excruciating pain but had just put it down to a chronic kidney infection. It was difficult to believe that I'd been suffering such serious injury. The medics traced it back to the trauma of an explosion in Northern Ireland. Even though I had walked away relatively fine at the time, I was now experiencing the aftermath."

I am encouraged that the Scottish Government already recognises the need for this longer-term planning. Its 2016 strategy *Renewing Our Commitments* states, *"looking ahead, we want to ensure that long-term clinical needs of Service personnel and veterans are better understood and supported..."*. This is an important statement and an ambition that I hope this report can help deliver.

Recommendation 8 – Access to Life-long Services

The Scottish Government, NHS(S), Health Boards and local Councils should make a commitment to veterans with the most severe and enduring physical (and mental) conditions that they can access the highest quality health and social care services for life and as their needs change. Health and Social Care Partnerships and Integrated Joint Boards will be instrumental in planning the delivery of these services and the national network recommended in chapter 2 should assume responsibility for oversight of this work as an early priority.

Severe Physical Conditions

What now follows is a consideration of some of the most severe physical conditions and illnesses faced by our veterans, and suggestions for how we can continue to provide the best care and support in the future.

Multiple and complex injuries

It is a fact of modern warfare that survival rates of those who sustain multiple injuries on the battlefield have increased significantly over the past 20 years or so. Better personal protection, rapid transfer to advanced hospitals and enormous improvements in medical treatment now mean that many more men and women make remarkable recoveries from the most horrific wounds. The initial treatment, in theatre and later back home, is the start of a very long recovery pathway that involves Defence Medical Services, NHS and charities. This is often a painful, complex and difficult process for all – including the families of those affected. It is also one that demands the wholehearted and co-ordinated support of many different organisations.

The most common cause of these multiple, severe injuries – typically labeled polytrauma – are the blast effects from Improvised Explosive Devices or Rocket Propelled Grenades. The impact can be devastating on the human body and can result in Traumatic Brain Injury, amputations, burns, internal injuries, hearing/sight loss and spinal cord injuries. Some victims also subsequently suffer from PTSD and other mental illnesses.

Care for the most severely injured puts clinical and financial pressures on statutory services but it is reassuring that these veterans, probably fewer than 150 individuals in Scotland, are typically looked after extremely well. This starts with specialist support at Queen Elizabeth Hospital in Birmingham or the Defence Medical Rehabilitation Centre at Headley Court and eventually involves local Personnel Recovery Centres/Units, NHS specialists and GPs. I have little doubt that this system provides a level of care that is only right and proper.

Edinburgh House Personnel Recovery Centre

Personnel Recovery Centres (PRCs) are MOD-run facilities for injured Service personnel and veterans undergoing recovery. They provide a range of medical, rehabilitation, welfare and education services that support either a return to duty or a good transition to civilian life.

Edinburgh House is an Army led PRC which is funded by the Royal British Legion and hosted in Erskine's Edinburgh Home. It was the first PRC to open in 2009 and was originally funded by Help for Heroes before RBL took over in 2011. During a recent visit I saw first-hand the excellent support given to injured Service personnel and veterans.

That said, I am aware that issues over the funding for this support come to the fore fairly regularly. Treatment can be expensive and there have been public disagreements about where costs should fall – whether between NHS Boards in Scotland or with their counterparts in the rest of the UK. This is worrying, but I am hopeful that instructions soon to be issued by NHS(S) will clarify which organisations should pay in disputed cases.

I have already addressed the general topic of funding in chapter two, but I also have a specific concern about how we pay for the complex needs of those affected by polytrauma. It has been suggested that their long-term care could be funded centrally through NHS(S)'s National Services Division as is done for other discrete groups who need expensive, specialist treatment. By doing so it would reduce the financial risk to individual Boards by spreading the costs between them, and would also minimise inequalities for those in need of such support. I believe this idea warrants further investigation.

Recommendation 9 – Funding for Multiple Injuries

The Scottish Government and NHS(S) should give consideration to whether the costs of specialist care for veterans who have suffered polytrauma should be funded through the National Services Division (NSD).

Finally in this section, I want to highlight current Scottish Government plans to establish a national Trauma Network that aims to deliver "the highest quality of integrated, multi-speciality care" to all severely injured patients. This project is still in its infancy but discussions with several medical professionals and officials point to its potential role in improving the quality of support to our most seriously injured veterans. This will be especially beneficial as they progress through the rehabilitation process.

I should mention that this proposed network is different from the Veterans Trauma Network, recently launched by NHS England, which is intended as an additional layer of support for trauma-recovering veterans and those transitioning from the Services. It is built around 10 trauma centres that bring together veterans and NHS doctors with military experience to offer bespoke care. Given our number of seriously injured veterans, I do not believe there would be sufficient demand for a similarly dedicated network here.

I sense that the intention of a national network to operate across geographical boundaries and clinical specialities fits well with the needs of veterans. It could promote best practice and contribute towards improving outcomes for all who have suffered the most devastating injuries. By taking specific account of these veterans' needs in the trauma network, there would also be the opportunity to provide an effective means of tracking them along their recovery pathway and into later life.

Recommendation 10 – The National Trauma Network

NHS(S) should include the specific needs of veterans who have suffered polytrauma as part of its work in setting up a national Trauma Network.

Amputees

Loss of a limb, whether or not as part of polytrauma, has a devastating impact on anyone, including those men and women who have previously led very active lives in the Armed Forces. For those affected, and in response to the Murrison reports mentioned earlier, the Scottish Government set up a dedicated national prosthetic service which provides specialist treatment and care. It operates using a single multidisciplinary team across two centres in Glasgow and Edinburgh, runs alongside the wider NHS(S) prosthetics service and charities such as BLESMA, and is funded by the National Services Division. The establishment and sustainment of this service can rightly be regarded as a key and impressive part of Scotland's commitment to those veterans who have suffered the most obvious and life changing injuries.

Notwithstanding the excellent care offered by the specialist centres, military amputees and their families have particular concerns about the provision of long-term care, and whether this will continue to adapt to their emerging needs. I heard this directly from Jay Hare, a former Corporal in 45 Commando Royal Marines, who sustained life-changing injuries from an explosion in Helmand Province in 2008. He lost his left leg below the knee, several fingers and had injuries to his right arm, right leg and face which required multiple reconstructive surgeries over a number of years.

Now aged 36, Jay already feels twinges from his prosthetic leg, his other injured knee and back. He questions whether the excellent care and support he has received to date, from both the national and his local clinic in Aberdeen, will be available in the future. He worries about breaking his prosthetics and having access to replacements and updated models. Jay's concerns are best summed up in his own words...

Jay Hare – Former Royal Marine

"The Armed Forces Covenant made a promise to the veterans community that we would be treated fairly. Are enough future resources in place to really deliver this promise? As 'Operational', we were told that we were going to be looked after – that was the deal that was on the table and I hope this is still the case"

Providing answers to these concerns and reassurances to veterans like Jay, whose full story can be read on page 62, lie at the heart of my proposal for the Scottish Approach to Veterans' Health.

Mobility

During a recent visit to one of the specialist centres, Southeast Mobility and Rehabilitation Technology (SMART) in Edinburgh, I was impressed by the wide range of facilities and the quality of support. These services include prosthetics, orthotics and bioengineering (artificial limbs and special equipment); mobility and posture; a disabled living centre; gait analysis; and the national driving assessment centre. This prosthetic service is evidently well resourced, with clinicians and technical staff being confident of providing first-rate support to veterans.

However, these specialists expressed concern about being able to offer the most appropriate wheelchairs to veterans they treat. As with prosthetics, the provision of mobility aids should meet both clinical need, and current and future lifestyles. It was concerning to learn that this is not always the case.

Many veterans have had very specialised and generally light-weight wheelchairs from DMRC at Hedley Court. When these need replaced, SMART can only provide chairs through NHS(S) contracts, thereby leaving veterans with reduced functionality. Furthermore, when it comes to maintaining these specialised chairs, I was told that the parts can be very difficult and costly to source due to current contract and procurement procedures.

Those I spoke to felt it would be hugely beneficial if they were able to access more specialised wheelchairs, in much the same way they do for specialist prosthetics. I now understand just how important a wheelchair is to an amputee – as important as their prosthetic in many ways – and this will become increasingly so when they become more reliant on them as they age.

This issue puts the provision and funding of wheelchairs in sharp contrast to that of the excellent prosthetics service and seems illogical to me. It may require some additional resourcing or it may simply be that more flexibility around current arrangements is all that is required. In either case, this is a problem which ought to be rectified and one I would like to see addressed as a priority.

Recommendation 11 – Wheelchairs for Amputees

NHS(S) should adapt current arrangements to ensure an appropriate level of funding is available to guarantee that wheelchairs provided by the MOD for veterans with severe amputations can be serviced, maintained and replaced with the best possible equipment commensurate with that individual's needs.

Musculoskeletal Disorders and Injuries

Musculoskeletal disorders (MSDs) and injuries are consistently the main cause of medical discharge across all three Services. In basic terms they are described as damage to the muscles, bones or connective tissue that support someone's limbs, neck and back. They almost always cause an individual to suffer pain – meaning that MSDs and long-term chronic pain are intrinsically linked – and can be resistant to some treatments.

Given the often physical nature of many jobs within the military, and the prevalence of related medical discharge, it is apparent that a significant proportion of veterans are likely to be affected by MSDs of varying severity. As with the general population, they receive treatment and care predominantly within the NHS, with GPs likely to be the first point of contact. Where ex-Service men and women can differ from their civilian counterparts is that their MSDs are more likely to be just one aspect of a complex picture of acute post-combat and/or training injuries. In the case of such injuries, which are likely to involve high levels of pain, a range of treatments and support will be required.

In an ideal world, GPs will be aware if a patient presenting with MSDs is a veteran and will be able to assess if these are linked to other severe and enduring injuries. In such cases, the GP can refer onwards to a number of specialist services, including rehabilitation treatments provided by physio and occupational therapists. However, I am also aware that these are in high demand and veterans can sometimes face long delays in gaining access. Given the long term benefits of proper rehabilitation – both to the individual and wider society – this is an area that clearly needs attention. I suggest there may also be an opportunity here for charities to play an increased role.

Finding 5:

Rehabilitation services, such as those provided by physio and occupational therapists, can be of huge benefit to those suffering from MSDs. Given the high demand for such services, veterans suffering from severe MSDs as a result of their military service should be given early access as part of their special treatment.

Chronic Pain and Pain Management

Chronic pain is often defined as a condition that causes disabling and severely limiting pain which lasts for more than three months. It can become progressively worse and reoccur intermittently.

"Chronic pain is not simply a physical problem. It is often associated with severe and extensive psychological, social and economic factors...The impact of chronic pain on patients' lives varies from minor restrictions to complete loss of independence" – Dr Colin Tidy, GP and author on chronic pain.

The above quote also demonstrates starkly the complexity and often multiple issues faced by sufferers. Given the links to MSDs, polytrauma and other severe physical injuries, many ex-Service men and women are consequently living with pain. This has been highlighted in my conversations with health professionals in both the statutory and charity sectors.

Pain Concern is an Edinburgh based charity whose goals are to produce information, provide support and raise awareness for those with pain. They have a dedicated veterans section on their website and in collaboration with Forces in Mind Trust and the MacRobert Trust, they provide information and support to veterans in pain and to those who care for them. They have produced three interesting radio programmes featuring ex-Service men and women sharing their experiences of managing pain and interviews with the healthcare professionals who treat them.

Most veterans will be treated firstly by GPs, who may prescribe analgesics and other painkillers. For more serious cases they can refer patients to NHS(S) run clinics that deliver a variety of pain management programmes. It has also been interesting to hear about alternative approaches, such as self-management, mindfulness and regular exercise. These approaches would appear to suit many in the veterans community.

Of note was the recent establishment by the Scottish Government of the National Advisory Committee for Chronic Pain (NACCP). The group has a remit to guide improvement of chronic pain management at all levels of health and social care, and to inform national policy. Given the relatively high proportion of veterans who are likely to suffer chronic pain, the work of this group will be highly relevant. There is obvious merit in it considering veterans as a distinct cohort.

Recommendation 12 – Chronic Pain Management

The National Advisory Committee for Chronic Pain (NACCP) should consider veterans specifically as part of their work to improve chronic pain management in Scotland.

Severe Sensory Impairment

Serious instances of hearing and sight loss impact significantly on an individual's life, both physically and psychologically. Severe sensory impairment may occur as a result of combat injuries from gunfire or explosions, or from other major accidents, and may be every bit as traumatic as some of the other physical conditions discussed earlier.

During conversations with several veterans and organisations I have become increasingly aware of the extent of hearing loss amongst the ex-Service community. One of the starkest figures I have come across is that veterans under the age of 75 are approximately three and a half times more likely than the general population to suffer some sort of hearing impairment. This is a staggering statistic that indicates a serious problem amongst the veterans population. On a positive note, it is clear that the MOD is now investing heavily in training and protective equipment to prevent such high instances in the future. This will, of course, do nothing for those who have been previously exposed to the sounds of artillery, explosions or been in close proximity to jet engines and heavy machinery without proper hearing protection.

For a number of these individuals their disability will have a severe and enduring impact for the remainder of their lives. As well as profound hearing loss, some may also experience tinnitus – a constant ringing, buzzing or whistling sound which can be so overwhelming that around a third of sufferers say they are driven to despair.

The first point of contact for veterans with hearing difficulties is likely to be, yet again, their GP and many will find their needs largely met by the statutory sector. However, for those with severe or profound hearing loss acquired as a result of their military service, they may find NHS(S) is limited in the types of specialist hearing aids that can be provided. In accordance with the commitment to 'special' care for these veterans and the principles of the Scottish Approach, resources should be found to provide them with the best possible aids and support in keeping with their needs and lifestyle.

Medical professionals and veterans dealing with hearing loss of whatever severity, should be aware of the substantial additional support available from the charity sector. Some of this has been funded by Government via LIBOR and the Aged Veterans Fund, with those providing support including the Royal British Legion, Action on Hearing Loss, and UK Veterans. They can provide access to some of the best hearing aids available.

Recommendation 13 – Funding Hearing Aids

The Scottish Government and NHS(S) should make funding available so that veterans with the most severe hearing loss as a result of their military service can have access to the best possible hearing aids and support.

Sight impairment is fortunately not as widespread in the veterans community as hearing loss, but for those affected it is significant and life changing. Partial or complete loss of sight may be the result of a combat injury or occur in later life, not necessarily because of military service. The charity Scottish War Blinded runs two centres providing support with independent living, sport and other activities, social events, financial assistance, and rehabilitation for veterans with sight loss.

During a visit to its Linburn Centre in West Lothian, I heard that the majority of those who are supported have lost their sight due to old age and illnesses such as glaucoma and macular degeneration. There are, though, still a proportion of veterans who are blind or partially sighted as a direct result of their military service and clearly the support of charities like this is invaluable.

One such individual, Robert Reid, was a 25 year old Lance-Corporal in the Royal Regiment of Scotland on duty in Iraq when a roadside bomb exploded. He was gravely injured, losing the sight in his right eye. He spent time at DMRC Headley Court and Selly Oak Hospital receiving treatment for his injuries, and while there was put in touch with Scottish War Blinded who have since helped him to adjust to his new circumstances. Such support, over and above that provided by NHS(S), has been a key feature of care for wounded service personnel in Scotland for many years. You can read Roberts' full story on the Scottish War Blinded website.

The treatment and support available to all veterans with severe sensory loss, both from the statutory and charity sectors, is largely very good, but we must never take it for granted or allow complacency to compromise that situation. Only by properly protecting current services and effectively planning for the future can we ensure that those severely affected can continue to be well supported and cared for. These often 'hidden' injuries can be devastating and I strongly encourage Health and Social Care Partnerships, in particular, to take account of these when designing support for veterans.

The Invictus Games

Sports and fitness programmes and events are amongst the most recognisable and popular non-clinical pursuits for veterans with severe injuries. Perhaps the most iconic and high-profile in terms of competitive sport are the Invictus Games.

