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

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

City Chambers
DUNDEE
DD1 3BY

22nd February, 2018

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

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 Tuesday, 27th February, 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

7 DUNDEE INTEGRATION JOINT BOARD 2018/2019 BUDGET PROGRESS REPORT

(Report No DIJB13-2016 by 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	Judith Golden *
Non Executive Member	Munwar Hussain *
Chief Officer	David W Lynch
Chief Finance Officer	Dave Berry
Registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978(b)	Frank Weber
Registered medical practitioner employed by the Health Board and not providing primary medical services	Cesar Rodriguez
Registered nurse who is employed by the Health Board	Sarah Dickie
Chief Social Work Officer	Jane Martin
Third Sector Representative	Christine Lowden
Staff Partnership Representative	Raymond Marshall
Trade Union Representative	Jim McFarlane
Director of Public Health	Drew Walker
Person providing unpaid care in the area of the local authority	Martyn Sloan
Service User residing in the area of the local authority	Andrew Jack

(b) DISTRIBUTION – FOR INFORMATION ONLY

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

ITEM No …7……..

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

REPORT ON: **DUNDEE INTEGRATION JOINT BOARD 2018/19 BUDGET PROGRESS REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB13-2018**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board with an update with regards to the development of the delegated budget 2018/19 and associated developing Transformation Programme required to deliver a balanced budget.

2.0 RECOMMENDATIONS

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

2.1 Notes the anticipated level of increased costs associated with the delegated budget and indicative funding levels from Dundee City Council and NHS Tayside and associated funding gap.

2.2 Remits the Chief Finance Officer to bring forward a full range of deliverable Transformation Programme efficiencies for consideration of the IJB at a special meeting arranged for the 30th March 2018.

3.0 FINANCIAL IMPLICATIONS

The financial planning projections highlighted in Appendix 1 have been updated from the January IJB meeting however remain provisional at this stage of the budget process until formal notice is received from Dundee City Council and NHS Tayside of the value of the proposed delegated resources following the conclusion of their respective budget processes. A final budget position will be presented to the special IJB meeting arranged for the 30th March 2018.

4.0 MAIN TEXT

4.1 Dundee IJB considered report DIJB1-2018 (Scottish Government Draft Budget 2018/19 – Implications for Dundee Integration Joint Board) at a special meeting of Dundee IJB held on 24th January 2018. This report set out to the IJB for the first time the potential range of additional costs which could impact on the delegated budget and the anticipated level of funding to be provided to the IJB from NHS Tayside and Dundee City Council following the Scottish Government's Draft Budget 2018/19.

4.2 Since then, discussions have continued with both Dundee City Council and NHS Tayside to refine the budget assumptions and funding levels. This includes considering the impact of the amendments to the Scottish Government's budget in relation to the extension of a 3% uplift to those earning up to £36,500 per annum (as against £30,000) and the impact of additional funding being provided to local government.

4.3 Dundee City Council Position

4.3.1 Dundee City Council agreed it's 2018/19 Budget at a special meeting of the Policy and Resources Committee on the 22nd February 2018. The Council's Revenue Budget and Council Tax 2018/19 Report (51-2018) sets out the Council's revised financial position for 2018/19, including the range of cost pressures anticipated to be faced by the Council totalling £23.868m, savings already included in the provisional budget of £8.64m, and new funding of £3.703m. The amendments to the Scottish Government's Budget Bill improved the Council's financial position from the previous projected position with the Council receiving an additional £4.422m of resources for 2018/19. The net effect of these and other minor changes left the Council with a savings target of £7.313m before consideration of council tax increases.

4.3.2 Included in the Council's budget is a position of providing Dundee Integration Joint Board with a net flat cash finance settlement for the delegated budget compared with the 2017/18 level of resources. This net settlement includes investment of £1.6m in delivering the new responsibilities for social care as part of the Scottish Government's budget settlement to local government of £66m nationally (eg Carers Act, Living Wage) and provision for inflationary increases offset by a reduction in funding to the delegated budget. After applying the estimated cost pressures such as pay inflation, the impact of the increase in the National Care Home Contract and other inflationary cost pressures in addition to the new commitments for 2018/19 in relation to the living wage, sleepovers at the living wage, the implementation of the Carers Act and increases to free personal and nursing care payments, the net impact on the delegated budget is a shortfall of £3.483m for 2018/19.

4.4 NHS Tayside Position

4.4.1 NHS Tayside will finalise its 2018/19 Budget on the 29th March 2018. Since the January IJB meeting, work has continued to refine the estimated costs for 2018/19 and the anticipated levels of funding from NHS Tayside. This includes the refinement of the costs of the pay award and associated additional funding provided by the Scottish Government and further detailed work in relation to the prescribing budget through the Prescribing Management Group (PMG). The PMG financial planning outlook for Dundee considers the projected changes in the cost and volume of prescribing over the next 12 months set against the potential resources available. Dundee will benefit from an increase in resources due to changes in the national allocation formula (NRAC) which when applied locally, will enhance the Dundee prescribing budget. Discussions are ongoing with NHS Tayside as to the exact value of this change for 2018/19. However currently, the net effect of these changes is likely to still result in a shortfall of approximately £1.3m in the prescribing budget.

4.4.2 The impact on the Dundee delegated budget of services hosted by Perth and Kinross and Angus IJB's will be affected by the range of pressures and efficiency measures identified to meet those pressures by those respective IJB's. It is assumed that at this stage, Dundee IJB will not be subject to a recharge of expenditure for any hosted services which is greater than the budgeted allocation.

4.5 Net Impact on Dundee IJB Budget

4.5.1 The updated financial position for Dundee IJB following consideration of the Dundee City Council and NHS Tayside current budget positions is detailed in Appendix 1. This shows a potential financial deficit of approximately £5m at this stage of the budget process. An important element of the 2018/19 IJB budget strategy is to significantly reduce the level of historical savings within the NHS budget currently being met by non-recurring savings and meet these shortfalls from permanent savings as noted in Appendix 1.

4.6 Dundee IJB's Financial Plan & Transformation Programme

4.6.1 Dundee IJB's response to this challenging financial position will be set out within its developing Transformation Programme. This will include a range of proposed budget adjustments with the aim of continuing to support, develop and deliver integrated services which meet the aims and priorities of the IJB's Strategic and Commissioning Plan. This will be presented in full to the IJB for consideration at its meeting on the 30th March 2018. Should the range of deliverable interventions be insufficient to balance the shortfall, the IJB may be required to consider the use

of any unallocated IJB reserves to provide short term support on a non-recurring basis while longer term proposals are taken forward or adjusting its Strategic and Commissioning Plan to fit with the resources available.

5.0 POLICY IMPLICATIONS

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

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that the IJB will not be able to balance its resources and achieve its strategic objectives should the combination of the level of funding provided through the delegated budget and the impact of the IJB's Transformation Efficiency Programme be insufficient.
Risk Category	Financial
Inherent Risk Level	Likelihood 4 x Impact 4 = 16 (Extreme)
Mitigating Actions (including timescales and resources)	Developing a robust and deliverable Transformation Programme Negotiations with Dundee City Council and NHS Tayside to agree the most advantageous funding package as part of the development of the IJB's delegated budget.
Residual Risk Level	Likelihood 3 x Impact 4 = 12 (High)
Planned Risk Level	Likelihood 3 x Impact 4 = 12 (High)
Approval recommendation	Despite the high level of risk, it is recommended that this should be accepted at this stage of the budget process with a reviewed position set out as the proposed budget is set out to the IJB in March 2018.

7.0 CONSULTATIONS

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

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 22 February 2018

Dundee Integration Joint Board - Delegated Budget 2018/19

Appendix 1

Projected Financial Position as at February 2018

	NHS Tayside	Dundee City Council	Integrated Resource Total
	£000	£000	£000
Estimated New Cost Pressures 2018/19			
Pay Inflation	1,500	933	2,433
Other Inflation (including National Care Home Contract)	100	920	1,020
Prescribing Growth / Inflation	1,177		1,177
New Scottish Government Policy Commitments		1,630	1,630
Total New Cost Pressures	**2,778**	**3,483**	**6,261**
Funded by:			
Estimated Funding Uplifts	(2,778)	0	(2,778)
Net Funding Pressures 2018/19	**0**	**3,483**	**3,483**
Previous Years Budget Shortfalls			
Non-Recurring Savings to Recurring	1,140		1,140
Less: Reshaping Care for Older People	(400)		(400)
Less: 2017/18 Reduced Operational Budgets Spend	(500)		(500)
Total Previous Years Shortfalls	**240**	**0**	**240**
Provisional Prescribing Shortfall Net of Tayside Initiatives	1,328		1,328
Net Anticipated Budget Shortfall 2018/19	**1,568**	**3,483**	**5,051**

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

(See Distribution List attached)

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

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

City Chambers
DUNDEE
DD1 3BY

20th February, 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 Committee Room 1, 14 City Square, Dundee on Tuesday, 27th February, 2018 at 2.00 pm.

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

Yours faithfully

DAVID W LYNCH

Chief Officer

A G E N D A

1 APOLOGIES FOR ABSENCE

2 DECLARATION OF INTEREST

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

3 MINUTES OF PREVIOUS MEETINGS - Page 1 and 7

(a) The minute of meeting of the Integration Joint Board held on 19th December, 2017 is attached for approval.

(b) The minute of meeting of the Integration Joint Board held on 24th January, 2018 is attached for approval.

4 ISSUING OF DIRECTIONS (DIJB14-2018)

The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on the Integration Joint Board to develop a strategic plan for integrated functions and budgets under its control. To action this plan the Integration Joint Board is required to issue binding Directions to one or both of Dundee City Council and NHS Tayside. A Direction must be given in respect of every function that has been delegated to the Integration Joint Board. The Direction must be in writing and must set out how each integrated health and social care function is to be exercised and the budget associated with that.

As the strategic plan develops and in order to ensure proper governance it is proposed that a 'Directions' section be included in Integration Joint Board Reports. The section will identify whether a Direction from the Integration Joint Board is necessary and if so to whom it is to be issued. If a Direction is to be issued, the formal written Direction will be contained within the body of the Report. This will keep all members of the Integration Joint Board fully informed of the terms of any Direction prior to its being issued. It will also enhance transport governance by the Integration Joint Board in the issuing of Directions.

The Integration Joint Board's approval is sought to implement this proposal.

5 TAYSIDE INTEGRATED CLINICAL STRATEGY - Page 11

(a) Presentation by Sue Muir, Programme Lead, Integrated Clinical Strategy and Dr James Cotton, Consultant, NHS Tayside.

(b) Report No DIJB5-2018 by the Chief Officer, copy attached.

6 FINANCIAL MONITORING REPORT AS AT DECEMBER 2017 - Page 33

(Report No DIJB12-2018 by the Chief Finance Officer, copy attached).

7 DUNDEE INTEGRATION JOINT BOARD 2018/2019 BUDGET PROGRESS REPORT

(Report No DIJB13-2018 by the Chief Finance Officer, to follow).

8 PERSONALISATION PROGRAMME (SELF-DIRECTED SUPPORT) - Page 45

(Report No DIJB3-2018 by the Chief Finance Officer, copy attached).

9 DELIVERING THE NEW 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND - Page 81

(Report No DIJB9-2018 by the Chief Officer, copy attached).

10 EQUAL, EXPERT & VALUED – INVOLVEMENT OF CARERS IN THE WORK OF DUNDEE INTEGRATION JOINT BOARD - Page 89

(Report No DIJB10-2018 by the Chief Officer, copy attached).

11 CLIMATE CHANGE REPORTING - Page 115

(Report No DIJB8-2018 by the Chief Finance Officer, copy attached).

12 MEASURING PERFORMANCE UNDER INTEGRATION – 2018/19 SUBMISSION - Page 185

(Report No DIJB11-2018 by the Chief Officer, copy attached).

13 TARGETS AND INDICATORS IN HEALTH AND SOCIAL CARE: A REVIEW - Page 211

(Report No DIJB7-2018 by the Chief Officer, copy attached).

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, 24th April, 2018 at 2.00 pm.

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
DISTRIBUTION LIST

(a) DISTRIBUTION - INTEGRATION JOINT BOARD MEMBERS

(* - DENOTES VOTING MEMBER)

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

(b) DISTRIBUTION – FOR INFORMATION ONLY

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

At a MEETING of the **DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 19th December, 2017.

Present:-

Members	**Role**
Ken LYNN *(Chairperson)*	Nominated by Dundee City Council (Elected Member)
Doug CROSS (*Vice 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)
Judith GOLDEN	Nominated by Health Board (Non-Executive Member)
Munwar HUSSAIN	Nominated by Health Board (Non-Executve Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
Cesar RODRIGUEZ	Registered Medical Practitioner (not providing primary medical services)
Drew WALKER	Director of Public Health
Raymond MARSHALL	Staff Partnership Representative
Christine LOWDEN	Third Sector Representative

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

Name	**Organisation**
Diane McCULLOCH	Dundee Health and Social Care Partnership
Arlene HAY	Dundee Health and Social Care Partnership
Dr David Shaw	Dundee Health and Social Care Partnership
Beth HAMILTON	Dundee Health and Social Care Partnership
Michelle WATTS	NHS Tayside
Lynn HAMILTON	NHS Tayside
Stewart DOIG	NHS Tayside
Keith RUSSELL	NHS Tayside
Bill NICOLL	NHS Tayside
Christina COOPER	Dundee Voluntary Action
Vered HOPKINS	Violence against Women Partnership

Ken LYNN, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Frank WEBER , Registered Medical Practitioner (whose name is included in the list of primary medical performers), Sarah DICKIE, Registered Nurse, Jane MARTIN, Chief Social Work Officer, Jim MCFARLANE, Trade Union Representative, Andrew JACK, Service User residing in the area of the local authority, and Martyn SLOAN, Person providing unpaid care in the area of the local authority.

II DECLARATIONS OF INTEREST

No declarations of interest were made.

III MINUTE OF PREVIOUS MEETING

The minute of previous meeting of the Integration Joint Board held on 31st October, 2017 was submitted and approved.

IV PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF MEETING OF 28TH NOVEMBER, 2017

The minute of meeting of the Performance and Audit Committee held on 28th November, 2017 was submitted and noted for information and record purposes.

(b) CHAIR'S ASSURANCE REPORT

There was submitted Report No DIJB60-2017 by the Chair of the Performance and Audit Committee outlining:-

- Delegated Decisions taken by the Committee
- Performance against Workplan
- Any Other Major Issues to Highlight to the Integration Joint Board

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

V MENTAL HEALTH AND WELLBEING

In the absence of Arlene Mitchell, Diane McCulloch gave a presentation on Mental Health and Wellbeing.

The presentation outlined the following areas:-

- Safety
- Sustainability
- Clinical Viability
- Workforce Availability
- Improved Environments
- Most Efficient Use of Resources

The Integration Joint Board noted the content of the presentation.

VI MENTAL HEALTH & LEARNING DISABILITY SERVICE REDESIGN TRANSFORMATION PROGRAMME – CONSULTATION FEEDBACK REPORT

There was submitted a Joint Report No DIJB49-2017 by the Mental Health Programme Director and Finance Manager, NHS Tayside, presenting the findings of the Mental Health and Learning Disability Service Redesign Transformation Programme Consultation and subsequent recommendations to the Dundee City Health and Social Care Integration Joint Board.

It was reported that the report would be presented to NHS Tayside Board and the Angus and Dundee Integration Joint Boards to note and comment before seeking approval from the Perth and Kinross Integration Joint Board on 26th January, 2018.

Lynn Hamilton, Stuart Doig and Keith Russell gave a presentation in supplement to the report.

The Integration Joint Board commented on the following areas:-

- CARSEVIEW CENTRE

There should be an aspiration that the current level of services provided by the Carseview Centre would be enhanced but as a minimum assurance was sought that there would be no diminution of service to the current user group utilising this resource, within Dundee.

- TRAVEL

It was critical that transportation issues should be examined and assurances sought in regard to the interests of families and users who may now have to travel from the Strathmartine location to Murray Royal in Perth. Appropriate support was required for user groups with learning and disability conditions and their families to ensure this group was not disadvantaged by the changes. In addition, the impact the changes may have on the workforce who would be required to service these new locations and their contractual arrangements in this regard in terms of risk assessments also needed to be addressed and appropriate consultation should be undertaken, and be continued to be undertaken with staff following any decision on the way forward.

- CONSULTANT POSITIONS – FILLING OF VACANCIES

That the filling of vacancies for consultant positions be successfully made to facilitate the smooth operation of the model of service delivery.

- CONSULTATION PROCESS

That in light of the outcome of the consultation process, there would be a requirement to work with the public to inform them on the rationale of proceeding with any particular option which seemed to be contrary to the views expressed.

- SAFETY AND QUALITY OF CARE

To recognise that the safety of patients and quality of care was paramount in considering any particular option in the provision of safe, clinical and sustainable services.
The Integration Joint Board agreed:-

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

(ii) to note the process followed in undertaking the three month formal consultation on the preferred option for future General Adult Psychiatry and Learning Disability services; and

(iii) to note the content and recommendations of the Consultation Feedback Report; and

(iv) that having considered the content of the report and having heard the presenters the comments received are as noted above.

VII JOINT SENSORY SERVICES STRATEGY & COMMISSIONING PLAN

There was submitted Report No DIJB52-2017 by the Chief Officer seeking approval of the Joint Sensory Services and Commissioning Statement for 2017-2020.

The Integration Joint Board agreed:-

(i) to note the contents of the report, particularly in relation to the engagement of the population of Dundee who had specific sensory requirements;

(ii) to note the role of the different elements of provision and creation of specific social work support within the joint sensory community; and

(iii) to approve the Joint Sensory Services Strategy and Commissioning Statement which was attached to the report as Appendix 1 as the vehicle for the planning and development of services in the next three years.

VIII SUBSTANCE MISUSE STRATEGIC & COMMISSIONING PLAN UPDATE

There was submitted Report No DIJB55-2017 by the Chief Officer informing of the progress made with the development of the Strategic and Commissioning Plan for Substance Misuse and the development of governance arrangements for substance misuse.

The Integration Joint Board agreed:-

(i) to note the content of the report and, in particular, the progress that was being made with the development of a Strategic and Commissioning Plan for substance misuse;

(ii) to approve the plans to launch the Strategic and Commissioning Plan in March 2018;

(iii) to note and approve the progress made with restructuring the governance arrangements for substance misuse in Dundee; and

(iv) to support the proposal for the development of a Commission on drug misuse.

IX GENERAL PRACTICE AND PRIMARY CARE

There was submitted Report No DIJB51-2017 by the Chief Officer outlining the current position for general practice in Dundee, outlining the progress made with the implementation of the primary care strategy, and highlighting some of the opportunities and challenges that the new GP contract offer would bring.

The Integration Joint Board agreed:-

(i) to note the positive progress towards delivering solutions to a range of the challenges faced by primary care outlined in the report and Appendix 1 of the report;

(ii) to note the outline of the proposals and the implications of the proposed General Medical Services contract for the Health and Social Care Partnership which was attached to the report as Appendix 2; and

(iii) to note the requirement for the Health and Social Care Partnership to produce a primary care improvement plan by 1st July, 2018.

X CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2016/17

There was submitted Report No DIJB53-2017 by the Chief Social Work Officer bringing forward for information the Chief Social Work Officer's Annual Report for 2016/17.

The Integration Joint Board agreed to note the content of the report and the Chief Social Work Officer's Annual Report for 2016/17 which was attached to the report as Appendix 1.

XI DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2016/17 – TRANSFORMATIONAL PUBLIC HEALTH

There was submitted Report No DIJB54-2017 by the Director of Public Health bringing forward for information the Director of Public Health's Annual Report 2016/17;

The Integration Joint Board agreed:-

(i) to note the content of the report and the Director of Public Health's Annual Report which was attached to the report as Appendix 1 of the report;

(ii) to note the progress made against 2015/16's recommendations which were outlined in pages 4-7 of Appendix 1 of the report; and

(iii) to support the recommendations for 2017/18 as outlined in page 8 of Appendix 1 of the report.

XII IMPROVING SCOTLAND'S HEALTH: A HEALTHIER FUTURE – ACTIONS AND AMBITIONS ON DIET, ACTIVITY AND HEALTHY WEIGHT

There was submitted Report No DIJB59-2017 by the Chief Officer informing of the Scottish Government's consultation on 'Improving Scotland's Health : A Healthier Future – Actions and ambitions on Diet, activity and Healthy Weight' and the proposed plan for responding to the consultation.

The Integration Joint Board agreed:-

(i) to recognise that the Scottish Government had firmly identified obesity as a priority for action;

(ii) to acknowledge that the Dundee Healthy Weight Partnership was co-ordinating a response to the consultation document on behalf of Dundee Health and Social Care Partnership;

(iii) to indicate support for the Dundee Healthy Weight Partnership response to inform the co-creation of a joint response from Tayside; and

(iv) to note that the Director of Public Health would advise the Integration Joint Board of events they may be able to participate in and would liaise with the Chief Officer towards providing a development session for the Integration Joint Board.

XIII WINTER PLANNING ARRANGEMENTS

There was submitted Report No DIJB58-2017 by the Chief Officer informing of the Winter Planning arrangements and Unscheduled Care Improvement Plan.

The Integration Joint Board agreed:-

(i) to note the content of the report and the NHS Tayside Winter Plan 2017/18 which was attached to the report as appendices 1 and 2 which were presented to the NHS Tayside Board Meeting held on 26th October, 2017;

(ii) to approve and endorse Dundee Health and Social Care Partnership's contribution to the Winter Plan;

(iii) to note the Improvement Plans that underpinned the Winter Plan; and

(iv) to note the Resilience Plans for winter preparedness.

XIV FINANCIAL MONITORING AS AT OCTOBER 2017

There was submitted Report No DIJB50-2017 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:-

(i) to note the content of the report including the overall projected financial position for delegated services to the 2017/18 financial year as at 31st October, 2017; and

(ii) to note the position with regards to the Large Hospital Set Aside as stated at 4.3.11 of the report and approve the proposal to not effect the planned saving in lieu of a recovery action plan.

XV TRANSFORMATION PROGRAMME - UPDATE

There was submitted Report No DIJB56-2017 by the Chief Officer providing an update of Dundee Health and Social Care Partnership's Transformation Programme.

The Integration Joint Board agreed to note the content of the report, the progress to date of the Transformation Programme and the planned next phases of development as outlined in the report.

XVI PROGRAMME OF MEETINGS 2018

The Integration Joint Board agreed that the programme of meetings for the Integration Joint Board over 2018 be as follows:-

DATE	TIME	VENUE
Tuesday, 27th February, 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 24th April, 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 26th June, 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 28th August, 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 30th October, 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 18th December, 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee

XVII 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 Tuesday, 27th February, 2018 at 2.00 pm.

Ken LYNN, Chairperson.

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

Present:-

Members	**Role**
Ken LYNN *(Chairperso*n)	Nominated by Dundee City Council (Elected Member)
Doug CROSS (*Vice 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)
Judith GOLDEN	Nominated by Health Board (Non-Executive Member)
Munwar HUSSAIN	Nominated by Health Board (Non-Executve Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
Sarah DICKIE	Registered Nurse
Jane MARTIN	Chief Social Work Officer
Drew WALKER	Director of Public Health
Raymond MARSHALL	Staff Partnership Representative
Jim MCFARLANE	Trade Union Representative
Christine LOWDEN	Third Sector Representative
Martyn SLOAN	Person providing unpaid care in the area of the local authority

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

Diane McCULLOCH	Dundee Health and Social Care Partnership
Arlene HAY	Dundee Health and Social Care Partnership

Ken LYNN, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of:-

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)
Andrew JACK	Service User residing in the area of the local authority

II DECLARATIONS OF INTEREST

No declarations of interest were made.

III SCOTTISH GOVERNMENT DRAFT BUDGET 2018/19 – IMPLICATIONS FOR DUNDEE INTEGRATION JOINT BOARD

There was submitted Report No DIJB1-2018 by the Chief Finance Officer providing an overview of the implications of the Scottish Government's Draft Budget 2018/19 for Dundee Integration Joint Board.

Thereafter, following discussion, Bailie Helen Wright moved "That the Board agrees that the Scottish Government's Draft Budget as it relates to NHS Tayside and Dundee City Council laid out in the Report does not represent a fair deal for the people of Dundee or for Health and Social Care in

Scotland as a whole, notes that there is no current majority in the Scottish Parliament for the budget, resolves to stand by the cross party stance set out by COSLA and in doing so make joint representation from all members of the Board to the Finance Secretary and the leaders of all parties in the Scottish Parliament ahead of the next budget vote calling for a fair deal for Health and Social Care funding in order to avoid damaging cuts in local services."

There being no seconder, the Amendment proposed by Bailie Wright fell and was not voted upon.

The Integration Joint Board then agreed:-

(i) to note the content of the Scottish Government's Draft Budget as it related to NHS Tayside and Dundee City Council;

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

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

(iv) to remit to the Chief Finance Officer to lay the developing Transformation Efficiencies Programme before the Integration Joint Board in February 2018 to inform the budget setting process; and

(v) to remit to the Chief Finance Officer to bring forward a proposed budget for 2018/19 in relation to delegated services for consideration by the Integration Joint Board at a special meeting of the Integration Joint Board prior to the end of March 2018.

IV REVIEW OF HOME CARE SERVICES

There was submitted Report No DIJB2-2018 by the Chief Officer advising of the review of social care services within the Dundee Health and Social Care Partnership Home Care Service and to seek approval to request that Dundee City Council commission the current in-house social care service in line with the recommended option. The proposed changes would provide additional social care support and maximise the use of the resources within the service.

Thereafter, following discussion, Councillor Ken Lynn, seconded by Doug Cross, moved that the report be agreed as submitted.

As an amendment, Bailie Helen Wright, seconded by Judith Golden, moved "that this Integration Joint Board only note the content of this report and take no further action until Dundee City Council's Administration lay out their proposals to address the £15.7 million gap to achieve a balanced budget".

On a division, there voted for the motion - Councillor Ken Lynn, Doug Cross, Munwar Hussain and Councillor Roisin Smith (4); and for the amendment – Judith Golden and Bailie Helen Wright (2) – whereupon the motion was declared carried and the Integration Joint Board agreed:-

(i) to note the previous, ongoing and planned engagement with the workforce and their trade union representatives as detailed in Appendix 1 of the report;

(ii) to note the Option Appraisal carried out to determine the future changes as appended at Appendix 1 of the report;

(iii) to implement Option 4 as the recommended option which provided additional hours, targeted resources, minimised disruption for service users and provided the best option for the current workforce as described in Section 4.3.4 of the report;

(iv) to seek agreement from Dundee City Council to progress to implement the proposed option as described in Section 4.3.4 of the report;

(v) to instruct the Chief Officer, Dundee Health and Social Care Partnership, and request the Head of Human Resources and Business Support, Dundee City Council, to continue formal consultation with the affected workforce and their trade union representatives with a view to agreeing to implement the proposal as detailed in Section 4.3.5 of the report; and

(vi) to delegate authority to the Chief Officer, Dundee Health and Social Care Partnership to implement the changes.

V INTEGRATED CARE FUND RECOMMENDATIONS

There was submitted Report No DIJB4-2018 by the Chief Finance Officer outlining the recommendations of the Integrated Care Fund Monitoring Group in relation to the extension and mainstreaming of a range of tests of change in the way community supports and health and social care services were provided and to seek approval to extend funding for these services, as outlined in Appendix 1, in the short term pending the conclusion of the Integration Joint Board's budget setting process 2018/19.

The Integration Joint Board agreed:-

(i) to note the recommendations of the Integrated Care Fund Monitoring Group in relation to the extension and mainstreaming of the range of tests of change as outlined in Appendix 1 of the report;

(ii) to extend the funding of these services, as outlined in Appendix 1 of the report, in the short term from 31st March, 2018 until 30th June, 2018 pending the outcome of the Integration Joint Board's budget considerations; and

(iii) to remit to the Chief Finance Officer to present these recommendations to a special Integration Joint Board Budget meeting in March 2018 as part of the wider prioritisation of resources under the budget setting process.

IV 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 Tuesday, 27th February, 2018 at 2.00 pm.

Ken LYNN, Chairperson.

ITEM No …5……..

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

REPORT ON: **TAYSIDE INTEGRATED CLINICAL STRATEGY**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB5-2018**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board with an update on progress toward the development of an Integrated Clinical Strategy for Tayside.

2.0 RECOMMENDATIONS

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

2.1 Notes the progress made to date on the development of an Integrated Clinical Strategy and the Staging Report that was approved by NHS Tayside Board in December 2017 (attached as Appendix 1).

2.2 Endorses the ongoing development of the Integrated Clinical Strategy in collaboration with Tayside Health and Social Care Partnerships.

2.3 Notes the intended public informing and awareness raising whilst a plan for long term, ongoing engagement with our stakeholders is developed.

3.0 FINANCIAL IMPLICATIONS

A detailed financial plan will be developed in line with the Partnership's Commissioning Strategy to support the delivery of the Integrated Clinical Strategy.

4.0 PURPOSE OF REPORT

4.1 NHS Tayside and the three Integration Joint Boards are developing an Integrated Clinical Strategy (the Strategy) that will set out a collective vision of how high quality, efficient and accessible clinical services will be delivered for the people of Tayside over the next five to ten years. The Integrated Clinical Strategy will complement the Joint Strategic Commissioning Plans of the three Health and Social Care Partnerships and provide a shared vision of how services will be configured to meet future demand.

4.2 The starting point for the Strategy is that the status quo is not sustainable. Clinical services will have to adapt to cope with the ageing population and ever greater patient needs and expectations. The future clinical model needs to shift the balance of care into the primary and community care setting whilst ensuring that high quality; safe and sustainable acute hospital services are maintained. The presumption throughout the Strategy is that changes to service configuration will streamline how our systems function and that this will translate into care provision at a lower cost; reflecting the challenges we face in terms of affordability, workforce and sustainability.

4.3 The Staging Report sets out the challenges that health and social care systems face in Tayside, and outlines the proposed strategic direction of travel for clinical services. The main points are summarised below:

- NHS Tayside will continue to promote population health, by supporting early intervention and disease prevention and the health improvement agenda;
- There will be a sustained investment in primary care services, with an increase in multidisciplinary team working as well as investment in new technology to support patient access;
- The majority of care provision will continue to be provided within the community through the strengthening of primary, community and social care teams. This will involve creating locality hubs providing health, social care and third sector services which will ensure the appropriate use of existing facilities and maintain a sustainable workforce model;
- A key priority over the clinical strategy period will be to ensure that there is a sustainable workforce across the system. Service models will need to reflect this, for example, Perth Royal Infirmary will continue to provide hospital services across the locality, including emergency services, medical services for the elderly and surgery. These service models will be developed as part of the Strategy;
- Robust clinical pathways will be put in place to ensure that the most severely injured patients are routed directly to Ninewells Hospital which will become one of four major trauma centres in Scotland and has the widest range of interdependent services on site;
- Ninewells Hospital will continue as a specialist hospital working in close partnership with the University as a teaching hospital, as well as building its reputation as a centre of excellence for innovation and research;
- Regional services will replace local services where there is a clear rationale supporting better patient outcomes and more efficient ways of working;
- There will be a bias towards investment in new technology and alternative models of care delivery rather than hospital buildings to promote self-care, such as, telecare and other digital forms of care delivery. The focus will be on patient pathways rather than physical hospital estate;
- These changes need to be made within the context of the current financial framework. The future clinical model should offer a more cost effective and lower cost method of care delivery as well as reducing the duplication of services within NHS Tayside.

4.4 Further work will be required jointly with public, patients and clinical teams to define and develop the strategic direction into options and proposals. In addition, it will be important to develop high level estimates of the potential impact of these changes on patient experience, on our workforce and our finances.

5.0 POLICY IMPLICATIONS

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

6.0 RISK ASSESSMENT

A risk assessment had not been carried out as the Integrated Clinical Strategy has yet to be developed.

7.0 CONSULTATIONS

The three Chief Officers of the Tayside Health and Social Care Partnerships, Chief Operating Officer, and Chief Executive of NHS Tayside were consulted in the preparation of this report.. The Integrated Clinical Strategy was commissioned by the Medical Director of NHS Tayside. The Staging Report updating on the work of the Strategy has been presented to and approved by Tayside NHS Board.

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 31 January 2018

Sue Muir
Programme Lead, Integrated Clinical Strategy
NHS Tayside

Appendix 1

NHS TAYSIDE AND TAYSIDE INTEGRATION JOINT BOARDS

An Integrated Clinical Strategy for Tayside

STAGING REPORT

December 2017

1. Our Task

NHS Tayside and our three Integration Joint Boards are developing an 'Integrated Clinical Strategy' to reflect the changing needs of its population, guided by [1-7]national policy drivers that focus on:

- Prevention, maintaining existing health through anticipation, co-production and self-management;
- Joined up pathways of care between primary and secondary care and between clinical services and social services.
- Enhanced community provision;
- Preventing hospital admissions or keeping them as short as possible and enabling people to go home as soon as it is appropriate;
- Safe, effective, high quality and person–centred care;
- Ensuring we have the infrastructure, workforce and organisational culture with the capacity and capability.

At the core of our work is a drive to work with people through realistic discussion on expectations and impacts of healthcare treatments, enabling people to care for themselves and care for each other in communities.

The ICS will provide a collective 'vision' of a future together that will provide a strategic guide for how changes to health and social care services will be consulted upon and ultimately delivered for the people of Tayside.

Our ICS will incorporate the co-dependencies and inter-dependencies between individual service areas and across partner organisations. It will reflect how service delivery for the future will be informed by population need, and a focus on realistic, affordable, effective and efficient ways of working. The ICS will describe the change opportunities that will map sustainable service delivery across acute care and health and social care over the next 5-10 years.

We will provide new and innovative ways of working that challenge traditional service delivery. We are working together to support new pathways of care that are built around those who need our support to maintain their lives in the way they wish to live. People needing care and support will be at the heart of decision-making as equal partners in care; informed, included.

Many of our systems are configured in a way that prevents person-centred care and treatment. Systems are set up to treat specific diseases or medical conditions and not those with a range of health care needs. Our aim is to ensure that our services can provide timely and appropriate support and treatments that avoid multiple visits to hospital sites and deliver more services at home or closer to home; moving resources out of hospitals and delivering them in our communities.

Our new pathways will address the financial and workforce challenges currently impacting on our ability to provide new models of care. By changing the way we work and collaborating to grow our workforce, we can provide care and treatment in new ways.