First held in London in 2014, they are now an established international, multi-sport fixture. Following the last gathering in Toronto in 2017, an evaluation was undertaken which concluded that it was 'a gift for competitors in their recovery' – something most of us instinctively knew and observed. Interestingly, the research also highlighted that Canadians' perceptions of, and support for, injured veterans shifted dramatically for the better in their aftermath. The next will be held in Sydney later this year.

It would be exciting to think of a future Games coming to Scotland. Both Edinburgh and Glasgow, of course, have a proud history of staging successful international sporting occasions and the idea of the Invictus Games being held here would be an enormous boon to our veterans community and fans of sport alike.

Recommendation 14 – The Invictus Games

The Scottish Government should work with partners, charities and others to scope a proposal to host a future Invictus Games in Scotland.

Conclusion

In this chapter I have highlighted some of the most severe physical conditions that can affect veterans following a career in the military. This is not an exhaustive list and I recognise that I haven't covered issues such as the impact of various cancers, Gulf War Illnesses, non-freezing cold injuries, or exposure to nuclear weapon testing. These often have very serious repercussions but I am confident that veterans have access to effective and compassionate care from NHS(S) in these and similar circumstances.

In concluding this chapter it is worth re-emphasising that the overall numbers of veterans struggling with severe and enduring physical conditions in Scotland is relatively small, and that the vast majority receive very good treatment and care. Mainstream and specialist NHS(S) services – complemented by the work done by a number of charities – are well-placed to provide this. At present, very few 'fall between the cracks' and fail to get the level of support they need.

That said, the concern amongst many veterans is that statutory services will struggle to provide this level of care in the long term, and that it will be unable to adapt to their needs as they age. This causes significant worry and I believe the Government can do much to allay such concerns by reinforcing its commitment to providing the best possible 'special' life-long care. Integrated Joint Boards, Health and Social Care Partnerships, NHS(S) and local Councils will be required to plan and deliver this. By doing so, I believe this vulnerable group will get the reassurance they seek and the care they deserve.

Chapter 5

Improving Outcomes for All

For much of this report the emphasis has been on veterans who face serious and life-changing injuries or conditions resulting from military service, our obligation to provide them with 'special' treatment and care and how this can be guaranteed for as long as it is required. This is only right given their previous sacrifice and the cost which they will bear over many years. As is evident from previous chapters, this has been the main thrust of the proposed Scottish Approach to Veterans' Health and I make no apology for giving these individuals, and their needs, such prominence.

However, it is also important to consider the wider population of veterans, their health and social care needs, and determine whether the support provided is as good as it could be.

Jane Duncan – Veterans Support Adviser

"When you leave the Armed Forces, you leave a community, and that is very difficult to step away from. Replicating that community sense via social groups and organisations can, for some, help military personnel feel part of a tight knit group and most importantly, valued. The appetite from the three councils [Renfrewshire, East Renfrewshire & Inverclyde] to help veterans integrate into the community has significantly increased since 2014 and they all want to play their part in ensuring that the region is viewed as a place to settle for veterans. They want ex-Service personnel to know that they, and their families, are welcomed to the area and that there is support and help in place at a local level."

Veterans in Society

The overall number of veterans who live in Scotland is still not known precisely, something that is a continued source of frustration for those who are responsible for planning and allocating resources for their treatment and care. A series of reports from MOD, Royal British Legion and Poppyscotland provide an estimate of the size and socio-demographic characteristics of the population and, although these have proved useful, they have their limitations. I have therefore strongly supported the campaign to include questions about previous military service in the next national census, given its potential to provide clarity and inform future policy and resource decisions.

Despite this lack of absolute certainty, the most recent studies suggest approximately a quarter of a million veterans currently live in Scotland, with the expectation that this figure will decrease over time as the older generation of National Servicemen pass away, and as a consequence of our Armed Forces having reduced in size. Of this community – which comprises about 4% of the nation's population and includes individuals who range in age from their late teens to over 90 – the majority will have served in the military for less than four years, in many cases up to 50 or 60 years ago, and at least half will be over the age of 75. They are found in every part of society, include increasing numbers of women and have very similar personal aspirations, worries and challenges to their peers who have not served. Many of their health and social care needs are no different to those in the wider population.

For everyone in Scotland, the Scottish Government makes clear they have a fundamental right to the *"highest possible standard of health"* and a *"fairer share of the opportunities, resources and confidence to live longer, healthier lives"*. This is enshrined in policy documents such as *A Fairer, Healthier Scotland 2017-22* and dictates the approach taken by NHS(S), Integrated Joint Boards, Health and Social Care Partnerships, Health Boards and Councils as they strive to reduce inequalities and improve the overall health of the nation. One of the key aims of my report is to ensure all veterans benefit from this strategic framework.

However, throughout this report I have also attempted to address the fundamental question as to whether veterans face any disadvantage when accessing health and social care provision. The good news is that I have come across very few instances where this is the case and none that suggest it is an endemic problem across the statutory services. That said, the focus on addressing inequalities within the health system has opened my eyes to members of the ex-Service community who may be experiencing what NHS(S) describes as *"unjust and avoidable differences in [their] health...that are socially determined by circumstances largely beyond [their] control"*.

Health Inequalities

According to the same source, health inequalities are rooted in the unequal distribution of power, wealth and income, and the associated social determinants of health which include housing, employment, education, family income, social support, communities and childhood experiences.

It has long been recognised in the veterans community how vital many of these determinants are to ensuring ex-Service men and women and their families prosper after a career in the military. Much effort and resource is invested by both government and charities to support those leaving the Armed Forces and veterans on these and other fronts.

As Commissioner, I have previously published reports on aspects of the transition to civilian life, housing, employment, skills and learning. All have been seeking, firstly, to promote veterans as valuable assets to their local communities and Scotland's wider economy and, secondly, to increase opportunities for them to secure suitable housing, meaningful and sustainable jobs, and college, university and training places. As well as helping to ensure veterans are properly recognised and rewarded for the skills and attributes they have, it is heartening to think that improvements in all of these areas may, in part, also contribute to them living well and being in good health.

As with the wider population, the veterans community stands to benefit from the holistic approach to health which exists in Scotland. There are, though, certain characteristics that distinguish veterans from the general population that mean some may still face health inequalities and are worthy of separate consideration within the system. Research by different academic organisations and my own discussions over the past few years indicate that Early Service Leavers (ESLs), the elderly and those who served as reservist members of the Armed Forces may be at particular disadvantage.

Early Service Leavers

ESLs are those who leave the military voluntarily before completing the minimum term of four years, have been compulsorily discharged or who have not completed basic training.

There is a growing body of research that shows this group at particular risk of being adversely affected by a range of health conditions. We also know some experience difficulty in securing accommodation and work, and on occasion end up in the criminal justice system after their time in the military. I have examined some of these challenges in previous reports and recognise they all have an effect on the future health and wellbeing of this more vulnerable cohort.

The reasons for ESLs being at higher risk of poor health are varied and complex. It is a subject that is increasingly the focus of investigation and debate amongst the academic, Armed Forces and veterans communities. I won't, therefore, go into detail here other than to highlight the emerging understanding that their physical and mental health issues can often be a legacy of their lives prior to joining the military. Factors such as social deprivation, lower educational attainment, childhood traumas and poverty all play a part.

A report on mental health in the military by ForcesWatch highlights just some of the challenges faced by these individuals: *"The youngest personnel from the most disadvantaged backgrounds are: more vulnerable to trauma; more likely to be in a close-combat role and exposed to traumatic stress when deployed; and then less likely to be able to draw on the social support they need to manage a mental health problem after leaving the forces. This group is therefore disadvantaged before, during and after their military career in terms of the mental health risks they face"*

Regardless of the reasons and whether they are attributable to time in the military or beforehand, what is clear is that some ESLs are more likely to suffer adverse health conditions and consequently face inequalities.

Armed Forces Reserves

Whether an individual has served as a regular member of the Armed Forces or a reservist, they have the same status as a veteran afterwards and are rightly regarded no differently by the health system, charities and others. There is, though, evidence to suggest reservists face a number of health challenges which merit separate consideration.

For example, a number of academic reports found that reservists who had been deployed in a combat situation were at higher risk of developing PTSD compared to regular members of the military. The reasons for this are likely to be many, and will include issues such as the stresses of balancing other jobs and family commitments, less well established networks of support and comradeship within the military, and the disruption of transitioning between Service and civilian life.

There are already joint NHS and MOD programmes with a particular focus on mental health, run for reservists who have previously been deployed. This is an important part of addressing the needs of this group. Notwithstanding, it remains a cohort that still faces an increased health risk and about which there appears to be limited understanding. While the numbers affected are relatively small, I still believe there is a clear need to invest time and effort in recognising and addressing the specific health and wellbeing needs of this group in Scotland.

Older veterans

Laura Anderson – Occupational Therapist

"At V1P Lothian we have seen a rise in physical problems, most commonly loss of hearing, general wear and tear, frailty, and occasionally weight management, breathing difficulties and malnourishment...

As with the elderly in the wider population, one of the biggest challenges we face is social isolation and the team facilitates group activities and attendance at drop-in sessions to combat this. Some veterans are fit enough to get themselves to such activities, but for those that aren't we work with partners to assess carer needs and assist with putting any requirements in place."

Our population of veterans is aging and declining in number. As I mentioned earlier, almost half of veterans are aged 75 or older, with the majority having spent a relatively short time in the military during National Service. Most encounter similar health challenges to anyone as part of the natural consequences of aging, such as different forms of dementia. They increasingly face a range of illnesses and conditions that have a cumulative and often significant impact on their quality of life. Some of these later-life health conditions can, at least in part, be attributed to or exacerbated by military service.

Veterans charities have traditionally provided invaluable support to older members of the community. However, the challenges faced by this group have gained a higher profile and a greater priority amongst many more organisations in recent years. For example, last year I was pleased to launch a large UK Government funded programme of services to veterans over the age of 65. Called Unforgotten Forces it brings together 15 organisations in a consortium led by Poppyscotland. It includes a number of the traditional military charities but also several others such as Age Scotland and Music in Hospitals Scotland. One of the main concerns the programme is seeking to tackle is loneliness and isolation, something that is particularly acute amongst many in the older veterans community.

There are also veterans whose military career will leave various legacies which can impact their future health and wellbeing. This is especially evident amongst the large number of ex-Service men and women who struggle with pain and mobility issues resulting from musculo-skeletal conditions, the long-term effects of smoking and excessive alcohol consumption, and the consequences of frequent exposure to extreme noise. All are associated, to a greater or lesser extent, with service in the Armed Forces and can have a detrimental impact on an individual's quality of life, health, employability and, in the most serious circumstances, their life expectancy.

Mobility Concerns

Severe Musculoskeletal Disorders (MSDs) are highlighted earlier and comprise the most common medical reason and conditions for someone leaving the Armed Forces. However, it is apparent that for a large number of veterans, other MSDs and conditions like arthritis may develop in later life and lead to considerable mobility and other difficulties. This is not surprising when one considers the physical nature of the working life many will have led and the associated risk of injury, stresses and strains to the body.

The most recent Household Survey produced by Poppyscotland highlights mobility, both inside and outside the home, as the most common health problem cited by veterans themselves. This is backed up by a number of other reports and reflects the older and aging profile of the ex-Service community. Mobility problems can often lead to struggles with activities of daily living, such as washing, cooking and dressing. They can also result in isolation and loneliness if, for example, someone struggles to get out of the home, cannot drive or readily use public transport.

Smoking

Many older veterans completed their military service, including National Service, in an era when the dangers of smoking were not well understood and cigarettes were given out freely as a daily allowance. The consequences have been highlighted by Dr Beverly Bergman in a 2016 report which confirmed veterans in Scotland born before 1955 were at increased risk of smoking-related diseases.

Although overall smoking rates are decreasing in the Armed Forces, it is still the case that serving personnel are more likely to smoke, and more heavily, than their civilian counterparts. The potential future health implications are now well-known and spoken about. It is encouraging that the MOD is taking action to reverse this trend. For example, a Tri-Service Tobacco Control Working Group has been tasked with increasing smoking cessation, including identifying ways of discouraging recruits from taking it up in the first instance.

I am optimistic that smoking levels within the military will continue to fall, as across the wider population, with the consequent positive impacts on future veterans' health. However, the effects of a historical culture of heavy smoking will still leave some with related health problems that include certain cancers, cardiovascular and respiratory diseases, that will be seen for many years to come.

Alcohol Consumption

A previous chapter covered the serious effects of very heavy drinking when linked to mental ill health. However, it is still the case that veterans are more likely than their civilian peers to display problem levels of drinking. Some of this can be explained by aspects of the culture and attitudes within the Armed Forces. The following quote from a 2011 King's College London report, *Alcohol Use and Misuse Within the Military*, by Edgar Jones and Nicola Fear neatly encapsulates the nature of the problem and the difficulties the medical profession have in responding to it.

"Of necessity, the Armed Forces recruit risk-taking individuals. It may be that some of the characteristics that make a successful combat soldier also put them at risk of alcohol misuse. Sub-groups within the Armed Forces are particularly predisposed to heavy drinking. In particular those who are young, single and who have been involved in traumatic incidents. Because drinking has been used by UK Armed Forces as an agent to assist cohesion and informal operational debriefing, it requires a powerful cultural shift to modify ingrained habits and traditions....Alcohol has played such a significant part in service culture for so long that any intervention will take the form of a war of attrition."

Research by The Northern Hub for Veterans and Military Families' Research at Northumbria University also found barriers to veterans accessing appropriate treatment for alcohol problems. These include the inherent drinking culture within the military, a lack of understanding amongst the medical profession of their unique needs, and the stigma associated with asking for help. As with smoking, there are encouraging signs of problem drinking being tackled and reduced both within military and veterans circles. However, the effects of heavy drinking still leave some facing related health problems which can adversely impact on the individual, their family and the community.

Hearing Loss

Almost everyone who served in the Armed Forces will have been exposed to a significant amount of noise, which will almost inevitably take a toll on their auditory system. Severe hearing loss has already been covered earlier but it is also important to recognise that many, perhaps most, veterans will experience lesser degrees of impairment following their time in the military. This may entail noise-induced hearing loss from prolonged and repeated exposure to loud noise, or acoustic trauma usually as the result of an explosion or gunshot at close range.

The Royal British Legion report *Lost Voices* succinctly summarises some of the impacts of this hidden cost of military service when it states, *"hearing problems can have a profound effect on an individual's career prospects, family relationships, social life and mental health".*

Veterans – a distinct group?

All of the above leads me to the conclusion that there are a number of veterans who, despite the many improvements made in recent years, remain susceptible to health inequalities after a Service career. For many, it will have exposed them to combat, harsh physical conditions, stressful situations and a lifestyle that has had a detrimental effect on their long-term health and general wellbeing.

Given NHS(S)'s emphasis on reducing such occurrences of disadvantage, and an increasing body of academic evidence that highlights the long-term health implications of a military career, I believe there is a strong case for considering veterans as a group that deserves closer attention. In most cases, there will be an existing national strategy, framework or plan that dictates the approach and treatment required for specific conditions. However, these sometimes fail to consider the often unique requirements and characteristics of a sizeable veterans population. I am also concerned that they don't always address the multiple co-morbidities that frequently appear amongst this group.

I should stress at this point that I am not making a direct plea for significant resources to provide exceptional treatment for veterans as a whole. This is only relevant to those with the most severe and life-changing injuries, as I have argued in previous chapters. However, I firmly believe that the Scottish Government, NHS(S) and their partners should identify veterans as a distinct group whose health and wellbeing is influenced by their prior military service which leads, in certain circumstances, to inequalities that need to be addressed. I appreciate this is a complex ask that will involve many different organisations but the approach mirrors that taken for other groups in Scottish society. It has the potential to help build a better understanding of veterans' needs and characteristics, and develop practical measures that will improve health and wellbeing outcomes for all.

Recommendation 15 – Tackling Health Inequalities

The Scottish Government, NHS(S) and partners should identify veterans as a distinct group in their work to tackle health inequalities. In doing so they should produce proposals for preventing or mitigating inequalities as they apply to this group, with the ultimate aim of improving health outcomes for all.

Process and Administration

Given the size and complexity of the health and social care sector in Scotland it is unsurprising that issues of process and administration are important. This affects veterans just as much as the rest of the population but I have become aware of several factors which can complicate and hamper access to treatment and affect health outcomes for this group. These cover a range of subjects which may, on first inspection, be relatively minor and procedural in nature. However, each has a noticeable impact on how veterans are treated by the system and the quality of care provided.

Identifying Veterans

One of the great frustrations expressed by many health professionals is their inability to identify consistently and accurately those who have served in the military. There is no doubt that the current practice that requires GP surgeries to ask new patients whether they have served is a good starting point but it is also evident that the process has several limitations.

One of the first hurdles to overcome is the reluctance by some veterans to identify themselves as such, typically citing security concerns or personal antipathy for their decision. This is an entirely legitimate and understandable response but the consequences can be far-reaching both for the individual and his/her access to bespoke care, and the health professionals who may not have a full medical history on which to base decisions. Ultimately, it is a personal choice to declare prior military service but I sense more can be done by the MOD, veterans organisations and NHS(S) to reassure and encourage people along this path. My personal experience is that this is a fundamental building block to enabling health professionals to better understand and consequently treat veterans.

There is also an internal problem with this process in that it misses a large proportion of those who may have been with a practice for many years and have never had the opportunity to formally share information about their previous military careers. Some are 'caught' during consultations and when surgeries request an update of personal records but too many are never identified. In the most serious situations this can limit access to the 'special' treatment covered in previous chapters but it may also deny health professionals extra background information that can influence diagnoses and decisions about treatment. I am also aware that this lack of basic data and medical statistics makes it more difficult to measure outcomes, shape future policy and address the health inequalities that affect some in our communities.

Recommendation 16 – Identifying Veterans

The Armed Forces and Veterans Joint Health Group should oversee work to increase the number of veterans declaring their previous service to GPs and others in the system. This will likely involve NHS(S), MOD and veterans organisations.

Using the Information

Further shortcomings of the present process concern the consistency of recording a veteran's military service on primary healthcare IT systems, the low profile this is given on electronic medical records once logged, and the difficulty of sharing it with systems supporting other areas within the NHS. This is partly a technical issue but I am surprised that there is still no contractual requirement, or incentive, for GPs to formally encode data fields about military service. The result is that busy surgeries will often give this work a lower priority despite the requirement to record such information during initial consultations with new patients.

To my mind this is a fundamental breakdown in a process that was first intended to ensure veterans were properly recognised by the health system and it is disappointing that after several years there is still no reliable method of recording, displaying and sharing this vital information. I strongly urge that NHS(S) address this issue as a priority since failure to do so could have an adverse impact on health outcomes for veterans and easily act as a block on other initiatives that rely on good statistical data.

Recommendation 17 – Using Information

The Armed Forces and Veterans Joint Health Group should oversee efforts to improve methods of recording, displaying and sharing information about veterans within the health and social care sector. This will be with a view to providing health professionals with the information needed to better understand and support veterans.

Registering with a GP

The final paragraphs in this section examine the recurring challenge of getting Service personnel to register with civilian medical practices when they leave the military.

I should stress that for the majority, and certainly for those with on-going severe medical conditions, responsibility for providing care is transferred effectively and efficiently from the Defence Medical Services to a local GP and NHS(S). In most routine cases the onus will be on Service leavers to follow instructions provided by MOD during their overall transition process. This is straightforward and rarely presents problems for those who are well-organised and confident of their future plans.

Despite this, there remains a significant number of Service men and women – usually younger and single – who leave and delay enrolling with a local medical practice. In the past I considered this to be a serious problem and disadvantage but am now aware that these individuals join many others in our society who rely on Accident & Emergency units, drop-in clinics and ad hoc visits to surgeries whenever they need treatment. This is not the preferred approach and I would encourage the MOD and NHS(S) – including through its *Inform* website – to do more to help these Service leavers to organise their healthcare more responsibly.

Veterans Champions

During the past four years I have had the privilege of meeting many Health Board veterans champions and have seen, at first hand, the positive impact they have in their local areas. Each has the latitude to tackle the role in their own way but there is no doubt that they have raised the profile of veterans amongst their colleagues and provided a valuable point of contact for those with concerns or needing help to access NHS(S) services. I admire and strongly support the work they do.

Warwick Shaw – Veterans Champion at NHS Borders

"By signposting help and resources, such as SSAFA and Veterans Scotland, champions allow GPs to direct veterans towards the right support as soon as they are seeking advice."

Circumstances have changed since the role was created and there is now a significantly different landscape following the integration of health and social care services across Scotland. Traditionally, champions have been recruited from the senior management or local board levels within NHS(S) but the introduction of Integrated Joint Boards (IJBs) and Health and Social Care Partnerships (HSCPs) present a markedly different structure in which they must now operate. With responsibility for delivery of services shared between this partnership of Councils and NHS Boards, champions will need to extend their influence more widely, work closely with a broader range of interested parties and be prepared to assist veterans who may struggle to understand the new set-up. This is likely to be a more complex and time consuming task.

A recent aide memoire issued by the Scottish Government and Veterans Scotland provides a welcome reminder about the role, its purpose and the key characteristics of an effective champion. I am pleased to see this document and believe it offers a good starting point as the role adapts to changing structures. Future work will, I anticipate, need to focus on (1) coordinating the efforts of local Council and NHS champions in supporting the provision of health and social care, (2) harnessing the clear commitment and tenacity of champions so they can influence IJB and HSCP decisions that affect veterans, and (3) empower champions as they support ex-Service personnel in their communities. In many cases this is already being done on an informal basis but there is a role for the Scottish Government, Veterans Scotland and NHS(S) to provide further advice and support as this important resource adjusts to changing demands.

Recommendation 18 – Veterans Champions

The Scottish Government and Veterans Scotland should build on recent work to support the network of NHS and Council champions to develop the role so that it can continue to be effective in supporting the delivery of health and social care to veterans within the new health landscape of Scotland.

Chapter 6

Conclusions

Conclusions

The topic of veterans health and wellbeing is, by far, the most wide-ranging and complex that I have tackled during my time as Commissioner. Preparing this report has been a fascinating and thought-provoking experience that has exposed my team and me to very many issues and concerns affecting the ex-Service community at a time of **significant change across Scotland's health and social care sector.** During the study we have turned, repeatedly, to the four fundamental questions I posed at the outset (and can be found in the Foreword) which were intended to determine whether we are 'getting it right' for some of the most deserving members of society. I sincerely hope that my conclusions, and the subsequent findings and recommendations, will assist those responsible for planning and delivering improved outcomes for these individuals.

The first – and probably key – conclusion I have come to is that there is both a need, and a timely opportunity, to **rekindle awareness and concern for veterans' healthcare** in Scotland today. I acknowledge that the vast majority of ex-military personnel, especially those with serious and life-changing conditions, have access to impressive standards of treatment and support but the levels of ambition and innovation which characterised Scotland's approach in previous years have sadly waned since peaking at the start of the decade. My proposal for a distinct Scottish Approach to Veterans' Health is intended to provide the motivation, agenda and governance structure that will raise the profile of veterans and reinvigorate efforts to provide them with the best possible treatment and care.

At the heart of this proposed approach is an unequivocal **emphasis on the small – but vitally important – group of veterans with the most severe and enduring injuries** and conditions caused or exacerbated by military service. It is my opinion that the provision of specialist services for these individuals, who have given the most in serving our country and suffered life-changing consequences, should be at the very centre of Scotland's health system. I should stress that this support, usually delivered by the statutory and third sectors, is very good and that one of the main purposes of any approach should be to protect and enhance this care for current and future generations.

Another area in which the commitment to providing the best possible treatment to veterans, and ensuring it is well planned and resourced, can be most usefully met is in the field of mental health. The Scottish Government, NHS(S) and charities have done much on this front in recent years but there are still concerns about sustainability and, in some instances, accessibility. This has led me to call for a **Mental Health Action Plan** that secures long-term delivery of dedicated services and support to veterans. I have concluded that this should be one of the responsibilities of a new **network focussed on all aspects of veterans' health.** It will be important that the network reflects, both in membership and approach, a significantly changed health and social care landscape and local models of service delivery in Scotland today.

A further factor for ex-military personnel with the most serious and debilitating conditions is ensuring that their **changing health and social care requirements are properly planned and met for the rest of their lives.** In studying this theme, it became apparent early on that the system in Scotland has undergone transformational change in recent years, most prominently through the integration of health and social care services. I have, therefore, offered suggestions and recommendations which I believe reflect that change and will ensure consideration of veterans' health issues, especially for this group, is embedded within this new landscape.

While my focus has rightly been on the needs of those with severe and enduring conditions, I also recognised that there are others in the community that merit attention. It is pleasing to report that most veterans are in good health and I have discovered no obvious examples of disadvantage in either the availability of, or access to, services and support. However, there are some who are at an increased risk of facing **health inequalities as a result of military service,** which in itself constitutes a disadvantage. I have, therefore, concluded that by identifying veterans as a distinct group within the health system, there is an opportunity which must be grasped to redress some of these inequalities and improve the outcomes for a broad number of our veterans.

In one sense this report provides a snapshot of veterans' health and associated issues in 2018. More than that and with an eye to the future, I hope that the proposals it contains also offer a vision, framework and ideas for ensuring a reinvigorated approach to veterans' health. Ultimately, I believe Scotland has an opportunity to build on its well-deserved reputation and the quality of care it provides to our veterans community.

Annex 1

Recommendations and Findings

Recommendation 1 – A Distinctive Scottish Approach to Veterans' Health

The Scottish Government and NHS(S) should commit to establishing a distinctive Scottish Approach to Veterans' Health at a strategic level, accept or adapt the guiding principles of this approach and work with their partners to embed it at an operational level.

Recommendation 2 – Improving Collaboration and Partnership

The Scottish Government should reinvigorate senior participation in cross-border networks with a view to improved information sharing and increased involvement in collaborative working and initiatives.

Recommendation 3 – Leadership and Governance

The Armed Forces and Veterans Health Joint Group should refresh its membership and remit in order to provide the vital strategic leadership that will deliver the Scottish Approach to Veterans' Health

Recommendation 4 – National Managed Clinical Network

The Scottish Government and NHS(S) should establish a network on veterans' health. The network will have oversight of delivering the Scottish Approach to Veterans' Health, and will consider the key issues raised in this report and others it deems relevant. It should reflect current structures in the health and social care sector in its membership and approach.

Recommendation 5 – Mental Health Action Plan

The Scottish Government and NHS(S), through the network on veterans health (see recommendation 4), should produce a Mental Health Action Plan for the long-term delivery of services and support. Systemic issues of funding, collaboration, leadership, planning, governance and training of staff will be key.

Recommendation 6 – Drugs Misuse

The Scottish Government and NHS(S) should assess the scale and nature of drugs misuse – especially prescription and non-prescription painkillers – amongst the veterans community in Scotland and introduce remedial measures. This should be taken forward by the Joint Group and network, and included as part of the Mental Health Action Plan.

Recommendation 7 – Barriers to Accessing Services

The Scottish Government and NHS(S) should build on existing work aimed at reducing barriers to veterans accessing mental health services. This will include measures to address issues of stigma, seeking help, and improving awareness and understanding within the medical profession. This should be taken forward by the Joint Group and network, and included as part of the Mental Health Action Plan.

Recommendation 8 – Access to Life-long Services

The Scottish Government, NHS(S), Health Boards and local Councils should make a commitment to veterans with the most severe and enduring physical (and mental) conditions that they can access the highest quality health and social care services for life and as their needs change. Health and Social Care Partnerships and Integrated Joint Boards will be instrumental in planning the delivery of these services and the national network recommended in chapter 2 should assume responsibility for oversight of this work as an early priority.

Recommendation 9 – Funding for Multiple Injuries

The Scottish Government and NHS(S) should give consideration to whether the costs of specialist care for veterans who have suffered polytrauma should be funded through the National Services Division (NSD).

Recommendation 10 – The National Trauma Network

NHS(S) should include the specific needs of veterans who have suffered polytrauma as part of its work in setting up a national Trauma Network.

Recommendation 11 – Wheelchairs for Amputees

NHS(S) should adapt current arrangements to ensure an appropriate level of funding is available to guarantee that wheelchairs provided by the MOD for veterans with severe amputations can be serviced, maintained and replaced with the best possible equipment commensurate with that individual's needs.

Recommendation 12 – Chronic Pain Management

The National Advisory Committee for Chronic Pain (NACCP) should consider veterans specifically as part of their work to improve chronic pain management in Scotland.

Recommendation 13 – Funding Hearing Aids

The Scottish Government and NHS(S) should make funding available so that veterans with the most severe hearing loss as a result of their military service can have access to the best possible hearing aids and support.

Recommendation 14 – The Invictus Games

The Scottish Government should work with partners, charities and others to scope a proposal to host a future Invictus Games in Scotland.

Recommendation 15 – Tackling Health Inequalities

The Scottish Government, NHS(S) and partners should identify veterans as a distinct group in their work to tackle health inequalities. In doing so they should produce proposals for preventing or mitigating inequalities as they apply to this group, with the ultimate aim of improving health outcomes for all.

Recommendation 16 – Identifying Veterans

The Armed Forces and Veterans Joint Health Group should oversee work to increase the number of veterans declaring their previous service to GPs and others in the system. This will likely involve NHS(S), MOD and veterans organisations.

Recommendation 17 – Using Information

The Armed Forces and Veterans Joint Health Group should oversee efforts to improve methods of recording, displaying and sharing information about veterans within the health and social care sector. This will be with a view to providing health professionals with the information needed to better understand and support veterans.

Recommendation 18 – Veterans Champions

The Scottish Government and Veterans Scotland should build on recent work to support the network of NHS and Council champions to develop the role so that it can continue to be effective in supporting the delivery of health and social care to veterans within the new health landscape of Scotland.

Finding 1:

Specialist physical and mental health services are a vital and valued part of supporting our veterans with the most severe and enduring injuries and conditions. While their exact make-up and models of delivery will inevitably change and adapt over time, it is imperative that the availability of specialist services – and the outcomes they support – are protected for current and future generations.

Finding 2:

Funding for specialist mental and physical health services for veterans is disjointed and in some cases ad hoc. This results in a degree of uncertainty and raised questions about the sustainability of some of these services, which is a worry for those who rely on and value them so much. It is an issue that needs addressed as a priority.

Finding 3:

The integration of health and social care services in Scotland provides a unique opportunity to ensure the longer-term needs of veterans are properly planned and met. The new structure of IJBs and HSCPs is the vehicle for delivering this ambition. They must play a central role in decision-making about veterans' health and wellbeing and the delivery of both mainstream and specialist services.

Finding 4:

The publication of the Suicide Prevention Action Plan by the Scottish Government later this year is a welcome step in ensuring everything possible is done to help anyone struggling with mental ill health. Vulnerable veterans, and their particular circumstances, will be an important consideration as the plan is developed.

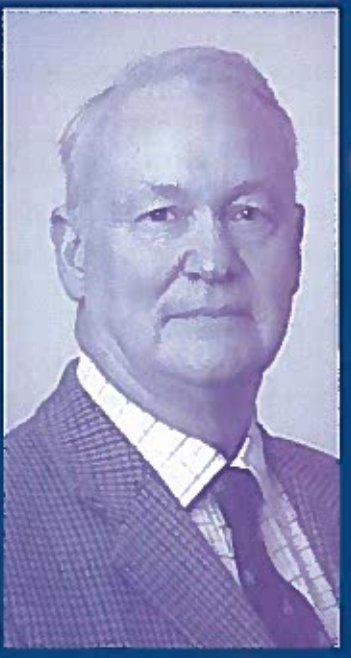
Finding 5:

Rehabilitation services, such as those provided by physio and occupational therapists, can be of huge benefit to those suffering from MSDs. Given the high demand for such services, veterans suffering from severe MSDs as a result of their military service should be given early access as part of their special treatment.