1.1 Our Healthcare Financial Challenge

We know that in Tayside over the next 20 years there will be more older people and at the same time, the number of young people will also increase. These changes to the make-up of our communities tell us that the demands for health and social care need to change and must look very different in future years.

Where we deliver our services must also reflect these changes. NHS Tayside is paying to maintain many properties; some are unsustainable, others unviable to be upgraded to deliver safe, modern healthcare. Working collaboratively with our partners in communities; our local

authorities, the voluntary sector, and charitable organisations; we can make more of how and where we base our care and support; hold clinics, health and well-being sessions, provide health education and focused leisure activities in centres that are locally based.

We are currently overspending the funding available to us. This means radical rethinking on how we maintain our services and keep delivering them to the highest quality. We cannot keep overspending public money in this way. The resources allocated for health and social care are precious and we need to ensure we are making best use of public funds, whilst ensuring services meet demand and expectation.

We cannot keep providing services in the way we are doing; the status quo for health and care services in Tayside is not an option.

1.2 The Change Challenge

Health and social care services do not, and cannot, stand still. Services change, grow, develop and improve, to respond to local needs. We continue to review our services and adapt and adjust to deliver safe and effective care and support.

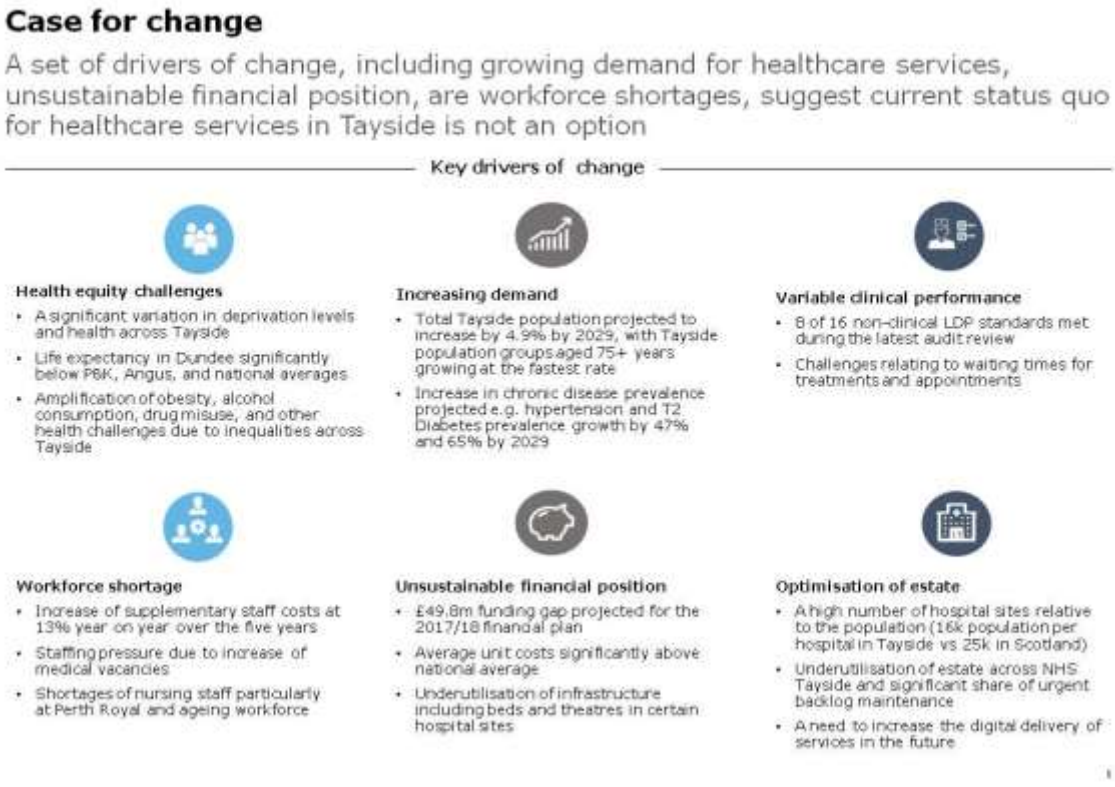
The ICS will provide an overarching framework for change. Any changes we make will be based on best evidence to provide safe and effective care, with a rationale for change supported by experienced and informed health and social care professionals, as well as our communities. Our communities will be partners in any changes we propose. Our overriding priority and our decisions will never compromise the quality of care and treatment we provide.

Changing demographics present challenges to health and social care systems as more people with complex needs and multiple conditions require health and social care support.

Unplanned hospital admissions account for a high proportion of healthcare expenditure and a reduction in these could allow a redirection of resources to enable a shift in the balance of care from in-patient to community services. Too often we resort to hospital based care as the ‘norm’ and now we will look to how care and treatment can be delivered out with hospital settings to bring them closer to communities.

Extended lengths of stay in hospital as a result of inefficient pathways, lack of seven day working and a reliance on systems that perpetuate medical only models of care, prevent opportunities for shared care between practitioners, agencies and people themselves to take a more effective and targeted focus on treatment and pathways of care.

We wish to ensure that the public are aware of the scale of change and what actions we need to consider, so we can make real progress in delivering collaborative and reconfigured services. We are developing a programme of public engagement events to share our thoughts and views, and hear the views of our communities.



1.3 Why this report

We need to clearly state our intentions as the providers and commissioners of health and social care in Tayside. We need to focus on what we can deliver and achieve more effectively through a joined up approach to provide a whole system view.

We need to identify the services we deliver that can move away from hospitals and build our community based resources. We need to look at scarce services that could be delivered in partnership with other Health Board areas and how very specialist skills and services are achieved by looking to local, regional and national centres of excellence.

We recognise that opportunities for working collaboratively have not been advanced as quickly as we would have hoped. Major reorganisation to achieve Health and Social Care Partnerships and the need to reduce costs in acute care and through IJBs, has been the priority and has focused our attention over recent months. We know that we need to do more together.

We have started that journey together through developing joint principles that support a collaborative approach to service developments. Our Vision, 'Guiding Principles' and our 'Principles for Care' have been developed from discussions with clinical teams, health and social care partners, patients, managers, educators and third sector agencies. The thoughts and views of over 800 people have been captured in key themes that reflect how we wish to work together for the future.

1.4 Our Vision and Principles

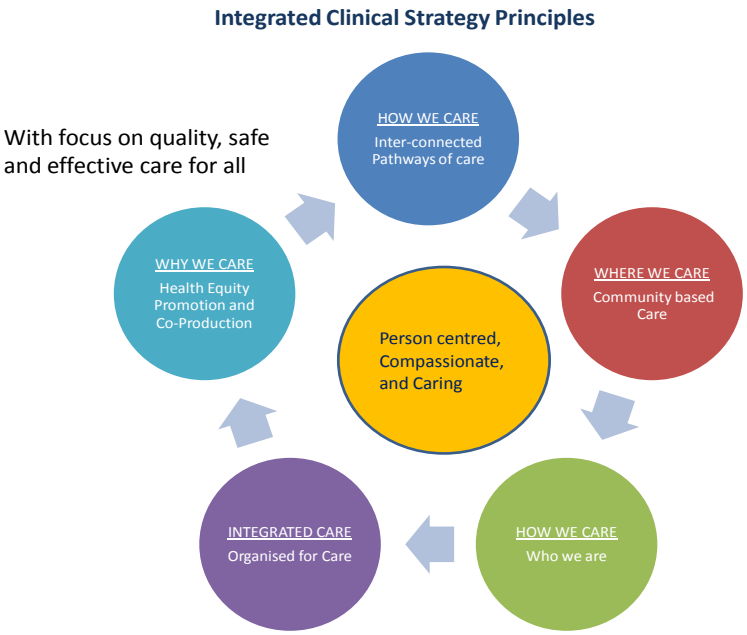
We have set out our vision for what we wish to achieve:

"***We will deliver the best possible health and social care outcomes together for everyone. We will do this by delivering clinical services where community provision is the norm, and health and care is integrated, sustainable, safe, effective and affordable."***

Our Guiding Principles

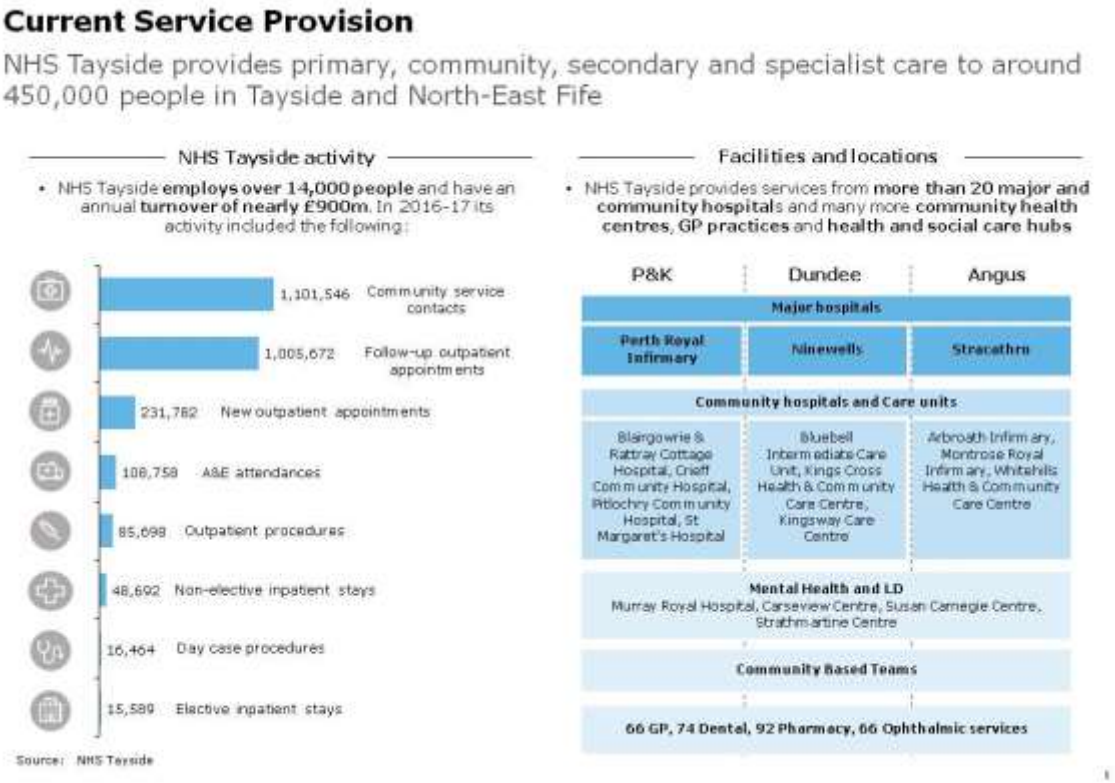
- We will make changes to reflect current and future health and social care demand
- We will manage the impact of change but where services need to change location, the reason will be clearly stated and supported by a clear rationale
- We are partners in care, with and for you
- We recognise that we can no longer deliver all services as they are currently configured and need to make changes
- We will make decisions, and confirm actions that will ensure changes are appropriate and implemented
- We will demonstrate commitment and provide clear direction and leadership to support change
- We will provide sustainable services that are future-proofed and provide continuity of care
- Our future services will be planned and not reactive
- We will provide specialist services in centres of excellence providing care in the right place at the right time to provide the best outcomes
- We will propose how hospital sites will be configured for the future to support sustainable models of care and treatment.
- We will manage the resources we have differently to sustain our ability to provide services

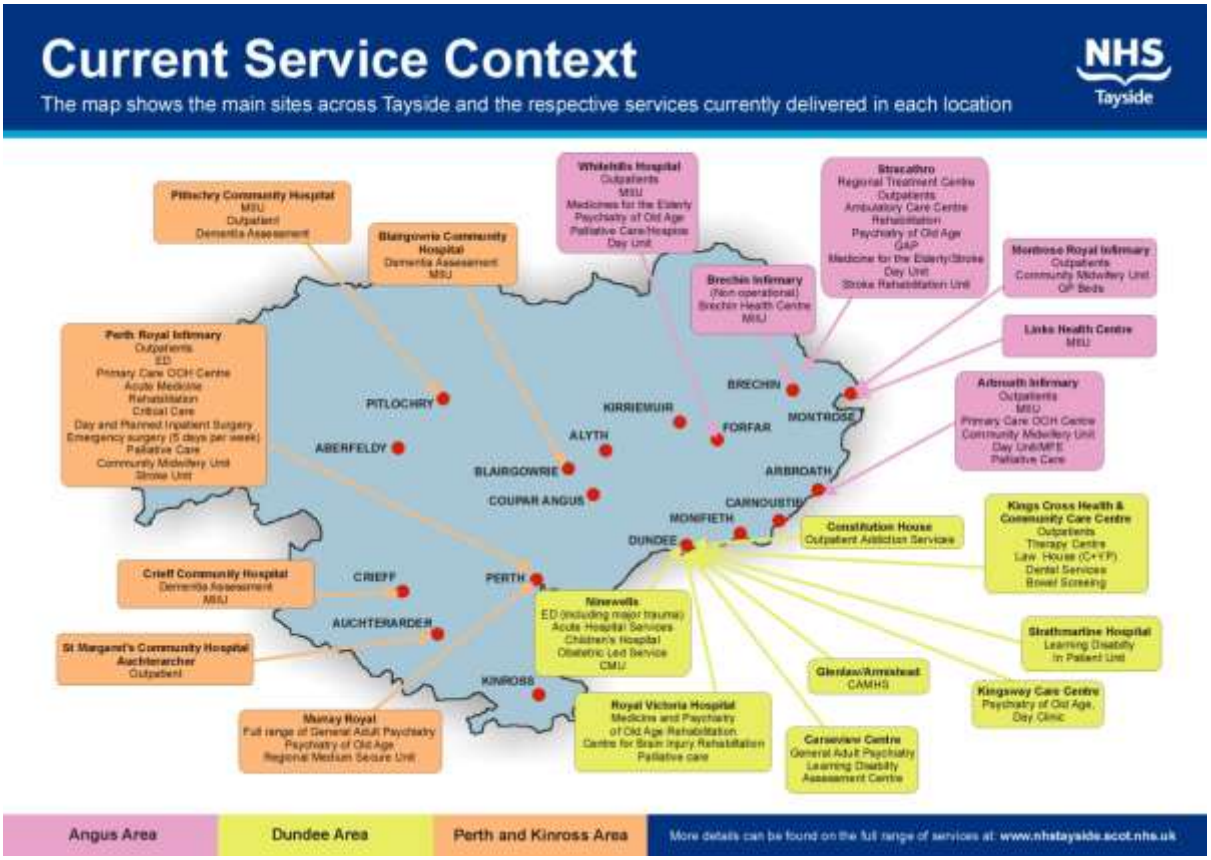
Our Principles for Care



2.0 What We Deliver

NHS Tayside and the IJB's together provide primary, community, secondary and specialist care to around 450,000 people in Tayside and North-East Fife from more than 20 major and community hospitals and many more community health centres, GP practices and health and social care hubs. Ninewells Hospital in Dundee, Perth Royal Infirmary and Stracathro Hospital are teaching hospitals. NHS Tayside employs over 14,000 people. The figure below illustrates our activity and site configuration.





2.1 Our population challenges

In order to plan services that will deliver our intentions it is vital that we understand our population challenges and their health and healthcare needs. This understanding will ensure that our strategic priorities supported by our initiatives, projects and programmes, are focused on where the greatest health gain can be made. Our population is likely to increase by 14% over the next 25 years as opposed to 8.8% for the rest of Scotland. This includes many older people living with complex and multiple conditions. We know that those who are disadvantaged often have poorer health and that is why tackling inequalities is one of our key priorities in Tayside, especially in the early years and with families. We will work with our experts in Public Health to anticipate how services need to be configured for future demand as well as ensuring that the messages of healthy lifestyles are embedded in our communities. Understanding and anticipating population health needs is essential to the planning and delivery of responsive and effective services for the future (a public health data pack is available to view on request). In seeking to respond to the variation in needs across our communities we will continue to support the principles of health equity described in our [9]NHS Tayside Health Equity strategy.

2.2 Collaborative Service Redesigns

We are already working together to ensure our services are better configured to meet demand.

Health & Social Care

Our Health and Social Care Partnerships are redesigning the way in which services are provided to people in our communities. For older people, our [8a,8b,8c]joint commissioning plans describe how we will provide health and social care services closer to home, and support people to stay in their own home for as long as possible. Where they do require hospital treatment they will be able to return to a homelike setting as soon as possible.

Primary Care Services
The delivery of modern primary and community care services is a focus for NHS Tayside and the three HSCPs. Over 90% of patients needs are met within Primary and Community care services. There is strong evidence that high quality, well-led general practice results in better and more cost effective patient care. The demographic challenges of an ageing population, with more complex multi-morbidities, combined with changing workforce, increasing shift of workload and demand means that the current model in "traditional" practices is no longer sustainable, and will not deliver a 2020 vision.

There are many demands on Primary Care services and GPs which make it difficult to deliver on all the expectations of national and local policy to deliver support to community based schemes and teams. The [10]Royal College of General Practitioners in Scotland has outlined the challenges in recruitment and retention of GPs and the need to grow our workforce and expand primary care teams, to meet demand. Through extended multidisciplinary working and workforce planning, shared learning and community based models of care, the GP as "expert medical generalist" plays a key role in the co-ordination and management of complex care. Our new service models will be supported by hospital based specialists supporting GPs in communities. Primary care teams must harness the power of working together in clusters in order to gain collective benefit from working at scale, whilst preserving the core values and nature of providing safe, accessible, person centred and effective care.

Modernising Outpatients
Work has already commenced to transform outpatient services to ensure they are effective, clinically appropriate and sustainable for the future by looking at the way we deliver services. We have identified where outpatient assessments and reviews could be delivered more locally by specialist practitioners.

Redesigning Mental Health Services
Our proposed reconfiguration of inpatient beds in Tayside will deliver and sustain more effective inpatient care. The opportunity now exists to allow us to focus on how we deliver and sustain more effective local supports for people experiencing mental health issues such as anxiety and depression through early intervention, assessment, peer support and community groups.

Shaping Surgical Services
We have recently completed a consultation on where we deliver general surgical procedures in Tayside. The proposed transformation of surgical services will create a service that allows NHS Tayside to deliver high-quality care across identified sites, and where all unscheduled surgery will be delivered 24-hours a-day on one specialist site.

Care Pathways for unplanned admissions
Unscheduled care pathways provide greater opportunity for integrated working across acute, health and social care, and primary care. A new medical model for patient admissions provides the provision of a seven day service, optimising our acute medical workforce. The model enhances supported pathways for older people in the evenings and at weekends.

3. Our Workforce

The role of our workforce is central to successful delivery of services in both health and social care in Tayside. It is through the people who work within NHS Tayside and our Health and Social Care Partnerships, their commitment, their effort, and their talent, that our service changes will be delivered. How we deploy our workforce directly influences the ongoing safety, quality and effectiveness of the care and services on which our patients rely.

We need to build the future partnerships required for a sustainable workforce. The alternatives will require all of those engaged to think differently. Current workforce planning processes,

teaching organisations, and the infrastructure for training and development need to react swiftly and collaboratively. The future profile of care providers should be based on integration as the norm, and establish a growing peripatetic workforce which captures and supports the role of the independent sector providers, social enterprise, carers and community action.

4. Working with Partners in Research and Education

Our close working with the University of Dundee, the Academic Health Science Partnership, the School of Nursing and Health Care Sciences, and the Tayside Medical Science Centre places us at the heart of how we can support future healthcare delivery in a strong partnership that positions us as an education and research centre for the future, with access to the latest and most contemporary developments and thinking in healthcare.

5. Technology

New breakthroughs in technology offer new ways to treat patients, and to support them at home. Remote consultation and telehealthcare provide opportunities for healthcare monitoring that can be interpreted centrally by experts.

6. Our Future Services

6.1 National, Regional and Local Service Delivery

NHS Tayside is one of 6 North of Scotland Boards working collaboratively to provide sustainable services through the development of a [11]Regional Delivery Plan (RDP). The RDP incorporates a number of clinically led programmes that are aligned to NHS Tayside's Integrated Clinical Strategy and will help to support the delivery of high quality sustainable services now and into the future. Initial programmes of work are building on collective and collaborative modelling, planning and service models.

The Integrated Clinical Strategy will take account of regional and national opportunities and the importance of closer collaboration between the North of Scotland Boards: Shetland, Orkney, Western Isles, Highland, Grampian and Tayside and their Health and Social Care Partners to support the sustainability of services for the future.

6.2 Our Delivery Objectives across Acute and Community Services

Working together we will deliver new and innovative health and care solutions to meet the needs of our patients and communities. Our focus will be on health equity, expanding and supporting primary care, shifting more services from hospital to communities and providing easier access to services, such as assessment and diagnostics, programmes of health and wellbeing and community support for mental health. Our intention is to:

***Radically transform our approach to improving health, wellbeing and independence, by** developing foundations for good health, tackling risks factors, not accepting the increasing profile of some conditions and diseases as something which is beyond our control, and supporting people and communities to care for themselves and each other across the life course. This will include more systematic and proactive management of chronic diseases and co morbidity in communities.

***Build Stronger Primary Care Service**
Establishing the full range of primary care based services required to support local communities, securing access to multi-disciplinary teams and a joint approach to assessment and care for all practice populations, with an early focus on joint assessment for priority care groups.

***Support Care Needs and Health at Home**
Co-producing with specialists a radical overhaul of the models of care and infrastructure required to deliver a greater proportion of anticipatory care, assessment, diagnosis, treatment and review away from the hospital and residential care settings.

***Establish a new focus on mental health**
Continuing the development of options for advice, support, and care in community settings, including the scope for a more proactive and a responsive framework for supporting people with early signs of depression and anxiety associated with key life changes.

Securing a Sustainable Acute Service
New integrated models of care will be sustained by reconfigured acute hospital services that focus on specialist procedures requiring an inpatient stay. Acute hospitals will provide care and treatment to patients with a length of stay that is proportionate to the intervention and promotes timely and supported discharge.

These themes are captured in the Health and Social Care Partnership's 'Joint Strategic Commissioning Plans 2016 – 2019'. These plans are currently being updated.

7.0 Securing a Sustainable Acute Service

We are already celebrating a number of recent successes in moving services closer to our communities and changing how traditional care models can be achieved by innovative ways of working; our work in glaucoma, moving screening to community opticians; our GP Practice based Qfit testing for bowel cancer; our iLFT testing to identify earlier those at risk of liver disease.

Liver function tests (LFTs) are frequently asked for by GPs. LFTs are often abnormal, the reasons for this being complex. Abnormal readings are frequently under investigated as a result. A proportion of these patients will progress to fibrotic liver disease leading to death or liver transplantation. This misses the opportunity to diagnose and treat liver disease at an early stage. An automated investigation algorithm developed in Tayside provides the GP with a risk assessed diagnosis and clinical advice, allowing treatment to be targeted in the community and referral to hospital only for those who will benefit the most. **Key Results:** The project shows that you can investigate all patients increasing diagnosis of liver disease by 44%, with an overall patient lifetime saving of an average £3,216 per patient.

To ensure that services for people needing hospital based treatments can be delivered with the specialist resources we have, targeted to deliver the best outcomes for patients, we need to review how acute health services are configured. We need to review where and how we deliver some procedures, and to focus our resources on options that utilise our workforce to best capacity. We have explored how the status quo is not allowing us to stand still.

We have considered how changes to the delivery of acute care could see our service configuration focused on dedicated sites for certain procedures. We have considered how, for example, whether a hospital site that deals with operations that are planned, and a hospital site that would support unplanned or an urgent need for surgery would be viable. We have concluded that our hospital sites and facilities and the needs of our patients do not fit with this simple configuration.

We believe that a mixed model of inpatient care best meets our population needs and geography, based on the facilities we have available to us, our resources and the specialist procedures we offer. This leads us to consider how we best deliver our intentions across all our main hospital sites and those services that could be delivered on a region-wide basis.

7.1 Our Future Delivery Models

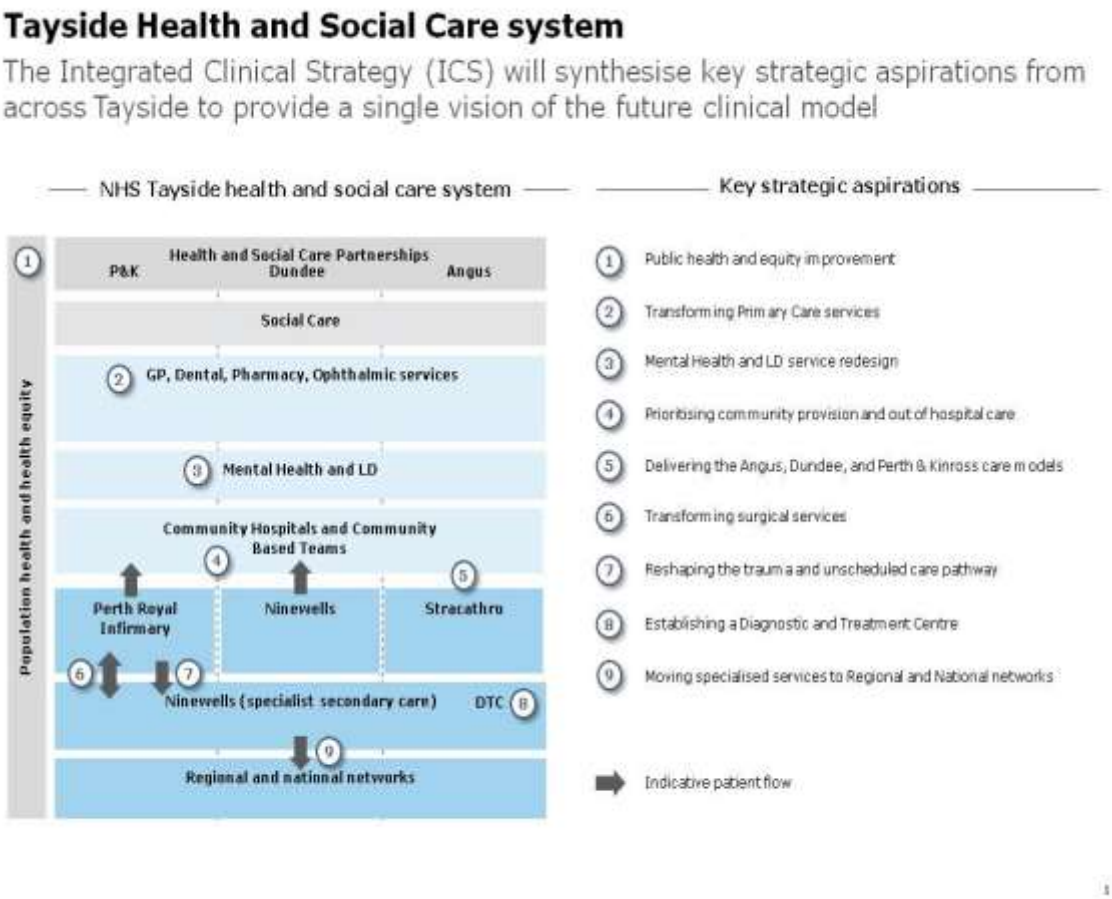
We have reviewed activity around our services, our theatres, outpatient clinics, admission units, specialist stroke care services and emergency medicine models. We believe that the best and most sustainable option is to focus our activity on clear site based models that best reflect the opportunities available to us to maintain and develop best practice and innovation for the future, including where our new robotic surgery unit is based.

We are proposing a series of changes that will start to build new models of health care across Tayside. We have started those changes with our reshaping of surgical services and this will be closely followed by changes to the way we deliver orthopaedic services; both redesigns focus on one site as a centre for complex surgery, and another as a centre for the management of traumatic and major injuries.

For stroke patients, our vision is for a 'hyper-acute' specialist centre to be developed on one site that provides expertise in early stroke management, and that has potential to carry out lifesaving specialist surgery that reduces the levels of post-stroke disability. Ultimately, this centre will be on one site with stroke rehabilitation delivered in our three localities.

We are reviewing our emergency medicine models to provide an Emergency Department response that is highly skilled, proportionate to patient need and built around our new trauma centre pathway to support those most severely injured.

The figure below sets out how a number of Tayside strategies will align to provide a new Tayside health and social care system model.



7.2 Key themes for change

The figure above represents the main themes underpinning the Integrated Clinical Strategy and a number of these are summarised below:

- NHS Tayside and the three Integrated Joint Boards will continue to promote population health, by supporting early intervention and disease prevention and the health improvement agenda.
- There will be a sustained investment in primary care services, with an increase in multidisciplinary team working as well as investment in new technology to support patient access.
- The majority of care provision will continue to be provided within the community through the strengthening of primary, community and social care teams. This will involve creating locality hubs providing health, social care and third sector services which will ensure the appropriate use of existing facilities and maintain a sustainable workforce models.
- A key priority over the clinical strategy period will be to ensure that there is a sustainable workforce across the system. Service models will need to reflect this, for example, Perth Royal Infirmary will continue to provide hospital services across the locality, and as such models of emergency service provision, medical services for the elderly and surgery are under review.
- Robust clinical pathways will be put in place to ensure that the most severely injured patients are routed directly to Ninewells Hospital which will become one of four major trauma centres in Scotland and has the widest range of interdependent services on site
- Ninewells Hospital will continue as a specialist hospital working in close partnership with the University as a teaching hospital, as well as building its reputation as a centre of excellence for innovation and research.
- There will be a bias towards investment in new technology and alternative models of care delivery rather than hospital buildings to promote self-care, telecare and other digital forms of care delivery. The focus will be on patient pathways rather than physical hospital estate.
- There is no new money, so these changes need to be made with the context of no real terms increase in funding in the medium term. The future clinical model should offer a more cost effective and lower cost method of care delivery as well as reducing the duplication of services within NHS Tayside.
- Regional services will replace local services where there is a clear rationale supporting better patient outcomes and more efficient ways of working.

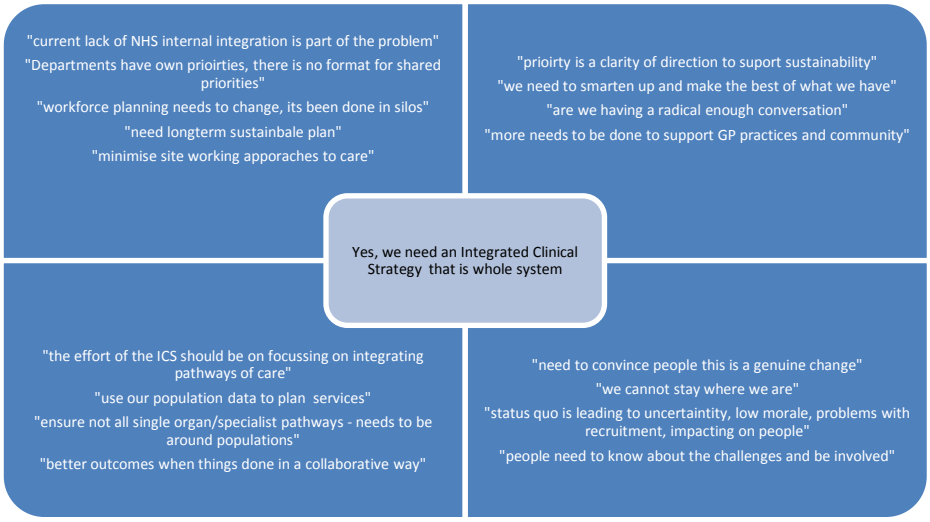
Further work is underway to estimate the impact of these changes on patient flows, bed numbers, staffing models and finances.

8.0 Priorities for Next steps

8.1 Stakeholder Communication & Engagement

Our initial stage of stakeholder engagement was with clinical staff across Tayside, we successfully met with over 80 groups and 800 key individuals. This enabled the ICS team to create a shared understanding of the challenges and have established support to work together to create change with NHS Tayside.

The diagram below gives examples of some of the views of our clinicians.



Stakeholder engagement is essential to developing new clinical care models. We know that change takes time and the messages supporting change must be consistent and clear. In relation to our internal stakeholders, we will continue to work with our clinical teams, Health and Social Care Partners, the Universities and our Transformation Programme, Organisational Development and Service Improvement teams. We will be sharing our vision and principles with those already engaged in our clinical communities to test their strength and applicability to support service change.

NHS Tayside is working in partnership with **involve**, an organisation which specialises in helping organisations to engage the public and communities in decisions which affect them. Involve are providing expert advice and guidance on the delivery of the right kind of engagement needed to develop the final published Integrated Clinical Strategy.

The work is planning for the right kind of engagement and **involve** is challenging NHS Tayside to think more strategically about its engagement and how it can be used as a powerful tool to assist strategic decision-making.

From the initial work with **involve**, including workshops with Health and Social Care Partnerships and Tayside NHS Board at its recent Board Development Day, it is clear that careful consideration must be given to the purpose, context, scope and stakeholder segmentation before deciding which methods of engagement to use and when.

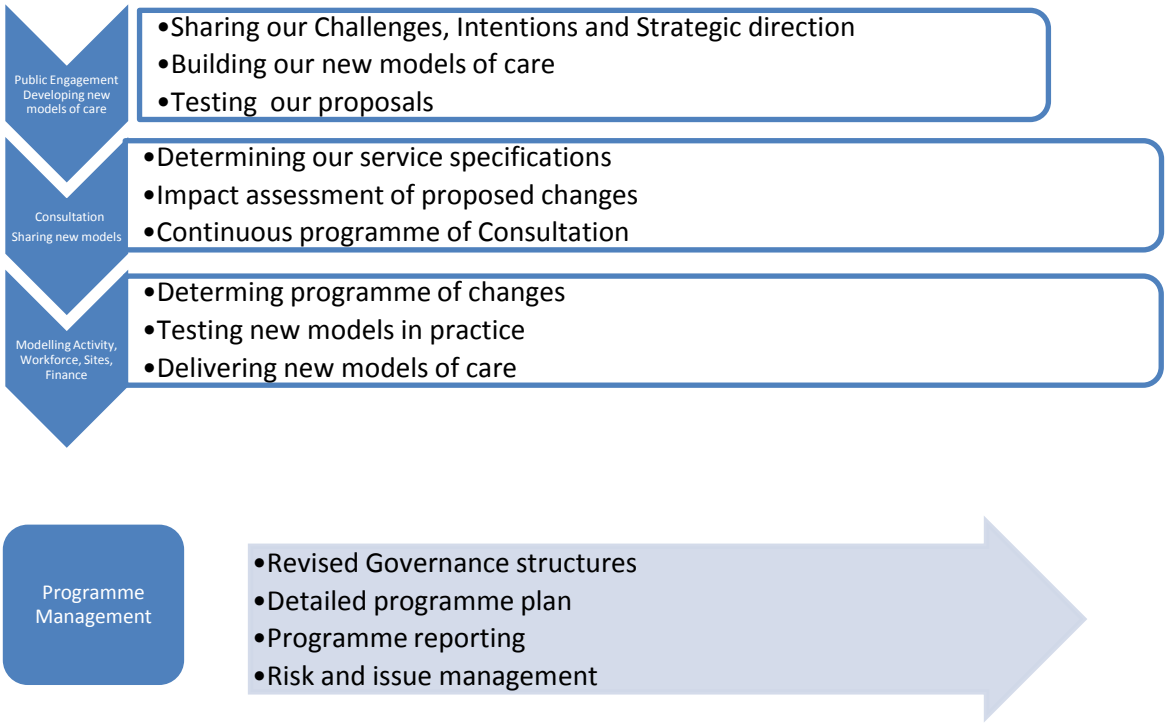
It is proposed that public engagement between January and March 2018 will be informing and awareness raising prior to the development of a plan for long term, ongoing engagement with our stakeholders about the changing models of health and social care in Tayside.