Annex 2

Case Studies



Case Study 1

Jason Hare – Veteran and Operations Manager - Horseback UK

Serving his Country

Jason (Jay) Hare was a Corporal in 45 Commando Royal Marines where he experienced some of the world's toughest and most hazardous environments, serving in Northern Ireland and Afghanistan. His case study provides an insight into the traumas he suffered and his hopes for the future.

Having previously been injured by an IED in Afghanistan in 2006, Jay then sustained severe injuries in 2008 after being blow up by another IED in Sangin, Helmand Province; frequently referred to as the 'valley of death'. Aged just 27, the incident left him with life-changing injuries including, the loss of his left leg below the knee, several fingers, injuries to his right arm and right leg and serious injury to his face which required multiple reconstructive surgeries over a number of years.

Jay received treatment at Selly Oak Hospital and then the Defence Medical Rehabilitation Centre Headley Court. Remarkably, Jay was only in hospital for five weeks before being discharged and back home for Christmas 2008 - something he attributes to the exceptional treatment he received at Selly Oak. Subsequently he received further treatment at the Recovery Centre near Epsom and returned to 45 Commando in April 2009. He notes that the Recovery Centre wasn't initially equipped to deal with such severe injuries, but quickly evolved due to the number of severely injured servicemen coming through its doors.

His welfare package extended to specialised support to his family, including the assignment of a welfare support officer. Part of this involved communication between families going through similar experiences, meaning they developed a close relationship adding an extra layer of support described by Jay as *"crucial"*.

Looking to the Future

Jay now works as Operations Manager at Horseback UK which uses horsemanship to inspire recovery, regain self-esteem and provide a sense of purpose and community to the wounded, injured and sick of the military community.

Aged 36, Jay already feels twinges in his prosthetic leg, other injured knee and back. He questions whether the same level of support he has received to date will be available in the next ten years. Now based in Aberdeen where he receives any treatment or assistance required, Jay worries that if he is to break his two prosthetics he would struggle to find funding for an equivalent replacement or new updated models. He questions what measures are in place to ensure that this is never a problem combat veterans will have to worry about.

Although Jay notes that it is highly promising and encouraging to see a variety of Scottish veteran charities allocated money, he is also concerned about enough funding being reserved for future resources to effectively deal with the delayed onset health conditions experienced by the ex-Forces community, such as PTSD and Adjustment Disorder.

He said: *"The Armed Forces Covenant made a promise to the veteran community that we would be treated fairly. It stated that 'British soldiers must always be able to expect fair treatment, to be valued and respected as individuals, and that they (and their families) will be sustained and rewarded by commensurate terms and conditions of service'. Are enough future resources in place to really deliver this promise? As Operational, we were told that we were going to be looked after if injured – that was the deal that was on the table and I hope that is still the case."*

Having said this, Jay is very positive of the current services and support that is available and believes that we need to

keep this momentum going.

"Although I think that we definitely need to readdress how we are preparing for veterans' future needs in terms of health and wellbeing, the current services available are the best that we have had access to for generations.

"Veterans also now have a louder public voice with a proactive Veterans Minister and the Scottish Veterans Commissioner working in parallel to improve outcomes for veterans in Scotland across a range of key areas - this is extremely encouraging."

Case Study 2

Aidan Stephen – Veteran and Full-time Art Student

47-year-old Aidan Stephen served in the Army (Royal Armoured Corps) for seventeen years, during which time he undertook operational tours in Northern Ireland, Bosnia, Kosovo and finally Iraq in 2003. When he returned from Iraq, his life spiralled badly, and he was medically discharged from the army due to serious mental health issues. After an extensive range of support over several years, he is back on track, and is now active on the veterans scene where he shares his story at events. For the past two years, he has sat as a member of the Scottish Veterans Fund panel, which makes recommendations to Scottish Ministers on the allocation of funding to veterans projects.

"I was diagnosed with depression in 2000 while still in the Army, however I was deployed to Iraq in 2003 regardless. At the time, if you were suffering from mental illness in the army, only your superior officer would be informed – you didn't want any of your juniors to know in case it lowered their respect for you and affected your leadership capabilities. There was a real stigma attached and I kept it very much to myself.

"A few months after returning from Iraq, I attempted suicide and spent five days in a coma. When I woke up, I was admitted to a military psychiatric facility in Germany for four months, where I spent many hours heavily medicated and receiving electroconvulsive therapy (ECT). Most patients were relatives of soldiers, and the support I received wasn't suitable for my needs.

"I returned to Scotland where my wife and I separated and I ended up living alone in a small basement flat in Edinburgh, isolated with little family support. I was still in the Army at this point and they were trying to figure out what to do with me. I was sent to the Priory in Glasgow, a civilian mental health unit which treats people with addictions and eating disorders. This was one of the worst decisions made in the duration of my treatment. None of the staff were trained to deal with patients from a military background and none of my fellow clients shared my experiences, yet I had to participate in group therapy with them.

"One day, one of the patients said she was feeling low because she had eaten loads of chocolate cake that morning. Whilst acknowledging that seemingly minor issues such as this can have a much deeper psychological root for some people, I was suffering from night terrors and traumatic flashbacks to my time in the Army, and comments like this only increased the distance I felt between myself and everyone else at the facility, leaving me feeling even more isolated.

"I was then sent to Bedlam in London, regarded as the best psychiatric hospital in the UK at the time, where I was given more medication and ECT. In 2006, I was given medical discharge from the Army, and with no progress in the previous three years, I was now in the care of civilian doctors rather than military doctors. Both had told me that it was up to me to make the changes I needed to start getting better.

"I returned to my flat in Edinburgh and continued to spiral, culminating in an incident where I threatened to kill myself and self-harmed in public. I was arrested for this and ended up on remand for eight days. A doctor I spoke with while there told me to get in touch when I was out and he made me aware of veteran-specific support services that he thought would help me. This is where things finally started to turn around.

"When Veterans F1rst Point launched in Edinburgh in 2009, for the first time I had the opportunity to access peer-to-peer talking therapy. It was the first time I had really spoken to anyone about my experiences – until that point, my treatment plan had mostly included medication and ECT. I was diagnosed with PTSD which I got support for from Combat Stress, and accessed a range of other services through veterans charities.

"I had a real breakthrough with Poppyscotland and SAMH in 2011. After identifying that I wasn't socialising enough and learning that art therapy had worked to a degree at Bedlam, they referred me to a project called Artlink. I really enjoyed it and Poppyscotland helped me explore art courses, taking me to visit Edinburgh College of Art. A woman at the Student Disability Service encouraged me to apply and I was accepted on my chosen course. I am now in my third year, and my mental health has improved massively.

"Looking back on my own experience, I would say that the value of recreational organisations and initiatives aimed at veterans, such as Horseback UK, should not be underestimated and the veterans support scene would benefit from more of these. For instance, I am not aware of any art organisation with a veteran-focus, despite art therapy being a common form of treatment for all people with mental health issues.

"Alongside reintegrating into the civilian community through art, actually talking to someone about my experience was key to making progress with my mental health. It seems obvious, yet it was six years after my suicide attempt before I was given the opportunity to do this with a fellow veteran, and I just didn't feel like I could open up to anyone else. I felt like they wouldn't understand and also that there were some things I could say which a civilian might consider reporting to the police. I think ensuring that peer-to-peer support is made available at the earliest stage possible would significantly improve the outcomes for Service leavers with mental health issues.

"All veterans have completely different experiences and needs, and have different ways of adjusting to the civilian world. However, being able to talk with someone openly and honestly provides the basis for developing a suitable treatment plan which can effectively address these.

"In addition to a one-to-one therapy setting, chatting on a social basis with other veterans is also extremely important, and I feel the support organisations which work best are ones which facilitate this through group settings. Building on the existing network of veteran cafes and respite break initiatives available in Scotland would be hugely beneficial in easing transition and combating isolation, which I know first-hand can be deadly.

"Although I have come a long way since my lowest point, I still have bad days which are unlikely to ever go away completely. Most veterans agree that continuity is essential - PTSD can't be cured, only controlled, and long-term support for this is vital. Many of the initiatives aimed at improving veterans' wellbeing can only provide certain types of support on a limited basis due to funding.

"Horseback UK runs a five-week course which many service users benefit from on a short term basis, however, for the impact to be maximised, their access to the service needs to be sustained. There needs to be more funding allocated to help veterans access specialised recreational programmes on a long-term basis, as recovery is a lifelong process."

Case Study 3

John Johnston – Veteran and Research Project Officer, Borders General Hospital

John Johnston of Galashiels left the Army in 1988 after six years of service, despite enduring a severe injury to his back in 1983. On returning to Civvy street, John went on to fulfil a successful career in the prison service for 23 years until 2011 when his injury prevented him from continuing work. After medical assessment, he was categorised as disabled. Forced into unemployment, John felt a great sense of worthlessness which led to suicidal thoughts until Veterans First Point Borders intervened.

Leaving a Community

Leaving the Armed Forces where there is a real sense of belonging and comradeship is difficult, John explained, as you feel as if you're going it alone in the civilian world. Employment within the prison service replicated this feeling of community for John, and it wasn't until he had to stop working due to his Service-sustained injury that a sense of worthlessness set in.

His mental health rapidly deteriorated which led to the breakdown of his long-term relationship and suicidal thoughts as he resorted to living in his car.

He said: *"I had hit rock bottom and felt as if I had literally been thrown on the scrap yard, I had lost a sense of belonging and felt as if I had no purpose with no job prospects."*

In September 2016 John initially approached Citizens Advice Bureau for housing advice, where a staff member recognised that he needed further support and directed him to Veterans First Point (V1P) Borders. Within just a few days, V1P assigned a peer support worker to John who was able to provide one to one support and that crucial feeling of military familiarity.

Within the subsequent days, John met with a psychologist who diagnosed him with clinical depression and high functioning autism. The lack of support in dealing with this was leading to his suicidal thoughts. Accessing the services through Veterans First Point Borders was the pinnacle moment of John transforming his future.

Why V1P Works

It can be extremely overwhelming for ex-Service personnel to even recognise that they are in need of help. The beauty of V1P, John explained, is that it can help you recognise that you do need support and that it is available.

John accessed the services at V1P from September 2016 to November 2017 where he was provided with weekly therapy sessions, open invites to group sessions and practical sessions such as CV writing to help him secure employment.

"The whole ethos of V1P is that they go the extra mile for everyone who accesses the service. They helped me get out of the house and meet with likeminded people which ultimately is the reason I am still here today.

"It gets people from all Forces backgrounds around the same table and creates that sense of belongingness that we have all been a part of. There is no medical jargon to cut through either which for many of us can be a deterrent from visiting health practitioners. Speaking with someone who 'gets you' from a Military perspective is fundamental."

Support at V1P extends to volunteers setting up mock job interviews, a technique which helped John secure his role as Research Project Officer at the Clinical Governance and Quality department at Borders General Hospital.

John continued: *"Even once you've finished treatment or completed a programme through V1P, it never closes its doors on you. 18 months ago I couldn't see a future, but through its continued support I now welcome the light at the end of the tunnel.*

"Now if I have an issue I can phone up and speak on the phone. That's probably the most important part – I feel like a person rather than just being a statistic."

Limitations and Looking to the Future

V1P is not an emergency service nor is it able to provide all levels of care, but what it does ensure is that when it can't provide a certain type of support directly, it will signpost veterans in the right direction.

John noted that whilst he thinks the promise set out in the Armed Forces Covenant is valuable, more needs to be done to ensure that those who make the pledge are taking steps to fulfil it.

He also voiced concerns about what would happen if the service was ever to permanently close its doors.

He said: *"I can confidently speak on behalf of almost all veterans who access V1P in saying that we would feel a great sense of loss if it wasn't for the support, comradeship and friendship the service has provided.*

"From personal experience I know how the mental health stability of veterans can go from one extreme to another rapidly, so having an instant support service in place is crucial and potentially life-saving. I don't believe that veterans should get support first just because they were a soldier, but we should get some sort of recognition for our Service to the country in reflection of what the Covenant sets out to achieve.

"Accessing treatment through GPs can sometimes be months and that length of time can hinder veterans seeking support, so it would be a fantastic step in the right direction if a service similar to V1P Borders was rolled out nationally."

After successfully completing his treatment, John now volunteers at V1P Borders.

Case Study 4

Andy McIntosh – Veteran and SSAFA Branch Secretary

Andy McIntosh, 44, from Strathaven near Glasgow, served as an Army Corporal with the Cheshire regiment for 15 years, serving in Bosnia, Iraq, Northern Ireland and the Falklands.

Andy decided to leave the military in 2003 with an exemplary record to pursue a different career path. After leaving the Forces, he found employment as a shift worker in a factory in Bellshill and later started to work as a depot manager in the East End of Glasgow. Whilst at work in 2008, a persistent kidney pain that Andy had been experiencing worsened and he collapsed. He was taken to hospital and treated for a kidney infection, but through further medical testing it was discovered that Andy had over 150 blood clots in his lower leg, afflicting the main vein that carries blood from the leg to the heart.

Andy explained: *"I had been in excruciating pain but had just put it down to a chronic kidney infection. It was difficult to believe that I'd been suffering such serious injury. The medics traced it back to the trauma of an explosion in Northern Ireland. Even though I had walked away relatively fine at the time, I was now experiencing the aftermath."*

Andy was referred to various vascular specialists across the UK and was told that he would never be able to work again. There was a glimmer of hope when he was referred to a specialist professor in London. Through consulting with a global vascular specialist based in Amsterdam, he proposed a procedure that would help Andy walk again if he could get physio to help his legs. With support from Poppyscotland and Erskine, he was given access to intense physiotherapy treatment to help him get to the required level of health. Unfortunately, despite his efforts, the specialist deemed the treatment too risky, and Andy's hopes were quashed.

He said: *"Being offered the chance of walking again and getting so far down the procedure line for it to then be, what felt like, snatched away, left me in a really dark place.*

"I didn't have an income and found myself in crippling debt, losing my house. Us in the Military are quite a proud lot and if I'm honest I didn't want to ask for help, nor did I know who to approach for help – I was at my wits end."

Whilst attending a talk by former British Army Officer and motivational speaker Chris Moon, Andy was advised to approach Poppyscotland and the Armed Services Advice Project (ASAP). This was a turning point.

He explained: *"An ASAP advisor visited me and helped me organise my finances. The beauty of the help that I received was that I didn't feel I was being judged by my situation. They didn't put any blame on me and told me to stop beating myself up. All they wanted to do was get me back on the right track. I also had the difficulty of dealing with my physical disability and had become a recluse, refusing to go out in my wheelchair. It just wasn't who I was and I was finding it difficult to adapt. That's when David McAllister, branch chairman for SSAFA Lanarkshire, visited me on behalf of Poppyscotland. He could see I was struggling with this new lifestyle and he helped me get a mobility scooter which has given me my life back."*

Looking to the Future

Through regaining confidence and use of his mobility scooter, Andy has now returned to work and is the SSAFA Lanarkshire's branch secretary and a case worker.

He said: *"It's great to give something back to SSAFA, and it's fulfilling to be able to speak with veterans who are referred to us who can relate to me and my experiences. For many veterans, speaking with someone on their level can be more effective than going to their GP or a psychologist.*

"Since starting the role, my eyes have been opened to the amount of veterans out there that are struggling and with so many charities, many ex-Service personnel don't know which one is right for their needs. As a company, Veterans First Point (V1P) has been one of the biggest benefits in the last 18 months – the work they provide is phenomenal and it would be good to see this or a similar project rolled out nationally.

"I think we also need to consider how we're going to ensure that we can sustain this level of support in the future. I'm an example of how health and wellbeing issues can arise way down the line after leaving Service, and I know that I'm not the only veteran in this situation. We need to ensure that we are equipped to meet the demand of veterans who require health and wellbeing services in the future, which is likely to increase if anything."

Case Study 5

Sharon Fegan & Lauren Anderson – V1P Therapists

Sharon Fegan, a psychological therapist and occupational therapist, and Lauren Anderson, an occupational therapist, both work at Veterans F1rst Point (V1P) Lothian, a service staffed by an alliance of clinicians and veterans with the aim of providing a one-stop-shop for the ex-Forces community. The service is delivered in partnership with the NHS, with a total of six V1P centres throughout Scotland.

Although they provide support and treatment for a wide range of issues, veterans experiencing mental health issues form the largest proportion of service users that Lauren and Sharon work with.

Meaningful occupation based on individual aspirations

On the subject of treatment, Lauren says: *"Our central aim is to ensure that our clients are engaged in diverse and meaningful occupation that will lead to regular social contact, routine, and improved self-esteem. Whether that is employment or leisure activities depends on the individual's situation, taking into account a range of factors including mental and physical health, their aims and their abilities.*

"The service users I see are seeking fulfilment through employment, and the key challenge I face with them is helping them identify a starting point. Collaboratively, we figure out what they are able to do, what they want to do and where they need to start to get there. Veterans sometimes require additional support and experience to navigate the employment "highway" of the civilian world.

"At Veterans First Point Lothian, a supported employment model known as Individual Placement and Support (IPS) is used. IPS is the most effective approach in helping people with mental health conditions gain employment and involves one-to-one support, rapid job searching, and ongoing support for an unlimited length of time once the individual is in work.

"Much of our day-to-day work involves providing practical employment support such as writing CVs and cover letters, liaising with employers, honing interview techniques, and learning how military skills can be transferred to the civilian workplace. In addition to this, I will provide ongoing emotional and practical support to veterans and their employers once they are in work. Although it is not essential for IPS to be delivered by an occupational therapist, our core skills help enhance this role with regards to mental health training, assessment skills, job retention and symptom management.

"At V1P Lothian we have seen a rise in physical problems, most commonly loss of hearing, general wear and tear, frailty, and occasionally weight management, breathing difficulties and malnourishment. As a team, we signpost and support veterans towards the most suitable services to assist with their physical issues, whilst looking at how we can manage the emotional aspects through meaningful activity.

"As with the elderly in the wider population, one of the biggest challenges we face is social isolation and the team facilitates group activities and attendance at drop-in sessions to combat this. Some veterans are fit enough to get themselves to such activities, but for those that aren't we would work with partners to assess carer needs and assist with putting any requirements in place.

"Our focus is not solely on a client's symptoms, but their aspirations. On the whole, age isn't a huge consideration; we work with the individual to identify their needs and goals, breaking down barriers to help them to engage in their desired occupations and activities."

Instilling a greater understanding of veteran-specific needs across the sector

Sharon continues: *"We are working in an environment that was developed by and for the ex-Forces community, therefore we are always aware of our client's Service background, with colleagues who are veterans themselves offering valuable insight on effective communication. We have access to a veteran's military records which also gives us greater understanding of their military experiences, and we work in partnership with veterans' statutory services and charities to best meet the needs of a veteran, which is difficult in mainstream services given the range of service charities in Scotland.*

"For veterans accessing services in a wider healthcare setting, their clinician may not even know they are a veteran, and their knowledge of veteran-specific issues and preferences may be limited.

"For instance, we've found that, across all healthcare settings, veterans frequently turn up 15 minutes early for their appointment, and when clinics are running late, this may result in a substantial wait which may lead to feelings of frustration around the support some veterans are accessing. Additionally, veterans, the majority of whom are male, are less likely to approach services for help and given they are mainly from the most deprived sections of society they are even less likely to access services. Due to the complexity of some veterans' experiences, many face multiple barriers to accessing the relevant care."

Lauren adds: *"Language is also a hugely important aspect of treating the ex-Service community. Since I began working at V1P, I've picked up a great deal of military terminology which I previously didn't know. Building a good relationship with veterans in a therapy context involves showing appreciation and respect for their background, and acknowledging that there are aspects of Service life you don't know about, but which you hope to learn from them."*

Sharon continues: *"Students and trainees come to V1P for placements as they would in any other health setting, and we have developed practice education placements for them. At a very early stage in their career they are learning how clients from a Service background might differ from civilian clients, and the best ways to approach this. Considering ways in which this increased awareness could be replicated across all positions in the NHS would be a really positive step towards improving engagement with veterans.*

"I was recently helping a client complete a PIP form and I noticed a question about having served in the Armed Forces was included. This is something which I think should be added to all forms when registering for health services. Through basic training, an affirmative answer would prompt a range of considerations for the clinician at the outset, such as whether or not there are any other physical or mental health issues, and how this client might require additional support to access public service systems.

"As standard, GPs in Scotland include the question on their registration forms, however, unfortunately, many still do not know what to do with that information. It would be beneficial to provide a short crib sheet on their system to give options for onward referral and analyse that information."

Occupational therapists as the specialist and influencers in engaging with veterans

Lauren says: *"Occupational Therapists are trained to promote physical and mental health and to work in both health and social care. These skills could potentially be utilised in V1P Teams to holistically address the needs of veterans and minimise onward referrals, or where appropriate, expedite the most appropriate supported onward referral."*

Sharon adds: *"Many of the current Scottish Government policies around health, wellbeing and justice are positioned within a rights-based approach. Our profession's resulting connection to occupational justice and people's right to engage in meaningful activities that influence health and well-being supports our unique understanding of the multiple factors that can limit or diminish engagement with occupation. A key message for the Scottish Government is that occupational therapists are the 'go-to' experts to influence and drive change towards the promotion of occupation for people and communities, including veterans, and increase their access and engagement.*

"It's important we instigate a sector-wide shift where we see staff develop a greater understanding of what support veterans actually need, as opposed to administering treatment programmes based on what they think veterans need."

Case Study 6

Jane Duncan – Veteran and Veterans Support Advisor

Jane Duncan is the Veterans Support Advisor for Renfrewshire Council, East Renfrewshire Council and Inverclyde Council. Having served 22 years in the British Army, Jane is a veteran herself and therefore has a wealth of understanding about the resources that are crucial to ensuring Military personnel are provided with the right services and tools when returning to Civvy street.

The idea of implementing a Veterans Support Advisor arose in 2012 when all three Councils signed the Armed Forces Covenant and it was decided that to maximise their commitment, a lead individual was necessary. Commencing the role in 2014, Jane underpinned what services were already in place and what needed to be implemented to improve services and opportunites for Military personnel within these regions. It was quickly apparent that whilst there was information and services available, these were not readily accessible for veterans due to poor communication.

After reviewing what initiatives, services and tools were already available within these Councils and NHS boards, Jane initiated a veterans' 'Mini Champions' programme. She built upon the information and tools already in existence and used this material to train individuals within Council teams such as employment, finance and housing so they were equipped to provide veteran specific advice.

Having the 'Mini Champions' programme ensures that someone within the local area is immediately aware of an issue faced by a veteran and in turn can guide them to the support available; whether it is locally or nationally. Many veterans voice that it can sometimes be overwhelming to know what support is available so having someone trained within their local area can remove this barrier.

Why 'Mini Champions' Works

The 'Mini Champion' programme extends to equipping veterans with the confidence to attend local social groups which is a valuable network for veterans.

Jane commented: *"There is no reason for any veteran to feel alone or isolated when leaving the Armed Forces and joining social clubs can often be a crucial element to help build confidence and give a sense of purpose.*

"When you leave the Armed Forces, you leave a community, and that is very difficult to step away from. Replicating that community sense via social groups and organisations can, for some, help Military personnel feel part of a tight knit group and most importantly, valued.

"My role extends to liaising with local clubs and initiatives within the area to ensure that they are equipped with the knowledge of how to help veterans in their community integrate. We need such clubs and groups to welcome veterans, and recognise the pool of talent and skills they withhold."

How have Attitudes Towards Veterans Changed

Through the implementation of Jane's role, she has noted that there has been a huge shift in attitudes towards veterans within the three Councils she works with.

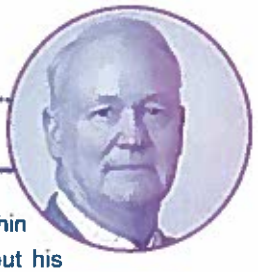
She said: *"The appetite from Renfrewshire Council, East Renfrewshire Council and Inverclyde Council to help veterans integrate into the community has significantly increased since 2014 and they all want to play their part in ensuring that the region is viewed as a place to settle for veterans. They want ex-Service personnel to know that they, and their families, are welcomed to the area and that there is support and help in place at a local level."*

Looking to the Future

Jane fundamentally believes that there would be great benefit for each Council in Scotland to implement a Veterans Support Advisor role but if it were to do so, then it would need to be coordinated through a body such as Veterans Scotland.

"I would love it if every veteran in Scotland was able to contact their local authority directly and get the support they required. Whilst it's great to promote national level services, it can be difficult for veterans to know who to turn to for advice. The 'Mini Champions' programme acknowledges a veterans' query immediately and can help prevent it manifesting onto a larger scale."

Case Study 7



Warwick Shaw – Veteran and NHS Borders Veterans Champion

Warwick Shaw is the NHS Borders Armed Forces and Veterans Champion. He has worked within the NHS after a fulfilling career in The Royal Artillery, Regular Army, for 19 years. Throughout his career in the NHS, he has always been personally interested in the care and provision for Armed Forces veterans due to his Military background and had a watching brief for arising ex-Forces issues. Warwick was depute for five years before his appointment to the role of Armed Forces & Veterans Champion.

What is an Armed Forces And Veterans Champion?

The NHS Armed Forces and Veterans Champion has a responsibility to provide support to past and present Armed Forces personnel, as well as their families, within their local authority area, to ensure their needs are met. The Borders no longer has the capacity levels of a large number of serving personnel to set up specific veterans services as in other locations. Instead, Warwick has concentrated his efforts and resources on equipping GPs with information and the right tools that they could use to help veterans.

He explained: *"By signposting help and resources, such as SSAFA and Veterans Scotland, we can cut out the middle man and allow GPs to direct veterans towards the right support as soon as they are seeking advice."*

Services Implemented

In 2015, Warwick, in cooperation with other NHS Scotland Boards, saw an opportunity with available LIBOR funding and helped establish a Veterans First Point Borders service.

Warwick explained: *"V1P has been a great tool and we have had about 80 referrals since establishing the service, of which about half are still accessing the advice and services that are provided.*

"The fundamental element that makes V1P a success is that veterans are provided with a peer support worker who, through shared experiences, one to one dialogue and assistance, ensures that veterans feel like they are being listened to and someone is actually trying to help.

"As well as being more equipped to understand veterans, using peer support workers has the secondary benefit of overcoming funding challenges, being more cost-effective than exclusively hiring clinicians."

Does the Current System Work?

Warwick believes that the peer support work delivered through V1P is key to facilitating successful support for veterans; repositioning the support as chatting to someone at the same level, as opposed to them being a *'recipient'* of care. It also encourages ex-Military personnel to feel part of a network, heightening their self-esteem and preparing them to move on to new ventures.

He commented: *"I think what we're doing is good but what we need to really showcase this is more financial support and ultimately rolling the programme out across the whole of the UK. We aren't looking for all singing, all dancing services but veterans do deserve the right to dedicated support."*

He continued: *"As an ex member of the Forces with physical injuries, I don't think I should get any more service than someone who sustained injuries from say a car accident, but I should get at least the same level of care.*

"Veterans with severe and enduring conditions should have equal access to specialist treatment and care, regardless of their geographical location."

How Could the Role of NHS Veterans Champion Be Improved?

Warwick highlighted that whilst the current system does work for the veterans who access the service, there is a large pool of veterans who are unaware that his role and support exists.

He commented: *"NHS Armed Forces and Veterans Champions are a complete mystery to veterans. V1P is helping raise awareness but the people who do access V1P did not know that there was a Veterans/Armed Forces Champion within NHS Boards or local authorities. I have never been approached directly by an ex-Servicemen."*

This insight indicates that there is a need to highlight that such bodies are available to veterans, although Warwick noted that Armed Forces champions could not cope with the demand from every single veteran in Scotland, so that's why it's so important to have a strong relationship with the likes of SSAFA and V1P.

He noted: *"V1P is an excellent model that I think should be made exemplary across Britain. Equally I think what should be rolled out across Scotland and perhaps Britain is for veterans to have access to NHS services through a GP rather than going to a specialist who they may only see infrequently."*

Case Study 7

'Joe' – a veteran

'Joe's' story was shared with us by Charlie Allanson-Oddy, Consultant Psychological Therapist at Veterans First Point Lothian. It gives a glimpse into the struggles and challenges faced by someone with PTSD and, in this case, a successful adjustment to civilian life.

'Joe' was medically discharged due to PTSD following events in Afghanistan in 2012. Following discharge he had been allocated a veterans house but was isolated and finding it very difficult to communicate with his neighbours. Eventually Joe attended the V1P Lothian offices in June 2016.

A Clinical assessment was offered but not attended. After discussion with Veterans UK another assessment was offered which Joe attended. He continued to present with PTSD and aspects of Generalised Anxiety Disorder (GAD) – difficulty in eye contact and a reluctance to discuss anything relating to events on a tour of Afghanistan.

Joe was offered Acceptance and Commitment Therapy (ACT) one of the Cognitive and Behavioural Therapies particularly effective in reducing avoidances. In Joe's case these avoidances were maintaining his trauma symptoms and affecting his quality of life significantly. Eventually, Joe was able to discuss in detail the events from his tour of Afghanistan that had so greatly affected his confidence in himself and other people and to take part in a range of social activities that had become increasingly difficult for him over the last few years.

He was encouraged to increase his activity levels and he now attends the gym regularly. He was also referred to the Citizens Advice Bureau (CAB) for a benefits related appeal. CAB attended the tribunal with him and helped to win his appeal.

Internally referred by his clinician to Occupational Therapy (OT), Joe now attends sessions with both the psychological therapist and occupational therapist. The OT meets Joe to discuss work options and as part of the graded exposure to work, and supports him to apply for jobs.

Joe is now largely free of symptoms, applying for jobs and continuing his adjustment to civilian life.

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ITEM No …8……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2018**

REPORT ON: **RESHAPING NON-ACUTE CARE IN DUNDEE UPDATE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB31-2018**

1.0 PURPOSE OF REPORT

This report is to update the Integration Joint Board in relation to the work of the Reshaping Non-Acute Care Programme in Dundee and outline progress towards the plans for non-acute care and residential care in Dundee described in report DIJB38-2017 (Reshaping Non-Acute Care presented to the Integration Board held on 31 October 2017).

2.0 RECOMMENDATIONS

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

2.1 Notes the contents of this report;

2.2 Instructs the Chief Officer to bring back to the IJB the initial business case at its meeting on 28 August 2018.

3.0 FINANCIAL IMPLICATIONS

3.1 The cost of developing the project will be outlined in the initial business case for onward submission to the Scottish Government for consideration of funding.

3.2 The proposed integrated model of care will provide opportunities for a more efficient use of resources, including shifting the balance of care which will be set out in the initial business case.

4.0 MAIN TEXT

4.1 Background

4.1.1 As described in the Reshaping Non-Acute Care in Dundee report (report number DIJB38-2017) a programme of work was initiated in 2014 as part of the Steps to Better Healthcare initiative. A review of the scope and deliverables of the programme was carried out in early 2016, with a new programme leadership, scope and deliverables and team emerging in mid-2016 focussing on the following:

- developing new models of care around frailty services in Dundee, including the services previously known and psychiatry of old age (POA) and medicine for the elderly (MFE);
- developing new models of care for neurological rehabilitation services, including the service previously known as the Centre for Brain Injury Rehabilitation in Dundee;
- developing a new model of care for stroke services in Dundee;
- developing a new model of care for specialist palliative care services in Dundee;
- identifying opportunities for integrated models of care for the above with Angus.

4.1.2 The proposed model of care for much of this work has been outlined in Proposed Model of Care for Older People - Business Case (report number DIJB37-2017 presented to the IJB on

31 October 2017) and Remodelling Care for Older People (report number DIJB21-2017 presented to the IJB on 27 June 2017).

4.1.3 Since these reports were submitted to the IJB, work is underway to develop an initial business case for the Scottish Government which seeks to secure project development investment. The initial discussions have identified that there may be opportunities to include the re-provisioning of Craigie House and the delivery of both the Menzieshill and Coldside Local Care Centres as key components of an integrated strategic programme. This will support the development of a whole system approach with a robust community model to allow the necessary shifts in the balance of care.