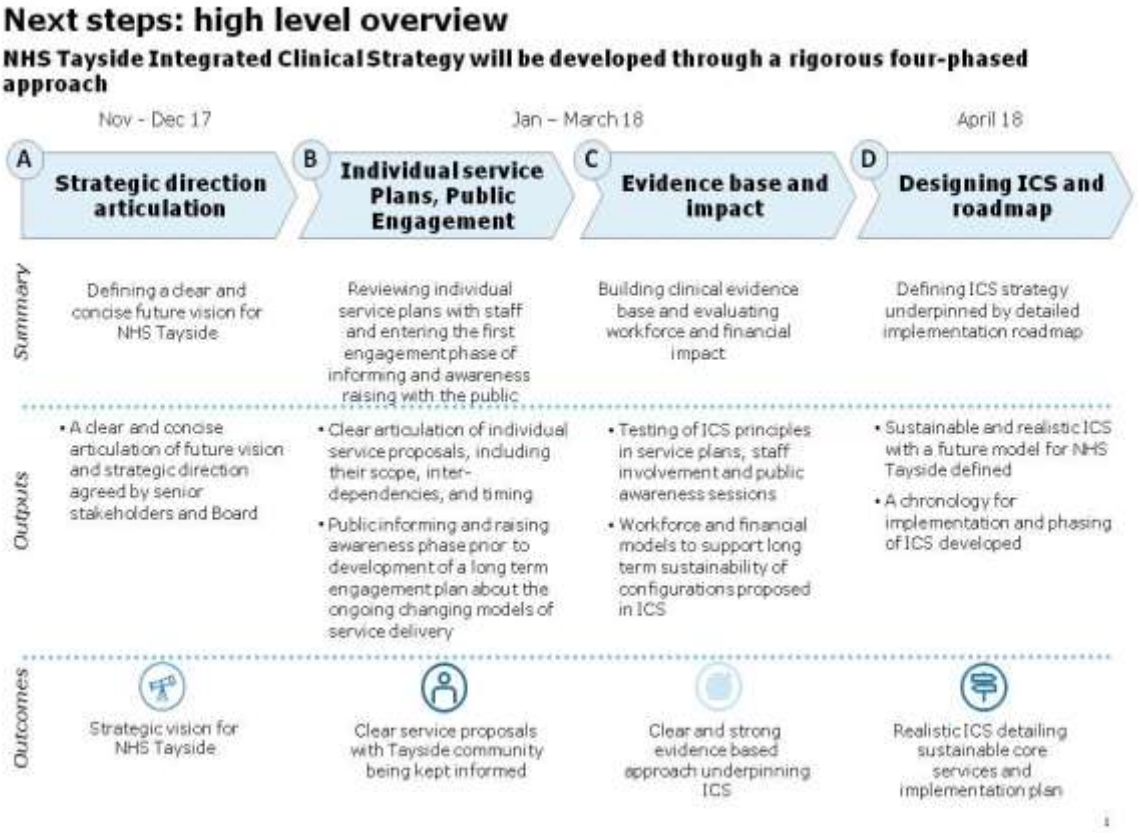
A Communications and Engagement Reference Group will be established to identify the nature and timing of public engagement which needs to be central to ongoing transformation. The reference group will have a Non-Executive Board Member as champion and will work with key stakeholders to develop an engagement plan for the Integrated Clinical Strategy and beyond.

8.2 Phase II - Staging our work – January – March 2018

Phase II of the build of the ICS will see us enhance the programme team to further develop the strategic models, underpinned by financial and workforce planning in the development of the ICS which supports the delivery of the NHS Tayside Five Year Transformation Plan.

Outline of phase II:





We will be growing our Planning Team to provide greater capacity to develop our new care pathways of care and to re-model our services. This will allow us to ensure a whole system review of service delivery and identify areas of impact.

We will work across our systems to develop new pathways of care. We will achieve this by systematic focus on service delivery and bringing those with knowledge and expertise together to achieve a collaborative approach built around the Integrated Clinical Strategy work.

We have seen the benefits of this approach in Perth & Kinross where managers and clinicians are working together across the Partnership and Perth Royal Infirmary, primary care and third sector to establish pathways that support older people at home and people to return home after a stay in hospital. The focus is on safe and effective support to older people and the system benefits are reducing lengths of hospital stay and delays in discharge.

We will test new ways of working to ensure that they are effective and that they fit with a whole system model of care. No changes will be made by partners without due consideration to the principles of the Integrated Clinical Strategy and the impact on other services.

We recognise that there is much to do to achieve our ambitions of co-produced and co-commissioned services for a more sustainable and effective future. We know that delivering more care into communities depends upon redesigning what is available in an acute hospital setting. Opportunities for regional delivery on some services will impact on our decisions for the future. This means that we need to focus on ‘what is’ and ‘what is not’ delivered by NHS Tayside and where a service is retained, where that service is delivered from.

This is a once in a generation opportunity for us to make the changes through co-production and partnership working. The case for change is compelling and through engagement we

have heard that the status quo is not an option, therefore this is an opportunity we cannot miss to make a radical shift in health and social care delivery.

1. “A Route Map to the 2020 Vision for Health and Social Care”, Scottish Government (2013)
2. “NHS in Scotland”, Auditor General for Scotland (2016)
3. “Health and Social Care Delivery Plan”, Scottish Government (2016)
4. “Realising Realistic Medicine”, Scottish Government (2017)
5. “2030 Nursing; A Vision for Nursing in Scotland”, Scottish Government (2017)
6. “Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland” (2017)
7. NHS Scotland “Quality Strategy”, Scottish Government (2010)
8a. “Joint Strategic Commissioning Plan”, Angus Health & Social Care Partnership (2016)
8b. “Joint Strategic Commissioning Plan”, Dundee Health & Social Care Partnership (2016)
8c. “Joint Strategic Commissioning Plan”, Perth & Kinross Health & Social Care Partnership (2016)
9. “Health Equity Strategy: Communities in Control”, NHS Tayside (2010)
10. “A Blueprint for Scottish General Practice”, Royal College of General Practitioners (2015)
11. “North Regional Delivery Plan”, North of Scotland Planning Group, NHS Scotland (2017)

ITEM No …6……..

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

REPORT ON: **FINANCIAL MONITORING POSITION AS AT DECEMBER 2017**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB12-2018**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board with an update of the projected financial monitoring position for delegated health and social care services for 2017/18.

2.0 RECOMMENDATIONS

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

2.1 Notes the content of this report including the overall projected financial position for delegated services to the 2017/18 financial year end as at 31 December 2017.

3.0 FINANCIAL IMPLICATIONS

3.1 The financial monitoring position for Dundee Health and Social Care Partnership based on expenditure to 31 December 2017 shows a net projected overspend position of £2,294k which is an improvement on the previously reported figures based on the October expenditure position of a £2,528k overspend. The overspend is primarily as a result of overspends in GP prescribing of £2,118k. The prescribing overspend is subject to the risk sharing arrangement outlined in the Integration Scheme whereby responsibility for meeting the shortfall in resources remains with NHS Tayside.

3.2 The current year projected overspend position is significantly less than the final outturn for delegated NHS services to Dundee IJB in 2016/17 where an overspend of £3,462k was incurred.

4.0 MAIN TEXT

4.1 Background

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

4.1.2 The IJB confirmed the overall budgeted resources for delegated services at its meeting in June 2017 following receipt of confirmation of the NHS delegated budget having already accepted Dundee City Council's budget at its meeting in March 2017. Members of the IJB will recall that risks around the prescribing budget and within services hosted by Angus and Perth & Kinross IJBs were identified. This financial monitoring position reflects the status of these risks as they display within cost centre budgets.

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

4.2 Projected Outturn Position – Key Areas

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

4.3 Services Delegated from NHS Tayside

4.3.1 Members will recall from the budget paper presented to the IJB in June that there were a number of significant risks and challenges highlighted within delegated budgets from NHS Tayside. This included a testing savings target across services as a reflection of the overall financial challenges facing NHS Tayside. The IJB has moved to deliver more savings on a recurring basis for 2017/18 with over £1.1m of efficiencies factored in to the staff costs budget to reflect turnover and vacancy management. NHS Tayside continues to develop its comprehensive Transformation Programme to deliver service efficiencies and improvement. A number of the workstreams within this programme have been applied to delegated services, which combined with local service delivery efficiencies, constitutes Dundee Health and Social Care Partnership's Transformation Programme. These efficiencies have been incorporated into service budgets where identifiable and the financial projections take into account the anticipated achievement of a number of these savings.

4.3.2 The financial projection for services delegated from NHS Tayside to the IJB indicates a projected overspend of around £2,199k by the end of the financial year.

4.3.3 A number of service underspends are noted within Community Mental Health including Drug and Alcohol services, Continuing Care, and Allied Health Professionals (AHP) primarily as a result of staff vacancies. This is additional to the staff efficiency savings incorporated into the base budget for these services and therefore provides a further contribution to achieving the overall savings target.

4.3.4 Staff cost pressures exist in a number of other services such as the Medicine for the Elderly budget and Palliative Care. The Medicine for the Elderly Budget was highlighted as a financial risk given the significant overspend associated with it. Over the last year however, this overspend has been managed downwards following reshaping of the wards at Royal Victoria Hospital and subsequent efficiencies.

4.3.5 It is anticipated that with further reshaping of services and emergence of efficiencies through NHS Tayside's Transformation Programme that overall services directly managed by Dundee Health and Social Care Partnership will balance by the end of the financial year.

4.3.6 The Family Health Services prescribing budget currently projects a shortfall totalling £2,118k. This reflects a decrease of £500k from that reported to the December IJB, based on the October 2017 expenditure to date (previously £2,618k projected overspend).

4.3.7 This decrease is mainly as a result of a refinement of the range of factors anticipated to impact on the prescribing budget by the year end (eg price changes) and the impact of a range of savings initiatives.

4.3.8 A number of initiatives continue to be developed through NHS Tayside's Transformation Programme supported by the Prescribing Management Group (PMG). The PMG function as a collaborative with delegated authority from the three Tayside IJBs and NHS Tayside Board, to allocate, monitor and agree actions to make optimal use of the prescribing budget. The PMG will deliver a whole system approach to developing prescribing action plans, implementation of prescribing projects and monitoring, identification and management of financial risks within prescribing. Dundee HSCP contributes to the PMG and will continue to explore innovative ways of safely delivering services in a more cost effective manner. Members will recall that the IJB agreed to invoke the risk sharing arrangement with NHS Tayside in relation to this budget whereby the leadership of delivery of efficiency savings within this budget remains the responsibility of NHS Tayside.

4.3.9 Members of the IJB will also be aware that Angus and Perth & Kinross IJBs host delegated services on behalf of Dundee IJB and a number of services are hosted by Dundee on behalf of Angus and Perth and Kinross. These are subject to a risk sharing agreement whereby any over or underspends are reallocated across the three Tayside IJBs at the end of the financial year. The financial monitoring position of these services in their totality are reflected in each of the IJB's financial monitoring reports and for information purposes the projected net impact of these services on each IJB's budgeted bottom line figure is noted. More detail of the recharges from Angus and Perth & Kinross IJBs to Dundee IJB are noted in Appendix 3. This shows overspends to the value of £448k being recharged with the net impact of hosted services to Dundee being £338k.

4.3.10 As outlined in Report DIJB27-2017 regarding Hosted Services Arrangements (June 2017), the financial position continues to be impacted on by the significant overspend in the Mental Health Inpatient service hosted by Perth & Kinross IJB. However, through the release of cost pressures funding and other interventions, the net share to Dundee is reduced from an initial reported figure of £500k based on the June figures to an overspend of approximately £300k based on the December outturn. Other hosted services previously highlighted as areas of financial risk such as the Out of Hours & Forensic services hosted by Angus have also seen reductions in the projected overspend for the year through a range of interventions. These will continue to be monitored closely over the remainder of the financial year.

4.4 Services Delegated from Dundee City Council

4.4.1 The financial projection for services delegated from Dundee City Council to the IJB notes a net overspend position of £95k with underspends primarily within Physical Disabilities, Mental Health and Substance Misuse services. This is mainly due to the timing of the completion of developments for accommodation based care and the original recurring revenue investment programme no longer in alignment for 2017/18. Within this overall position, a number of pressure areas continue to emerge which have been primarily met through funding for demographic pressures as part of additional social care investment, particularly for Older People's services. The financial position continues to reflect the impact of responding to the challenge of reducing delayed discharges through investment in additional capacity for care at home services and care home placements.

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

6.1 In preparing the Dundee City Integration Joint Board's 2017/18 revenue monitoring (to December 2017), the Chief Finance Officer considered the key strategic, operational and financial risks faced by the IJB for the 2017/18 financial year. In order to alleviate the impact these risks may have, should they occur, a number of general risk mitigation factors are utilised by the Integration Joint Board. These include the:-

- identified current integration funding set aside to meet any unforeseen expenditure
- system of perpetual detailed monthly monitoring enabling early identification of budget pressures and subsequent remedial work where required
- level of general fund balances available to meet unforeseen expenditure
- level of specific reserves (Integration and Transformation) to meet any unforeseen expenditure
- possibility of identifying further budget savings and efficiencies during the year
- specific underwriting of constituent bodies where overspends occur. The Integration Scheme outlines specific risk sharing arrangements whereby responsibility for meeting any shortfall lies with one of the constituent bodies.

6.2 The risks in 2017/18 revenue monitoring have now been assessed both in terms of the probability of whether they will occur and the severity of their impact on the Integration Joint Board should they indeed occur. These risks have been ranked as either zero, low, medium or high. Details of the risk assessment, together with other relevant information including any proposed actions taken by the Integration Joint Board to mitigate these risks, are included in

Appendix 4 to this report. Given the actions identified to mitigate these risks these are deemed to be manageable.

7.0 CONSULTATIONS

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

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 8 February 2018

Appendix 1

DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP - FINANCE REPORT 2017/18 AS AT Dec 2017

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Net Budget £,000	Projected Overspend / (Underspend) £,000	Net Budget £,000	Projected Overspend / (Underspend) £,000	Net Budget £,000	Projected Overspend / (Underspend) £,000
Older Peoples Services	37,892	920	14,458	-297	52,350	624
Mental Health	4,489	-199	3,386	-45	7,875	-244
Learning Disability	22,310	24	1,224	-32	23,534	-8
Physical Disabilities	6,684	-416	0	0	6,684	-416
Substance Misuse	801	-118	2,408	-132	3,209	-250
Community Nurse Services / AHP / Other Adult	421	64	11,358	-86	11,779	-22
Hosted Services	0	0	17,946	-491	17,946	-491
Other Dundee Services / Support / Mgmt	639	-181	26,142	-373	26,781	-553
Centrally Managed Budgets			-1,383	1,455	-1,383	1,455
Total Health and Community Care Services	**73,236**	**95**	**75,540**	**0**	**148,776**	**95**
Prescribing (FHS)	0	0	32,581	2,118	32,581	2,118
Other FHS Prescribing	0	0	707	-170	707	-170
General Medical Services	0	0	24,307	-137	24,307	-137
FHS - Cash Limited & Non Cash Limited	0	0	17,120	5	17,120	5
Grand Total	**73,236**	**95**	**150,255**	**1,816**	**223,491**	**1,911**
Hosted Services*			6,351	383	6,351	383
Grand Total	**73,236**	**95**	**156,606**	**2,199**	**229,842**	**2,294**

***Hosted Services - Net Impact of Risk Sharing Adjustment**

Appendix 2

Dundee City Integration Joint Board – Health & Social Care Partnership – Finance Report

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Psychiatry Of Old Age (POA) (In Patient)			4,594	175	4,594	175
Older Peoples Services -Community			501	(17)	501	(17)
Continuing Care			2,252	(550)	2,252	(550)
Medicine for the Elderly			3,625	248	3,625	248
Medical (POA)			634	0	634	0
Psychiatry Of Old Age (POA) - Community			1908	(223)	1,908	(223)
Intermediate Care			944	70	944	70
Older People Services	37,892	920			37,892	920
Older Peoples Services	37,892	920	14,458	(297)	52,350	624
General Adult Psychiatry			3,386	(45)	3,386	(45)
Mental Health Services	4,489	(199)			4,489	(199)
Mental Health	4,489	(199)	3,386	(45)	7,875	(244)
Learning Disability (Dundee)	22,310	24	1,224	(32)	23,534	-8
Learning Disability	22,310	24	1,224	(32)	23,534	-8

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Physical Disabilities	6,684	(416)			6,684	(416)
Physical Disabilities	6,684	(416)	0	0	6,684	(416)
Alcohol Problems Services			483	(32)	483	(32)
Drug Problems Services			1,925	(100)	1,925	(100)
Substance Misuse	801	(118)			801	(118)
Substance Misuse	801	(118)	2,408	(132)	3,209	(250)
A.H.P. Admin			363	(20)	363	(20)
Physiotherapy			3,265	(43)	3,265	(43)
Occupational Therapy			1,378	(38)	1,378	(38)
Nursing Services (Adult)			5,454	50	5,454	50
Community Supplies - Adult			160	(15)	160	(15)
Anticoagulation			368	(21)	368	(21)
Joint Community Loan Store			371	0	371	0
Intake/Other Adult Services	421	64			421	64
Community Nurse Services / AHP / Intake / Other Adult Services	421	64	11,358	(86)	11,779	(22)

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Palliative Care – Dundee			2,481	79	2,481	79
Palliative Care – Medical			1,008	1	1,008	1
Palliative Care – Angus			315	5	315	5
Palliative Care – Perth			1,567	87	1,567	87
Brain Injury			1,552	95	1,552	95
Dietetics (Tayside)			2,523	(160)	2,523	(160)
Sexual & Reproductive Health			1,991	(50)	1,991	(50)
Medical Advisory Service			151	(43)	151	(43)
Homeopathy			26	2	26	2
Tayside Health Arts Trust			57	0	57	0
Psychology			4,427	(465)	4,427	(465)
Eating Disorders			288	(5)	288	(5)
Psychotherapy (Tayside)			790	8	790	8
Learning Disability (Tayside AHP)			771	(45)	771	(45)
Hosted Services	0	0	17,946	(491)	17,946	(491)
Working Health Services			0	0	0	0
The Corner			394	(5)	394	(5)
Resource Transfer			8,570	0	8,570	0
Grants Voluntary Bodies Dundee			176	(30)	176	(30)
IJB Management			748	(20)	748	(20)
Partnership Funding			14,523	0	14,523	0
Carers Strategy			143	0	143	0
Public Health			473	8	473	8
Keep Well			576	(200)	576	(200)
Primary Care			540	(125)	540	(125)
Support Services/Management Costs	639	(181)			639	(181)
Other Dundee Services / Support / Mgmt	639	(181)	26,142	(373)	26,781	(553)
Centrally Managed Budgets			(1,383)	1,455	(1,383)	1,455

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Total Health and Community Care Services	**73,236**	**95**	**75,540**	**0**	**148,776**	**95**
Other Contractors						
Prescribing (FHS)			32,581	2,118	32,581	2,118
Other FHS Prescribing			707	(170)	707	(170)
General Medical Services			24,307	(137)	24,307	(137)
FHS - Cash Limited & Non Cash Limited			17,120	5	17,120	5
Grand Total H&SCP	**73,236**	**95**	**150,255**	**1,816**	**223,491**	**1,911**
Hosted Recharges Out			(10,512)	(65)	(10,512)	(65)
Hosted Recharges In			16,863	448	16,863	448
Hosted Services - Net Impact of Risk Sharing Adjustment			**6,351**	**383**	**6,351**	**383**
Large Hospital Set Aside			**21,000**	**0**	**21,000**	**0**

NHS Tayside - Services Hosted by Integrated Joint Boards - Charge to Dundee IJB				Appendix 3
Risk Sharing Agreement - Dec 2017				
Services Hosted in Angus				
	Annual Budget	Forecast Over (Underspend)	Dundee Allocation	
Forensic Service	907,129	(97,500)	(38,415)	
Out of Hours	6,767,549	70,000	27,580	
Tayside Continence Service	1,409,638	(58,000)	(22,852)	
Ang-loc Pharmacy	2,100,000	(300,000)	(118,200)	
Speech Therapy (Tayside)	963,790	(17,000)	(6,698)	
Hosted Services	**12,148,106**	**(402,500)**	**(158,585)**	
2017/18 Efficiency Target	-188,425	38,425	15,139	
Grand Total Hosted Services	**11,959,681**	**(364,075)**	**(143,446)**	
Services Hosted in Perth				
Angus Gap Inpatients	2,917,985	3,500	1,379	
Dundee Gap Inpatients	5,201,111	550,500	216,897	
Dundee Gap Snr Medical	2,130,786	114,000	44,916	
P+K Gap Inpatients	5,831,389	69,500	27,383	
Learning Disability (Tayside)	5,840,455	(125,000)	(49,250)	
T.A.P.S.	635,198	(27,500)	(10,835)	
Tayside Drug Problem Services	838,154	(42,500)	(16,745)	
Prisoner Health Services	3,557,027	90,000	35,460	
Public Dental Service	2,006,298	(85,000)	(33,490)	
Podiatry (Tayside)	2,843,310	(7,500)	(2,955)	
Hosted Services	**31,801,713**	**540,000**	**212,760**	
2017/18 Efficiency Target	-960,510	960,510	378,441	
Grand Total Hosted Services	**30,841,203**	**1,500,510**	**591,201**	
Total Hosted Services	**42,800,884**	**1,136,435**	**447,756**	

Appendix 4

Risk Assessment

Risks – Revenue Monitoring	Assessment*		Risk Management / Comment
	Original	**Revised**	
General Inflation – General price inflation may be greater than anticipated	(3/2)	(3/2)	Procurement strategy in place, including access to nationally tendered contracts for goods and services. In addition, fixed price contracts agreed for major commodities i.e. gas and electricity.
Savings – Failure to achieve agreed level of savings and efficiencies	(2/2)	(2/2)	General risk mitigation factors (reference section 6) in particular, regular monitoring will ensure savings targets are met.
Emerging Cost Pressures – The possibility of new cost pressures or responsibilities emerging during the course of the financial year.	(2/2)	(2/2)	General risk mitigation factors (reference section 6) in particular, regular monitoring to ensure shortfalls are identified as early as possible and corrective action can be taken as necessary.
Chargeable Income – The uncertainty that the level of chargeable income budgeted will be received.	(3/3)	(3/3)	General risk mitigation factors (reference section 6) in particular, regular monitoring by departments to ensure any shortfalls are identified as early as possible and corrective action can be taken as necessary.
Demographic Changes – This can lead to increased demand both in a client sense and in the contents of clients' packages. This is particularly relevant in cases where needs lead to expensive packages.	(3/2)	(3/2)	General risk mitigation factors (reference section 6), in particular, regular monitoring by departments to ensure any shortfalls are identified as early as possible and corrective action can be taken as necessary.
Specific Pressures – These include specific areas where overspends are expected. GP Prescribing; net impact of hosted services; and Family Health Services have indicated an overspend position for 2017/18.	(4/4)	(4/4)	These overspends are subject to the risk sharing arrangement outlined in the Integration Scheme whereby responsibility for meeting the shortfall in resources remains with NHS Tayside as noted in Dundee IJB's Budget Report agreed in June 2017

***Scoring recorded (Impact/Likelihood)**

ITEM No …8……..

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

REPORT ON: **PERSONALISATION PROGRAMME (SELF-DIRECTED SUPPORT)**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB3-2018**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board (IJB) with an overview of the Partnership's progress and challenges in realising the aspirations and vision of delivering Person Centred Care, under Self-directed Support legislation, through our personalisation and transformation programmes.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board:

2.1 Notes the detail of Dundee Health and Social Care Partnership's Personalisation self evaluation report as summarised in Appendix 1, as a response to the direction and recommendations reflected in Dundee Health and Social Care Partnership's Strategic and Commissioning Plan 2016-2021, Scottish Government's National Self-directed Support Strategy and Audit Scotland August 2017 Progress Report: Self-directed Support.

2.2 Instructs the Chief Finance Officer to report back to the IJB on the progress being made in achieving the actions set out in the self evaluation report to meet the recommendations detailed in the reports in paragraph 2.1 above, on behalf of the Personalisation Programme Board.

3.0 FINANCIAL IMPLICATIONS

Funding for Dundee Health and Social Care Partnership to implement and support Self Directed Support legislation equates to £108,000 per annum. This has been fully invested in the infrastructure noted in section 4.5.

4.0 MAIN TEXT

4.1 This is the first report on Person Centred Care and Self-directed Support under the umbrella term of personalisation being brought before the IJB for consideration. Dundee Health and Social Care Partnership's Strategic and Commissioning Plan sets out a range of actions to support the Partnership's ambition to improve health and social care services and improve outcomes for individuals living in Dundee. Strategic Priority 3 specifically focusses on Person Centred Care and Support, with a specific suite of actions against Self-directed Support.

4.2 The national strategy for Self-directed Support 2010-2020 is a joint Scottish Government and COSLA 10 year plan, dedicated to driving forward the personalisation of social care in Scotland. It was launched on 23 November 2010 and sought to make best use of the strengths that people, communities and the workforce have to achieve transformational change in social care provision.

4.3 Since the national strategy was launched there have been a number of significant public sector reforms, most notably health and social care integration. Integration has come at a time where there has been an increase in fiscal pressures set against an increasing demand for support and whilst considerable progress has been made in delivering person centred care and implementing Self-directed Support there remains scope for improvement.

4.4 The Social Care (Self Directed Support) (Scotland) Act 2013 was part of the national ten year strategy and came into effect on 1 April 2014. Self-directed Support provides individuals, assessed as having eligible social care needs, with a range of choice options for how their care and support arrangements can be delivered to meet their agreed outcomes. Self-directed Support involves identifying a budget for the individual's support and it encourages them to consider and decide how much ongoing control and responsibility they want over their own support arrangements. It is an approach which is designed to bring about independence and choice for people with care or support needs.

4.5 Infrastructure

4.5.1 Funding has been provided by the Scottish Government to support the implementation of Self-directed Support. This funding will enable the establishment of a small dedicated, but time limited, self-directed support team to support an increase in the uptake of SDS option 1 (a direct payment) and option 2 (directing the available support). The team will also provide a mentorship role to the wider workforce.

4.5.2 In order to ensure that direct payment recipients, choosing to employ their own personal assistants, were able to pay their staff the living wage an uplift in the hourly direct payment rate was recently applied. The increase in the new hourly rate was the same as the percentage increase applied to our commissioned Care at Home Providers. Any agreed subsequent rises in the living wage will be automatically reflected in the direct payment hourly personal assistant employee rates and should meet any auto enrolment pension requirements.

4.5.3 Over the past three years there has been a 12% overall increase in the financial amount paid in direct payments. In 2016/17 £1,079,655 was paid to direct payment recipients.

4.5.4 Following the launch of the national strategy and the implementation of the Social Care (Self-Directed Support) (Scotland) Act 2013 it was recognised that Dundee required to embark on a significant change programme if the requirements set out in the new legislation and the aspirations in the national strategy were to be met.

4.5.5 A Personalisation Project Board and Delivery Team were set up to oversee this work and a project plan was developed setting out a number of work-streams, crucial to supporting whole system change programmes with lead officers identified.

4.5.6 The work-streams include the following:

- Workforce planning and development
- Commissioning and Procurement
- Outcome focussed assessment and support planning
- Resource allocation release framework, and
- Communication and Involvement

4.5.7 The local infrastructure to support the implementation of Self-directed Support has been subject to both internal and external scrutiny and it is this scrutiny that has over the past few years helped inform and direct continued investment and development with the aim of improving not only the quality of the lives of those who require support, but also improve performance as reported through the Local Government benchmarking information.

4.6 The findings from an Internal Audit Report No 132-2017 on Self-directed Support was brought before the Council's Scrutiny Committee on 19 April 2017. The scope and objectives of the internal audit were to "review the Council's approach to fulfil the legislative requirement that authorities should offer those with eligible needs, greater choice and control over the support

required to meet their needs." The principal conclusion drawn from the review was that whilst there was basically a sound system of control, there were some areas where it was viewed improvements could be made and this was primarily in relation to the time period for reminder letters requiring to be formally determined and service users monitoring procedures in relation to the financial monitoring forms, including accelerating the issue of reminder letters, should be followed. Action to address these issues have since been implemented.

4.7 At the time of the audit fieldwork there were 5,726 clients receiving care under SDS; the vast majority having selected option 3 where the local authority arranged the services on the service user's behalf.

4.8 The Scottish Government National Self-Directed Support Strategy - Implementation Plan 2016-2018 (attached as Appendix 3) essentially took stock of what had been achieved nationally and set out four key strategic outcomes required to successfully implement self-directed support and these are:

- Supported people have more choice and control
- Workers are confident and valued
- Commissioning is more flexible and responsive
- Systems are more widely understood, flexible and less complex.

4.9 Furthermore, the Audit Scotland August 2017 Progress Report: Self-Directed Support also recognised the challenges Partnerships had experienced in implementing self-directed support and explicitly highlights that there was an underestimation of both the scale of change and challenges required in implementing Self-directed Support and that some of the challenges could not have been foreseen in the early years of the strategy. This report also recognised and to an extent echoed what the Scottish Government Self-directed Support Strategy - Implementation Plan 2016-2018 had set out as required further actions for successful implementation within its key strategic objectives. A summary of the key messages and recommendations is attached as Appendix 2.

4.10 Dundee Health and Social Care Partnership's approach through the Personalisation Project Board and Delivery Group has been to take the recommendations and actions from both of these reports along with the recommendations from the Internal Audit report and identify and progress a number of actions, the most significant of these being:

- **Conducted a Staff survey:** This involved all Care and Assessment Teams aligned with the Health and Social Care Partnership including integrated teams. A series of questions were designed to inform us about the workforce's levels of confidence in relation to offering self-directed support and their understanding of the current processes in place across the service.

- **Commissioned a Third Party Money Management Service:** this was developed in partnership with the independent support service we commission in order to support people who wished to direct and manage their own care and support arrangements, but who may struggle with, or would be unable to undertake the range of financial requirements in managing a direct payment.

- **Developed Outcome Focussed Assessment Processes:** the approach to assessment has been completely changed by moving to a participative outcomes approach.

- **Enhanced Information Technology Systems:** the implementation of the new electronic client management system (MOSAIC) for health and social care services has been configured to provide improved processes to support staff in navigating the various SDS options and to provide quantitative performance information in relation to SDS for the first time.

- **Developed E-Learning:** in partnership with the neighbouring Health and Social Care Partnerships an E-Learning personalisation module has been developed and this is

currently being tested across all three partnerships to support the Partnership workforce as well as the wider NHS Tayside workforce.

- **Facilitating Market Development:** Dundee Social Enterprise Network has been commissioned to help develop social micro providers within the marketplace to provide a wider range of support options under Self-directed Support option 2.

- **Production of a Charter Mark**: a good employer Charter Mark for individuals who are employing their own person assistants is being co-produced.

- Investment in Supporting Infrastructure: a small Self-directed Support delivery team has recently been created to take forward a number of initiatives and to ensure the personalised approach is embedded in practice.

- **Developed a Personalised Budget Allocation System:** an equivalency model has been developed to support the appropriate allocation of resources to service users in relation to their personalised budget.

4.11 Although much has been achieved over a relatively short period of time it is recognised that some significant tasks remain. The Audit Scotland report noted "*Authorities are experiencing significant pressures from increasing demand and limited budgets for social care services. Councils' total spending on all services decreased by five per cent in real terms between 2011/12 and 2015/16. At the same time, their spending on social work services alone increased by 8.6 per cent."*

4.12 The Audit Scotland Report outlined a checklist that councillors and board members may wish to consider in seeking assurance about progress in implementing self-directed support in their council or integration authority. This is attached at Appendix 1 with an assessment of the current position from a Dundee perspective noted alongside required actions.

4.13 In this context the Partnership needs to continue to implement change in how services are commissioned to enable people to have choice, control and flexibility over their supports and more significantly their lives. This includes developing long term commissioning plans which will be transformational in that they are different from current service provision and continue to test the market place to seek creative, local solutions and options for people and the communities they belong to

5.0 POLICY IMPLICATIONS

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

6.0 RISK ASSESSMENT

This is a mandatory field and an explanation must be provided which covers the fields below. Please fill in and copy this table for each individual risk identified.

Risk 1 Description	We will not achieve our Strategic Priority to deliver Person Centred Care or meet our statutory duty, as set out in the Social Care (Self-directed Support) (Scotland) Act 2013, to offer individuals assessed as having eligible social care needs with a range of choice options for how their care and support arrangements can be delivered to meet their agreed outcomes.
Risk Category	Operational, Legal, Workforce and Governance
Inherent Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (High)
Mitigating Actions (including timescales and resources)	• Develop a robust and deliverable action plan which incorporates the actions required set out in the self-evaluation appendix 1. • Personalisation Board tasked with monitoring and evaluating progress of delivery plan
Residual Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (Moderate)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (Moderate
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable

7.0 CONSULTATIONS

The Chief Officer and Head of Service - Health and Community Care were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 7 February 2018

Avril Smith Hope
Senior Manager
Transformation Programme & SDS Lead

Audit Scotland Self-directed Support **Appendix 1**

Checklist for Councillors and Board Members

How users, carers and families experience self-directed support in our authority

Questions for consideration	Assessment & Self Evaluation	Required Action
Do we now offer self-directed support (SDS) to all eligible people when we assess or review their social care needs?	Yes – this is a fundamental element of the assessment process.	
• In what circumstances are people not offered the four SDS options?	When people are not eligible we sign post or refer them onto community supports and direct them to the Mylife on-line information portal. When it is a short-term service or intervention that has been put in place (eg enablement) Or When there are significant risks which would place the person at risk	Review option to either continue investment with current on-line information portal – Mylife or plan for disinvestment with suitable replacement through further development of the new MOSAIC care management system information portal.
•What are we doing to give these people more choice and control?	Ensure that through the assessment and personal planning processes we are identifying actions to reduce risk factors and open up all four options.	Introduce a Third Party Money Management Service to support people who would struggle with the business end of managing a direct payment, but who are able to direct their care arrangements.