4.1.4 This whole system approach will strongly be considered by the Scottish Government in relation to the provision of project funding. This approach supports the transformational service changes outlined in the Primary Care Improvement Plan and NHS Tayside Transformation Programme. It will allow for a range of services to be delivered in localities, support more people to remain at home and enable the restructuring of patient services to meet the needs of the population. As part of this work a long list of site options has been drawn up, an engagement strategy drafted and design workshops are being planned to coproduce the design statement. This initial business case is intended to be ready to bring back to the IJB in autumn for submission to the Scottish Government in October.

4.1.5 In the meantime we have further developed the range of models described previously that promote a rapid assessment in the community with direct access to a range of resources which can prevent people deteriorating, prevent unnecessary admission and facilitate a timely discharge with a range of supports. This, along with the management of people with more complex needs in care homes with the support of an integrated care home team has meant a reduction in the numbers of people in hospital wards. As a result it has been possible to achieve the interim model in Royal Victoria Hospital (RVH). There are currently a dedicated stroke ward for older people and three assessment and rehabilitation wards. As the success has exceeded expectations there is an opportunity to look at improvements in other pathways of care such as the development of an Orthogeriatric model for people who have experienced trauma such as fractures but have underlying frailty issues. This will allow better outcomes by caring for people in a multidisciplinary team with geriatric specialists as well as orthopaedic surgeons. In addition this will seek to meet the needs of people who are chronologically younger but have complex needs.

4.1.6 The current layout in Kingsway does not support a move to the model outlined in the Reshaping Non Acute Care report and this will not be achieved until alternative provision is identified. As described in the previous report there are gaps in the current provision which include younger people with dementia and those with more complex challenging needs. Work is underway to support the proposal that care homes managed by the Partnership develop as a specialist resource for these people. There is now an integrated care home team and this has meant that care homes have been able to support more people with complex needs.

4.1.7 As outlined in the previous report the neuro rehabilitation redesign will enable resources to be used more efficiently and effectively to support the rehabilitation needs of patients and their families. The redevelopment of the facilities and redesign of the service will markedly improve the quality of the service that is provided and much improve the environment for both patients and staff. It will also allow the service to reduce the likelihood of delayed discharge and to cope with predicted future demands on the service.

4.1.8 Initial discussions have now taken place around the future of provision of Specialist Palliative Care Services with a range of stakeholders and this will now be taken forward as part of the Reshaping Non Acute Care work.

4.1.9 In addition, options to work more collaboratively with Angus Health and Social Care Partnership continue to be explored as part of this programme of work.

4.2 Engagement

4.2.1 A wide range of stakeholders have been involved in the development of the wider service proposals and will continue to be involved in the coproduction of the initial agreement. Engagement with staff has been done in partnership with staff side representatives and a

transition group was set up at RVH to manage the change process. Wider discussion has taken place through Strategic Planning Groups, Local Medical Committee (LMC) Cluster Lead meetings, team meetings and other fora. In order to ensure a comprehensive approach a draft engagement strategy has been produced.

5.0 POLICY IMPLICATIONS

5.1 The objectives of the project support the strategic aims of person centred, community based care in keeping with the principles of the IJB's Strategic and Commissioning Plan. The objective is also to ensure that this is delivered as safely and efficiently as possible in line with the emerging NHS Tayside Integrated Clinical Services Strategy for Older People, produced by the Older People Clinical Board.

5.2 The proposals within the report are in line with the NHS Tayside Property Strategy. The obtainment of additional Scottish Government resources will provide the development of a centre for excellence and support the remodelling of care.

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

6.0 RISK ASSESSMENT

No specific risks have yet been identified however, as part of the wider programme of work, a risk workshop will be conducted and all the risks identified. A risk log will be created highlighting risk owner and mitigation strategy. This risk log will be maintained and monitored at the regular programme review meetings.

7.0 CONSULTATIONS

7.1 Dundee IJB cited the project as a key development in their Strategic and Commissioning Plan. Detailed components of this summary document have been submitted to the following gateway committees:

- Integrated Strategic Planning Group
- The Older Peoples Board
- Strategic Planning Groups
- Clinical Fora including:
    - Older Peoples Clinical Board
    - LMC Cluster Lead Meeting.

7.2 The Chief Finance Officer and the Clerk were also 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.

David W Lynch
Chief Officer

DATE: 24 May 2018

Jenny Hill
Locality Manager

ITEM No …9……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2018**

REPORT ON: **ANNUAL REPORT OF THE DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP CLINICAL, CARE & PROFESSIONAL GOVERNANCE GROUP**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB38-2018**

1.0 PURPOSE OF REPORT

This annual report is to provide assurance to the Integration Joint Board regarding matters of Clinical, Care and Professional Governance. In addition, the report provides information on the business of the Dundee Health & Social Care Partnership Clinical, Care and Professional Governance Group (The Group), and to outline the ongoing planned developments to enhance the effectiveness of the group.

2.0 RECOMMENDATIONS

It is recommended that the IJB:

2.1 Notes the content of this report.

2.2 Notes the work undertaken by the Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group (R2) from April 2017 – March 2018 to seek assurance regarding matters of Clinical, Care and Professional Governance (Sections 4.3 – 4.5).

2.3 Notes the update in response to the Audit of Clinical, Care and Professional Governance systems as detailed in section 4.6.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Background

4.1.1 The purpose of this annual report is to inform the Integration Joint Board of the activities of the Clinical, Care and Professional Governance Group. The activities of the Group are governed by 'Getting it Right for Everyone – A Clinical, Care and Professional Governance Framework'. The report covers the period April 2017 to March 2018.

4.2 Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group

4.2.1 The Group meets every two months. The members of the group consider:

- Service Area Reports/Service Area Updates (reported in Sections 4.3.2 – 4.3.8 of this report).
- The Risk Register (reported in Section 4.4 of this report).
- Outcome of Inspection Reports.
- Updates on Clinical Governance and Risk Management Local Adverse Event Reviews/Significant Case Adverse Event Reviews/Significant Case Reviews.
- Exception reports relevant to the Clinical, Care and Professional Governance Domains as reported in Section 4.5 of this report.
- Processes for the introduction of new clinical, care and professional policies and procedures.

4.2.2 Over the past year the Group has sought to support the sharing of information across a range of services and to ensure the work of the Group reflects the broad range of services delegated to the Integration Joint Board. While the breadth of service considerations can be a challenge for Group members, in that there remains a level of variance in the style and detail of governance reporting across the partnership, the Group has retained an objective to develop a fuller understanding of each of the services and the associated risks. Throughout this year, further work was progressed to reach a reporting style which made best use of the available time and targeted the analysis at core and relevant data. More recently, members of the Group, along with the Chief Social Work Officer, have been invited to attend the Clinical Quality Forum (NHS Tayside) to further develop a sharing of information and scrutiny at a Tayside wide level.

4.3 Service Reporting

4.3.1 In order to fully understand the specific risks and governance arrangements associated with service/care delivery areas, the Group has prepared a reporting programme which will ensure each service area provides a service governance report. Consideration was given to the impact of the issues raised by managers; the recording of the risks identified and the actions to be taken to eliminate or mitigate the risks. Each service was asked to provide an update on the performance and follow up service reports were presented. The following extracts report on the issues raised through a range of services.

4.3.2 <u>Palliative Care Services</u>
Historically, a Steps to Better Healthcare Project had recommended a single Specialist Palliative Care Service, complemented by a Tayside Palliative Care Managed Clinical Network. The service reported a number of positive actions and recognised potential risks as follows:

- A single hosted service carries the strong advantage of maintaining specialist support in palliative and end of life care - available, visible and able to provide leadership.
- There are a range of training and education opportunities.
- The integration of Partnership services, such as community nursing and social care services, fully supports the development of defined core competencies in palliative and end of life care expected for all roles within the health and social care system.
- The Managed Clinical Network is a good opportunity for Tayside-wide working and supports the wider community based aspects of Palliative and End of Life Care (PEOLC) across all of Tayside, with potential for the development of a standardised approach, without the loss of the unique identity of each locality and their local populations.
- The balance of the benefits of a Tayside model with locality based approach inherent in integration models will be the main challenge and risk. Partners will need to feel the unique partnership and locality representation.
- Prior to current relationships there has not been a purposeful, broad based/specialist service approach structure in Tayside, with a history evolving through time, but now with consensus, this is being progressed. There will be a need to work hard and devote time to building relationships.
- The commitment and ownership of all those engaged, particularly the Health & Social Care Partnerships, who are not directly hosting or managing their services. It will be key to ensure both financial and active accountable buy-in.

- Processes are being developed collaboratively to ensure that staff, within specialist palliative care, not only deliver specific care directly, but support others to deliver palliative care through support, education and resources.
- Clear clinical and management leadership structures, to support the development of standards and outcomes which feed into the corporate, Clinical and Financial Governance across the matrix of bodies, will be developed and embedded across the four main clinical sites, as well as the wider communities. There is real buy in from consultants in Palliative Care; good relationships currently exist with Macmillan and Marie Curie and are being further developed with primary care.

4.3.3 Mental Health Officer Service

The Mental Health Officer service is a dedicated service. The service has experienced significant capacity issues over the last two years. To address this the following were actioned:

- Mental Health Officer (MHO) Practice Group established.
- Adults with Incapacity procedures updated.
- MHO procedures developed.
- Vacant posts recruited to.
- New duty rota will be more flexible and support the progression of MHO activity and in particular guardianship applications.
- Dedicated MHO cover identified for Murray Royal Hospital to improve the response for Dundee patients placed there.
- MHO review reported.
- Further report to be submitted following the completion of the Tayside Mental Health Review detailing the impact of proposed changes on the Mental Health Officer service.

4.3.4 Integrated Substance Misuse Services

Dundee Substance Misuse Services have experienced a very high level of national and local scrutiny arising from the high level of deaths associated directly with substance use. The service has identified a number of risks and capacity issues. To support the development of the service and to understand and mitigate the risks, the following were reported:

- Alcohol and Substance Misuse Strategic Planning Group established which will support and set out the direction for future redesign.
- Integrated Alcohol and Substance Misuse Improvement Planning Group established which will consider identified risks and take forward the actions to address these.
- A Quality Improvement Group looking at scrutiny and governance across the service is established.
- These Groups will also report and work within the Mental Health Clinical, Care and Professional Governance reporting arrangements.
- Multi-agency group which includes key services and agencies established and focussing on four key aspects: Balance Scorecard, Integrated Risk Register, Single Evaluation Report, and a single Budget Statement.
- Staffing capacity identified as a key risk within the service. Additional nursing and clerical staff have been recruited to mitigate this risk and an escalation plan has been developed outlining service expectations within current staffing levels and ratios.

4.3.5 Early Screening Group

The Early Screening Group is a multi agency response for the screening of Adult Support & Protection (ASP) concerns and referrals. This is a partnership of Social Work, Police Scotland, Fire & Rescue Service, Substance Misuse Service and Mental Health Service. The next steps for the Early Screening Group will be to:

- Focus on implementing the new approach and embedding continuous learning and improvement through ongoing self-evaluation, implementing a learning and reflection Group.
- To have oversight and governance from the Dundee Health & Social Care Partnership (DHSCP) Public Protection Quality Assurance Group.

- From this Assurance Group reports will be submitted to the Adult Support & Protection Committee and the Clinical, Care and Professional Governance Group.

4.3.6 Dundee and Angus Equipment and Loan Service

The Dundee and Angus Equipment and Loan Services have now merged and are hosted in the Dundee Health and Social Care Partnership.

- The merger has resulted in financial savings of £50k for the DHSCP.
- Performance has improved within the Angus service and there has been no detriment to the Dundee service arising from the merger.
- A Joint Steering Group was established in 2016 to support the merger and provide oversight, governance and coordination in relation to the provision of equipment to the community.
- The service is now delivering well across key service outcomes :
    - To support people to live independently in their own homes
    - For people to have a positive experience of the service
    - For equipment to be provided efficiently, effectively and safely
    - For the workforce to be confident and competent.

4.3.7 Sexual and Reproductive Health Service

The Sexual and Reproductive Health Service is a walk-in service that provides triage and subsequent care, specialist treatment and specialist clinical provision. The service incorporates The Corner and HIV Nursing Service.

- Very low numbers of complaints are received within this service – only four in the last year.
- Clinical audits are routinely undertaken across the service with current audits focussing on ensuring clinical protocols are being met.
- Service has been awarded a Quality Award and a Lesbian, Gay, Bisexual and Transgender Award.
- Menopause service has not been able to meet targets and the service have commenced improvement work locally to address this.

4.3.8 Older Peoples Services

A report was submitted on behalf of the Older People's Services which set out the future developments and the identified risks. This included:

- Unsuitability of the Royal Victoria Hospital site and considerations around future accommodation.
- Workforce concerns regarding staffing complement on ward – this will be addressed as the number of wards are reduced.
- The risks associated with significant change – staff engagement; timing of environmental changes.
- Impact of financial constraints both short term and long term.
- Noted that patients using the services are increasingly frail. The current and future workforce planning will take into account the required staffing compliments including the development of more skilled roles such as Advanced Nurse Practitioners.
- Noted that both nursing and junior doctor pressures will improve should the service move to a joint site with Psychiatry of Old Age services.
- Performance against the care quality standards to be included in future reports.

4.4 Risk Register

4.4.1 Risks are identified by service managers and recorded on DATIX (patient safety reporting system) and are actively monitored at the Clinical, Care and Professional Governance Group. The Group members ensure that actions are in place to mitigate these risks. The Group members have asked that these risks be reviewed to ensure actions are specific, measurable, achievable, realistic and time-related (SMART) and that actions are completed.

4.4.2 The following risks were added to the service risk register on DATIX during the last year:

- Challenges in recruiting staff.
- Access to services.
- Budget restriction (Drugs).
- Interconnectivity of IT systems.
- Potential impact of GP Contract on service areas.
- Potential new cost pressures and / or loss of services.
- Workforce planning – implications of additional staffing requirements.
- Environmental/ Building Requirements – observation risks.
- Transcribing of medications in the community.
- Shortfall in registered and support working staff.

4.5 Governance Domains

4.5.1 There are six governance domains that form the basis and structure for the Clinical, Care and Governance Framework. Feedback against these domains is provided at each Group meeting and the feedback over this year has included:

4.5.2 Information Governance

- Joint Information Technology (IT) information sharing across the HSCP has been discussed to support integrated and efficient services. Further work is required, at National Level, to support enhanced information sharing within the Partnership.
- Work was presented on a refreshed dataset which is to be reported through the Clinical, Care and Professional Governance Group. This dataset captures key information under each of the six domains in the Governance Framework. It was identified that further work is still required with the dataset to ensure all functions across the HSCP are captured and reflected.
- The introduction of the TRAKcare IT systems within NHS Tayside was identified as a Tayside risk and it was noted that relevant teams are working with the IT TRAK team to resolve this.

4.5.3 Professional Regulation and Workforce Development

- The Group received a presentation from Dr Ann Ramsay on the GP Appraisal system. This highlighted the good work done across GPs in ensuring compliance with the process and the positive outcomes achieved. The appraisal programme has a 100% uptake rate and there have been no issues in terms of GP revalidation, although an escalation process does exist if there is any failure to engage.
- The Group reviewed the registration process for Allied Health Professions (AHP). Assurance was provided around the process and checks undertaken for each AHP and it was reported that Occupational Therapists who had re-registered prior to the discussion has 100% success rate.
- The HSCP Joint Induction Programme has been designed and delivered for new staff to the Partnership. This process is being evaluated after each session and will continue to evolve to ensure effectiveness and suitability.
- The Group heard an update on the Safe Staffing Bill and supported the HSCP to provide a response to the National Consultation.

4.5.4 Patient, Service User, Carer and Staff Safety

- The Group reviewed a report following a clinical incident in a Care Home in Dundee from the Care Inspectorate. While this was not a directly managed Care Home under the HSCP there was a broad discussion around the immediate management of residents following the incident and how best to support residents. Contingency plans contributed to the successful outcome of this situation and the HSCP were able to reflect on this situation and ensure future such incidents could be well managed.