How users, carers and families experience self-directed support in our authority

Questions for consideration	Assessment & Self Evaluation	Required Action
How many people do we support, how many people have been offered the SDS options, and how many people have chosen each option? • How do we expect these numbers to change in future, and why?	At the time of the internal audit there were 5,726 people receiving care under SDS although the majority of those continue to receive services arranged by the local authority (SDS Option 3) We are looking to increase the number of people selecting option 1 and 2 and we are looking for a decrease in option 3. Introduce support which reduces barriers for people e.g. - Third Party Money Management Service, Chartermark, review and improve current resource allocation process, continue to invest in staff development opportunities, continue to invest in developing the marketplace	Full commissioning of the Third Party Money Management Service Carry out a review of the flexibility of the funding allocation process Continue to support the development of micro businesses
How do we involve service users, carers and providers to help design more flexibility and choice into support options? • What do they tell us about how we could improve?	Historical examples available: • Providers Personalisation event we hosted. • Mental Health Short Breaks Public Social Partnership as a good example of involvement with carers, service users and providers • Focus Groups we set up for testing out ideas and hearing suggestions.	Further engagement with service users and carers is required to be taken forward by the newly established SDS Implementation team

How users, carers and families experience self-directed support in our authority

Questions for consideration	Assessment & Self Evaluation	Required Action
Have we reviewed our assessment and support planning processes to make them simpler and more transparent? • What do users and carers think about the processes?	Yes – as part of the introduction of the new MOSAIC IT client management system all such processes have been mapped and simplified. This has not as yet been assessed	SDS Implementation team to develop consultation and engagement options
Have we reviewed our processes for supporting children to transition into adult services? • Have we jointly agreed improvement actions between children's and adult services?	This is currently to be developed. The SDS implementation plan covers both children and adults services	SDS Implementation team to review transition processes
Have we reviewed the information and help we offer to people during assessments, reviews and planning discussions? • Do people understand our information? Does everyone who needs it get it? Do they get it at the right time? • How have we involved users, carers and providers in reviewing the information and help? • Do we offer people independent advice and advocacy when they need it?	No formal review has taken place to date No assessment has taken place to date No assessment has taken place to date Yes – this is carried out through externally commissioned advocacy and support services	SDS Implementation team to develop consultation and engagement options As above

How users, carers and families experience self-directed support in our authority

Questions for consideration	Assessment & Self Evaluation	Required Action
What difference is SDS making to people's personal outcomes?	There are individual examples of the positive impact SDS is having on people's personal outcomes however there has been no formal review carried out at this stage	SDS Implementation team to develop review framework to provide overview of the impact of SDS on personal outcomes
• How do we record and monitor this so that we know if things are improving across the board?	The new MOSAIC IT client recording system will assist in gathering and reporting on the outcomes for individuals	
• How are we using this information to plan future SDS processes and services?	This is currently not sufficiently evidenced to provide a good assessment of needs and gaps in processes or services	As above – then take learning into Strategic Planning and Commissioning intentions

Supporting social work staff to implement SDS

Questions for consideration	Assessment & Self Evaluation	Required Action
Do all our social work staff feel they have the time, information, training and support they need to be able to identify and plan for people's personal outcomes?	Generally staff feel positive around taking forward SDS however some concerns raised around complex processes and associated paperwork and the need for refresher training	Implementation of MOSAIC case management system, development of e-learning modules and the establishment of the SDS implementation team will assist with this. Further series of staff development events to be arranged during 2018 with specific Direct Payment learning events to be established on a rolling programme of 2/3 times a year
Do all our social work staff fully understand outcomes? • Are they confident about working with personal outcomes? • Have they had sufficient training?	From the staff survey, there is a general sense that they do however this needs to be expanded to an integrated workforce Yes – a significant training programme on developing outcomes has been underway for a number of years	Further development of Personal Outcomes learning opportunities are required to ensure a holistic outcomes approach is undertaken As above
Do our behaviours and processes encourage and support social work staff to develop innovative solutions to meet individual needs flexibly?	There is some evidence of this however not established across all service areas	Further develop and embed SDS processes within MOSAIC IT system Further develop the range of options available to meet the needs of service users through contract with Dundee Social Enterprise Network and though development of tri-partite contractual agreement in relation to SDS Option 2

Questions for consideration	Assessment & Self Evaluation	Required Action
Do social work staff have sufficient guidance and support on how to balance innovation, choice and risks with service users and carers?	There is some evidence of this however not established across all service areas	Review operational guidance and procedures in relation to SDS options 1 & 2 Provide support to managers to develop a range of outcome focussed commissioning approaches and arrangements

Monitoring and planning progress in SDS implementation

Questions for consideration	Assessment & Self Evaluation	Required Action
Do we regularly review our progress in implementing SDS? • Do we review progress against our SDS implementation plans? • Do we monitor and report on the SDS options chosen by people, ensuring this data is accurate and consistent? • Do we monitor and report on whether people's personal outcomes are being met with SDS?	This is mainly carried out through the Personalisation Project Board. Some information is presented to the Performance and Audit Committee and IJB through annual and mid-year performance reporting. Assessment of whether SDS is meeting personal outcomes is made by care managers as part of regular reviews however no formal reporting mechanism developed	Reporting on SDS progress to be highlighted within H&SCP performance monitoring reports to the PAC, with separate reports developed as required by PAC
Do we use national information, reports and tools to help us improve how we are implementing SDS?	Yes – through the national SDS leads network and benchmarking information and Scottish Government and Audit Scotland reports	Analysis of national information and learning from other areas has influenced the tasks reflected in the local action plan and range of developments noted in the main report This will continue to be a priority in improving local performance
Do our strategic commissioning and related plans show: • how more choice and control will be achieved for service users? • how decisions will be made about re-allocating resources from one type of service to another in response to people making their SDS choices?	Yes – Person Centred Care and Support is one of the IJB's Strategic Priorities as set out in its Strategic and Commissioning Plan. This highlights the changes in financial planning to transition the shift from the current use of resources to free up funding for increased individual self-directed packages of support	Ensure review of Strategic and Commissioning Plan continues to provide a focus on increasing choice and control in the development of services to meet outcomes

Monitoring and planning progress in SDS implementation

Questions for consideration	Assessment & Self Evaluation	Required Action
Are we using flexible contractual arrangements that give supported people and providers the opportunity to be flexible about support? • Have we involved users, cares and providers in developing this? • If we do not have outcomes-focussed contractual arrangements, how are we giving supported people flexibility, choice and control.	Good progress has been made however current arrangements do not provide the full flexibility required for service users	Continue to develop the Tri-Partite contractual agreement for Option 2
Are we working with communities to develop alternative services and activities that meet local needs? • How are these community-based services and activities helping to support people? • Are there opportunities to develop more community-based services and activities?	This has partly been achieved through the investment in Dundee Social Enterprise Network and extensively through the Reshaping Care for Older People and Integrated Care Fund programmes where building community capacity and alternative supports have been fundamental priorities	Continue engagement through the emerging locality based model of integrated care services to identify the range of services necessary to meet local needs.

Appendix 2

AUDIT SCOTLAND REPORT – SELF DIRECTED SUPPORT 2017 PROGRESS REPORT EXTRACT

Key messages

1 Our evidence shows many examples of positive progress in implementing SDS. But there is no evidence that authorities have yet made the transformation required to fully implement the SDS strategy. Most people rate their social care services highly and there are many examples of people being supported in new and effective ways through SDS, but not everyone is getting the choice and control envisaged in the SDS strategy. People using social care services and their carers need better information and help to understand SDS and make their choices. More reliable data is needed on the number of people choosing each of the SDS options. Data should have been developed earlier in the life of the strategy in order to measure the progress and impact of the strategy and legislation.

2 Social work staff are positive about the principles of personalisation and SDS but a significant minority lack understanding or confidence about focusing on people's outcomes, or do not feel they have the power to make decisions with people about their support. Front-line staff who feel equipped, trusted and supported are better able to help people choose the best support for them. What makes this possible for staff is effective training, support from team leaders or SDS champions, and permission and encouragement from senior managers to use their professional judgement to be bold and innovative.

3 Authorities are experiencing significant pressures from increasing demand and limited budgets for social care services. Within this context, changes to the types of services available have been slow and authorities' approaches to commissioning can have the effect of restricting how much choice and control people may have. In particular, the choices people have under option 2 are very different from one area to another. Authorities' commissioning plans do not set out clearly how they will make decisions about changing services and re-allocating budgets in response to people's choices.

4 There are tensions for service providers between offering flexible services and making extra demands on their staff. At the same time, there are already challenges in recruiting and retaining social care staff across the country owing to low wages, antisocial hours and difficult working conditions.

5 SDS implementation stalled during the integration of health and social care services. Changing organisational structures and the arrangements for setting up, running and scrutinising new integration authorities inevitably diverted senior managers' attentions. Some experienced staff are also being lost through early retirement and voluntary severance schemes as the pressures on budgets mount.

Recommendations

Directing your own support

Authorities should:

• work in partnership with service users, carers and providers to design more flexibility and choice into support options
• review their processes for supporting children to transition into adult services.

The Scottish Government, COSLA, partners and authorities should:
• continue working together to develop:
— the accuracy and consistency of national data on the number of people choosing each SDS option
— methodologies to understand the impact of SDS on people who need support and their carers.

Assessing needs and planning support

Authorities should:

• provide staff with further training and help on identifying and planning for outcomes
• work with service users and carers to review their assessment and support planning processes to make them simpler and more transparent
• establish clear guidance for staff on discussing the balance between innovation, choice and risks with service users and carers and implementing local policies in practice
• support staff in applying professional judgement when developing innovative solutions to meet individual needs flexibly
• ensure they are providing information on sources of support to those who are accessing SDS
• work with service users, carers and providers to review the information and help they offer to people during assessments, reviews and planning discussions.

Commissioning for SDS

Authorities should:

• develop longer-term commissioning plans that set out clearly how more choice and flexibility will be achieved for local service users and how decisions will be made to re-allocate money from one type of service to another
• work with service users, carers and provider organisations to develop more flexible outcome-focused contractual arrangements
• continue to work with communities to develop alternative services and activities that meet local needs.

Implementing the national SDS strategy

Authorities should:

• develop targeted information and training on SDS for healthcare professionals who have a direct or indirect influence on people's health and social care support
• monitor and report the extent to which people's personal outcomes are being met and use this information to help plan for future processes and services.

The Scottish Government, COSLA and partners should work together to:

• review what independent information, advice and advocacy people will need in future, and how that should be funded after current Scottish Government funding for independent organisations comes to an end in March 2018. This review should fully involve users, carers, providers and authorities, and should conclude in time for appropriate action to be taken
• agree how any future financial support should be allocated, taking into account how authorities' local commissioning strategies will inform future spending priorities
• seek solutions that address the problems of recruitment and retention in the social care workforce
• ensure that the requirement to effectively implement SDS is reflected in policy guidance across all relevant national policies, such as health and social care integration, community empowerment, community planning, housing and benefits
• routinely report publicly on progress against the 2016-2018 SDS implementation plan and the SDS strategy.

The Scottish Government should:

• report publicly on the outcomes it has achieved from the almost £70 million funding it has committed to support implementation of SDS.

Healthier Scotland
Scottish Government

Appendix 3

2010-2020

Self-directed Support Strategy

Implementation Plan 2016-2018

COSLA

“Self-directed Support can let you do your absolute favourite things and lets you live the life you want.

Lewis Drummond, 19

Foreword

When he was four, my son Lewis was diagnosed with moderate learning difficulties and hypotonia (decreased muscle tone). Lewis always had an avid interest in music and singing – musical instruments and nursery rhymes always held his attention when not much else would. When he was growing up we took him to all the free music events we could – bagpipe championships, choirs and hymns at church. But as a teenager Lewis needed more in his life than his family and school, and that's when his social worker introduced him to Self-directed Support and the Community Brokerage Network.

Self-directed Support has been crucial in helping Lewis excel in his talent and experience many new things. He has learned so much over the last couple of years, not just musically but socially too.

Information, advice and encouragement from the Brokerage Network helped to match opportunities to Lewis' individual wishes and interested. They played a huge part in this success for Lewis.

Lewis now attends the Royal Conservatoire of Scotland with a support worker. This gives him time away from the family environment with peers who have much the same interests. Lewis can finally have meaningful conversations about in-depth classical music notations, scales and compositions. His musical composition lecturers commented on how much he has matured over the last year, that he is more able to listen and he is calmer.

Gillian Drummond,
Kilmarnock

I would like to see my pieces being performed by a band or orchestra. I would like to go to the Royal Conservatoire of Scotland full time – although I don't know what Ayrshire college would do without me! I still need to learn important things in college like following the law and learn how to do a job, hopefully in music. I'm hoping to learn to go out by myself and how to look out for traffic without any help. My main wish is to go to RCS full time.

Lewis Drummond, 19

Introduction

What is Self-directed Support?

Self-directed Support allows people, carers and families to make informed choices about what their social care support is and how it is delivered. It aims to empower people to be equal partners in their care and support decisions and to participate in education, work and social life.

Local authorities have a legal duty to offer people who are eligible for social care four options about how their care and support is delivered. Local authorities must also ensure they have access to support to help them make informed choices. The options are (1) a Direct Payment (a cash payment); (2) funding allocated to a provider of your choice (sometimes called an individual service fund, where the council holds the budget but the person is in charge of how it is spent); (3) the council can arrange a service for you; or (4) you can choose a mix of these options for different types of support.

The principles of choice and control should apply to any assessment process, contact with universal public services and engagement with voluntary organisations about care and support.

You can find out more on the dedicated Scottish Government information site www.selfdirectedsupportscotland.org.uk.

The Self-directed Support Strategy

The National Self-directed Support Strategy 2010-2020 is a joint Scottish Government and COSLA 10-year plan, dedicated to driving forward the personalisation of social care in Scotland. In the first phase of the strategy, from 2010-2012, we developed information to promote understanding of Self-directed Support. The second phase, 2012-2016, was focused upon development of the Social Care (Self-directed Support) (Scotland) Act 2013, guidance, and supporting innovation. We have now reached the third phase, and there is still a lot more to do.

A wide set of public service reforms have been taken forward since the Strategy was launched in 2011, most notably health and social care integration. Set in this context, the priority for 2016-2018 is to **consolidate the learning** from innovative practice and the application of guidance; and to embed Self-directed Support as Scotland's mainstream approach to social care. Since 2011 Scottish Government has invested £58.8m in facilitating this transition.

> People must be empowered to make choices and have greater control over their lives. Our shared journey to creative and flexible support has started, but we need to continue to work together to make this a reality for everyone.
>
> **Aileen Campbell, Minister for Public Health and Sport**

Thousands of people across Scotland have worked tirelessly to create the changes that have already been achieved. This includes people from disabled peoples' organisations, social care providers, independent support and information organisations, local authorities, health boards, regulators, and of course people who use social care services and support.

The Scottish Government, COSLA, Self Directed Support Scotland (SDSS), Social Work Scotland, Scottish Social Services Council (SSSC), Coalition of Care and Support Providers in Scotland (CCPS), Care Inspectorate, Scottish Care and Healthcare Improvement Scotland have worked together to produce this plan; and we will continue to work together to deliver the actions.

> Councils and their integration partners are committed to reforming health and social care services and changing the way we think about care and support. We want to build on people's strengths and I'd encourage all stakeholders to support this by focusing on how they can help deliver the outcomes set out in this plan.
>
> **Councillor Peter Johnston, COSLA Health and Wellbeing spokesperson**

About this plan

This implementation plan reinforces the human rights based values and principles enshrined in the Social Care (Self-directed Support) (Scotland) Act 2013.

Values	Principles
Respect	Involvement
Fairness	Collaboration
Independence	Informed Choice
Freedom	Participation
Safety	Dignity

The content of this plan is drawn from evidence produced in the first two phases of the strategy, practice evidence and analysis of 18 months of engagement activity.

Renews our vision that:

The lives of people who require support are enriched through greater independence, control, and choice. This leads to improved or sustained health and wellbeing, and the best outcomes possible.

Self-directed Support is the mainstream approach by which we deliver social care and support, ensuring people can make real informed choice which enables them to achieve their identified outcomes.

Set against four **strategic outcomes**, this plan sets out what has started to change, what national partners will do during 2016-2018 to address the **challenges** that have been identified, and what success will look like. It ends with how we will evaluate impact.

Who is the plan for?

This plan is for people who believe in the values and principles of Self-directed Support and must continue to make the changes necessary to realise the vision. It should be read by people leading strategic change within health and social care partnerships, social workers, people who manage social care services, care workers, supported people, commissioners of social care support, organisations providing information and advice, centres for inclusive living, allied health professionals, unpaid carers and those working in national organisations that support improvement in, and provide regulation of, the social care workforce and services.

Your action counts

The vision and strategic outcomes will not be realised through the actions in this plan alone. It will take the commitment of many more partners working collaboratively within local communities and nationally to achieve this. There is a key role for local authorities who hold many statutory duties under the Self-directed Support Act 2013. They will continue to take a lead role in collaborating with a full set of local partners, including the arrangements put in place with NHS Boards for integrated health and social care, to drive the changes necessary within their local authority areas to deliver the strategic outcomes and realise the vision in this plan.

To date there has been considerable innovation driven by voluntary organisations and local communities, working together with statutory partners. Learning from this and creating more of it will make a significant contribution to the success of this plan.

While the actions detailed in this plan will be led by the named partners, your contribution to this work is essential. You will find details of how you can get involved on our website.

You can also share practical tools, stories of change, and evidence of what you are doing by sending them to us.

Website: www.selfdirectedsupportscotland.org.uk
Email: selfdirectedsupport@gov.scot
Twitter: @SG_SDSPolicy

Strategic Outcomes

The following **strategic outcomes** relate to the ambitions of the Self-directed Support Strategy and set out the changes we want to see in making Self-directed Support a reality. These outcomes contribute to all of the Health and Wellbeing Outcomes.

1 Supported people have more choice and control

Citizens are engaged, informed, included and empowered to make choices about their support. They are treated with dignity and respect and their contribution is valued.

2 Workers are confident and valued

People who work in health and social care have increased skills, knowledge and confidence to deliver Self-directed Support and understand its implications for their practice, culture and ways of working.

3 Commissioning is more flexible and responsive

Social care services and support are planned, commissioned and procured in a way that involves people and offers them real choice and flexibility in how they meet their personal outcomes.

4 Systems are more widely understood, flexible and less complex

Local authorities, health and social care partnerships and social care providers have proportionate, person-centred systems and participatory processes that enable people who receive care and support live their lives and achieve the outcomes that matter to them.

Challenges

At this stage in the 10-year strategy it was important to take stock of what has been achieved and what has been challenging to achieve.

People told us these are the things that continue to be challenges to making Self-directed Support work for everyone who receives social care support:

- **Commissioning** – How to develop good flexible commissioning and procurement arrangements which place people at the heart of decision making.
- **Risk enabling practice** – How we better support people to achieve their agreed outcomes creatively whilst balancing the need for protection.
- **Working with limited public resources** – How we better manage demand and expectations through effective use of resources and develop a shared understanding of how this can be achieved in the context of reduced public funding.
- **Knowledge and awareness** – How we increase awareness and understanding of Self-directed Support amongst the workforce, supported people, carers and communities.
- **Major system change** – How we understand and work with other public sector reform agendas to ensure that Self-directed Support remains a high priority, particularly in the new integrated arrangements.
- **Systems and processes** – How we develop systems and processes for delivering Self-directed Support which are easy to navigate, transparent and focused on the person.

Having greater control of your life and decision making leads to improved health and wellbeing.

Strategic Outcome 1

Supported people have more choice and control
Citizens are engaged, informed, included and empowered to make choices about their support. They are treated with dignity and respect and their contribution is valued.

What has changed?
Over phases 1 and 2 of the Self-directed Support strategy we have observed that:

- There is a greater understanding of Self-directed Support and how it can lead to positive outcomes.
- There is greater use of local facilities, community groups and personal networks as part of people's care and support.
- There are better conversations between workers and supported people that help to understand what matters to them.
- People are seeking and receiving help and advice from a variety of sources, including independent support organisations and health and social care services as well as their social workers.
- More social care providers are offering flexible, personalised and outcome based support.
- Supported people, their carers and family members are increasingly being recognised as equal partners in decisions made about their care and support.
- Technology is being used more effectively to give people greater choice and control over their support.

What we will do during 2016-18 to facilitate change

- Scottish Government will implement new human rights based National Health and Care Standards across health and social care services.
- Scottish Government will continue to invest in the 34 projects of the Support in the Right Direction programme. These are building the capacity and availability of independent information, advice and support services across Scotland to enable more people to exercise choice and control.
- SDSS will support more user-led disabled people's organisations to build their capacity and standing within the localities they operate.
- Scottish Government will evaluate the role of quality information and advice to enable people to make genuine individual choices and promote independent living.
- Scottish Government and SDSS will lead a national communication group to promote a clearer, shared understanding of Self-directed Support across Scotland.
- SDSS will carry out a survey of service users experience of Self-directed Support every two years.
- We will share learning from tests of direct payments within residential care homes across Moray and East Renfrewshire.
- All partners will continue to capture and share stories and evidence, of what is working well, and what still needs to change.

Success

We will know this outcome is being achieved when:

- There is a shared understanding across supported people, carers, care providers and commissioners of what Self-directed Support is and how it can work.
- More people report they had a good quality conversation about what matters to them with workers, that enabled them to make genuine individual choices, empowered them to take control and promoted independent living.
- Specific tests teach us how Self-directed Support can work for more people, for example, people with mental health problems, children and families, people who are homeless or recovering from addictions.
- Care Inspectorate and Healthcare Improvement Scotland Inspections of registered services demonstrate more people experience the principles of the new National Health and Care Standards: dignity and respect, compassion, be included, responsive care and support and wellbeing.
- Strategic Commissioning plans help us better understand how major system changes such as integration of health and social care support the implementation of Self-directed Support.

> Citizens are engaged, informed, included and empowered to make choices about their support.

Strategic Outcome 2

Workers are confident and valued

People who work in health and social care have increased skills, knowledge and confidence to deliver Self-directed Support and understand its implications for their practice, culture and ways of working.

What has changed?

Over phases 1 and 2 of the Self-directed Support Strategy we have observed that:

- Workers and operational managers tell us they have increased skills, knowledge and confidence in implementing Self-directed Support.
- Workers and operational managers are recognised and supported to deliver strength based, outcomes-focused support for individuals.
- Social care providers are changing the way that they organise and deliver support, adopting a more person-centred, outcomes-focused approach.
- Organisations have fostered a culture of continual learning and development and reflective practice.
- Technology is being used more effectively to share information and innovations across a diverse workforce.

What we will do during 2016-18 to facilitate change

The Scottish Government will:

- Continue to invest in SSSC Integration and Self-directed Support workforce development programme to build the confidence and capacity of workers in health and social care partnerships for problem solving and improvement approaches.
- Continue to invest in Social Work Scotland programme to support the integrated partnership workforce to better understand and implement Self-directed Support.
- Continue to invest in Providers and Personalisation (P&P), a policy and practice change programme hosted by CCPS. The programme will deliver workshops and events to share practice; discuss and address challenges; and explore the application of Self-directed Support in new service areas www.ccpscotland.org/pp/.
- Continue to invest in the 21 projects of the Innovation Fund to enable third sector organisations to promote culture change that will enable more flexible and creative social care support.
- Review the actions in the Vision and Strategy for Social Services to create a socially just Scotland with excellent social services delivered by a skilled and valued workforce.

Success

We will know this outcome is being achieved when:

- There is a shared understanding across the whole workforce, including for example finance and administration, of what Self-directed Support is and how it can work.
- The workforce and supported people feel more confident in managing risk together, and develop a culture that supports innovation and creativity. This will balance the need for protection and compliance with legislation.
- There is an understanding of how to support practice which is focused on assets, personal outcomes and prevention is widespread, within the context of reduced public funding.
- More communities will be engaged in addressing needs within their communities.
- There will be a sustainable social care workforce who are equipped and endorsed to work collaboratively and develop partnerships at both a local and national level.


Good conversations empower people to take control and promote independent living.

Strategic Outcome 3

Commissioning is more flexible and responsive
Social care services and support are planned, commissioned and procured in a way that involves people and offers them real choice and flexibility in how they meet their personal outcomes.

What has changed?

Over phases 1 and 2 of the Self-directed Support strategy we have observed that:

- Commissioners, providers and communities are working together to create more innovative approaches to ensuring greater choice of support, for example, through the development of micro and social enterprise.
- We have seen increased interest in collaborative approaches to commissioning including alliance contracting and public-social partnerships.
- New social care procurement legislation and guidance promotes flexible contracting which will facilitate more choice and control for supported people.
- There is now more understanding of Option 2 (Self-directed Support Act 2013) by commissioners and providers and more flexible approaches to support provided through Option 3.
- There is significant interest in making Option 2 work from a commissioning and procurement perspective.

What we will do during 2016-18 to facilitate change

- The improvement hub (ihub) at Healthcare Improvement Scotland and the Care Inspectorate, will work with the health and social care partnerships and national bodies to support co-production, and engagement of local communities, in the provision of social care services. This will help ensure that a range of services are available to people to meet their needs.
- Coalition of Care Providers in Scotland will deliver events and workshops for providers and commissioners to share learning about commissioning, market facilitation and the impact of procurement on Self-directed Support Option 2.
- CCPS will deliver a collaborative learning programme to bring together providers, commissioners and service users to discuss working within financial constraints.
- Care Inspectorate and Healthcare Improvement Scotland will scrutinise strategic commissioning as part of their joint inspection programme.

Success

We will know this outcome is being achieved when:

- More health and social care partnerships are taking collaborative approaches to commissioning to deliver more flexible and responsive support and services.
- The flexibilities available within new procurement legislation are being used to develop more innovative approaches to delivering social services, including models of care developed by and for local communities. In particular, where there is a shortage of providers within an area.
- Health and social care partnership strategic commissioning and implementation plans clearly support flexible and innovative services that promote Self-directed Support.

People are able to live their lives and achieve the outcomes that matter to them.

Strategic Outcome 4

Systems are more widely understood, flexible and less complex

Local authorities, health and social care partnerships and social care providers have proportionate, person-centred systems and participatory processes that enable people who receive care and support live their lives and achieve the outcomes that matter to them.

What has changed?

Over phases 1 and 2 of the Self-directed Support strategy we have observed that:

- Social work services, commissioners and providers are re-designing their assessment and support systems to focus on people's strengths and on the outcomes they want to achieve.
- We have better information about the choices people are making through Self-directed Support, and can use this to help plan flexible services for the future.
- Statutory services and care providers are beginning to work more effectively together to provide earlier interventions, build relationships with people who are disengaged or isolated, and deliver more personalised care.
- Health and social care partnerships are working with communities and providers to plan for more joined-up health and social care support which gives people greater choice and control.

What we will do during 2016-18 to facilitate change

- Scottish Government will invest £3.52m in local authorities to embed culture change and continue to develop simple and effective systems which are easy to navigate and enable people to access the support they need.
- Scottish Government, COSLA and Social Work Scotland will carry out a survey of local authority implementation of Self-directed Support. The information gathered will help shape improvement support.
- CCPS P&P programme will continue with their three-year commissioned research project into provider experiences of implementation of Self-directed Support and the sector's responses to this.
- Scottish Government, COSLA and Social Work Scotland will lead a project to support local authorities, health and social care partnerships and providers to overcome barriers to system changes.
- The Care Inspectorate, Healthcare Improvement Scotland, SSSC and NHS for Education Scotland will support social care and primary health care leaders to develop more integrated services and commissioning arrangements, which support the implementation of Self-directed Support across the health and social care system.
- SSSC will facilitate the co-design of a Self-directed Support Systems Map and resources that will help to overcome barriers to system change.
- Scottish Government and the Care Inspectorate will work with three localities to test and refine a national outcomes based improvement framework for Self-directed Support.
- The Care Inspectorate will highlight successful practice, and areas for improvement, in the implementation of Self-directed Support across social work, social care and commissioning practice.

Success

We will know this outcome is being achieved when:

- Local authorities, partnerships and providers have effective systems and processes which are easy to navigate and enable people to access the support they need.
- Input of the whole workforce, including finance, legal and procurement staff, is valued and its impact on how people experience support is recognised.
- The information we have about the choices people are making and the difference that this is making to their lives is improved.
- Scrutiny evidence demonstrates improved outcomes for people.

How will we know?

We will review a full range of evidence to evaluate impact across the four strategic outcomes including:

- Social Care Survey.
- Health and Social Care Experience survey.
- Survey of local authority implementation.
- Support in the Right Direction six-monthly programme reports.
- Innovation Fund six-monthly programme reports.
- Self Directed Support Scotland survey of service users experience.
- Audit Scotland Self-directed Support Audit
- Care Inspectorate and HIS Service Inspection Reports.
- Care Inspectorate and HIS Strategic Inspection Reports.
- Scottish Government-led evaluation of the role of information and advice to support people to make informed choices about their care and support.
- Evaluation of specific projects and programmes.
- Health and Social Care Partnership Strategic Commissioning Plans.
- Health and Social Care Partnership Performance Reports.
- Ongoing review of learning from activity contained in this plan.

78


Scottish
Social Services
Council


Self Directed
Support Scotland
the organisation of choice


cps
IN SCOTLAND


care
inspectorate


social work
scotland


ScottishCare


Healthcare
Improvement
Scotland


COSLA

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78652-638-0 (web only)

Published by The Scottish Government, November 2016

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS79004 (11/16)

ITEM No …9……..

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

REPORT ON: **DELIVERING THE NEW 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB9-2018**

1.0 PURPOSE OF REPORT

The purpose of the report is to outline to the Integration Joint Board; the content of the new 2018 General Medical Services (GMS) Contract in Scotland, outline the Memorandum of Understanding (MoU) between the Scottish Government, British Medical Association, Integration Authorities and NHS Boards, outline the requirement for Primary Care Improvement Plans to be developed by 1 July 2018 and outline how the Primary Care Improvement Plan (PCIP) will be developed and the timescales for this.

2.0 RECOMMENDATIONS

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

2.1 Notes the content of this paper;

2.2 Instructs the Chief Officer to progress the necessary actions within Dundee and jointly with the other Tayside Health & Social Care Partnerships (HSCP) to develop the Primary Care Improvement Plan as set out in paragraph 4.12.1, and present this to the IJB for approval at its meeting on 26 June 2018.

3.0 FINANCIAL IMPLICATIONS

The implementation of the 2018 General Medical Services contract for Scotland will see £250million per annum phased investment in support of General Practice. This is part of an overall commitment of £500million per annum investment in Primary and Community Health and Care services by the end of this parliament. The level of funding to Dundee is not yet known.

4.0 MAIN TEXT

4.1 A strong and thriving general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities.

4.2 On 13 November 2017, the Scottish Government published the draft 2018 General Medical Services Contract in Scotland.

4.3 The benefits of the changes in the new contract for patients are to help people access the right person, at the right place, at the right time in line with the Scottish Government Primary Care Vision and Outcomes. In particular this will be achieved through:

- Maintaining and improving access;
- Introducing a wider range of health and social care professionals to support the Expert Medical Generalist (GP);
- Enabling more time with the GP for patients when it is really needed; and

- Providing more information and support for patients.

4.4 The benefits of the changes in the new contract for the profession are:

- A refocusing of the GP role as Expert Medical Generalist;
- Phase 1 of Pay and Expenses, including new workload formula and increased investment in general practice;
- Manageable Workload – additional Primary Care staff to work alongside and support GPs and practice staff to reduce GP workload and improve patient care; and
- Improving infrastructure and reducing risk: including management/ownership of premises, shared responsibility as data controller for information sharing and responsibilities for new staff.

4.5 The draft contract is the culmination of negotiations between the Scottish GP Committee (SGPC) of the British Medical Association (BMA), and the Scottish Government. The formal negotiations were informed and supported by a range of other forums including GMS Reference Group (jointly chaired by Andrew Scott, Director of Population Health, Scottish Government and John Burns, Chief Executive NHS Ayrshire & Arran) and tri-partite meetings between Scottish Government, BMA, and nominated Chief Officers of Integration Authorities.

4.6 The contract was set out in the following documents:

- Contract Framework
- Premises Code of Practice
- Draft Memorandum of Understanding
- Letter describing the Memorandum of Understanding

4.7 The new contract will support significant development in primary care. A draft Memorandum of Understanding between Integration Authorities, SGPC of BMA, NHS Boards and Scottish Government, sets out agreed principles of service redesign, ring-fenced resources to enable change to happen, new national and local oversight arrangements and agreed priorities. The initial implementation requirements are set out in the Memorandum of Understanding (MoU) for the first three years (April 2018-March 2021).

4.8 The MoU recognises the statutory role of Integration authorities in commissioning primary care services and service redesign. It also recognises the role of NHS Boards in service delivery, employers and partners to General Medical Service contracts.

4.9 The MoU provides reassurance that partners are committed to working collaboratively and positively in the period to March 2021 and beyond to deliver real change in local health and care systems that will reduce workload and risk for GPs and ensure effective multi-disciplinary team working for the benefit of patients.

4.10 Implementation of the new contract and MoU is subject to the new contract being approved by the SGPC following a poll of the profession. The outcome of this was published on 18 January 2018, with an agreement to progress the contract

4.11 NEW GP CONTRACT

The aim of the new contract is to achieve:

4.11.1 Sustainable funding:

- New funding formula that better reflects GP workload from 2018 with additional investment of £23 million. Nationally, 63% of practices gain additional resources;
- Practice income guarantee that means the 37% of practices who are not gaining additional resources will see their funding maintained at current levels;
- A new minimum earnings expectation will be introduced from April 2019. This will ensure that GPs in Scotland earn at least £80,430 (whole-time equivalent – and includes employers' superannuation).

4.11.2 Manageable workload:

- GP practices will provide fewer services under the new contract to alleviate practice workload. New primary care services will be developed and be the responsibility of IJBs / NHS Boards.
- There will be a wider range of professionals available in and aligned to practices and the community for patient care. New staff will be employed mainly through NHS Boards and attached to practices to support development of the Expert Medical Generalist role;
- Priority services include Pharmacotherapy support, treatment and care, and vaccinations;
- Changes will happen in a planned transition over three years commencing in 2018/19 and there will be national oversight involving Scottish Government, SGPC and Integration Authorities and local oversight involving IJBs, NHS Boards, and the profession, including Local Medical Committees.
- Dundee will take a co-productive approach to these developments. Stakeholder engagement in this process is not just in relation to the development of the improvement plan, but to influence and inform ongoing developments, as they progress across the 2018-21 period.

4.11.3 Reduced risk:

- GP owned premises: new interest-free sustainability loans will be made available, supported by additional £10 million annual investment.
- GP leased premises: over time there will be a planned programme to transfer leases from practices to NHS Boards.
- New information sharing agreement, reducing risk to GP contractors with NHS Boards as joint Data Controllers.

4.11.4 Improve being a GP:

- Move to recognise the GP as the Expert Medical Generalist (EMG) and senior clinical decision maker. In this role the GP will focus on three main areas: undifferentiated presentations; complex care in the community; and whole system quality improvement and clinical leadership.
- GPs will be part of, and provide clinical leadership to, an extended team of Primary Care professionals.
- GPs will be more involved in influencing the wider system to improve local population health in their communities. GP Clusters will have a clear role in quality planning, quality improvement and quality assurance.
- GPs will have contractual provision for regular protected time for learning and development.

4.11.5 Improve recruitment and retention:

- GP census will inform GP workforce planning.
- Explicit aim to increase GP numbers with a workforce plan due to be published in early 2018.

4.12 THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND (Contract Framework or Scottish Blue Book)

Key aspects of the new contract and MoU requiring early action are summarised below.

4.12.1 Development of Primary Care Improvement Plan:

- IJBs will set out a Primary Care Improvement Plan to identify how additional funds are implemented in line with the Contract Framework;
- The Plan will outline how these services will be introduced before the end of the transition period at March 2021, establishing an effective multi-disciplinary team model at Practice and Cluster level.
- These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. Any specific contractual elements must be agreed with the Local Medical Committee.

- IJBs have a statutory duty and the infrastructure established to consult in relation to Strategic Planning and stakeholders should be engaged in the Plan's development.
- Local and Regional Planning will recognise the statutory role of IJBs as commissioners. IJBs will give clear direction to the NHS Board on its function to secure these primary care services.
- In developing and implementing these plans, IJBs should consider population health needs and existing service delivery.
- Integration Joint Boards will be accountable for delivery and monitoring progress for the local Plan.
- Where more than one IJB is covering a NHS Board area, the IJBs must collaborate in relation to effective and efficient use of resources.
- A principle has been agreed in Tayside where a Tayside approach is taken to development but local delivery is implemented to local population needs and resources.

4.12.2 Key Priorities

4.12.2.1 Existing work has shown the benefits from working with a wider multi-disciplinary team aligned to General Practice. The MoU outlines the priorities over a three year period (April 2018-March 2021);

- The priority new services and staff are:

  i. Vaccination services (staged for types of vaccinations but fully in place by April 2021);
  ii. Pharmacotherapy services – made up, by 2021, of level one core (acute prescribing, repeats, discharge letters, medication compliance reviews); followed by level two additional advanced (medication review, resolving high risk medication problems); level three additional specialist (polypharmacy reviews, specialist clinics);
  iii. Community treatment and care services (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring) with phlebotomy delivered as a priority in the first stage;
  iv. Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care;
  v. Additional professionals for multi-disciplinary team dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal, mental health services);
  vi. Community Link Workers.

- New staff will be employed predominantly through the NHS Board and work in models and systems agreed between each HSCP and local GPs;
- New staff should, where appropriate, be aligned to GP practices or groups of practices (e.g. clusters);
- Where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices;
- Existing practice staff continue to be employed by Practices;
- Practice Managers will contribute to the development of the wider Practice Teams; and
- Where opportunities arise as part of the on-going review of primary care assets and infrastructure, premises developments will be designed specifically to support these priorities.

- Current position in Dundee for priority new services and staff:

  i. Public Health have a group established to look at the Vaccination Transformation programme, building on work already implemented for childhood immunisations;
  ii. NHS Tayside has led the way with development of locality pharmacy. This is a challenging agenda to deliver the contract expectations including workforce development. However there is a strong foundation to build on;
  iii. A working group has been established to develop this model and it is planned to prioritise this work. It will build on work directly being delivered for care and treatment of those with leg ulcers;
  iv. Plans, outlined in previous IJB papers, to redesign services for older people are progressing aspects of this work. The Dundee Enhanced Community Support –

Acute work is in the early stages of work. Other aspects of urgent care will require detailed planning;

v. A range of services are already considering how they can develop models to support care delivery close to people, including both physiotherapy and community mental health services. A Tayside paper for physiotherapy has been developed;

vi. Dundee is fortunate in having recruited to additional link worker posts recently. This service will evolve as wider models become clearer.

4.12.3 Improving Together Cluster Framework:

4.12.3.1 GP Clusters are professional groupings of general practices that should meet regularly with each practice represented by their Practice Quality Lead. The 2017 Scottish Government document - Improving Together - is a quality framework for GP Clusters that shapes continuous improvement of the quality of care that patients receive and states:

- Cluster purpose is to improve the quality of care within the practices and extrinsically through localities;
- Clusters priorities for 2018/19 will support the current Transitional Quality Arrangements;
- Clusters will provide advice in the development and implementation of Primary Care Improvement Plan(s);
- Practices will provide activity and capacity information to enable quality improvement work to progress and deliver;
- Clusters will be supported by Local Intelligence Support Team (LIST) analysts and Healthcare Improvement Scotland support to HSCPs;
- The peer review process for Clusters is still being negotiated.

4.12.4 Funding:

4.12.4.1 Over the period of implementation, £250m of new funds will be invested in support to General Practice. The funds will support the new practice funding formula, national support arrangements, premises support and the development of the multi-disciplinary team.

- The Scottish Draft Budget proposals for 2018/19 published in December 2017 confirmed a first phase of funding of £110m for 2018/19;
- A letter was circulated in November 2017 to Practices setting out the implications from the new proposed funding formula and allocating the £23m. No practice has a reduction in funding;
- A proportion (to be confirmed) of the £110m for 2018/9 will be allocated using the National Resource Allocation Committee (NRAC) formula to support the development of multi disciplinary teams in line with the MoU. Primary Care Improvement Plans will set out how these funds will be used.

4.12.5 The Wider Role of the Practice:

- Practice core hours will remain as 8am – 6.30pm (or in line with existing local agreements);
- Practices can opt in to provide Out of Hours services and there will be a new enhanced services specification;
- Practices will continue with extended hours directed enhanced service where they chose to do so. The intention is that there will be no more new enhanced services but as there is no alternative to delivering many of the current enhanced services, there is no intention of reducing these and the funding to practices would continue to be available. Any further changes will need to be carefully planned with a rate of change that ensures patient safety, quality of service and practice stability;
- Role and training of Practice Nurses – with the introduction of dedicated treatment and care services, General Practice nurses will be enabled to support holistic and person centred care supporting acute and chronic disease management enabling people to live safely and confidently at home;
- Role of Practice Managers and Receptionists will change. It is recognised that Practice Managers and other practice staff already have a wide range of skills that will continue to be essential for the future. In addition they will work more closely with the wider primary care system including GP clusters, NHS Boards, HSCPs and emerging new services;

- Information technology investments – it is intended that all GP practices will transition to a new clinical IT system by 2020;
- The contract will set out the roles and responsibilities of GPs and NHS Boards in relation to information held in GP records. The contract will recognise that contractors are not the sole data controllers of the GP patient's record but are joint data controllers along with their contracting NHS Board;
- Practices will be required to provide activity, demand and workforce data (through the new SPIRE system unless practices wish to collect the information themselves) and to participate in discussions at cluster level on sustainability and outcomes.

4.12.6 Implementation In The HSCP

4.12.6.1 Under the new contract there is a requirement to develop a Primary Care Improvement Plan for each HSCP which must be agreed by the GP Sub Committee. The MoU acknowledges where more than one HSCP is covering a NHS Board area, the HSCPs will collaborate in relation to effective and efficient use of resources.

4.12.6.2 HSCPs have responsibility for commissioning primary care services which integrate with locality services and are responsive to local needs and work with GP Clusters. The responsibility for the GMS Contract sits with the NHS Board. The changes envisaged in the new contract with implementation of the priority developments, changes to the role of GPs, training and role of Practice staff, premises, quality planning, improvement and assurance arrangements are significant and will require coordination across the Tayside area in order to be efficient and effective. Current structures are being revised to support this. A Dundee group is being established to pursue this locally.

4.12.7 People Who Use Services And Carers Implications

4.12.7.1 The benefits of the proposals in the new contract for patients are to help people access the right person, at the right place, at the right time in line with the Scottish Government Primary Care Vision and Outcomes.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues associated with this report. However, a more detailed assessment will be undertaken as part of the development of the Primary Care Improvement Plan.

6.0 RISK ASSESSMENT

A full risk assessment will be undertaken as part of the development of the Plan, which outlines the range of risks across the priorities to be delivered over the next three years. This will be submitted to the IJB Meeting on 26 June 2018 alongside the Plan.

7.0 CONSULTATION

The Clinical Director, Head of Service - Health and Community Care, Chief Finance Officer, Chair – LMC and GP Sub Committee and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 6 February 2018

Shona Hyman
Senior Manager
Service Development & Primary Care

ITEM No …10…..……

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

REPORT ON: **EQUAL, EXPERT AND VALUED – INVOLVEMENT OF CARERS IN THE WORK OF DUNDEE INTEGRATION JOINT BOARD**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB10-2018**

1.0 PURPOSE OF REPORT

To advise the Integration Joint Board of the outcome of assessment against "Equal and Expert" – Best Practice Standards for Carers Engagement.

2.0 RECOMMENDATIONS

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

2.1 Notes the assessment undertaken;

2.2 Instructs the Carers Strategic Planning Partnership (supported by the Communication and Engagement sub-group of the Integrated Strategic Planning Group) to address the identified gaps in relation to carer engagement;

2.3 Instructs the Communication and Engagement sub-group to take the Best Practice Standards for Carers Engagement into account in the ongoing development of engagement and participation mechanisms.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 The Coalition of Carers in Scotland (The Coalition) developed 'Equal and Expert', 3 Best Practice Standards for Carer Engagement, as a bridge to help planning officers and commissioners of services move from good intentions to better practice in relation to engagement of carers. The standards were developed jointly with carers and carer organisations, with support from the Scottish Government's carer policy unit and the Scottish Health Council and are attached as appendix 1.

The standards

Standard 1 – Carer engagement is fully resourced

To fulfil a representative role on any strategic group takes time and effort in the preparation for, attendance at and follow up to meetings. To ensure carers are able to give of their best they need training, induction, mentoring and support with clear structures to exchange views and information with a strong network of carers. In addition to the reimbursement of normal expenses such as travel that are provided for volunteers on strategic groups, there needs to be a commitment on the part of statutory authorities to meet the costs of any substitution care that carers require to put in place to fulfil their roles. They also need to invest in local structures for carer engagement, such as carer forums and social media platforms

Standard 2 – Carers on Strategic planning groups represent the views of local carers

Carers fulfilling a representative role need to engage with a strong, healthy network of carers from different caring backgrounds. This network needs to be sustained and developed by a carer organisation, properly resourced for this task. Without this, carers cannot speak with authority and may be viewed as an unrepresentative lone voice

Standard 3 – The Involvement of carers on strategic planning groups is meaningful and effective

It is critical to avoid tokenistic involvement of carers on strategic groups. For carers to be assured that their voices will be heard and acted upon, all those involved in the operation of strategic groups need to be ready to accept carers as equal and expert partners. This means having a commitment to listen and respond appropriately to the views of carers. As with other members of the strategic groups, carers need to know that their involvement is meaningful and elective. This will be evidenced when the work produced by these groups is demonstrably leading to an improvement in services and support for carers and the people they care for.

Equal and Expert – 3 best practice standards for carer engagement, Coalition of carers in Scotland

4.2 The Best Practice Standards identified work in Dundee as a best practice example for Standard 2.

4.3 Following publication of the standards The Coalition assessed the evidence for the extent to which the three engagement standards have been met by IJBs to date. The generated report did not give detailed local feedback, but highlighted areas of good practice and examples of practice to be improved. The Summary report is attached as Appendix 2 and a full report can be found at:

http://www.carersnet.org/wp-content/uploads/2014/06/Equal-Expert-and-Valued-Full-Report-.pdf

4.4 The standards clearly give the Integration Joint Board a benchmark against which it can assess its engagement with carers, but may also provide some guidance on our wider user engagement (particularly in relation to representation of stakeholder groups on the IJB). The standards will be used alongside other existing guidance and standards which guide our engagement and participation with service users and the public (i.e. NHS Scotland Participation Standards and The Community Engagement Standards). This work is overseen and supported by the Communication and Engagement sub-group of the Integrated Strategic Planning Group.

4.5 A group of key officers from the Health and Social Care Partnership, the Chief Executive Officer and involvement worker from Dundee Carers Centre and the Carer representative on the Integration Joint Board used the template contained within the National Report to assess how well Dundee meets the standards and to identify areas for improvement and this is attached as Appendix 3. Areas for improvement identified are:

- Identification of Health & Social Care Partnership Officer support for the Carers' Representative;
- Provision of "business" e-mail address for carers' representative;
- Encouragement of all IJB members to place items on the agenda and raise concerns;
- Carry out further work to ensure that impact assessment is carried out effectively and includes the impact on carers;
- Ensure that evaluation of carers' engagement is integrated with the wider evaluation of participation and engagement via the Integrated Strategic Planning Group.

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	Carers are not engaged effectively in the work of the Integration Joint Board
Risk Category	Operational
Inherent Risk Level	Likelihood 4 x Impact 2 = Risk Scoring 8 (High)
Mitigating Actions (including timescales and resources)	Strong evidence that Carer engagement is fully resourced Strong evidence that Carers Representative represents the views of local carers Evidence that engagement is meaningful and effective – some gaps identified
Residual Risk Level	Likelihood 2 x Impact 2 = Risk Scoring 4 (Moderate)
Planned Risk Level	Likelihood 1 x Impact 2 = Risk Scoring 2 (Low)
Approval recommendation	Given the low level of planned risk, the risk is deemed to be manageable

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report. This report was developed in Partnership with the Dundee Carer's Centre and the Carer Representative of the Integration Joint Board.

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 2 February 2018

Allison Fannin
Planning & Development Manager
Dundee Health & Social Care Partnership

EQUAL AND EXPERT

3 best practice standards for carer engagement

coalition of carers in Scotland

Tel: 01786 825529
Email: coalition@carersnet.org
Web: www.carersnet.org
Twitter: @CarersCoalition
Facebook: www.facebook.com/CoalitionofCarers
Scottish Charity: SC039434

INTRODUCTION: Why we need standards for carer engagement

No one would argue that unpaid family carers should not be equal partners in care, as their care constitutes over 50% of all care provided in every local authority and NHS region of Scotland. Consistent and meaningful carer engagement must therefore be at the heart of all good health and social care policy.

But a great gulf remains between good intentions and good practice.

The Coalition of Carers in Scotland is pleased to offer the carer engagement standards in this document as a bridge to help planning officers and commissioners of services move from good intentions to better practice. The standards were developed jointly with carers and carer organisations, with support from the Scottish Governement's carer policy unit and the Scottish Health Council.

Investment in carers and carer engagement will bring many valuable returns - stronger planning and policy, improved services, more creative use of resources and improved outcomes for carers. In short, better care for people with support need. We commend these standards to all planning partners.

STANDARD ONE: Carer engagement is fully resourced

To fulfil a representative role on any strategic group takes time and effort in the preparation for, attendance at and follow up to meetings. To ensure carers are able to give of their best they need training, induction, mentoring and support with clear structures to exchange views and information with a strong network of carers. In addition to the reimbursement of normal expenses such as travel that are provided for volunteers on strategic groups, there needs to be a commitment on the part of statutory authorities to meet the costs of any substitutionary care that carers require to put in place to fulfil their roles. They also need to invest in local structures for carer engagement, such as carer forums and social media platforms.

OUTCOMES

1. Carer representatives will feel confident in undertaking the responsibilities of their role and be able to express clearly and fully the views of other carers.
2. The strategic groups will benefit from the views of carers being regularly and directly represented and will produce work which address the needs and meets the aspirations of carers more fully.

EVIDENCE OF IMPLEMENTATION

Carers in representative roles will:

1. Receive training and a full induction.
2. Be supplied with the information they require timeously.
3. Be mentored.
4. Be able to obtain the views of other carers via a strong network of carers.
5. Have the full costs of their work in and for the strategic groups met – this includes the costs of any substitutionary care that is required.

BEST PRACTICE EXAMPLE: TRAINING FOR CARERS ON PLANNING GROUPS

The Coalition of Carers in Scotland provides training for carers who are representatives on strategic planning groups, or who are interested in getting involved in local community planning. Courses have been held both nationally and locally, providing carers with the opportunity to develop their knowledge and skills and learn how best to promote the carers' voice.

The course includes information on policy and legislation relating to community involvement, preparing for meetings, speaking with intent and how to challenge effectively. The training provides carers with the confidence and authority to fully participate in meetings. It also increases the number of carers who are involved in community planning, so that the responsibility doesn't fall on one or two people.

As one carer commented after attending the course: "I now know the amount of work and preparation which is needed and I feel confident in taking on such a role. I'm looking forward to being able to make a difference to benefit other carers."

STANDARD TWO: Carers on strategic planning groups represent the views of local carers

Carers fulfilling a representative role need to engage with a strong, healthy network of carers from different caring backgrounds. This network needs to be sustained and developed by a carer organisation, properly resourced for this task. Without this, carers cannot speak with authority and may be viewed as an unrepresentative lone voice.

OUTCOMES

1. Carers on strategic groups will be:
   (a) representative of the various communities of carers
   (b) able to express in informed ways the views of a range of carers
2. The other partners on the strategic groups will know with confidence that they are learning of the views of a range of carers.
3. The work produced by the strategic groups will fully take into account the views of carers

EVIDENCE OF IMPLEMENTATION

1. Carer organisations will be properly resourced to establish and support a strong carer network, which offers a variety of ways for carers to get involved
2. The number and carers involved in exchanging views through the network will grow
3. The diversity of carers involved in the network will be broad
4. There will be a continual emergence of new carers willing to undertake representative roles
5. The information provided through and by the supported network will be of a high quality

BEST PRACTICE EXAMPLE: DUNDEE CARERS VOICE

In Dundee carer involvement was highlighted as a priority for development in the local Carers Strategy. Carer involvement also featured strongly in NHS Tayside's priorities for implementing the Scottish Government's Carer Information Strategy (CIS). A paper was drawn up outlining a proposal to take this forward, which involved building the capacity of the Dundee Carers Centre to increase the level and quality of carer involvement through the recruitment of a new Deputy Manager post. It was felt that a post at this level would place strategic importance on the development of carer involvement, while also allowing a number of other local CIS priorities to be met: e.g. developing counselling, carers support, and carers training. CIS funding initially met the whole cost of the Deputy Manager post, with the expectation that as capacity was increased so the Carers Centre would commit progressively more core funding towards the position and the involvement agenda.

The funding has enabled the creation of the Carers Voice group which engages carers in a variety of ways, both locally and further afield, and acts as a reference group bringing carers together from all backgrounds to exchange information and discuss issues that are important to them. This ensures that carer representatives on planning groups are able to represent not just their own views, but also the views of the wider carer community. Carers from the group also sit as representatives on the local Carers Strategy action group and have taken part in a number of initiatives including consultation around the development of the new Dundee Carers Strategy.

STANDARD THREE: The involvement of carers on strategic planning groups is meaningful and effective

It is critical to avoid tokenistic involvement of carers on strategic groups. For carers to be assured that their voices will be heard and acted upon, all those involved in the operation of strategic groups need to be ready to accept carers as equal and expert partners. This means having a commitment to listen and respond appropriately to the views of carers. As with other members of the strategic groups, carers need to know that their involvement is meaningful and effective. This will be evidenced when the work produced by these groups is demonstrably leading to an improvement in services and support for carers and the people they care for.

OUTCOMES

1. Carers will be treated as equal and expert partners in strategic groups
2. The views of carer representatives will be evident in the strategic decisions taken and the plans that are developed.
3. Carers will be treated as equal and expert partners in the provision of care.

EVIDENCE OF IMPLEMENTATION

1. Carers will be placed on the right strategic planning groups including at the top level of governance structures.
2. Other partners in strategic groups will have had Carer Awareness training so that the perspectives brought by carers is understood and accepted as the statements of people who are "equal and expert" partners.
3. Meetings will be open and inclusive, allowing time for discussion and contributions from all members of the group. Language will be accessible and jargon will be avoided.
4. Sufficient time will be given for preparation. Papers will be sent out in advance in a timely fashion and carer representatives will have the opportunity to clarify any information in advance.
5. The agenda will be jointly owned with all group members having the opportunity to place items on it or raise issues of concern.
6. All plans and policies produced by strategic groups will be 'carer proofed' so that the impact on carers is explicitly stated to ensure that carers needs and aspirations have been fully considered.
7. Through their network carers will be supplied with information about the opportunities for participation in strategic planning groups.
8. The outcomes of carer engagement will be evaluated.

BEST PRACTICE EXAMPLE: PAUL'S STORY

Paul Weddell, Carer, West Lothian says:

"My involvement in the West Lothian Community Health and Care Partnership was a really positive experience. I was genuinely welcomed into the process and my expertise, views and ideas were valued by everyone involved.

Before joining I received an induction which included information on the design of services and local structures. I had on-going support from the Patient Involvement Officer and attended a pre-meeting, prior to each Board meeting, with the Chairperson and the Director of the CHCP Board. This allowed me to bring up any information that I needed clarification on in relation to the papers which were sent out 7 days in advance.

If you want ordinary people to get involved in strategic planning groups, you have to make sure that they are made to feel welcome in what is often a new and intimidating environment. Carer representatives need to feel valued and convinced that their views are treated equally to other members of the group. The use of specialised language and acronyms should be kept to a minimum and where they have to be used explanations should be given on first use.

It is absolutely clear to me that those leading the process in West Lothian were genuinely committed to carer and patient involvement at the strategic decision making level and that it was their attitude that was fundamental to making the system work."

Appendix 2

coalition
of carers in Scotland

EQUAL, EXPERT *and* VALUED

Enhancing Carer Representative involvement on Integration Joint Boards

REPORT SUMMARY

Background

The Carers Collaborative is a project that seeks to

- Research the current landscape in relation to Carer Representation on Integration Joint Boards (IJBs)
- Develop and facilitate a forum for Carer Representatives on IJBs
- Make recommendations for future work in relation to ongoing support and training of Carer Representatives, and support for local Integration Authorities in relation our Equal and Expert Best Practice Standards for Carer Engagement.

The Collaborative ran events and research activities between March and October 2016, involving 38 Carer Reps from 27 local authority areas, leading to this report.

AIM

The report offers positive and constructive insights in order to:

- Help improve carers' involvement in IJBs
- Help planning officers and commissioners to move from good intentions to better practice
- Start conversations and stimulate further progress by sharing good practice.

Equal and Expert?

In 2013 The Coalition of Carers developed 'Equal and Expert' 3 best practice standards for carer engagement. The standards were co-produced by carers and local carer support organisations, with support from the Scottish Government and the Scottish Health Council.

The report assesses evidence for the extent to which the three 'Equal and Expert' carer involvement standards have been met by IJBs to date:

STANDARD ONE:

Carer engagement is fully resourced

Practice varies. Carer Reps have found training and induction beneficial, particularly where it involves the full Board. Meeting papers are rarely sent in time to allow proper preparation. Where replacement care is provided for carers, it tends not to include time spent preparing for meetings.

STANDARD TWO:

Carers on strategic planning groups represent the views of local carers

This was the best evidenced of the three standards. Carer Reps have worked hard to be 'representative', but their visibility to other carers remains an issue. Some carers' centres support Carer Reps to represent local carer networks. Some areas struggle to engage carers, and most would like more carers in networks 'underneath' IJB board level. Where carers have been able to make contributions these appear to be valued (writing strategies, supporting consultations, improving governance, assisting inspections, contributing to commissioning etc.). It is important to note that strategic plans should reflect the issues which have been identified as priorities by Carers, not just carers' responses to consultation on pre-determined issues.

STANDARD THREE:

The involvement of carers on strategic planning groups is meaningful and effective

Carer Rep effectiveness appears to increase when they are included on Strategic Planning Groups, Carer Forums and IJB Agenda groups. Those with access to agenda-setting meetings report feeling more included and productive. There are some good examples of IJBs being trained in Carer Awareness (e.g. Dumfries and Galloway, North Ayrshire). However across Scotland Carer Reps' equality and expertise are still far from universally accepted.

Experience so far

Between May and October 2016 we analysed IJB Strategies and meeting minutes to determine how easily accessible information was and to identify any references to unpaid carers. 27 out of 30 Strategies include carer outcomes. 28 IJBs make their meeting minutes publicly available, and 26 publish meeting dates in advance. Between April and October 2016, 17 IJBs discussed carers or carer-specific issues.

Carers Collaborative meetings shared more detailed information on local practice. Although these focused on good practice examples, they highlighted some common gaps:

- Being listened to
- Agenda setting
- Consultation on plans
- Paperwork
- Power
- Process
- Voting
- Resourcing
- Engagement

The report gives more detail on these, and of good practice from around the country, leading to the recommendations listed below.

Sharing experience: Good practice notes from around the country

This section of the report is based on mapping and scoping activities carried out during the three Carer Collaborative meetings. It aims to put a spotlight on good practice and to draw attention to practice that can be improved.

RECRUITMENT, INDUCTION AND ROLES	
Examples of good practice	**Examples of practice to be improved**
Several Carer Reps were appointed after an application process and interview. In one example this was carried out by the Carers' Centre, meaning this was a more open process and the representative role of the Carer Rep was clearly established from the outset. Unsuccessful applicants now form a consultation group, which means their expertise and willingness to engage has not been lost.	Some areas do not yet have a Carer Representative, or have appointed on an interim basis. This risks losing continuity of 'the carer's voice'.
Many IJBs allow for two Carer Representatives. This helps to share the workload and the pressures. If the Carer Rep can't make a meeting, a substitute can be agreed with the IJB Chair.	Some IJBs only allow for one Carer Representative. Others do not allow deputes to take part in meetings, only observe them, sometime without access to all the papers.
A few areas have provided Carer Reps with a role description. A small number of IJB Chairs have given helpful guidance on the Carer Rep's role. For example, about their right to comment on, or challenge, issues that are raised at meetings.	Most IJBs appear not to have identified a description of the Carer Rep's role or purpose.

SUPPORT AND RESOURCES	
Examples of good practice	**Examples of practice to be improved**
In some areas, carers are provided with travel expenses for attending meetings. In others, replacement care is provided for time spent in meetings.	Some areas do not provide travel expenses or replacement care. Where replacement care is provided, this does not cover time spent reading papers and preparing for meetings.
Some IJBs identify a Carers' Champion or lead officer who can work directly with Carer Reps and Carer Centres.	It is not always know who the local Carer Lead is, or what their role is.
Carer Reps find IJB development sessions beneficial – some IJBs schedule these every other month, between formal Board meetings.	Some Carer Reps have received no induction or training.

STRUCTURES FOR INCLUSION AND REPRESENTATION	
Examples of good practice	**Examples of practice to be improved**
Several Integration Authorities have run 'carer aware' training for members of IJBs and other key partners	In some areas carer reps report a lack of understanding of the contribution of unpaid carers and the value carer reps bring to IJBs through their lived experience.
Some areas have good support structures to encourage different levels of involvement and coordination of carers' views. Carers Reference Groups and Carers Voice Networks have been particularly helpful, as have pre-Board meetings with other public representatives.	These are often facilitated by Carer Centres or Third Sector Interfaces, but not always resourced by Integration Authorities.
'Carer forums' can help ensure Carer Reps hear and represent the wider views of carers. Some IJBs raise Carer Representatives' profiles by including their photos, biographies and an IJB email address on their websites.	Some areas do not have good carer networks to connect carers at different levels.
Some areas are further ahead in ensuring carers are represented at Strategic Planning Groups 'underneath' the IJB and at a locality level and that there are good lines of communication between the different planning structures and the IJB	This work is still developing in some areas and carers are not fully involved at a strategic planning level and locality level

MEETINGS AND PAPERS	
Examples of good practice	**Examples of practice to be improved**
Meetings are made accessible to Carer Reps. For example, one rural area rotates its meetings around the region. Video links can help, but need careful planning and facilitation.	Barriers to involvement include long or unfocused meetings; jargon; meetings being conducted at high speed; and an emphasis on process.
Papers are made accessible by being provided in time to let carer prepare, in electronic and paper versions. In one area papers can be collected from a local access point. One IJB provides Carer Reps with I-pads. In some areas, Carer Reps receive confidential 'green papers' including financial information, which helps them fulfil their governance role.	Papers are frequently lengthy and sent too late to allow Carer Reps to prepare. Several Carer Reps are not included in 'green paper' circulation.
Carer Representatives are able to request agenda items and submit papers via Agenda Committees, SPG Chairs, IJB Committee Services, pre-Board meetings or under 'Any Other Business'.	Several Carer Reps have no way to influence or contribute to agendas.

STRATEGY	
Examples of good practice	**Examples of practice to be improved**
Some IJBs are actively preparing for the Carers Act, for example discussing it at Board level; reviewing their Strategic Plans in readiness; scheduling development days on the Act; and asking Carer Reps to prepare Board papers or presentations on the Act.	Several IJBs have not discussed or begun preparing for the Carers Act.
A small number of Strategic Plans use several indicators for National Health and Wellbeing Outcome 6, giving a rounded measure of carer outcomes. Some IJBs have worked with Carer Reps and carer centres to develop appropriate indicators.	Most areas use just the one indicator ("I feel supported to continue caring").

Work in Progress

It became evident during both the scoping activity and the group events that progress was being made. During early scoping (May-June) for example, only 17 IJBs had published meeting minutes, and carers had been mentioned just four times in these. However by October, 28 had minutes available and carers had been mentioned 29 times.

The tone of conversation had also changed. At the first Collaborative meeting in May, there was some frustration about lack of training, level of involvement, quality of governance etc. But by October, positive improvements were being reported. For example, some Carer Reps had been able to ensure that the Carers Act appeared on the agenda.

Recommendations to improve Carer Representation

The report shares five recommendations and 12 straightforward suggestions for improving carer involvement, all drawn from real life experience of what works for Carer Representatives across the country.

1. INCLUDE CARERS' REPRESENTATIVES IN DECISION MAKING

1.1 Find ways to involve carers in consultation and decision-making

It is important to recognise the demands on carers' time. Frequent or formal meetings can be a barrier to attracting or retaining carers. IJBs would benefit from sessions that enable carers to contribute more effectively, such as ideas exchanges. They should also consider ways to provide appropriate recognition and reward for Carer Reps.

1.2 Include Carer Reps in different groups

Ensure carers are represented on different groups within the wider structures of the Integration Authority, particularly groups that set agendas or agree decisions. Arrange collective voice meetings for service user reps, service provider reps, Carer Reps, and third sector reps – before agenda deadline dates. If you don't have one, establish a carers' advisory group.

2. INCREASE AWARENESS AND PROFILE

2.1 Raise profile of Carer Reps

Ensure that the Carer Rep's identity and role are clearly signposted on relevant websites, with contact details so other carers can get in touch. Give Reps an email address so they don't have to use their own. Business cards are a nice touch. Use locality groups to ensure carer issues are accessed and represented.

2.2 Raise IJB awareness of carers

Chairs, Chief Officers and other partnership staff can learn a lot about the impact of their decisions by attending carers' centres and meetings. Making Carers Awareness Training available for all IJB members has also been a popular and effective way to do this.

3. VALUE AND RESOURCE CARER REPRESENTATIVES

3.1 Value Carers Representatives and their contributions

Valuing Carer Reps can be as simple as inviting, minuting and acknowledging their contribution to meetings. The real test is then to listen, act and follow through.

3.2 Train and support Carer Representatives

Carer and User Representative training is essential to good involvement – and governance. Arrange regular training or development days for the whole IJB. Arrange inductions for new members, for example meetings with key officials. Supportive mentoring increases confidence.

3.3 Resource representation

Take steps to make sure Carer Representatives are not worse off as a result of contributing to the IJB's work. Provide travel costs and replacement care for the time they spend carrying out their IJB duties.

3.4 Ensure Carer Representatives have a clear remit

Agree clear roles for and with Carer Representatives. Make sure everyone knows what is expected of them.

4. SHARE PRACTICE AND LEARNING

4.1 Share practice between IJBs

Arrange exchanges with other IJBs to improve each other's practice. Support IJB Carer Reps to meet up to share ideas from different areas (it's where everything in this report came from!).

4.2 Improve communication

Ask what Carer Reps need. Make sure your agendas and minutes are publicly available. Carers can be fantastic conduits for 'bottom up' and 'top down' communication when supported by the right networks and structures.

5. MAKE MEETINGS BETTER

5.1 Create structures to allow agenda items to be raised

If you don't already, establish a pathway for agenda items to be raised. Set clear deadlines, establish an agenda setting meeting, committee or process. Join the dots between IJB and Strategic Planning Group meetings.

5.2 Make meetings, minutes and papers accessible

Produce minutes, agendas and meeting papers as promptly as possible. This lets representatives get feedback to and from their carer networks. It's especially helpful when officers identify issues affecting carers and seek advice before papers are tabled.

Spotlight:
SHETLAND

A Carers Forum facilitated by a carers support worker gives carers the opportunity to voice individual concerns

Spotlight:
FIFE

Carer Rep was appointed through interview by the Carers' Centre. Others applicants now form a consultation group.

Spotlight:
MORAY

issues papers 7-10 days ahead of meetings, giving carers time to prepare.

Spotlight:

on best practice:

HIGHLAND

The role of Carer Voice Coordinator in Highland was created as a self-employed consultant role to be carried out by a carer. The ethos behind the role being self-employed was to allow the carer to have complete flexibility to fit the requirements of the role around their caring responsibilities.