- Volunteering – Lampard Report. This was a report written following the Jimmy Saville investigation and sets out guidance and recommendations in relation to visitors to the workplace, including celebrity visitors. The Group discussed ensuring that staff had undergone appropriate levels of training to comply with recommendations. This work is still ongoing.
- The Group reviewed a paper setting out the impact of Duty of Candour. The relevant procedures have now been developed and an e-module developed for health staff, for Dundee City Council employees, training will be delivered once procedures are developed. An annual report will be submitted by both parent organisations confirming compliance against an agreed data set and whether a duty has been triggered. The separate approaches applied to public bodies could result in different processes for the Partnership. Any duty of candour issues will be reported through the Group. It was agreed that a further report be brought back to the Group to confirm that procedures are in place.

4.5.5 Patient, Service User, Carer and Staff Experience

- A new complaints process was introduced across Scotland with both Health and Local Authority Procedures adhering to the same set of procedures. Work was undertaken cross the Partnership to ensure all staff were aware of and able to support the new guidance.
- Review on the quality of complaint responses was undertaken by the Governance Huddle. This showed a variance in the quality of complaints responses being issued and further work was identified to ensure feedback to authors of complaints and learning shared across the Clinical, Care and Professional Governance Group.
- iMatter has been rolled out to all staff across the Partnership. Uptake has been positive and teams are working locally to develop and implement action plans based on their own local survey results.
- The Health and Social Care Standards have been published and will form a central part in the governance reporting of the HSCP in the coming year. The standards are written from the perspective of service users and will support the ongoing ambition to provide person centred, safe and effective care.

4.5.6 Quality and Effectiveness of Care

- The Care Home Grade report was taken to the Performance & Audit Committee (PAC) and sets out what the grades are for the different care homes which includes both external and internal care homes. There were very few care homes sitting at Grade 3 or below. Most of the Dundee care homes sit much higher with some at Grade 6. There were two care homes which were recognised as being poor performing homes. One of these was Wellburn which has since closed and the other was Brae Cottage which has also closed.
- The Care Home Grade report reflected over the last financial year to Care at Home Services which includes Supported Housing, Home Care and Independent Sector. This included Weaversburn which was rebuilt as tenancies from a residential care facility. A new model was identified which required additional staff and management. There have been 2/3 follow up inspections and a lot of issues have been resolved and Weaversburn is building up its continuity in terms of its approach to care.
- Information was provided on the progress of the ASP Inspection. The Group will support any Clinical Care And Professional Governance outcome areas from this work.

4.6 Clinical Care and Professional Governance Audit Report

4.6.1 A report was presented to the PAC setting out the audit findings of the Clinical, Care and Professional Governance systems within the Partnership (Report carried out by NHS Tayside Internal Audit Service – Clinical, Care and Professional Governance – Report No D07/17). The report findings placed the Dundee Health and Social Care Partnership at Category B – Broadly Satisfactory, in that there is an *'adequate and effective system of risk management, control and governance to address risks to the achievement of objectives, although minor weaknesses are present'.* The Audit Report set out four key findings with associated recommendations which included actions for the Group.

4.6.2 In response to the Audit report, the following actions were implemented:

- Terms of Reference was developed and agreed by the Group.
- Work to develop and agree a core partnership data set to report prevalence and performance with regard to clinical, care and professional governance is progressing.
- Annual work plan developed for the Group.
- The Group holds membership of the Clinical Quality Forum through the Chair.
- Integration Scheme - Delegated Functions mapped to the work plan/service reporting.

4.7 Professional Leadership – Health Professionals

4.7.1 Professional Leadership is provided through integrated posts set within the Dundee Health and Social Care Partnership. The functions of this role include clinical, care and professional leadership, accountability and governance for specific professions; clinical, care and professional strategic leadership within service redesign; support and advice in matters of workforce planning and development; and support to the partnerships governance arrangements. These roles include:

- Lead Nurse (HSCP)
- Lead Allied Health professional (HSCP)
- Clinical Director (HSCP)
- Associate Nurse Director (Dundee)
- Associate Medical Director

All of the above are members of the Dundee HSCP Clinical, Care and Professional Governance Group.

4.8 Professional Leadership - Social Work/Social Care Professionals

4.8.1 The Social Work (Scotland) Act 1968 (amended by S.45 of the Local Government (Scotland) Act 1994) requires local Authorities to appoint a Chief Social Work Officer for the purposes of listed Social Work functions. The post holder required to be a qualified Social Worker who can demonstrate extensive experience at a senior level and can provide effective professional advice at all levels. The Chief Social Work Officer is employed within Dundee City Council as Head of Integrated Children Services and Criminal Justice but maintains a leadership role for all social work and social care services.

4.8.2 To support the development and governance of social work services, the Joint Social Work Management Team brings together the Chief/Senior Officers (or their representatives) with responsibilities for Social Work functions, alongside supporting officers from the Health and Social Care and Children and Families Service Strategy and Performance Teams. The group maintains oversight and leads on developments relating to:

- Key national and regional legislative, policy and practice developments with implications for social work practice;
- Local developments, both strategic and operational, with specific implications for the social work workforce and services;
- Datasets and performance management relating to statutory social work functions;
- The effectiveness of arrangements to support the Chief Social Work Officer in discharging their statutory role; and
- The production and publication of the Chief Social Work Officer's annual report, which outlines activities over the previous year and opportunities and challenges ahead.

4.8.3 The Chief Social Work Officer Annual Report 2016/2017 was presented to the Integration Joint Board at its meeting held on 19 December 2017 (report number DIJB53-2017 refers). In this report the Chief Social Work Officer set out the governance arrangements for social work services and reported on a range of quality indicators including complaints; service inspection grades and workforce development. The report highlighted both the improvements made over 2016/2017 and the challenges facing social work services.

4.8.4 To support the governance arrangements the Chief Social Work Officer is preparing a Chief Social Work Officer Governance Framework for 2018 – 2026 which will set out the governance arrangements for the redesign and delivery of safe, effective and high quality Social Work and Social Care services, under the leadership and oversight of the Chief Social Work Officer in Dundee City.

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	The absence of clear clinical, care and professional governance arrangements and monitoring can impact on the ability to provide safe services for both employees and service users/patients. Without the ability to both monitor compliance and take action to address concerns the Health & Social Care Partnership will be unable to gain assurances around service delivery.
Risk Category	Governance
Inherent Risk Level	Likelihood 4 x Impact 3 = 12 – High risk
Mitigating Actions (including timescales and resources)	- Established clinical, care & professional governance Groups in place. - Reporting arrangements agreed.
Residual Risk Level	Likelihood 3 x Impact 3 = 9 – High Risk
Planned Risk Level	Likelihood 2 x Impact 3 = 6 – Moderate Risk
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable.

7.0 CONSULTATIONS

The Chief Finance Officer, Head of Service – Health & Community Care, Clinical Director, Lead Allied Health Professional, Lead Nurse, the Professional Advisers to the IJB 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.

David W Lynch
Chief Officer

DATE: 5 June 2018

Diane McCulloch
Head of Health & Community Care

Matthew Kendall
Interim Lead AHP

ITEM No …10…..…..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 JUNE 2018**

REPORT ON: **DUNDEE PRESCRIBING MANAGEMENT POSITION**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB41-2018**

1.0 PURPOSE OF REPORT

This report provides an overview to the Integration Joint Board of the prescribing position within Dundee and sets out the plans to meet the challenges associated with prescribing resources.

2.0 RECOMMENDATIONS

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

2.1 Notes the content of the updated position in relation to prescribing activity in Dundee as set out in this report.

2.2 Notes the proposed response to the challenging prescribing position as developed through the Tayside wide Prescribing Management Group in addition to the range of local interventions as set out in this report and associated appendices.

2.3 Instructs the Chief Finance Officer to reflect the prescribing financial position for consideration by the IJB as part of the final confirmation of the delegated budget to be presented to the August IJB meeting.

2.4 Instructs the Chief Finance Officer to provide regular updates to the IJB on the prescribing position throughout 2018/19.

3.0 FINANCIAL IMPLICATIONS

3.1 The revised prescribing financial framework for 2018/19 as outlined in Appendix 2 to this report highlights a projected net residual budget shortfall of £415k at the financial year end should all planned interventions be achieved. This is an improvement on the previous projected position presented to the IJB in March 2018 which noted a projected shortfall of £564k. However the achievement of this is reliant on the delivery of a range of efficiencies which are high risk and after applying a risk assessment against these plans, the projected net shortfall could be £712k.

3.2 The prescribing position will be reflected in a report in relation to the final confirmation of the delegated budget to be considered by the IJB in August 2018 following receipt of formal notification from Tayside NHS Board of their delegated budget offer.

4.0 MAIN TEXT

4.1 Background

4.1.1 The challenges of the GP prescribing budget have consistently been highlighted to the IJB since the Due Diligence process was carried out at the time of formal transfer of operational responsibility of operational budgets to the IJB in 2016. Financial monitoring reports over the previous two years have shown the scale of the financial pressures associated with GP Prescribing and in the absence of a robust, risk assessed plan of interventions, the IJB had

previously decided not to formally accept responsibility for the financial performance of prescribing as part of its delegated budget.

4.1.2 In recognition of the developing actions around controlling prescribing activity and spend through the Tayside wide Prescribing Management Group (PMG) in addition to local initiatives developed through the Dundee Medicines Management Group, with further prescribing investment through NHS Tayside to reflect the impact of the national resource allocation methodology (NRAC), Dundee IJB agreed at its meeting on the 30 March 2018 to accept responsibility for the prescribing budget, albeit with a number of caveats as follows:

Table 1 – March 2018 Dundee GP Prescribing Budget Projections 2018/19

	£000
Indicative Share of Prescribing Budget (incl additional NRAC allocation)	*33,451*
2018/19 Anticipated Baseline Spend	*35,354*
2018/19 Anticipated Growth (inc Price Increases)	*515*
Anticipated Spend 2018/19	*35,869*
Less:	
Price Changes / Drugs Off Patent	*(1,253)*
Tayside Wide Active Interventions	*(601)*
Revised Anticipated Spend	*34,015*
Projected Funding Shortfall	*564*

- *the final GP prescribing budget delegated by NHS Tayside is, as a minimum, set at the level noted in Table 1 above* (this refers to the overall budget resource and included an assumption that additional funding of £800k through NRAC formula would flow to Dundee);
- *the IJB will not be held responsible for any overspends incurred on account of the PMG actions not being delivered at the scale and pace set out in the associated cost reduction plan;*
- *the IJB will not be responsible for significant changes in price increases (drug tariffs) against those estimated in the prescribing plan.*

The IJB would take responsibility for the level of volume growth and the impact of the local interventions as part of the Dundee Medicines Management Plan.

4.1.3 This paper provides a further update of actions agreed through NHS Tayside Board to manage prescribing costs and activity, sets out a revised financial framework as developed by PMG and provides an overview of Dundee's approach to managing the prescribing budget.

4.1.4 During 2017/18, the number of prescribing items used by the Dundee population reduced slightly from the previous year by 0.29% to just under 2.5m however the average cost per item rose by 2.4% to £12.22. In relation to national benchmarking, the cost per weighted patient indicator is used as a comparison of relative need. The most recent data is shown in the table below:

	Cost per Weighted Patient		
Excludes Flu Costs & Items	**2017/18**	**2016/17**	**% Growth**
Angus HSCP	£206.57	£200.72	2.92%
Dundee HSCP	£181.26	£189.88	-4.54%
Perth & Kinross HSCP	£196.30	£191.32	2.60%
Tayside	£194.82	£195.86	-0.53%
Scotland	£181.63	£179.11	1.40%

4.1.5 While caution should be applied when comparing the shift in growth from 2016/17 to 2017/18 due to the impact of changes in the weightings applied under the NRAC formula, the 2017/18 figures highlight that Dundee is on a par with the Scottish average in relation to costs per patient. However, the budget remains under significant pressure with an overspend of £2.6m incurred

in 2017/18 therefore this leads to a conclusion that with activity in line with expectations, it is the level of budgeted resource which is the main contributor to the overspending position. The allocation of further funding through NHS Tayside as part of the NRAC formula change in 2018/19 of £800k is reflected in the Dundee prescribing base budget for 2018/19 and will support reducing this gap further.

4.1.6 There is recognition through both PMG and Dundee's Medicines Management Group that significantly more can be done within the local area to further manage prescribing activity and costs. A paper outlining further interventions to the Prescribing budget across Tayside was laid before and accepted by the NHS Tayside Board on the 29 March 2018 by The Director of Pharmacy at NHS Tayside and the Associate Medical Director – Primary Care on behalf of the PMG (see Appendix 1). This identified further prescribing savings across Tayside to close the gap between activity and available resources. It was acknowledged that in order to achieve the level of savings across Tayside to close the prescribing gap, difficult decisions would have to be made, including the cessation of current services or the redirection of specific teams to deliver specific interventions. The NHS Board subsequently agreed to the following

1) Intervention: Lidocaine Plasters
NHS Tayside will no longer support the prescribing of lidocaine plasters outwith their license. The rationale for this is due to the lack of published evidence and affordability. If new evidence emerges an application can be made to the Medicine Advisory Group (MAG). Specialist services will be required to undertake a review of all existing patients. This will require assurance that reviews are being completed in primary care in line with formulary guidance.
Anticipated Financial Savings: Recurring impact up to £100k (Dundee share - £46k)

2) Intervention: Diabetes
Diabetes Managed Clinical Network to focus on the development, delivery and evaluation of a diabetes prescribing strategy that will deliver health gain whilst reducing prescribing costs. The resultant pathway will invest in non-drug restrictive diet options for type 2 diabetes over pharmaceutical options in light of published evidence to support this more cost effective option which produces better reductions in HBA1c and also the determination of alternatives to prescribing e.g. exercise, weight management.
Anticipated Financial Savings: Recurring impact up to £150k (Dundee share – n/a)

3) Intervention: Liothyronine
NHS Tayside will not support the endorsement of any new patients commencing on liothyronine. The rationale for this is due to lack of published Randomised Controlled Trial (RCT) evidence and affordability. Liothyronine will be removed from Tayside Area Formulary. An urgent review to be undertaken of those patients currently prescribed Liothyronine with a view to discontinuation wherever possible. If new RCT/meta analysis evidence emerges, an application can be made to MAG if required.
Anticipated Financial Savings: Recurring impact up to £300k (Dundee share - £77k)

4) Intervention: Pregabalin
Tayside NHS Board agreement that only the branded generic version of Pregabalin which is at variance to current Scottish Government advice is prescribed within NHS Tayside.
Anticipated Financial Savings: Recurring impact of up to £1.5m (Dundee share - £786k)

5) Intervention: Mental Health Prescribing
Tayside NHS Board agreement that mental health prescribing will be reduced to come within the bottom quartile within Scotland. Mental Health prescribing to be reviewed against the British National Formulary subchapters on antidepressants and antipsychotics. The aim being to deliver safe and effective care whilst reducing prescribing costs.
Anticipated Financial Savings: Recurring impact of up to £100k (Dundee share – n/a in 18/19)

6) Intervention: Cessation of Non-routine Primary Care Prescriptions
Tayside NHS Board endorsement of the recommendations of the NHS England document "Items which should not be routinely prescribed in primary care: Guidance for CCGs" [Clinical Commissioning Groups].
Anticipated Financial Savings: Recurring impact up to £300k (Dundee share – to be confirmed)

7) Intervention: Intervention: Homeopathy
Tayside NHS Board agreement to cease prescribing homeopathy products within Tayside.
Anticipated Financial Savings: Recurring impact up to £30k but subsequently amended to £10k (Dundee share - £2k in 18/19)

4.1.7 There is a high degree of risk associated with these changes which require strong system wide clinical and organisational support and leadership if they are to be delivered at the required scale and pace. Progress in delivering these interventions will be closely monitored through PMG with further scrutiny and actions delivered through the Dundee Medicines Management Group. As noted above, the most significant opportunity for cost reduction is through the use of the branded generic version of Pregabalin and this has already seen a reduction in price in line with the plan therefore is anticipated to deliver the required cost savings. Further savings have also been seen through the wider PMG workplan in relation to edoxoban with a further workstream adopted by PMG in relation to the prescribing of non medicines (eg baby milk, catheters).