The remit is to increase the engagement and involvement of carers in the planning and delivery of services that affect their lives and the lives of the people they care for.

> 'The vision for Highland to have carers involved in the planning and delivery of all services that affect their lives is a work in progress, however with the creation of this role, we now have someone who has that ambition at the core of their role and is dedicated to making the vision a reality.'
>
> Karen Anderson, Carer Voice Co-ordinator

In North Ayrshire, carers were on the shadow board and helped to establish how the IJB structures and meetings would operate. All board members received the same training, which reinforced the feeling of equality among partners. Councillors also received carer awareness training.

STRATEGY

The IJB Strategy has an accessible summary, and includes a section on carers, which was approved by carers before going to print. The Carers Strategy sits underneath this, written with carers.

STRUCTURE

To provide a link between communities and the IJB, a Carers Advisory Group brings carers together from different localities and carer groups. It is chaired by a 'Carer Champion', a councillor with a remit for social work. Carers from the Carers Advisory Group populate other strategic planning groups, which helps provide a network of support underneath the IJB Board. In these and other ways, community members can raise issues and get items on the agenda.

SUCCESS FACTORS

Marie McWaters, a Carers Rep, puts these successes down to the positivity of councillors and council leaders towards involving carers. Other carers could see the benefits that involvement was having, so more signed up.

> 'Once you make the pathway it's easy – you just keep using the same path.'

Spotlight:

on best practice:

NORTH AYRSHIRE

NEXT STEPS

Members would like to continue the Collaborative's work, though providing regional events alongside national ones would be an improvement for several members. The practice-sharing format has built Carer Reps' confidence and their ability to understand their IJB's practice in the context of developments elsewhere. However a next step might be to explore whether a common or agreed role specification for Carer Reps would be useful.

Thanks and acknowledgements

This report was produced by the Coalition of Carers in Scotland, authored by Graeme Reekie of Wren and Greyhound Limited.

We would like to thank the Carer Representatives involved in Integration Joint Boards across Scotland, without whose input and involvement this report would not have been possible.

The work was funded and supported by the Scottish Government.

Published February 2017

Contact Details

The Coalition of Carers in Scotland
PO Box 21624
STIRLING
FK7 1EF

Tel: **01786 850 247**

Email: **coalition@carersnet.org**

Web: **www.carersnet.org**

Twitter: **@CarersCoalition**

Facebook: **www.facebook.com/CoalitionofCarers**

Registered Charity: SC 039434

Standard one: Carer engagement is fully resourced	
Outcomes 1. Carer representatives will feel confident in undertaking the responsibilities of their role and be able to express clearly and fully the views of other carers 2. The strategic groups will benefit from the views of cares being regularly and directly represented and will produce work which addresses the need and meets the aspirations of carers more fully	
Evidence of implementation Carers in representative roles will:	
Receive Training and a full induction	All Board members (including Carer's representative) receive the same training and induction. Support is available from the Carers' Centre for the Carers Representative.
Be supplied with the information they require timeously	Board papers are sent out to all members electronically one week in advance and are available in hard copy on the day of the meeting. The Carers Representative receives hard copies in advance.
Be mentored	The Chief Executive and the Involvement Worker at Dundee Carers Centre provides mentorship support. ***It would be useful to identify a lead officer to provide additional support***
Be able to obtain the views of other carers via a strong network of carers	The Carers representative links into a local carers network, supported by Dundee Carers Centre and the Carers Strategic Partnership. The Network is currently being redeveloped following the recruitment of a new involvement worker. The Carer's representative attends "Carer's Blethers" and other

Standard one: Carer engagement is fully resourced	
	events including the Carer's Centre AGM to hear the views of carers.
Have the full costs of their work in and for the strategic groups met – this includes the costs of any substitution care that is required	All costs incurred as a result of sitting on the IJB are met

Standard two: Carers on the Integration Joint Board represent the views of local carers	
Outcomes 1. Carers on strategic groups will be a) Representative of the various communities of carers b) Able to express in informed ways the views of a range of carers 2. The other partners on the strategic groups will know with confidence that they are learning the views of a range of carers 3. The work produced by the strategic groups will fully take into account the views of carers	
Evidence of implementation	
Carer organisations will be properly resources to establish and support a strong carer network, which offers a variety of ways for carers to get involved	Dundee Carer's centre resourced via the Health and Social Care Partnership to support carer's engagement, this includes funding for a specific post for involvement work including support for carers representation. The post also supports young carers involvement. Additional staff within the Carer's Centre (mainly funded via the HSCP) also support this work. A wide range of engagement methodologies are used including Carer's Voice, Carers Blethers, the Carer Information Network, and the Carer's of Dundee Website.
The number of carers involved in exchanging views through the network will grow	There is a continuous improvement approach to this element of the network. A development plan is in place within the Carer's Centre and recently a new "layer", Carer's Blethers, has been established to further enable carers views to be heard.

Standard two: Carers on the Integration Joint Board represent the views of local carers	
The diversity of carers involved in the network will be broad	This is now increasing with the addition of Young Carers Voice and discussions have taken place with other organisations who support carers to grow and widen the diversity of the network. Discussions are taking place with the Centres BME Development worker to ensure further representation of BME communities.
There will be a continual emergence of new carers willing to undertake representative roles	Consultation on involvement has identified that there are barriers to being involved in representative roles including the time carers have and confidence. Building confidence is one of the aims of Carers Blethers.
The information provided through and by the supported network will be of a high quality	Information is shared in a number of ways, verbally, via printed/electronic formats, newsletters, and via social media. There are new publicity materials for Carers Blethers and on the Centres website however there is a need for use to make more use of technology to involve people. The new 'Carers of Dundee' website will have a specific area for involvement including identifying all the ways that people can get involved.

Standard three: The involvement of Carers on the Integration Joint Board is meaningful and effective	
Outcomes 1. Carers will be treated as equal and expert partners in strategic groups 2. The views of carers representatives will be evident in the strategic decisions taken and the plans that are developed 3. Carers will be treated as equal and expert partners in the provision of care	
Evidence of implementation	
Carers will be placed on the right strategic planning groups including at the top level of governance structures	Carers represented on the IJB and the Carers Partnership. There are a number of carer's vacancies (a place on Carer's Partnership and a place on ISPG). It is a priority of Carers Voice to fill these places. Other SPGs have a range of systems to ensure carers' voices are heard.
Other partners in strategic groups will have had carer awareness training so that the perspective brought by carers are understood and accepted as the statements of people who are "equal and expert" partners	Partners in HSCP Strategic Planning groups and the IJB have regular updates about Carers matters – both through briefing papers and presentations. Currently there are a series of updates planned about the Carer's Act and Dundee Carers Strategy. The Dundee Carers Charter has pledges to carers and has been approved by the IJB. Later this year arrangements will be made for all SPGs to consider separate sign-up and to explore the impact of this.
Meeting will be open and inclusive, allowing time for discussion and contributions from all members of the group. Language will be accessible and jargon will be avoided	The Carer's representative has fedback that he feels respected as an equal Partner

Standard three: The involvement of Carers on the Integration Joint Board is meaningful and effective	
Sufficient time will be given for preparation. Papers will be sent out in advance in a timely fashion and carer representatives will have an opportunity to clarify any information in advance	The Carers' representative has confirmed that the papers are being received in advance and support is available if required. **The representative has identified that a "business" e-mail address would be useful, as would provision of appropriate IT to support access to information.**
The agenda will be jointly owned with all group members having the opportunity to place items on it or raise concerns	**All IJB members should be encouraged to place items on the agenda and raise concerns**
All plans and policies produced by strategic groups will be "carer proofed" so that the impact on carers is explicitly stated to ensure that carers needs and aspirations have been fully considered	**Further work required to ensure that impact assessment is carried out effectively and includes the impact on carers. A carers impact assessment has been developed for use by the ISPG – this could be adapted for wider use.**
Through their network carers will be supplied with information about the opportunity for participation in strategic planning Groups	This has been circulated through the Carers Centre newsletter and social media. A new presentation describing these roles has been developed and was a feature of a meeting of Carers Blethers. We will also be looking to design a simplified diagram that will be on the 'Carers of Dundee' website.
The outcome of carer engagement will be evaluated	Informal evaluation takes place, and this **requires to be integrated with wider evaluation of participation and engagement via the Integrated Strategic Planning Group.**

ITEM No …11…….

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

REPORT ON: **CLIMATE CHANGE REPORTING**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB8-2018**

1.0 PURPOSE OF REPORT

To inform the Integration Joint Board of its duties in relation to Climate Change reporting under the Climate Change (Scotland) Act 2009, to present the latest submitted Climate Change report and the subsequent high level analysis report from Sustainable Scotland Network published on 31 January 2018.

2.0 RECOMMENDATIONS

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

2.1 Notes their duties in relation to Climate Change Reporting;

2.2 Notes the Climate Change Report submitted on its behalf by the Chief Finance Officer (attached as Appendix 1);

2.3 Notes the high level analysis report published by Sustainable Scotland Network on 31 January 2018 (attached as Appendix 2);

2.4 Instructs the Chief Finance Officer to continue to work with NHS Tayside, Dundee City Council and the Sustainable Scotland Network to ensure that its Climate Change duties continue to be met, including reviewing the high level analysis report and identifying any impact on the IJB.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 As a public body the IJB has a responsibility to produce a Climate Change Report under the Climate Change (Scotland) Act 2009 (The Act).

4.2 Part 4 of the Act states that a *"public body must, in exercising its functions, act: in the way be*st *calculated to contribute to the delivery of (Scotland's climate change) targets; in the way best calculated to help deliver any (Scottish adaptation programme); and in a way that it considers most sustainable"*.

4.3 The three elements of the public bodies climate change duties are:

Mitigation - Reducing Greenhouse Gas Emissions

- The first element of the duties is that, in exercising their functions, public bodies must act in the way best calculated to contribute to delivery of the Act's greenhouse gas emissions reduction targets. Reducing emissions is referred to as climate change *mitigation*.

- The Act has set an interim target of a 42% reduction in greenhouse gas emissions by 2020 and an 80% reduction in greenhouse gas emissions by 2050, on a 1990 baseline. The long-term targets will be complemented by annual targets, set in secondary legislation.

Adaptation - Adapting to the Impacts of a Changing Climate

- The second element of the duties is that public bodies must, in exercising their functions, act in the way best calculated to deliver any statutory adaptation programme. The first statutory adaptation programme – Scotland's Climate Change Adaptation Programme (SCCAP) – was published in 2014. While public sector bodies will have varying degrees of influence in relation to adaptation, all public bodies need to be resilient to the future climate and to plan for business continuity in relation to delivery of their functions and the services they deliver.

Acting Sustainably - Sustainable Development as a Core Value

- The third element of the duties places a requirement on public bodies to act in a way considered most sustainable. This element of the duties is about ensuring that, in reaching properly balanced decisions, the full range of social, economic and environmental aspects are taken into account, and that these aspects are viewed over the short and long term.

4.4 The *Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015* came into force in November 2015 as secondary legislation made under the Climate Change (Scotland) Act 2009. The Order requires bodies to prepare reports on compliance with climate change duties. This includes 'An integration joint board established by order under section 9(2) of the Public Bodies (Joint Working) (Scotland) Act 2014(c)'.

4.5 Integration Authority Climate Change Report 2016/2017

4.5.1 As the Dundee Health and Social Care Partnership Integration Joint Board has no responsibility for staff, buildings or fleet cars the submitted report does not need to contain a great deal of detail, and aspects related to staff, buildings or fleet cars are contained within constituent authorities reports.

4.5.2 Although the IJB is not required to report on elements which are contained within constituent authorities' reports, the Health and Social Care Partnership contributes towards mitigation of climate change in a number of ways, for example:

- Increasing the use of electric vehicles for the delivery of care at home services;
- Moving to locality working will reduce the length of journeys for both staff and recipients of services;
- Reviewing the routes where transport is provided by the Partnership in order to reduce the length and number of journeys;
- Continuing to encourage the use of public transport and active travel by staff where practical and possible;
- Implementation of flexible working and the availability of hot desking across Dundee to minimise cross City travel;
- Consideration of climate change when developing the Dundee Health & Social Care Partnership accommodation strategies and relocation of staff.

4.5.3 The Dundee IJB Draft Climate Change Report 2016/17 was approved for submission to the Sustainable Scotland Network by the submission date of November 2017 (attached as Appendix 1) by the Chief Officer's Senior Management Team.

4.6 Sustainable Scotland 2016/17 Analysis Report

4.6.1 The analysis report focuses on the quantitative information on the corporate emissions reported by Scottish public bodies. It is noted in the report that "Since IJBs do not have operational control of the services provided by their NHS and local authority partners, no emissions data has been reported directly by the IJBs. All emissions data relating to integrated health and social care services is captured and reported within the NHS and local authority reports"

4.6.2 The report highlights the efforts of 180 public bodies across Scotland in reducing carbon emissions from the public sector last year. The overall **8% reduction in emissions** is a result of factors including the direct efforts of public bodies through emission reduction projects and increased use of renewables, and a cleaner electricity grid. These all point to the public sector driving forward action in moving Scotland towards a low carbon society.

4.6.3 The document also details that since 2015/16:

- There has been a 20% increase in carbon savings from implementation of mitigation projects across the sector
- There has been a 20% increase in reported carbon savings from renewable generation
- There was a reduction in 6% of waste tonnage going to landfill
- There was a 2.2% drop in electricity consumption
- Almost 60% of public bodies reported renewable generation – with solar panels featuring prominently, closely followed by biomass generation.

4.7 Further analysis of reports is to be undertaken by Sustainable Scotland Networks, to allow further analysis of corporate emissions and other aspects of the climate change reports, including management, governance and strategy, and the public bodies' wider influence on emissions.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues. It should be noted that the implementation of an Integrated Impact Assessment by Dundee City Council (which is being adapted by the Health and Social Care Partnership) has been highlighted in the Sustainable Scotland Report.

6.0 RISK ASSESSMENT

The Integration Joint Board has fulfilled its statutory obligations in relation to Climate Change Reporting. Any future risks will be identified as part of the ongoing work with NHS Tayside and Dundee City Council and will be returned to the IJB as necessary.

7.0 CONSULTATIONS

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

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 1 February 2018

Allison Fannin
Planning & Development Manager

Appendix 1

Public Sector Climate Change Duties 2017 Summary Report: Dundee City

TABLE OF CONTENTS

Required

PART 1: PROFILE OF REPORTING BODY

1(a) Name of reporting body
Dundee City

1(b) Type of body
Integrated Joint Boards

1(c) Highest number of full-time equivalent staff in the body during the report year
0

1(d) Metrics used by the body			
Specify the metrics that the body uses to assess its performance in relation to climate change and sustainability.			
Metric	**Unit**	**Value**	**Comments**

1(e) Overall budget of the body	
Specify approximate £/annum for the report year.	
Budget	**Budget Comments**
257494000	The IJB does not directly employ staff. All staff are employed by either NHS Tayside or Dundee City Council. Our current performance monitoring framework does not include any metrics in relation to climate change and sustainability. We contribute to the metrics identified by NHS Tayside and Dundee City Council

1(f) Report year	
Specify the report year.	
Report Year	**Report Year Comments**
Financial (April to March 2016/2017)	

1(g) Context
Provide a summary of the body's nature and functions that are relevant to climate change reporting.
The Public Bodies (Joint Working) (Scotland) Act 2014 required NHS Boards and Local Authorities to integrate the planning and delivery of certain adult health and social care services. The Dundee Integration Joint Board (IJB) was established on 1st April 2016 to plan, oversee and deliver adult health and social care services through the Dundee Health and Social Care Partnership. The Dundee Health and Social Care Partnership consists of Dundee City Council, NHS Tayside, partners from the third sector and independent providers of health and social care services. The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly people whose needs are complex and require support from both health and social care services. The Vision of the Health and Social Care Partnership is: "Each citizen of Dundee will have access to the information and support that they need to live a fulfilled life"

PART 2: GOVERNANCE, MANAGEMENT AND STRATEGY

2(a) How is climate change governed in the body?
Provide a summary of the roles performed by the body's governance bodies and members in relation to climate change. If any of the body's activities in relation to climate change sit outside its own governance arrangements (in relation to, for example, land use, adaptation, transport, business travel, waste, information and communication technology, procurement or behaviour change), identify these activities and the governance arrangements.
The Integration Joint Board continues to develop its governance structures as our operational structures become clear. Once our obligations (over and above reporting) in relation to climate change become clearer we will agree appropriate governance routes. Many of the activities in relation to climate change sit outwith our own governance arrangements and governance and accountability for these sit with NHS Tayside and Dundee City Council (e.g.Staff travel, Procurement Land/building use IT Waste)

2(b) How is climate change action managed and embedded by the body?
Provide a summary of how decision-making in relation to climate change action by the body is managed and how responsibility is allocated to the body's senior staff, departmental heads etc. If any such decision-making sits outside the body's own governance arrangements (in relation to, for example, land use, adaptation, transport, business travel, waste, information and communication technology, procurement or behaviour change), identify how this is managed and how responsibility is allocated outside the body (JPEG, PNG, PDF, DOC)
Dundee IJB does not have specific decision making routes in relation to climate change and has not allocated responsibility to departmental heads. Once the IJB is clear about its responsibilities in relation to climate change responsibility will be allocated via the Chief Officer to the appropriate senior manager(s).

2(c) Does the body have specific climate change mitigation and adaptation objectives in its corporate plan or similar document?		
Provide a brief summary of objectives if they exist.		
Objective	**Doc Name**	**Doc Link**
see NHS Tayside/Dundee City Council submission		

2(d) Does the body have a climate change plan or strategy?
If yes, provide the name of any such document and details of where a copy of the document may be obtained or accessed.
The IJB does not have a Climate Change Plan or strategy of its own. It works closely with NHS Tayside and Dundee City Council to support the implementation of the relevant plans and strategies of NHS Tayside/Dundee City Council

2(e) Does the body have any plans or strategies covering the following areas that include climate change?				
Provide the name of any such document and the timeframe covered.				
Topic area	**Name of document**	**Link**	**Time period covered**	**Comments**
Adaptation				
Business travel				
Staff Travel				
Energy efficiency				
Fleet transport				
Information and communication technology				
Renewable energy				
Sustainable/renewable heat				

Waste management				
Water and sewerage				
Land Use				
Other (state topic area covered in comments)				

2(f) What are the body's top 5 priorities for climate change governance, management and strategy for the year ahead?
Provide a brief summary of the body's areas and activities of focus for the year ahead.
The IJB's priority for the coming year is to achieve a better understanding and clarity in relation to any obligations or responsibilities it has in relation to climate change over and above the responsibilities and obligations of NHS Tayside and Dundee City Council. This will include considering how our contracted services support these responsibilities.

2(g) Has the body used the Climate Change Assessment Tool(a) or equivalent tool to self-assess its capability / performance?
If yes, please provide details of the key findings and resultant action taken.
The IJB has not yet assessed its capability/performance in relation to climate change.

2(h) Supporting information and best practice
Provide any other relevant supporting information and any examples of best practice by the body in relation to governance, management and strategy.

PART 3: EMISSIONS, TARGETS AND PROJECTS

3a Emissions from start of the year which the body uses as a baseline (for its carbon footprint) to the end of the report year
Complete the following table using the greenhouse gas emissions total for the body calculated on the same basis as for its annual carbon footprint /management reporting or, where applicable, its sustainability reporting. Include greenhouse gas emissions from the body's estate and operations (a) (measured and reported in accordance with Scopes 1 & 2 and, to the extent applicable, selected Scope 3 of the Greenhouse Gas Protocol (b)). If data is not available for any year from the start of the year which is used as a baseline to the end of the report year, provide an explanation in the comments column. (a) No information is required on the effect of the body on emissions which are not from its estate and operations.

Reference Year	Year	Scope1	Scope2	Scope3	Total	Units	Comments

3b Breakdown of emission sources	
Complete the following table with the breakdown of emission sources from the body's most recent carbon footprint (greenhouse gas inventory); this should correspond to the last entry in the table in 3(a) above. Use the 'Comments' column to explain what is included within each category of emission source entered in the first column. If, for any such category of emission source, it is not possible to provide a simple emission factor(a) leave the field for the emission factor blank and provide the total emissions for that category of emission source in the 'Emissions' column.	

Total	Comments – reason for difference between Q3a & 3b.	Emission source	Scope	Consumption data	Units	Emission factor	Units	Emissions (tCO2e)	Comments
0.0									

3c Generation, consumption and export of renewable energy					
Provide a summary of the body's annual renewable generation (if any), and whether it is used or exported by the body.					
	Renewable Electricity		Renewable Heat		
Technology	**Total consumed by the organisation (kWh)**	**Total exported (kWh)**	**Total consumed by the organisation (kWh)**	**Total exported (kWh)**	**Comments**
Other					

3d Targets										
List all of the body's targets of relevance to its climate change duties. Where applicable, overall carbon targets and any separate land use, energy efficiency, waste, water, information and communication technology, transport, travel and heat targets should be included.										
Name of Target	**Type of Target**	**Target**	**Units**	**Boundary/scope of Target**	**Progress against target**	**Year used as baseline**	**Baseline figure**	**Units of baseline**	**Target completion year**	**Comments**

3e Estimated total annual carbon savings from all projects implemented by the body in the report year			
Total	**Emissions Source**	**Total estimated annual carbon savings (tCO2e)**	**Comments**
0	Electricity		

	Natural gas		
	Other heating fuels		
	Waste		
	Water and sewerage		
	Business Travel		
	Fleet transport		
	Other (specify in comments)		

3f Detail the top 10 carbon reduction projects to be carried out by the body in the report year

Provide details of the 10 projects which are estimated to achieve the highest carbon savings during report year.

Project name	Funding source	First full year of CO2e savings	Are these savings figures estimated or actual?	Capital cost (£)	Operational cost (£/annum)	Project lifetime (years)	Primary fuel/emission source saved	Estimated carbon savings per year (tCO2e/annum)	Estimated costs savings (£/annum)	Behaviour Change	Comments

3g Estimated decrease or increase in the body's emissions attributed to factors (not reported elsewhere in this form) in the report year	
If the emissions increased or decreased due to any such factor in the report year, provide an estimate of the amount and direction.	

Total	Emissions source	Total estimated annual emissions (tCO2e)	Increase or decrease in emissions	Comments
0	Estate changes			
	Service provision			
	Staff numbers			
	Other (specify in comments)			

3h Anticipated annual carbon savings from all projects implemented by the body in the year ahead			
Total	**Source**	**Saving**	**Comments**
0	Electricity		
	Natural gas		
	Other heating fuels		
	Waste		
	Water and sewerage		
	Business Travel		
	Fleet transport		
	Other (specify in comments)		

3i Estimated decrease or increase in the body's emissions attributed to factors (not reported elsewhere in this form) in the year ahead				
If the emissions are likely to increase or decrease due to any such factor in the year ahead, provide an estimate of the amount and direction.				
Total	**Emissions source**	**Total estimated annual emissions (tCO2e)**	**Increase or decrease in emissions**	**Comments**
0	Estate changes			
	Service provision			
	Staff numbers			
	Other (specify in comments)			

3j Total carbon reduction project savings since the start of the year which the body uses as a baseline for its carbon footprint	
If the body has data available, estimate the total emissions savings made from projects since the start of that year ("the baseline year").	
Total	**Comments**

3k Supporting information and best practice
Provide any other relevant supporting information and any examples of best practice by the body in relation to its emissions, targets and projects.

PART 4: ADAPTATION

4(a) Has the body assessed current and future climate-related risks?
If yes, provide a reference or link to any such risk assessment(s).
The IJB has not yet assessed current and future climate-related risks

4(b) What arrangements does the body have in place to manage climate-related risks?
Provide details of any climate change adaptation strategies, action plans and risk management procedures, and any climate change adaptation policies which apply across the body.
none

4(c) What action has the body taken to adapt to climate change?
Include details of work to increase awareness of the need to adapt to climate change and build the capacity of staff and stakeholders to assess risk and implement action.
reference NHS Tayside/Dundee City Council return. We will continue to utilise the tools and strategies of NHS Tayside and Dundee City Council to raise awareness with staff and communities re climate change, risk assessment and implementing improvements

4(d) Where applicable, what progress has the body made in delivering the policies and proposals referenced N1, N2, N3, B1, B2, B3, S1, S2 and S3 in the Scottish Climate Change Adaptation Programme(a) ("the Programme")?	
If the body is listed in the Programme as a body responsible for the delivery of one or more policies and proposals under the objectives N1, N2, N3, B1,B2, B3, S1, S2 and S3, provide details of the progress made by the body in delivering each policy or proposal in the report year. If it is not responsible for delivering any policy or proposal under a particular objective enter “N/A” in the ‘Delivery progress made’ column for that objective. (a) This refers to the programme for adaptation to climate change laid before the Scottish Parliament under section 53(2) of the Climate Change (Scotland) Act 2009 (asp 12) which currently has effect. The most recent one is entitled “Climate Ready Scotland: Scottish Climate Change Adaptation Programme” dated May 2014.	

Objective	**Objective reference**	**Theme**	**Policy / Proposal reference**	**Delivery progress made**	**Comments**
Understand the effects of climate change and their impacts on the natural environment.	N1	Natural Environment		N/A	
Support a healthy and diverse natural environment with capacity to adapt.	N2	Natural Environment		N/A	
Sustain and enhance the benefits, goods and services that the natural environment provides.	N3	Natural Environment		N/A	

Understand the effects of climate change and their impacts on buildings and infrastructure networks.	B1	Buildings and infrastructure networks		N/A	
Provide the knowledge, skills and tools to manage climate change impacts on buildings and infrastructure.	B2	Buildings and infrastructure networks		N/A	
Increase the resilience of buildings and infrastructure networks to sustain and enhance the benefits and services provided.	B3	Buildings and infrastructure networks		N/A	
Understand the effects of climate change and their impacts on people, homes and communities.	S1	Society		N/A	
Increase the awareness of the impacts of climate change to enable people to adapt to future extreme weather events.	S2	Society		N/A	

Support our health services and emergency responders to enable them to respond effectively to the increased pressures associated with a changing climate.	S3	Society		N/A	

4(e) What arrangements does the body have in place to review current and future climate risks?
Provide details of arrangements to review current and future climate risks, for example, what timescales are in place to review the climate change risk assessments referred to in Question 4(a) and adaptation strategies, action plans, procedures and policies in Question 4(b).
Reference NHS Tayside/Dundee City Council

4(f) What arrangements does the body have in place to monitor and evaluate the impact of the adaptation actions?
Please provide details of monitoring and evaluation criteria and adaptation indicators used to assess the effectiveness of actions detailed under Question 4(c) and Question 4(d).
Reference NHS Tayside/Dundee City Council

4(g) What are the body's top 5 priorities for the year ahead in relation to climate change adaptation?
Provide a summary of the areas and activities of focus for the year ahead.
Improve links with NHS Tayside and Dundee City Council and other Tayside HSCP climate change leads Ensure service delivery change considers climate change impact where appropriate Clarify the obligations and accountabilities of the HSCP in relation to climate change adaptation

4(h) Supporting information and best practice
Provide any other relevant supporting information and any examples of best practice by the body in relation to adaptation.
ref NHS Tayside and Dundee City Council submission

PART 5: PROCUREMENT

5(a) How have procurement policies contributed to compliance with climate change duties?
Provide information relating to how the procurement policies of the body have contributed to its compliance with climate changes duties.
Ref NHS Tayside and Dundee City Council submission

5(b) How has procurement activity contributed to compliance with climate change duties?
Provide information relating to how procurement activity by the body has contributed to its compliance with climate changes duties.
Ref NHS Tayside and Dundee City Council submission

5(c) Supporting information and best practice
Provide any other relevant supporting information and any examples of best practice by the body in relation to procurement.
Ref NHS Tayside and Dundee City Council submission

PART 6: VALIDATION AND DECLARATION

6(a) Internal validation process
Briefly describe the body's internal validation process, if any, of the data or information contained within this report.
Report contents shared with NHS Tayside, Dundee City Council and other Tayside HSCP Climate Change leads

6(b) Peer validation process
Briefly describe the body's peer validation process, if any, of the data or information contained within this report.
As above

6(c) External validation process
Briefly describe the body's external validation process, if any, of the data or information contained within this report.
None

6(d) No validation process
If any information provided in this report has not been validated, identify the information in question and explain why it has not been validated.

6e - Declaration		
I confirm that the information in this report is accurate and provides a fair representation of the body's performance in relation to climate change.		
Name	**Role in the body**	**Date**
Allison Fannin	Planning and Development Manager	2017-11-20

Sustainable Scotland Network

PART OF THE Keep Scotland Beautiful CHARITY

Appendix 2

Scottish Public Bodies Climate Change Reporting 2015/16

Contents

About this report

This report presents high-level analysis of the information contained in the Public Bodies Climate Change Reports for the period 2015/16.

Public Bodies Climate Change Reporting is a national annual mandatory reporting process for those public sector bodies in Scotland categorised as 'major players'. The reports detail compliance with the climate change duties that came into force in 2011, under the Climate Change (Scotland) Act 2009.

The standardised reporting template contains six 'required' sections that must be completed, and one optional 'recommended' section. This Analysis Report follows the same format.

As well as providing a summary of key findings for each section of the reporting template, the report also makes recommendations that will support the public sector and improve the overall standard of reporting.

The analysis and data contained in this report, while subject to a quality assurance process, is based on the information submitted by public bodies and can present a picture of only the reported data and activities.

About us

Public Bodies Climate Change Reporting is managed and coordinated on behalf of the Scottish Government by the Sustainable Scotland Network (SSN) team at the environmental charity Keep Scotland Beautiful (KSB).

Supported by the Scottish Government, SSN is a national network for public sector professionals working on sustainable development and climate change.

SSN works with the 150 public sector organisations in Scotland which have been identified as 'major players'. The major players include Scotland's 32 local authorities, 25 colleges, 19 universities, 14 regional NHS boards, five Special NHS Boards, seven Regional Transport Partnerships and many other bodies including Scottish Water, Scottish Natural Heritage, the Scottish Environment Protection Agency and Historic Environment Scotland. SSN currently has over 650 individual members from across the public sector.

The purpose of the SSN is to:

- Improve public sector performance on sustainability and climate change
- Allow members to share information and good practice
- Provide information and support on relevant policy areas

SSN also supports compliance with Scottish Government legislation, in particular the Public Bodies Climate Change Duties under the Climate Change (Scotland) Act 2009.

The work of SSN is guided by the SSN Steering Group which is made up of 14 SSN members from across the public sector, and representatives from the Scottish Government and Keep Scotland Beautiful. The Convention of Scottish Local Authorities (COSLA) is represented as an observer on the Steering Group.

Supported by the Scottish Government

The Scottish Government

Background to Public Bodies Climate Change Reporting

Prior to Public Bodies Climate Change Reporting, Scottish public bodies reported on their climate change activities through participation in a number of different voluntary arrangements.

In June 2015, following a period of consultation, the Scottish Government invited public bodies who appeared on the major players list to voluntarily submit a Climate Change Report using a new standardised template. The successful trial saw 110 public bodies submit Climate Change Reports for the period 2014/15.

It was the intention of the Scottish Government that this trial would pave the way for a transition to mandatory climate change reporting for major players in 2016. This was confirmed by the passing of a Statutory Order to this effect in November 2015.

The first mandatory cycle of reporting therefore covers the period 2015/16. Public bodies were required to submit a report covering that period by 30 November 2016, and 145 reports were accepted for analysis.

Pre-2015

Public bodies participated in different voluntary climate change reporting processes, including:

- Scotland's Climate Change Declaration (SCCD)
- Universities and Colleges Climate Commitment for Scotland (UCCCfS)
- NHS Estate Asset Management Project
- Scottish Government Public Sector Sustainability Reporting

2015

February

Scottish Government opens consultation on the introduction of mandatory public sector climate change reporting.

2015

June

Public bodies categorised as 'major players' by the Scottish Government were invited to participate in a trial year of climate change reporting using a new standardised template.

2015

November

110 public bodies submitted Climate Change Reports in the trial year.

2015

November

A Statutory Order makes submission of an annual Climate Change Report mandatory for all public sector bodies classified by the Scottish Government as 'major players'.

150 major player public bodies were required to report data for the period 2015/16 by 30 November 2016, using the new standardised online reporting platform.

2016

November

145 Public Bodies Climate Change Reports were accepted for analysis.

The benefits of climate change reporting

Standardised reporting is central to public bodies optimising climate change action.

Supports compliance

Annual reporting supports compliance with the duties on public bodies set out in the Climate Change (Scotland) Act 2009.

Improves data collection

All key public sector climate change data is brought together in one place, in a standardised format. Transparency of data is improved.

Tracks progress

Annual disclosure and monitoring of emissions, targets and action builds a national picture of progress, and shows how the public sector is contributing to key national climate change policies.

Raises profile

Annual reporting to raises the profile of climate change internally with public sector leaders and senior managers.

Showcases action

Annual reporting identifies and consolidates existing good practice and innovation. Public sector ambition and commitment to climate change action is highlighted.

Informs improvement

Better monitoring and evaluation leads to better targeting of support and resources. Data and good practice arising from reports can be shared via learning networks, strengthening collaboration and partnership working.

Section 1

Profile of the Reporting Bodies

Public bodies reporting in 2016

Local Authorities • Aberdeen City Council • Aberdeenshire Council • Angus Council • Argyll and Bute Council • Clackmannanshire Council • Dumfries and Galloway Council • Dundee City Council • East Ayrshire Council • East Dunbartonshire Council • East Lothian Council • East Renfrewshire Council • City of Edinburgh Council • Comhairle nan Eilean Siar • Falkirk Council • Fife Council • Glasgow City Council • Highland Council • Inverclyde Council • Midlothian Council • Moray Council • North Ayrshire Council • North Lanarkshire Council • Orkney Islands Council • Perth and Kinross Council • Renfrewshire Council • Scottish Borders Council • Shetland Islands Council • South Ayrshire Council • South Lanarkshire Council • Stirling Council • West Dunbartonshire Council • West Lothian Council • **Transport Partnerships** • SPT (Strathclyde Partnership for Transport) • HITRANS (Highlands and Islands Transport Partnership) • Nestrans (North-East of Scotland Transport Partnership) • SEStran (South-East of Scotland Transport Partnership) • SWestrans (South-West of Scotland Transport Partnership) • Tactran (Tayside and Central Scotland Transport Partnership) • ZetTrans (Shetland Transport Partnership) • **National Health Service** • NHS National Services Scotland • The Scottish Ambulance Service Board • The State Hospitals Board for Scotland • The National Waiting Times Centre Board • NHS Ayrshire & Arran • NHS Borders • NHS Dumfries & Galloway • NHS Fife • NHS Forth Valley • NHS Grampian • NHS Greater Glasgow & Clyde • NHS Highland • NHS Lanarkshire • NHS Lothian • NHS Orkney • NHS Shetland • NHS Tayside • NHS Western Isles • **Educational Institutions** • Ayrshire College • Borders College • City of Glasgow College • Dumfries and Galloway College • Dundee and Angus College • Edinburgh College • Fife College • Forth Valley College • Glasgow Clyde College • Glasgow Kelvin College • New College Lanarkshire • Newbattle Abbey College • North East Scotland College • South Lanarkshire College • Scotland's Rural College (SRUC) • West College Scotland • West Lothian College • Inverness College UHI • Lews Castle College UHI • North Highland College UHI • Orkney College UHI • Perth College UHI • Sabhal Mòr Ostaig UHI • West Highland College UHI • Edinburgh Napier University • Glasgow Caledonian University • Glasgow School of Art • Heriot-Watt University • Queen Margaret University • The Royal Conservatoire of Scotland • Open University in Scotland • Robert Gordon University • University of Aberdeen • University of Glasgow • Abertay University • University of Dundee • University of Edinburgh • University of St Andrews • University of Stirling • University of Strathclyde • University of the Highlands and Islands • University of the West of Scotland • **National/regional bodies** • Disclosure Scotland • Education Scotland • National Records of Scotland • The Scottish Children's Reporter Administration • Student Awards Agency for Scotland • The Cairngorms National Park Authority • Care Inspectorate • Highlands and Islands Enterprise • Historic Environment Scotland • The James Hutton Institute • The Loch Lomond and Trossachs National Park Authority • The Moredun Research Institute • The National Galleries of Scotland • The National Library of Scotland • The National Museums of Scotland • The Office of the Scottish Charity Regulator • Registers of Scotland • The Royal Botanic Garden Edinburgh • Scottish Enterprise • The Scottish Environment Protection Agency • Scottish Funding Council • The Scottish Legal Aid Board • Scottish Natural Heritage • The Scottish Parliament • The Scottish Police Authority • Scottish Prison Service • The Scottish Public Services Ombudsman • The Scottish Qualifications Authority • The Scottish Social Services Council • Skills Development Scotland • sportscotland • Visit Scotland • The Registrar General of Births, Deaths and Marriages for Scotland • Audit Scotland • Revenue Scotland • Food Standards Scotland • Scottish Public Pensions Agency • Transport Scotland • The Scottish Courts and Tribunals Service • The Scottish Housing Regulator • Scottish Canals • Scottish Water • The Crofting Commission • The Scottish Fire and Rescue Service




Public body major players are diverse in nature and function, with variable operational, regulatory, executive or advisory functions and have varying sizes of estate.

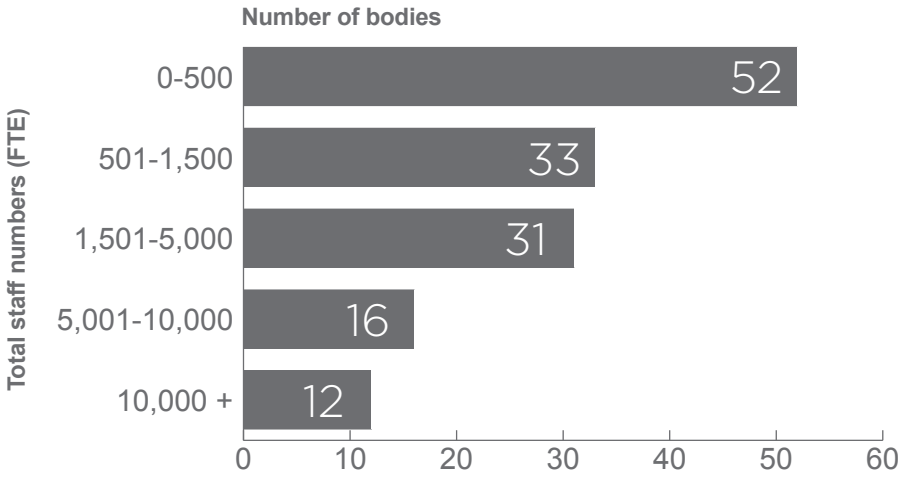
Public bodies reporting by sub-sector

Sub-sector	Number of reports received	Sub-sector %
Local authorities	32	100%
Educational institutions	42	95.5%
National Health Service	18	94.7%
National/regional bodies	46	95.8%
Transport partnerships	7	100%
Total	145	n/a

There is considerable variance of staff numbers across the public bodies.

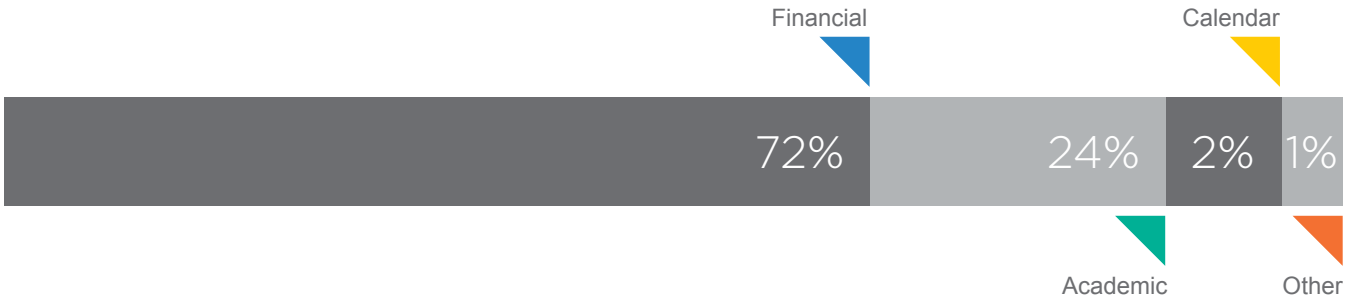
458,769

Total number of full time equivalent staff represented by the Climate Change Reports (circa **8.5%** of Scotland's population)



Reporting year

There is some variability in the years used by public bodies for their Climate Change Reports. Most bodies use the standard financial year (1 April - 31 March), while most universities and colleges use academic year timeframes.



In accordance with UK Government reporting guidance, different sets of emission factors were applied depending on the administration period reported. This meant that those reporting using the academic year timeframes used emission factors one year ahead of the others, as UK Government emission factors are published in June each year. Fluctuations in emission factors from one year to another need to be factored in when analysing and comparing public body Climate Change Reports.

Performance metrics

Floor area is the most popular metric that public bodies are using to assess their climate change performance over time.

Other metrics used by public bodies included: turnover (£); $kgCO_2e$ per £ of budget; carbon emissions per full time equivalent staff; number of operational buildings; hospital heated volume in units of $100m^3$.

Section 1: Profile of reporting bodies **recommendations**

Sharing good practice to build capacity

- Drawing on information provided in this section, it would be useful to benchmark performance between bodies of similar size and function, to inform and support the sharing of good practice on reporting and climate action.

Section 2

Governance, management and strategy

The Climate Change Report asks public bodies to outline how they address climate change within their governance, management and strategy structures and processes. It also asks for evidence of how climate change is embedded as a responsibility throughout the public body.

Most public bodies have a climate change governance structure in place

119	7	19
bodies reported having a climate change governance structure.	bodies are setting up or reviewing their full climate change governance structure.	bodies do not have a structure or did not comment.

Public bodies are taking steps to manage and embed climate change action in their organisations.

111 bodies (77% of reporting bodies) provided information on how climate change action is being embedded throughout their organisations. Responses varied in the level of detail provided. Some reports only provided high-level outlines of internal policies or strategies. However, some reports provided useful examples of actions being undertaken on the ground. These actions range from carbon champions, greening funds where staff influence the allocation and carbon assessments undertaken at project planning stages. Some of the common actions undertaken are outlined below.

49	Working groups or mechanisms to involve staff or other stakeholders including through Community Planning Partnerships
47	Awareness raising activity with staff and / or students including events such as Earth Hour
25	Plans / policies with climate change considerations to be addressed
19	Specific service / department responsibility for actions including carbon targets
19	Green Champions / Networks
8	Induction / Appraisal Process / Job Descriptions and contracts specifying low carbon principals to be followed
7	E-learning Module / similar available to all staff

Examples of work to embed climate change within the public sector

Aberdeenshire Council The council has approved the development of a carbon budget approach for the 2017/18 financial year. This will further embed climate change throughout all services by placing responsibility for reductions to all service directors.

Dumfries and Galloway College The college has recently created a Sustainability Working Group which has members from across the college, from curriculum and support, and students. The aim of the Group is not only to address carbon management from an Estates perspective, but also to focus on embedding education for sustainable development in the curriculum and to work with the wider campus partners to address sustainability and climate change on as wide a basis as possible.

The Scottish Parliament An employee led initiative called Real Action on Carbon Emissions (RACE) has grown from engaged employees seeking fast action on climate change. This acts as a catalyst for change amongst the employee base and senior management to drive forward initiatives and gain support and quick decision making within the normal governance and management structure.

The University of Edinburgh conducted an extensive programme of review from 2015/2016, to reconsider its approach to climate change mitigation and adaptation. The review resulted in identification of approaches to measure emissions, international best practice in the university sector, the business cases for renewables and best practice in carbon reporting. Lessons learned and recommendations from best practice informed development of the new Climate Change Strategy 2016-26.

Highland Council In 2015/16, leadership on climate change was demonstrated by the Council's climate change team and through its Carbon CLEVER initiative, which sets area-wide carbon emissions targets, and provides a framework for coordinating collaborative action on climate change issues across the Highlands.

Highlands and Islands Enterprise have a carbon champion in each of their offices who takes responsibility for communicating and providing feedback to their own office, which aids buy in and implementation across the organisation.

NHS Lanarkshire have a well embedded Sustainable Development Action Plan which has a range of projects and initiatives designed to ensure the Board meets the published targets.

Dundee City Council A new Integrated Impact Assessment tool will be launched to incorporate climate change mitigation and adaptation impacts into the committee reporting process.

Fife Council To boost uptake of the electric vehicles (EV) in the pool car fleet, it is cheaper for services to hire an EV than a conventional pool car.

Specific climate change plans and strategies

88 **bodies (61%) have specific climate change mitigation and/or adaptation objectives in their corporate plans or similar**

The majority of bodies have a dedicated overarching climate change plan or strategy:

79	have a climate change plan or strategy in place
21	have a climate change plan or strategy under review
10	are planning to create a climate change plan or strategy
5	have a climate change plan or strategy that is out of date
10	have included a climate change strategy as part of another strategy
20	do not have a climate change plan or strategy

283 individual plans or strategies in operation that include climate change.

782 climate change plans or strategies embedded into another overarching document.

63 specific climate change plans or strategies under development across various policy areas.

Specific plan or strategy	Policy Area	Reported as embedded into another overarching document
12	Adaptation	71
13	Business travel	105
18	Staff travel	92
16	Fleet transport	73
19	Energy efficiency	119
40	Information and communication technology	40
3	Sustainable / renewable heat	81
38	Waste management	77
10	Waste and sewerage	82
57	Land use	42
57*	Other	

*Examples of others include Procurement (16); Open Space / Conservation (10); Housing (4).

Public bodies' top five priorities for climate change governance, management and strategy for the year ahead

75	65	63	48	47
Energy	Awareness / behaviour change	Transport	Adaptation	Governance

Aberdeenshire Council plan to publish a North East of Scotland and Aberdeenshire Sustainable Energy Action Plan (NESSEAP and SEAP) and establish governance arrangements with appropriate level of status and authority to oversee plan implementation.

NHS Ayrshire and Arran plan to establish impacts of climate change on health and adaptation requirements.

SWestrans plan to refresh and re-focus the climate change strategy to include specific performance metrics

University of Stirling A sustainable travel working group will develop ways to encourage and enable staff & students to use greener methods of travel to commute to the university as well as reducing or using greener methods for travel for business or study.

Highlands and Islands Enterprise The main priority for the organisation in the year ahead is to produce a refreshed carbon management plan for a further 5-year period. This will include gathering accurate and precise data from the new Inverness office, to capture an overall picture of emissions as a result of premises changes, and provide a transferable baseline in which to set future targets against.

56 public bodies have used either the Climate Change Assessment Tool (CCAT) or equivelant tool such as the Good Corporate Citizenship Tool or Life Tool to self assess their capability programme.

Behaviour Change and the ISM Framework

While awareness raising/behaviour change is identified as the second highest priority, very little reference is made in the Climate Change Reports to the use of the Scottish Government's ISM[1] (Individual, Social, Material) behaviour change framework. ISM is a robust and flexible framework that can be used to develop, implement and evaluate climate change policies and projects, and their influence on behaviour change. SSN can provide support to public bodies on using ISM in their climate change work.

[1]Making sustainable change happen requires changes in behaviours and decision-making. ISM (Individual, Social and Material) is the Scottish Government's preferred method for understanding and addressing barriers to behaviour change. It provides a holistic approach for involving stakeholders in the co-design and delivery of projects, programmes and strategies for ensuring effective action on climate change that takes account of material and social contexts, not leaving change to individuals alone.

Section 2: Governance, management and Strategy **recommendations**

Focussed support to address gaps in performance

- Direct support and training should be offered to those public bodies who do not have a climate change plan or strategy in place, and who need to embed climate change into governance and management structures.

Sharing good practice to build capacity

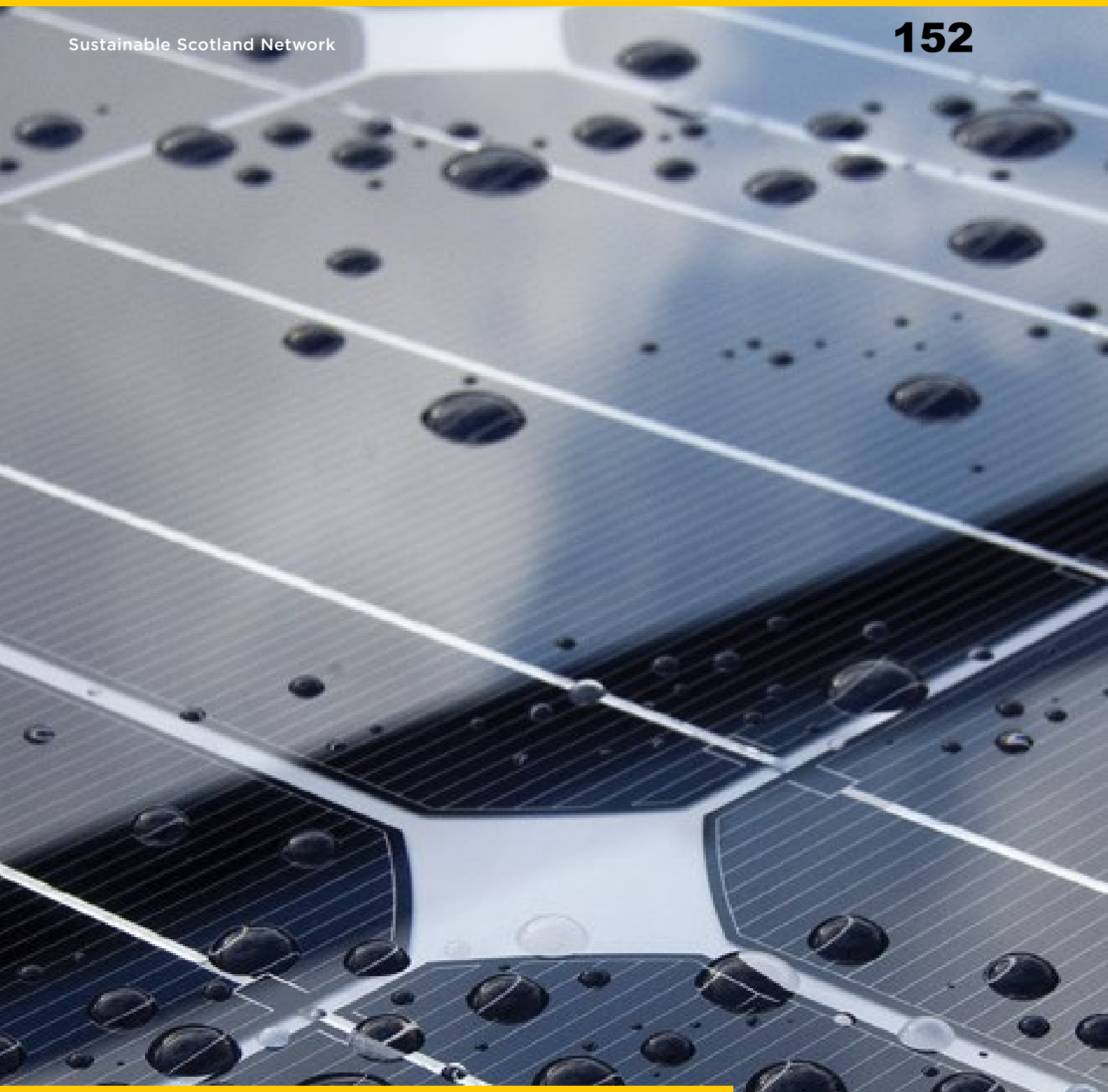
- There is a need to share good practice on effective governance, management and strategy, including how this relates to the setting and monitoring of climate change targets and relevant projects. More is needed to promote good practice on climate change decision-making, including how this influences finance and investment decisions on projects to meet climate change targets and objectives.
- SSN to produce a register, logging where each public body currently has a project, plan or policy, and logging what they are planning to work on going forward. This will aid the sharing of best practice and resources.

Making better use of existing tools

- Public bodies should make more use of the CCAT Tool to assess their performance and to identify improvement objectives.
- Public bodies should make better use of the ISM framework[1] to help integrate climate change into governance and management structures and drive more coordinated action on climate change.

Clearly linking governance and management to projects and targets

- Many reports would be improved by providing clarity on how governance, management and strategy relates to the setting and monitoring of targets and objectives.
- Reports should aim to explain how governance, management and strategy tracks progress and influences decisions-making to keep projects and initiatives on-track to meet targets and objectives, including how finance and investment decisions are taken to maintain action on climate change.



Section 3

Corporate emissions, targets and projects

Corporate emissions

This section of the reporting process asks for information on the greenhouse gas (GHG) emissions that the reporting organisations produce through carrying out their functions. When collated, this information provides an approximate overview of the emissions identified by the reporting bodies as being within their boundaries.

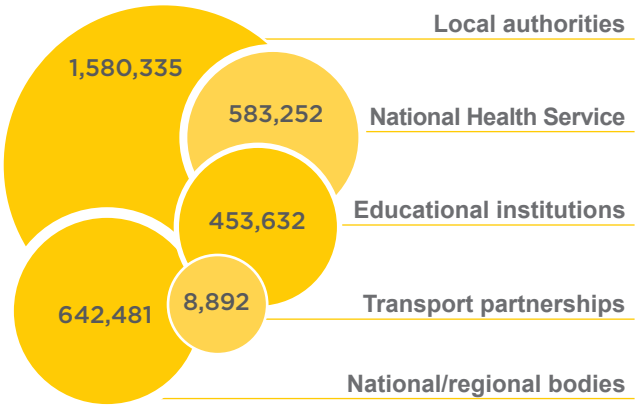
Please note, all the analysis below is based on data as reported by public bodies. Some scrutiny of this data did take place however, in general it was left in its origional and submitted form.

CO_2e

Total reported emissions from the 145 public bodies who completed reports for the 2015/16 reporting year were

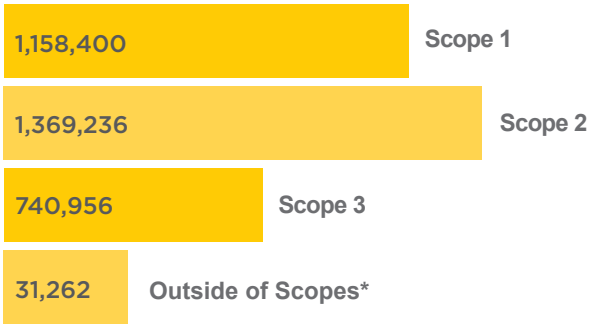
3,268,592 tCO_2e

Total corporate emissions reported by sector 2015/16 (tCO_2e)



Total: 3,268,592 tCO_2e

Total corporate emissions reported by scope* 2015/16 (tCO_2e)



* Outside of scopes emissions not included in final total emissions.

Total: 3,268,592 tCO_2e

The bubble chart shows that the majority of emissions are from the 32 local authorities. The NHS and educational institutions are fairly even in terms of emissions, with the transport partnerships representing a significantly smaller source of emissions.

Understanding Emissions Scopes

Scope 1 – These emissions occur from sources that are owned or controlled by the organisation.

Scope 2 – accounts for GHG emissions from the generation of purchased electricity (or steam) consumed by the organisation.

Scope 3 – These emissions are a consequence of the activities of the organisation, but occur from sources not owned or controlled by the organisation. Some examples of Scope 3 activities are the use of hire cars or sending waste to landfill

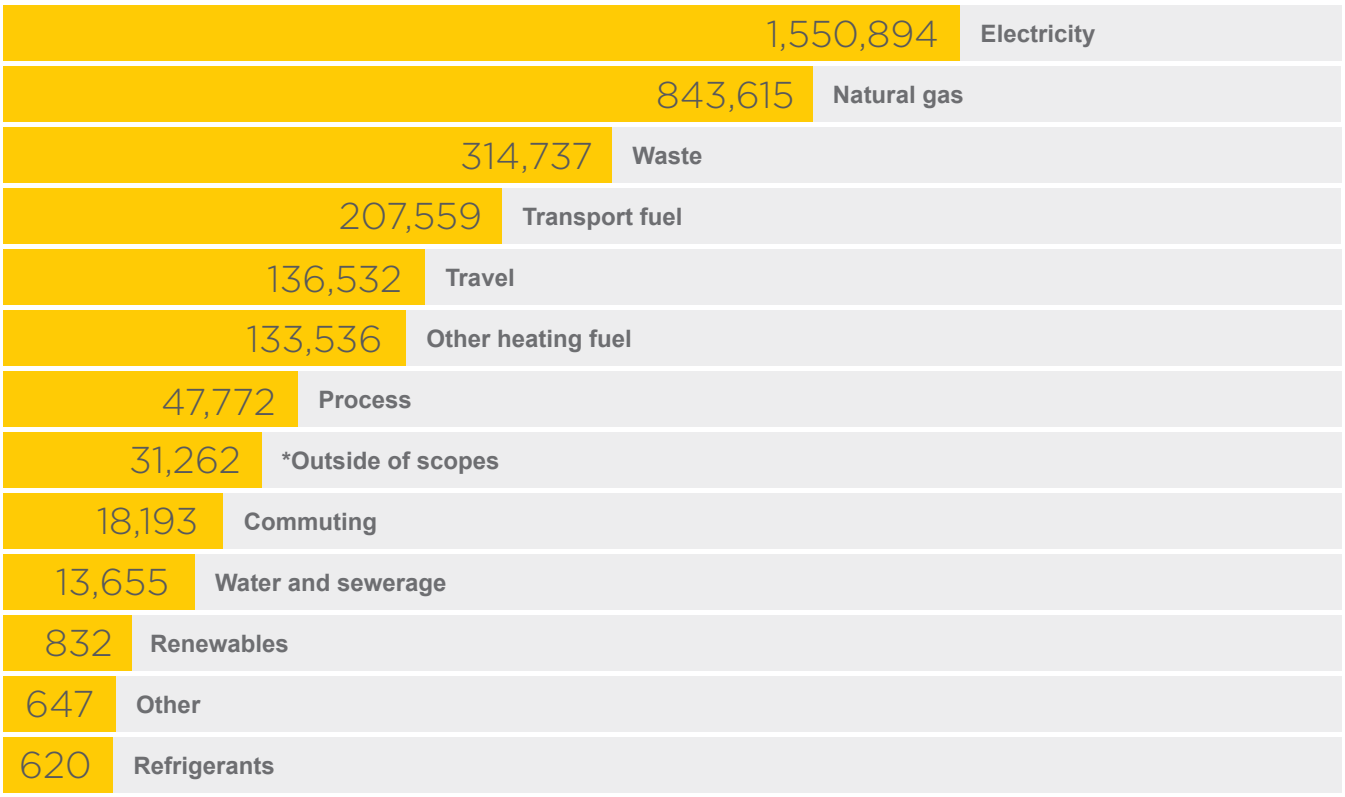
Emissions by scope and sub-sector

Scope	Local authorities	National Health Service	Educational institutions	Transport partnerships	National/regional bodies
Scope 1	565,576	291,756	167,671	602	132,794
Scope 2	615,908	251,255	171,957	6,868	323,248
Scope 3	398,850	40,241	114,004	1,422	186,439
Outside of Scopes*	13,670	7,987	7,476	-	2,129
Total	**1,580,335**	**583,252**	**453,632**	**8,892**	**642,481**

* Outside of scopes emissions not included in final total emissions.

Scope 2 emissions (purchased electricity) make up the majority, narrowly surpassing Scope 1 emissions. Scope 3 emissions make up less of the overall emissions account. This is to be expected as Scope 3 emissions are more challenging to monitor and quantify, and standardised, professional methodologies for accounting for some Scope 3 emissions are still under development.

Emissions by source (tCO_2e)

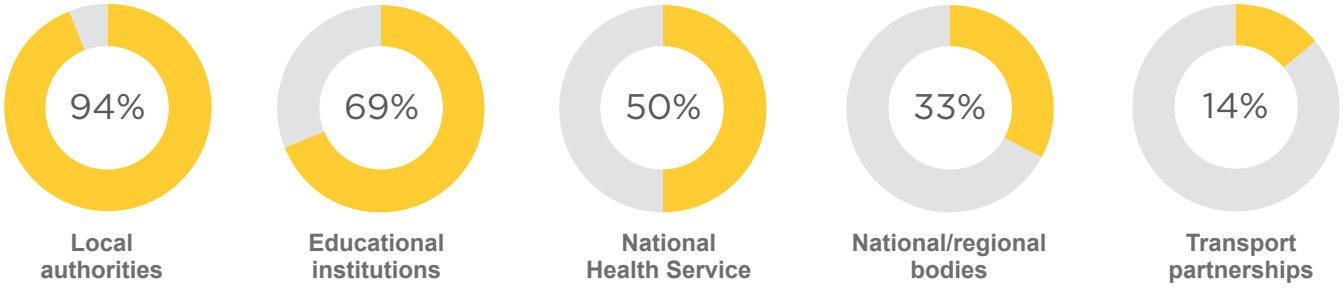


* Outside of scopes emissions not included in final total emissions.

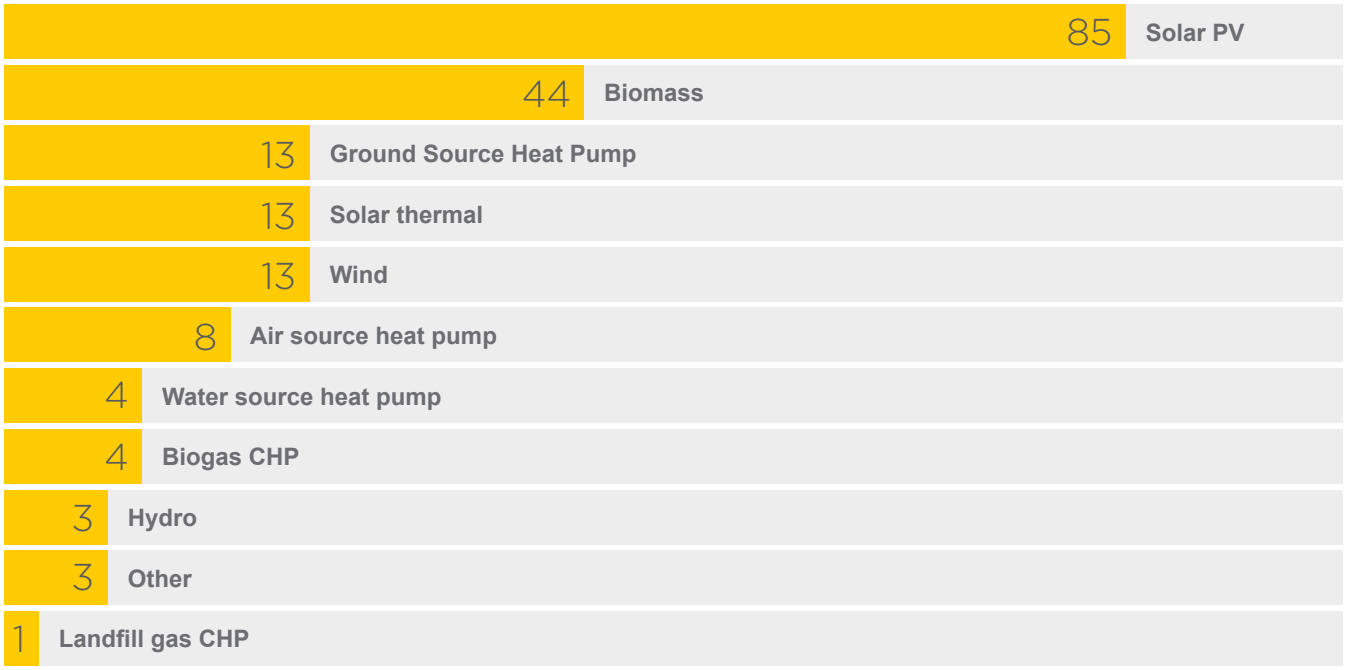
Renewables

105 out of 145 bodies (72%) reported some form of renewable installation, with 94% of local authorities having at least one installation.

Percentage of bodies with renewable installations (by sector)



Number of renewable installations by type



The energy generated from renewable installations was **82 GWh** of renewable electricity and almost **139 GWh** of renewable heat. This amounts to almost **66,000 tCO_2e** in abated emissions attributable to renewable installations in 2015/16.

Biofuels

Biofuels (biomass, biogas, bio blended fuel) are an established source of low carbon energy. Looking at the use of these in isolation, it was found that **51%** of all reporting organisations utilise some form of biofuel. Over **90%** of local authorities reported using at least one type of biofuel throughout 2015/16.

Projects

Climate change mitigation projects implemented in 2015/16 should have resulted in carbon savings in the region of 91,000 tCO_2e in the reporting year.

Project emissions savings by sector (tCO_2e)

48,066	24,315	10,711	7,563	442
Local authorities	**Educational institutions**	**National/regional bodies**	**National Health Service**	**Transport partnerships**

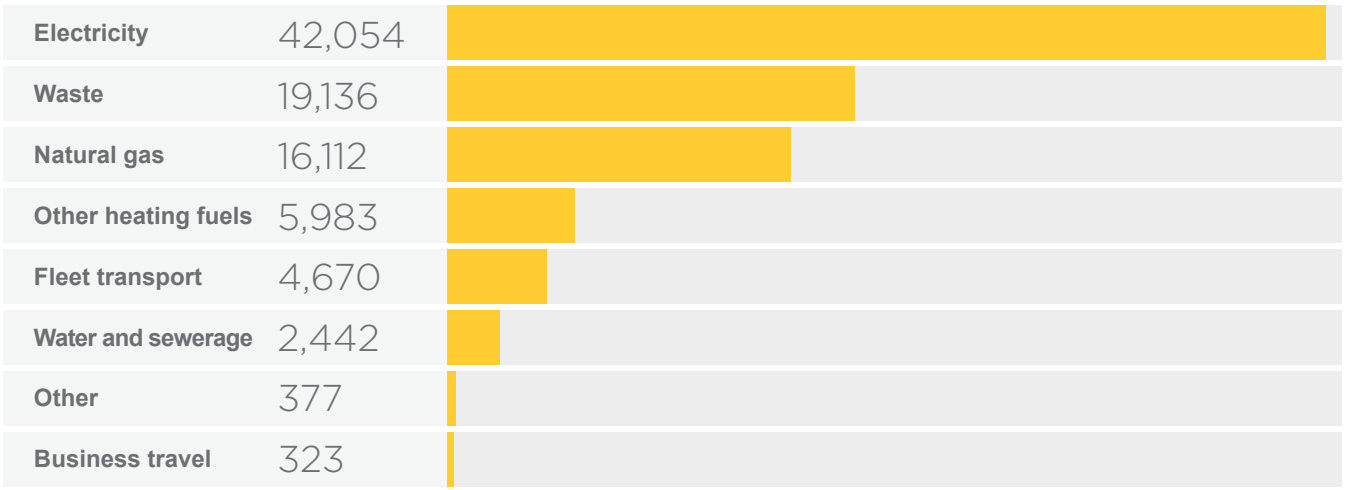
As the largest source of emissions, local authorities are doing the most to reduce emissions through projects, particularly from waste projects.

However as a percentage of total sub-sector emissions, it is the education sector that is saving the most through mitigation projects. This sector is also achieving most savings via electricity projects, largely due to the high number of solar PV installations.

In the NHS sector, good work is being done in the form of converting oil-fuelled boilers to more efficient gas fuelled boilers, as well as lighting upgrades within estates.

In the National/regional bodies sector, lighting upgrades were also common, as well as projects reducing air conditioning in offices, reduce business flights and setting emission limits (gCO_2/km) for new fleet vehicles.

Project emissions savings by source (tCO_2e)



The table below describes some of the common projects in each of the categories.

Category	Common projects
Electricity	■ LED lighting ■ Lighting - internal, external and street lighting ■ Photovoltaic (PV) panels ■ Building Management Systems including timing controls, ventilation controls, voltage optimisation, gas Combined Heat and Power, variable speed drives, IT solutions (virtual servers, thin client PCs)
Waste	■ Diversion of waste to landfill through improved separation and material capture of municipal waste and separate collections for food waste ■ Reduced printing projects
Natural gas	■ Building insulation and upgrades (roof, walls, pipes and windows etc.) ■ Building Management System including boiler replacements, heating protocol changes, steam system replacements
Other heating fuel	■ Replacement fuel boilers (oil to gas or oil to biomass)
Fleet transport	■ Fleet replacement programs ■ Electric vehicle roll outs ■ Reduction in idling time ■ Driver training
Water and sewerage	■ Repairing water leaks and pipe upgrades
Travel	■ Bike to work schemes ■ Increased availability of pool cars and electric vehicle charging points ■ Awareness campaigns and travel policies

Most project savings come from electricity, with waste and natural gas savings also featuring highly. Examples of good practice vary from LED lighting and solar PV, installations of several biomass boilers, implementation of a council wide glass collection scheme, and the introduction of a fleet replacement programme aimed at reducing transport emissions.