4.1.8 The impact of these planned changes in addition to applying the most up to date information available in relation to the impact of price changes, drugs off patent and the progress of other prescribing interventions have been factored in to a revised financial framework prepared by PMG, summarised below and shown in detail at Appendix 2.

Table 2 – Revised Dundee Projected Prescribing Position 2018/19

	Assuming all interventions delivered as planned *£000*	*Risk Assessed Interventions* *£000*
Share of Prescribing Budget (incl additional NRAC allocation)	*33,223*	*33,223*
2018/19 Anticipated Baseline Spend	*35,354*	*35,354*
2018/19 Anticipated Growth (inc Price Increases)	*515*	*515*
Anticipated Spend 2018/19	*35,869*	*35,869*
Less:		
Price Changes / Drugs Off Patent	*(683)*	*(628)*
Tayside Wide Active Interventions	*(449)*	*(353)*
Share of Additional High Risk Savings Plans	*(1,099)*	*(952)*
Revised Anticipated Spend	*33,638*	*33,935*
Projected Funding Shortfall	*415*	*712*

4.1.9 The revised projected outturn shows an improved prescribing position for Dundee assuming that all the interventions outlined in the PMG plan are delivered in full. However, given the range of high risk interventions as outlined in 4.1.7 of this report, a risk assessed version, outlining the likelihood of delivery of the interventions highlights that this shortfall could increase to £712k. A range of local initiatives to the value of £200k will also be progressed within Dundee under the direction of the Dundee Medicines Management Group to further reduce the prescribing shortfall in 2018/19. The Chief Finance Officer will continue to bring regular financial monitoring information, including prescribing to the IJB meetings for information and scrutiny.

4.1.10 The new General Medical Services (GMS) contract will see a significant investment in a Practice based pharmacotherapy service that will see considerable augmentation of the local Practice team over the next three years. While the intent of this service is to ease pressures in primary care it is likely to make some impact on rationalising patient medication and offers an opportunity to improve the quality and safety of prescribing.

4.1.11 Reports regarding variation in medicines use by practice and cluster are being locally and regionally developed to assist in similarly improving safety, quality and efficiency within primary care prescribing.

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 range of interventions to reduce prescribing spend are not delivered as anticipated and that projected price changes and growth are higher than predicted.
Risk Category	Financial
Inherent Risk Level	Likelihood 4 x Impact 4 = Risk Scoring 16 (which is Extreme Risk Level)
Mitigating Actions (including timescales and resources)	The range of interventions will be closely monitored through PMG and Dundee MMG to identify problems and associated solutions for delivery of efficiencies.
Residual Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is a High Risk Level)
Planned Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (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 should be accepted.

7.0 CONSULTATIONS

The Chief Officer, Clinical Director and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

9.0 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	

Dave Berry
Chief Finance Officer

DATE: 11 June 2018

David Shaw
Clinical Director

Appendix 2

HSCP Planned Prescribing Expenditure Profile 2018/19 - DUNDEE IJB			
	2017/18 (Sept-Nov)	**2018/19**	**Value of Risk Assessed Interventions**
	£k	£k	£k
Baseline Spend	35354	35869	**35869**
Cumulative Growth Effect (£k)		515	
Volume		***0***	
Price		***354***	
Short Supply		***-354***	
Margin Sharing		***515***	
Cumulative Growth Effect (%)		101.46%	
Passive Interventions			
Price Changes / Switch			
Prescribing for Chronic pain - Lidocaine (LOW RISK)		28	0
Rosuvastatin (future tariff change)		245	245
Inhaled Medicines Class		21	15
Xaggatin		81	81
Tiotropium		14	14
Emollients		72	72
Total		**460**	**428**
Drugs Off Patent			
Bimatoprost		10	5
Ezetimibe		25	12
Ivabradine		10	5
Tadalafil		178	178
Total		**223**	**201**
Total Passive Changes		**683**	**628**
Active Interventions Changes			
Alogliptin		12	12
Melatonin		22	22
ONS		191	96
Stoma		27	27
Doacs - Edoxaban		196	196
Total		**449**	**353**

HIGH RISK SAVINGS PLANS			
Lidocaine		46	23
DOACs		35	17
Liothyronine		77	39
Pregabalin		786	786
Homeopathy		2	1
Vitamin D		14	7
Revise managed Repeats		98	49
Wound Care & Catheters (logistics saving)		41	31
Total		**1099**	**952**
Total Active Intervention Changes		**1547**	**1305**
Grand Total Changes		**2231**	**1934**
Revised Planned Expenditure		**33638**	33935
Share of Tayside Funding		**33223**	33223
Likely Shortfall/Surplus		**415**	**712**
		1%	**2%**

Please note any items relating to Board business are embargoed and should not be made public until after the meeting

BOARD38/2018
Tayside NHS Board
29 March 2018

INTERVENTIONS TO FURTHER ADDRESS THE PRESCRIBING FINANCIAL GAP FOR 2018/19

1. SITUATION AND BACKGROUND

Following financial planning discussions members of Prescibing Management Group (PMG) were directed to consider further interventions to deliver additional prescribing savings within primary care.

It should be noted that in the development of the current prescribing plan for 2018/19 Pharmacy colleagues from NHS Tayside have developed and continue to lead a virtual prescribing support network across all North Boards allowing for shared prescribing intelligence; publishing a medicines budget forecasting paper. This has allowed for early sight of all North Boards efficiency saving plans, increasing our rigour in development of our local plans.

This report details a series of interventions that requires Tayside NHS Board direction, support, and agreement to move forward with implementation.

Accountability for the delivery of this programme will sit with the NHS Tayside's Chief Operating Officer, Integration Joint Board Chief Officers, Associate Medical Directors and IJB Clinical Directors.

2. ASESSMENT

The following is an extract of additional interventions brought forward by the PMG, and comprises seven interventions that will require tough decisions to be made. This may mean the cessation of a current service or the redirection of teams to deliver specific interventions, within challenging timelines.

Without tough decisions being made, previous experience has demonstrated that no progress will be made in relation to the interventions detailed in this report. The potential full year effect on the NHS Tayside budget for all of the additional interventions described by PMG equate to **£3.025m**.

It is important to recognise the limited workforce and clinical capacity to deliver these intiatives. In particular pharmacy teams will be at capacity to address the identified initiatives to deliver the existing £4.5m savings target. The Board are asked to note the importance of not losing focus on the identified savings initiatives to deliver the £4.5m. It is therefore critical that the Board supports the need for additional resources and recognises the need for clinical staff to commit to this challenging programme.

Due to the timescales to bring forward the recommended interventions Tayside NHS Board are advised that these have not been developed in consultation with clinical teams, however the list of

interventions has been developed with a cohort of PMG members. Tayside NHS Board are asked to acknowledge the fact that the interventions will not be delivered without strong system wide clinical and organisational support and leadership.

For each secondary care intervention listed it is recommended that a leadership team work with the clinical areas and agree an escalation process and timescale for prompt delivery.

An executive oversight group will be established and will comprise of directors and a clinical reference panel consisting of IJB clinical directors, associate medical directors and/or lead clinicians and representatives of the associate nurse directors and/or senior nurse management.

The following table details the interventions which require the Board's agreement to progress. These will yield savings of **£2.58m**.

1.	Intervention: Lidocaine Plasters	NHS Tayside will no longer support the prescribing of lidocaine plasters outwith their license. The rationale for this is due to the lack of published evidence and affordability. If new evidence emerges an application can be made to the Medicine Advisory Group (MAG). Specialist services will be required to undertake a review of all existing patients. This will require assurance that reviews are being completed in primary care in line with formulary guidance.	Recurring impact up to **£100K**
	Decision	Tayside NHS Board agreement to the cessation of prescribing Lidocaine plasters. Supporting action: • Medical Director/ Chair of PMG and Area Drugs and Therapeutic Committee to cascade guidance across all prescribers informing them of Tayside NHS Board's prescribing position not to prescribe Lidocaine plasters. • Clinical engagement to ensure review of pain pathway. • Clinical directors to put in place a process ensure reviews are being completed in primary care in line with formulary guidance. • This specialist pain service to ensure all current patients are reviewed in primary care.	

2.	Intervention: Diabetes	Diabetes Managed Clinical Network to focus on the development, delivery and evaluation of a diabetes prescribing strategy that will deliver health gain whilst reducing prescribing costs. The resultant pathway will invest in non-drug restrictive diet options for type 2 diabetes over pharmaceutical options in light of published evidence to support this more cost	Recurring impact up to **£150K**

		effective option which produces better reductions in HBA1c and also the determination of alternatives to prescribing e.g. exercise, weight management.	
	Decision	Tayside NHS Board agreement to the development of a diabetes prescribing strategy by the Diabetes MCN. Supporting action: • Diabetes MCN to lead the development of this strategy. The strategy to be available for delivery by June 2018 along with an implementation and resource plan.	

3.	Intervention: Liothyronine	NHS Tayside will not support the endorsement of any new patients commencing on liothyronine. The rationale for this is due to lack of published Randomised Controlled Trial (RCT) evidence and affordability. Liothyronine will be removed from Tayside Area Formulary. An urgent review to be undertaken of those patients currently prescribed Liothyronine with a view to discontinuation wherever possible. If new RCT/meta analysis evidence emerges, an application can be make to MAG if required.	Recurring impact up to **£300K**
	Decision	Tayside NHS Board agreement that all prescribing is transferred back to secondary care and patients reviewed by 1 June 2018. As a consequence of this no future prescribing of liothyronine within primary care. Board support for the release of 30 clinical sessions to undertake this work. Supporting action: Engagement with medical staff in secondary care to ensure all patients are reviewed by secondary care clinicians.	

4.	Intervention: Pregabalin	Tayside NHS Board agreement that only the branded generic version of Pregabalin which is at variance to current Scottish Government advice is prescribed within NHS Tayside. Please see the SBAR at Appendix 1 for further information. This will be delivered through existing resources.	Recurring impact up to **£1.5m**

	Decision	Tayside NHS Board agreement to move to branded generic prescribing for Pregabalin.	

5.	Intervention: Mental Health Prescribing	Tayside NHS Board agreement that mental health prescribing will be reduced to come within the bottom quartile within Scotland. Mental Health prescribing to be reviewed against the British National Formulary subchapters on antidepressants and antipsychotics. The aim being to deliver safe and effective care whilst reducing prescribing costs.	Recurring impact up to **£100K**
	Decision	Tayside NHS Board requirement that mental health prescribing is contained within the terms of reference of the Mental Health Priority Improvement Programme.	

6.	Intervention: Cessation of non routine primary care prescriptions	Tayside NHS Board endorsement of the recommendations of the NHS England document "*Items which should not be routinely prescribed in primary care: Guidance for CCGs" [Clinical Commissioning Groups].*	Recurring impact up to **£300K**
	Decision	Tayside NHS Board endorsement for implementation within NHS Tayside of the recommendations of the NHS England document "*Items which should not be routinely prescribed in primary care: Guidance for CCGs" [Clinical Commissioning Groups].* Supporting action: • Medical Director to highlight the importance of accepting the recommendations that have been developed by the clinical community and to ensure the benefit of ScriptSwitch is being realised across Tayside. • Strengthening the monitoring of prescribing to ensure the guidance is adhered to.	

7.	Intervention: Homeopathy	Tayside NHS Board agreement to cease prescribing homeopathy products within Tayside.	Recurring impact up to **£30K**
	Decision	Tayside NHS Board agreement to cease prescribing homeopathy products within Tayside.	

3. RECOMMENDATIONS

Tayside NHS Board is asked to confirm its support and agreement to take forward the implementation of the seven interventions detailed in the table above, noting the accountability for the delivery of this programme will sit with the NHS Tayside's Chief Operating Officer, Integration Joint Board Chief Officers, Associate Medical Directors and IJB Clinical Directors.

In taking this action Tayside NHS Board is asked to note the following:

- The establishment of an Executive Oversight Group.
- A leadership group will be formed for each secondary care intervention
- The risks associated with the actions required to deliver these savings.
- The importance of engagement.
- Support a whole system approach to realise the benefits from these interventions.

Ms F Rooney
Director of Pharmacy

Dr M Watts
Associate Medical Director – Primary Care

March 2018

APPENDIX 1

ADDRESSING THE ELEVATED PREGABALIN DRUG TARIFF PRICE WITHIN NHS SCOTLAND

1. Situation and Background

Following increased pressure on the costs associated with FHS prescribing we want to raise concerns at the current drug tariff price of pregabalin and the unfavourable affect this is having on NHS Tayside.

The Lyrica® brand of pregabalin came off patent in July 2017(secondary patent for neuropathic pain). The Drug Tariff price for pregabalin was reduced by 30% in Scotland, but **reduced by greater than 90% in England**; resulting in different prices within the UK. NHS Boards had factored savings of the level seen in England in to their financial plans for 2017/18 and beyond, resulting in shortfalls in delivery of savings.

Part7 of the Scottish Drug Tariff is part of the Community Pharmacy Contract and the efficient Purchasing and Prescribing Programme for contractors. The Scottish Government (SG) have issued guidance to Boards to prescribe generically where possible to protect this scheme. The Scottish Government agreed following representations from Community Pharmacy Scotland (CPS) to artificially maintain an increased tariff price in Scotland. CPS argued that dropping the tariff price too quickly could destabilise Community Pharmacy payments under their contract. SG agreed to move at a slower pace towards market rates with the tariff.

3. Assessment

As a consequence of the decision by SG, the lost financial opportunity for NHS Tayside during 2017/18 has been **£2.4m**.

There is now increased pressure to prescribe the ‘branded generic’ which could deliver savings of up to £2m for NHS Tayside. Primary Care prescribing for a “branded generic” would mean Community Pharmacies being reimbursed for the specified product, rather than the artificially elevated Drug Tariff price for pregabalin.

The use of branded generics has a series of risks:

If there was a general move by Boards away from using generic pregabalin reimbursed at tariff price to branded prescribing this would lead to a shortfall in the funding SG has promised as part of the financial package to CPS.

2. At present there is some degree of transparency about the excess Boards are paying through this process, if pregabalin was switched to branded generic and SG decided to offset the savings then this could be spread over a range of products, making monitoring much more difficult, and with more variable impact by Board depending on the mix of products chosen and local usage patterns, once again by trying to "play the system" and continually try to undermine these increased costs SG would have to continually change the mix of products with increased prices leading to even more difficulty in tracing the costs .

3. If all Boards moved to branded generics there could be issues maintaining supply chain, with greater exposure to shortages.

4. There is no guarantee that the chosen brand would maintain a price that is below tariff, leading to the potential to have to switch patients again in a matter of months

5. The potential reputational damage to patient/clinician confidence, clinical/organisational confidence etc with continual switching may undermine the ability to progress future pieces of work

Prescribing variation aside, if Health Boards are being challenged to reduce costs, it would seem prudent that NHS Scotland reimburses at the same rate as NHS England, allowing health boards to realise the current missed opportunity.

4. Recommendations

NHS Tayside recommends parity of tariff price with the English Drug Tariff for pregabalin be sought as a matter of urgency to minimise the risk of Boards taking short term actions to mitigate the price differential.

ITEM No …13……..

REPORT NO. DIJB43-2018

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				
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	√				
NHS Tayside (Registered Medical Practitioner (not providing primary medical services)	Cesar Rodriguez	A	√	A	√				
NHS Tayside (Registered Nurse)	Sarah Dickie	√	√	√	A				
Dundee City Council (Chief Social Work Officer)	Jane Martin	√	√	√	√				
Voluntary Sector Representative	Christine Lowden	√	A	√	√				
NHS Tayside (Staff Partnership Representative)	Raymond Marshall	√	A	A	√				
Trade Union Representative	Jim McFarlane	√	√	√	√				
NHS Tayside (Director of Public Health)	Drew Walker	√	A/S	A	√				
Carer Representative	Martyn Sloan	√	√	A	√				
Service User Representative	Andrew Jack	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