Savings through business travel amounted to the lowest number of carbon mitigation projects reported.

It is worth noting that only 17% of projects reported actual savings data, with the vast majority providing estimated savings. Looking in more detail, less than 10% of local authority projects included actual CO_2e savings data. The NHS sector performed best in this respect, with over 50% of projects reported having actual savings data available.

Reporting action on behaviour change

28 bodies (19%) identified one or more projects as having a behaviour change dimension. Of those, only four mentioned behaviour change as part of climate change governance or actions embedded within their organisation although many organisations have identified behaviour change as a key corporate priority.

There was very little reference to the ISM Framework, with only one organisation reporting that they implement ISM when undertaking a carbon reduction project. This indicates that either ISM is being under-utilised within the public sector, or that its use is not being fully reported within the Climate Change Reports.

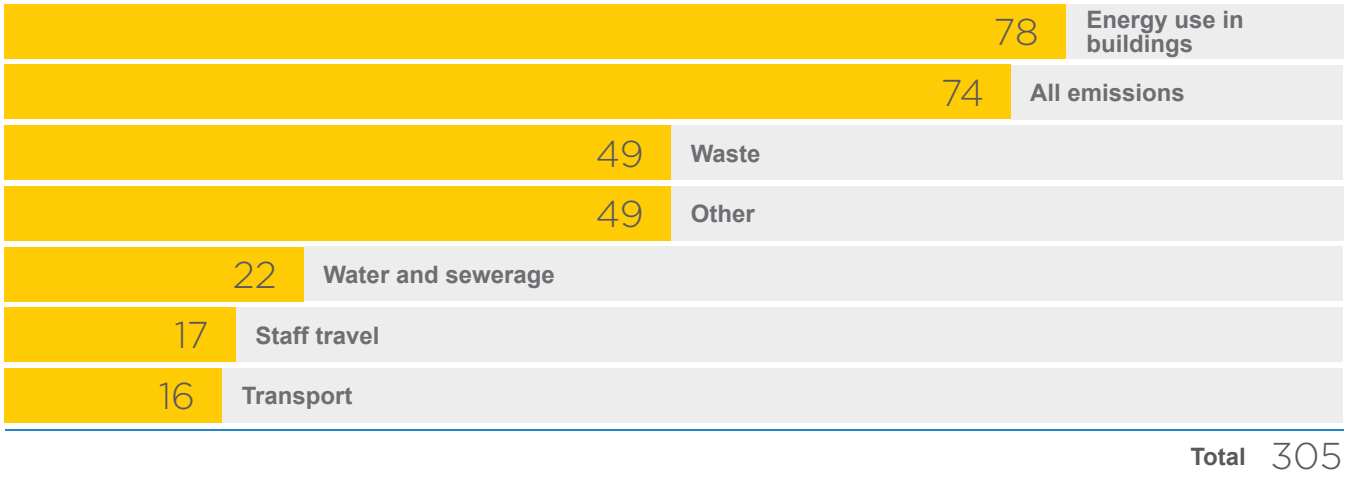
Emission reduction targets

A wide range of targets are being used to drive public sector climate action

109
bodies report
at least one target

67
bodies reported
multiple targets

Level of target types used within the public sector



75% of targets relate to specific policy areas, with **25%** being more general targets to reduce 'all emissions'. Of the **75%**, energy use in buildings is most popular, with transport being the area least addressed.

Section 3: Corporate emissions, targets and projects **recommendations**

Improving reported data

- There is a need for continuous improvement on data reporting in line with the GHG Protocol[2] key principles of: relevance, completeness, consistency, transparency, and accuracy.
- More attention is needed to ensure that emissions are reported accurately by scope.
- Specific work should be taken forward to improve the reporting of biomass, biofuels and renewables.
- The reporting of projects and targets needs to be improved. Capacity in the public sector needs to be developed to undertake better project level carbon assessment and reporting, and to set, monitor and report progress against more consistent and robust targets. Information on targets and projects needs to be better aligned with information on governance and management.

Focussed support to address gaps in performance

- There is a need to improve reporting of data on emissions from waste, especially outwith local authorities. This includes the need to gather data specifically on corporate waste.
- More attention needs to be given to transport related emissions. This source of emissions requires more attention both at target, and project level and in ensuring that activity and fuel use data is captured and reported.
- In line with developments internationally, there is a need to develop work to better address Scope 3 emissions, most notably on key aspects such as business travel, supply chain and procurement impacts, etc.

Sharing good practice to build capacity

- More should be done to use the climate change reports to identify examples of good practice and to share these across the network to support learning and improvement. This would include work on:
  - Good quality data reporting
  - Examples of good practice in setting and monitoring targets
  - Integrating consideration of behaviour change and how to report this effectively
  - Project or policy theme examples that can be shared across SSN

Making better use of existing tools

- Some public bodies should be making more use of the tools that have been developed to support reporting and climate action. These include the:
  - SSN guidance on reporting, including related training videos
  - Climate Change Assessment Tool
  - ISM (Individual, Social, Material) Behaviours Framework
  - Carbon Project and Footprint Register Tool
  - Adaptation Scotland's Five Steps to Climate Adaptation guidance

Clearly linking governance and management to projects and targets

- More should be done to improve the setting of corporate emission reduction targets, and to develop and maintain project registers that are adequate for meeting targets.
- More should be done to demonstrate a clearer link between targets and projects and corporate governance and management structures and processes. This should more clearly demonstrate how management and governance arrangements track progress and make decisions based on project delivery and performance information.
- Reports could be improved if organisations communicated more clearly whether they are on track or not to meet their targets, and how they plan to respond if progress is not on track.

[2]The Greenhouse Gas Protocol. A Corporate Accounting and Reporting Standard (Revised Edition). World Resources Institute and World Business Council for Sustainable Development, March 2004. ISBN 1-56973-568-9

Section 4

Adaptation

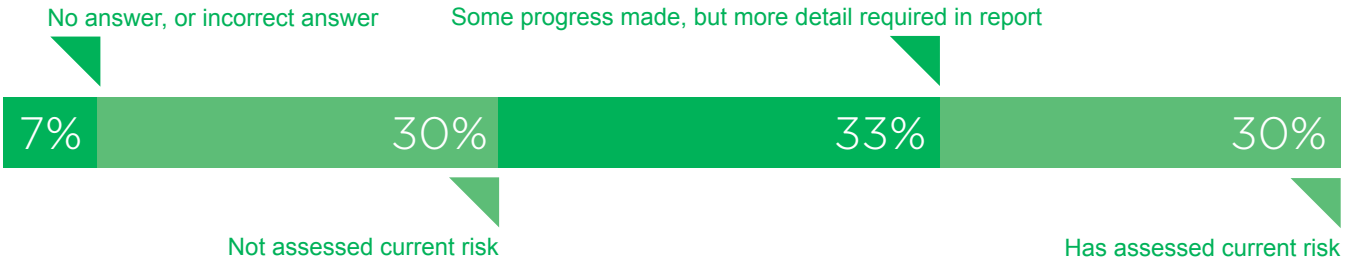
Global climate is changing and this is impacting how we live and work in Scotland. We are already experiencing increases in autumn and winter rainfall, increased heavy rainfall, sea level rise and long term increases in temperatures across all seasons. These changes are impacting all areas of life and will pose an increasing challenge in the future.

Taking early action to assess current and future climate risks and adapt to the impacts of a changing climate will safeguard public sector assets, infrastructure, services, communities and business continuity.



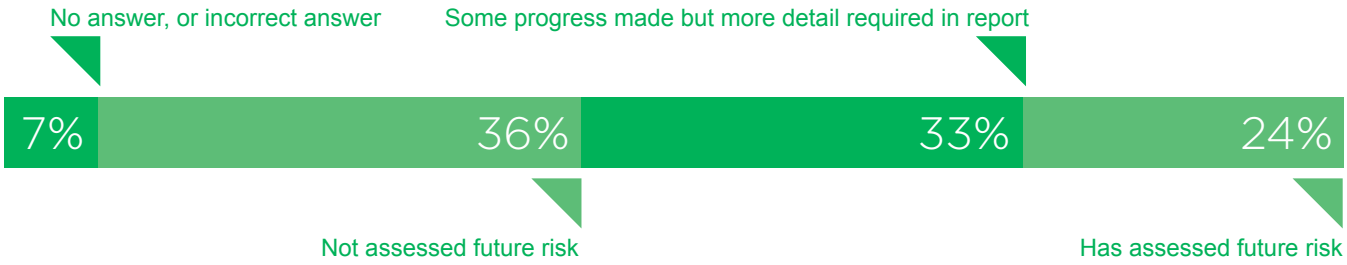
Assessing current climate risks

63% of public bodies have undertaken work to assess current climate risk.



Assessing future climate risks

57% of public bodies report progress in assessing future climate risk.



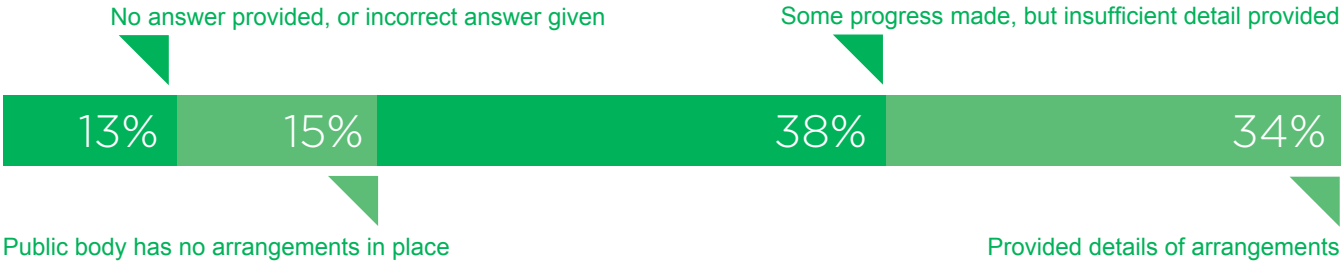
Examples of risk assessments include:

- 15 public bodies have completed a Local Climate Impacts Profile (LCLIP)
- 22 public bodies have conducted further specialist risk assessments, for example Strategic Flood Risk Assessments and Estates Risk Assessments.

The largest number of public bodies that had not assessed current or future climate risks were in the education sector, notably further education colleges.

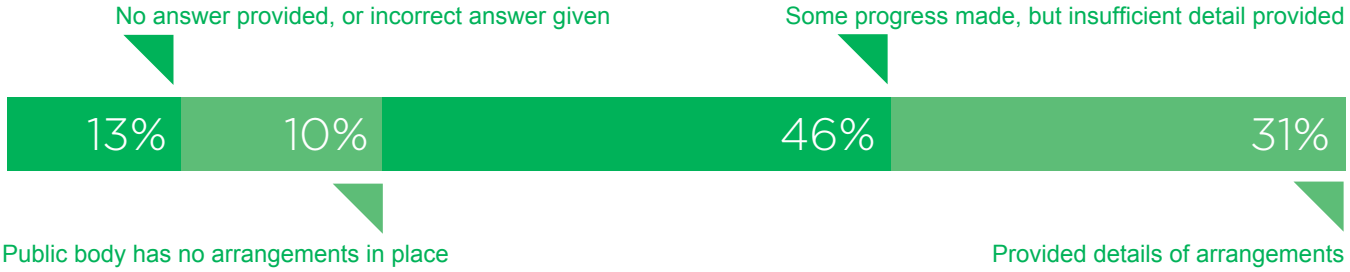
Arrangements for reviewing current and future climate risks

72% of public bodies provided information on arrangements for reviewing their climate risks.



Managing climate-related risks

77% of public bodies are making some progress in putting arrangements in place to manage climate-related risks.



Examples of the type of arrangements detailed include:

- Establishing a risk management committee/board.
- Incorporating adaptation risk into corporate risk registers;.
- Including adaptation within existing climate change strategies or sustainable development action plans.

Adaptation actions reported by public bodies

Public bodies provided the following information on their actions to adapt to climate change, and their efforts to raise awareness of climate change adaptation with staff and the wider community.

There was a wide range of actions detailed within this question including:

- Flood prevention works.
- Treatment of invasive non-native species.
- Soil erosion prevention projects.
- Inclusion of green infrastructure in building design.

More public bodies reported adaptation actions than had reported assessing current and future climate risk. This may infer that, for many, taking action on climate change rather than assessing risk is their focus.

Examples of reported adaptation actions

Fife Council: Woodland Planting
Fife Council have a target to plant a minimum of 10ha of woodland per year for the next 10 years planting a species mix expected to cope and protect against potential future climate change.

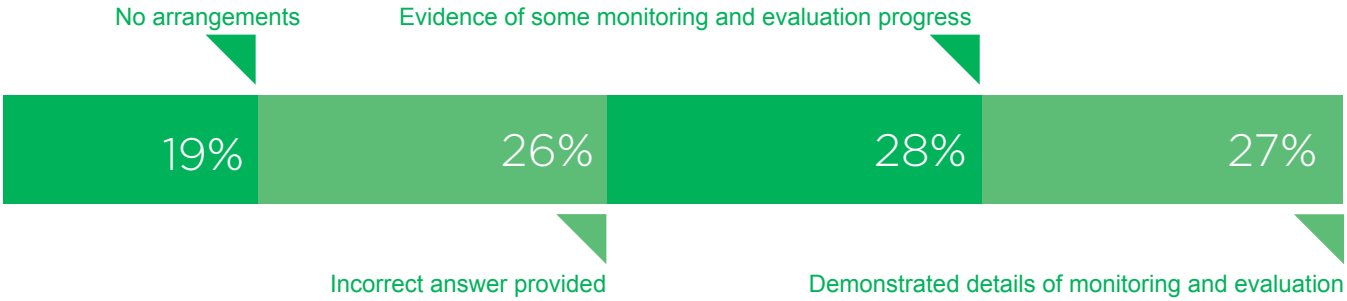
Skills Development Scotland
Adverse Weather and Disruption to Transport Policy to explain what to do if you can't get to work and gives advice on alternative working arrangements.

University of Strathclyde: John Anderson Campus
The University is developing plans for a range of adaptation solutions as part of a major infrastructure upgrade at the John Anderson Campus as part of the 'Heart of Campus' works.

Scottish Fire and Rescue Service
Has procured Flood First Responder PPE pods to be located within 66 community fire and rescue stations with plans to increase to 100 Responder Stations.

The impact of adaptation actions

Based on reported information, public bodies were weaker on monitoring and evaluating the impact of current adaptation actions.



Key insights

- The standard of reporting on adaptation has improved from the 2014/15 submissions, and this should be commended.
- Many of the public bodies that provided an incorrect response provided climate change mitigation details.
- Public bodies are making some progress on putting in place arrangements to manage climate change risks.
- It is encouraging to see the wide range of actions currently underway to manage climate risk in the public sector.
- Seven public bodies not identified as a delivery agency within the Scottish Climate Change Adaptation Programme (SCCAP) included additional information on their progress against SCCAP objectives.
- There are some public bodies that are still in the early stages of addressing adaptation concerns within their organisations.

Section 4: Adaptation **recommendations**

Improving reported data

- SSN will work with public bodies and enhance guidance documents to improve the standard of information submitted on adaptation actions in Climate Change Reports.
- Further collaboration is required between SSN, Adaptation Scotland, the Scottish Government and the listed accountable public bodies within Scotland's Climate Change Adaptation Programme (SCCAP), to reduce duplication for public bodies who report as part of SCCAP.

Focussed support to address gaps in performance

- SSN and Adaptation Scotland should collaborate to use the information in the reports to better target the public bodies most in need of support. Efforts should be focussed on those bodies who have not assessed current or future climate change risks and are at the earlier stages of climate change adaptation work.

Clearly linking governance and management to projects and targets

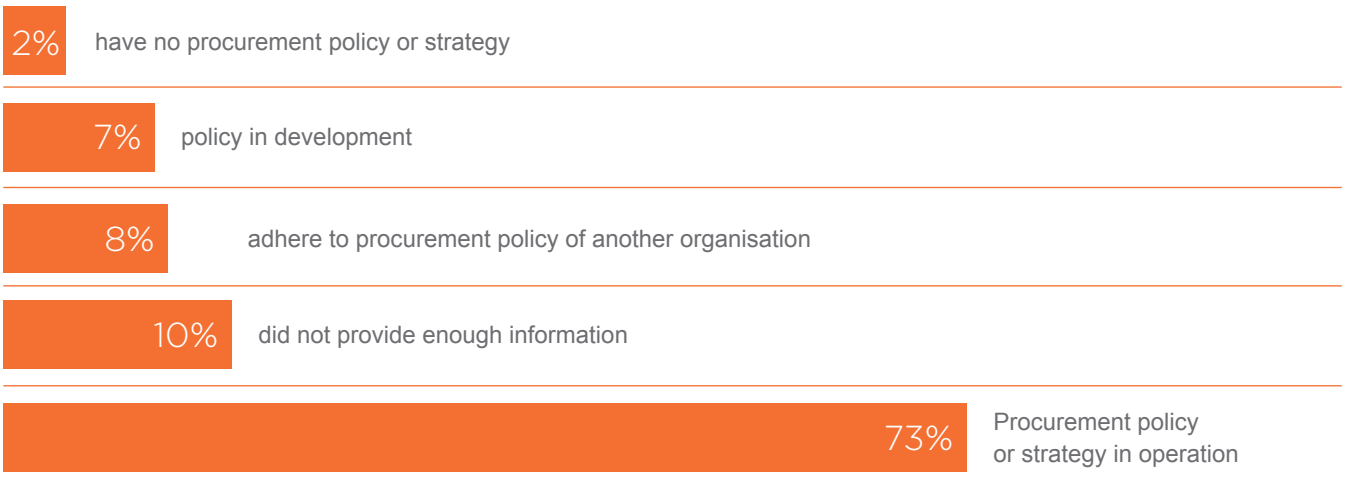
- More should be done to improve the setting of corporate adaptation objectives, and to develop project and policy registers that are adequate for meeting objectives.
- More should be done to demonstrate a clearer link between objectives, policies and projects, and corporate governance and management structures and processes. This should more clearly demonstrate how management and governance arrangements of adaptation track progress and make decisions based on performance information.

Section 5

Procurement

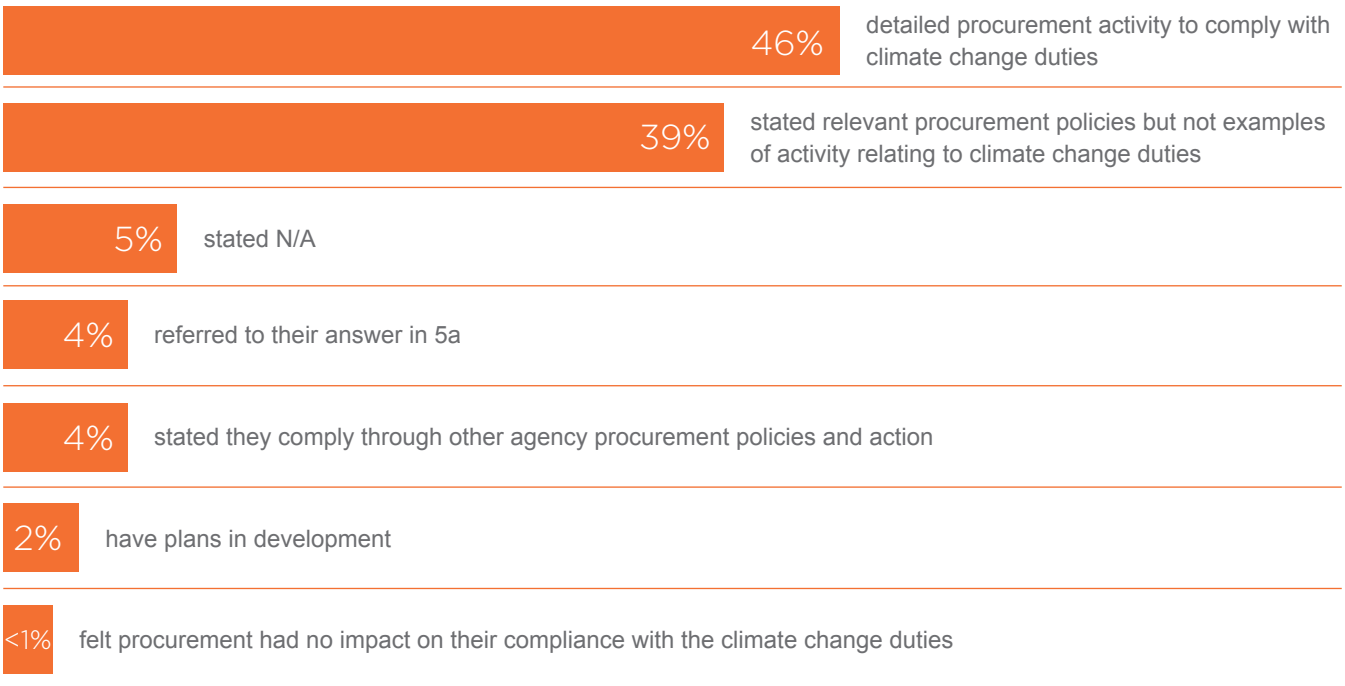
The Scottish public sector spends around £11 billion a year[3] on the purchasing of goods and services. Under the Climate Change (Scotland) Act 2009 and the Procurement Reform (Scotland) Act 2014, public sector procurement is expected to contribute to the achievement of Scotland's climate change targets and support climate change adaptation.

Public bodies with a procurement strategy or policy and information on how these contribute to the climate change duties (% out of 143 responses)



24% of the 104 bodies who have a procurement policy in place specifically reference how these policies have contributed to compliance with the climate change duties.

Public bodies reporting procurement activity that specifically contributes to their climate change duties (%)



[3] http://www.gov.scot/Topics/Government/Procurement/10yearsProcurmentReformAinslie.

Examples of Reported Procurement Policies and Actions

West Lothian Council sustainability policies include sustainable building standards for council controlled buildings; corporate procurement – through the provision of contracts for low carbon and renewable energy solutions to support the delivery of council services.

Perth and Kinross Council The Tayside Procurement Consortium Sustainable Procurement Policy was introduced to support the Tayside Councils to broadly comply with their climate change duties.

South Lanarkshire Council e-Invoicing has been introduced in May 2016 to a number of high transactional suppliers who submit over 250 invoices per year, this will reduce paper invoices by approx. 30,000.

Edinburgh Napier University use the APUC draft tender document which includes a question for bidders on compliance with the Climate Change (Scotland) Act 2009.

Inverness College bought seven low carbon vehicles (four Peugeot 308s and three Ford transit minibuses) to replace existing models. It is anticipated that this will save the college £2,310 and 4.3 tonnes CO2 annually.

University of Dundee are part of a large procurement consortia to share resources through re-use of furniture, stationary and other goods. This is operated through the Warpit web portal. In the last 2 years they have saved over £102,000 and over 60 tonnes of carbon.

The National Museums of Scotland Procurement of new chiller plant downsized existing plant by 30% and further reduced running cost.

Procurement of new lighting controls ensures lighting only has to be switched on when required.

Procurement of a ground source heat pump system has enabled two hangers at National Museum of Flight to be heated using geothermal.

City of Glasgow College A food waste station was procured and installed which has resulted in an 80% reduction in food waste by removing water from food content before disposal.

Key insights

- In line with the Procurement Reform (Scotland) Act, many organisations have re-drafted their Procurement Strategies, with 88% of reporting bodies either having a strategy in place, in development or covered by another body.
- The reports contain many examples of sustainable procurement practices, particularly from local authorities and the education sector. These examples provide good quality information on procurement policies and actions that could be shared.
- Further work is needed to articulate how procurement specifically addresses climate change. Few bodies were able to provide specific data examples of how procurement policies or initiatives had contributed to compliance with the climate change duties, especially accounting for the influence of procurement on emissions reduction or climate change adaptation outcomes.

Section 5: Procurement **recommendations**

Improving reported data

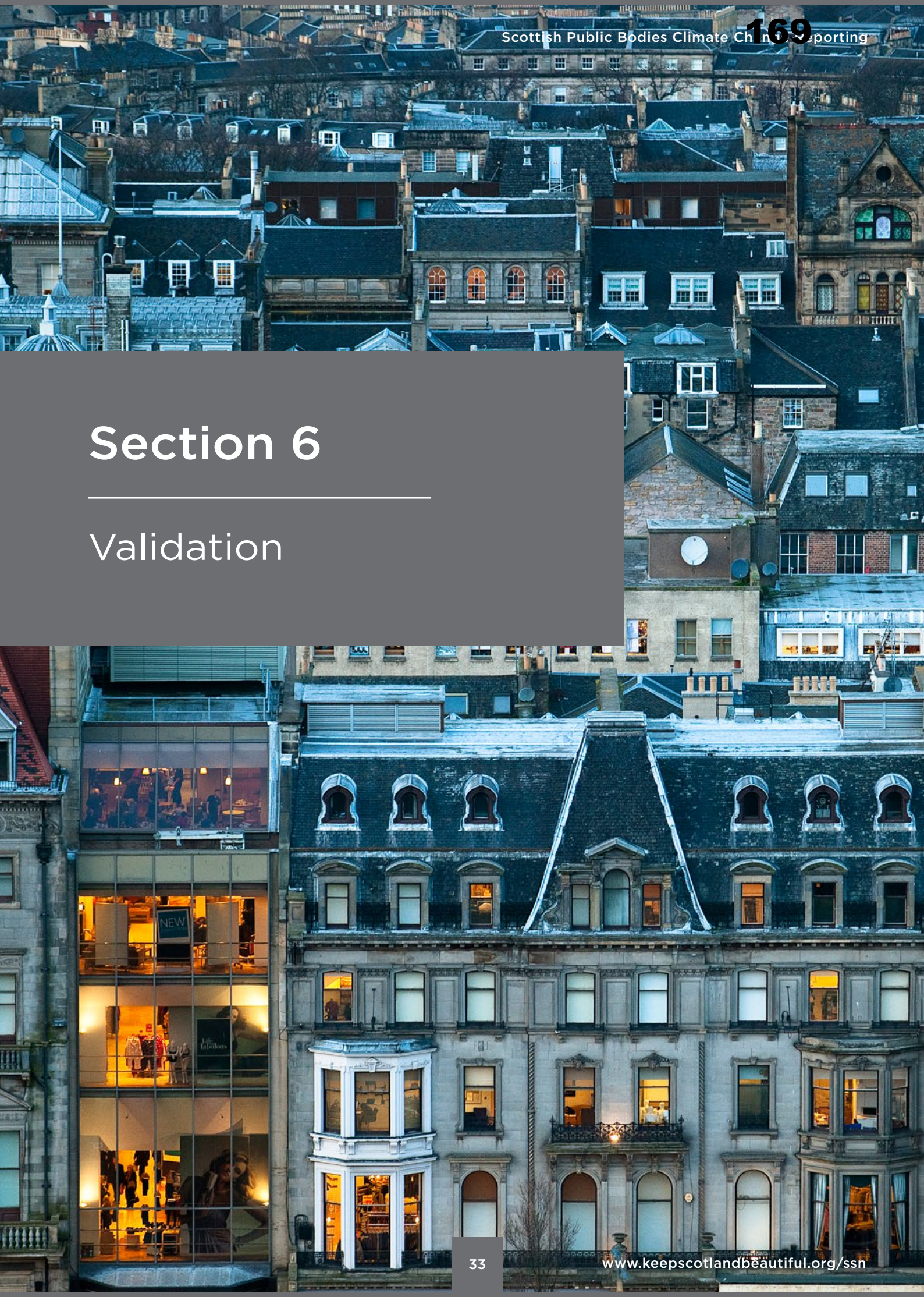
- Public bodies should seek to better articulate the specific climate change relevant objectives and impacts of their procurement activities. A more direct link to climate change project registers and project funding would be useful, as would the articulation of how procurement is specifically contributing to the reduction of emissions or adapting to a changing climate.

Focussed support to address gaps in performance

- More is needed to address gaps in understanding, methods and data availability for specifically assessing the climate change implications and opportunities of procurement. This work relates to the need for more support in addressing Scope 3 emissions noted in Section 3 of this report. This will require the gathering of good practice examples and evolving professional standards, the development of guidance and support tools, and support to improve reporting. This will require the collaboration of key stakeholders with expertise in climate change data, public sector climate action, and public procurement.

Sharing good practice to build capacity

- More should be done to promote and enable learning from examples of good procurement practice contained in the climate change reports. Opportunities for collaborative procurement and for mainstreaming innovative procurement examples should be explored, involving all relevant stakeholders from climate change and procurement areas of expertise.

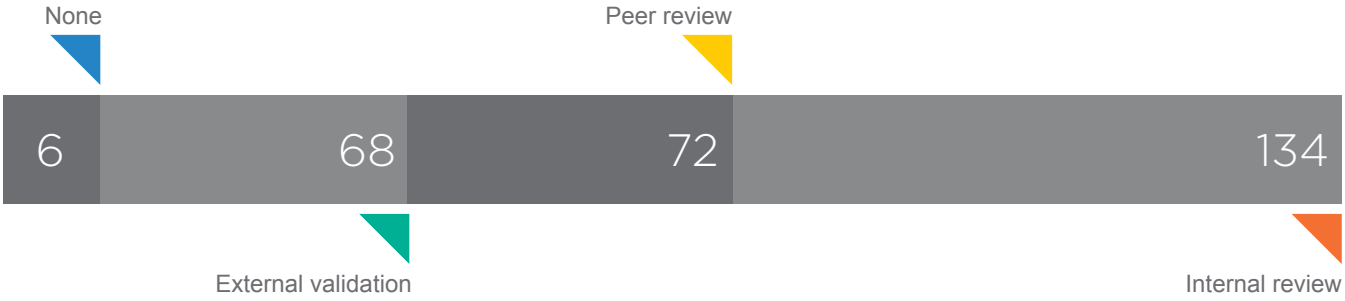


Section 6

Validation

Validation can include internal, peer-to-peer and external review. While acknowledging that the Climate Change Reports cover a wide range of activity, and that some data is already validated through existing statutory processes, public bodies are encouraged to expand the scope of validation of their reports.

Validation processes carried out by public bodies



- Internal validation was high across the public sector, usually involving senior management sign off or approval.
- Out of the 68 bodies, only 5 public bodies noted that they have had their full report externally validated.
- The majority of public bodies had their corporate emissions data validated for other purposes, such as CRC-Energy Efficiency Scheme obligations or as part of ISO accreditation.
- Some bodies reported barriers to undertaking validation. Barriers included lack of resources for internal review and lack of funds available to carry out external validation.

Section 6: Validation recommendations

Focussed support to address gaps in performance

- Build up a map of existing external validation which is adequate, and work to develop effective peer to peer and external validation approaches on other areas. Improve the quality and scope of validation across the reports, while avoiding duplication of validation already in place.
- SSN to explore options to provide cost effective support for peer-to-peer external validation support for public bodies.

Sharing good practice to build capacity

- SSN to provide a 'match making' service to assist those who do not have a peer review process in place to match with bodies with similar estates / functions.

Section 7

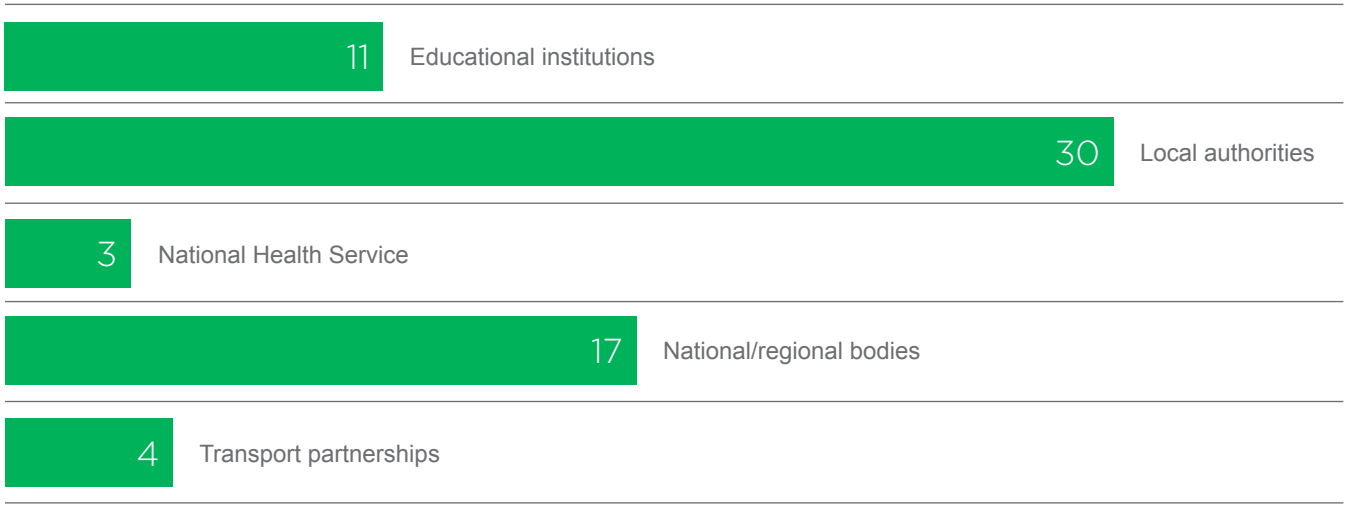
Recommended Reporting: Reporting on Wider Influence

The public sector's wider influence on climate change

The public sector has a critical wider influence role to play, beyond their own corporate boundaries. This role includes both demonstrating leadership and commitment on climate change action, and enabling and influencing Scotland's people, organisations and communities to reduce their impact on climate change and to adapt to a changing climate.

The non-mandatory wider influence reporting template was provided to allow public bodies to report a range of activities relevant to Scotland's action on climate change and sustainable development.

Number and type of public body that completed recommended reporting (65)



Local authority use of DECC/BEIS Emission Datasets (out of 29 reporting organisations)

The Department for Business, Energy & Industrial Strategy (BEIS), formerly Department for Energy and Climate Change (DECC), produce UK local authority and regional estimates of carbon dioxide emissions from 2005 onwards. These estimates are intended as a resource to help those working on local or regional indicators and inventories as part of their efforts to reduce carbon dioxide emissions.

Local authorities can use either the full dataset or subset dataset to set targets and track progress. The full dataset includes all the emissions that occur within the boundaries of each local authority; however, the dataset of emissions within the subset dataset excludes certain emissions that local authorities have considered unable to directly influence e.g. emissions from motorways and large industrial installations.

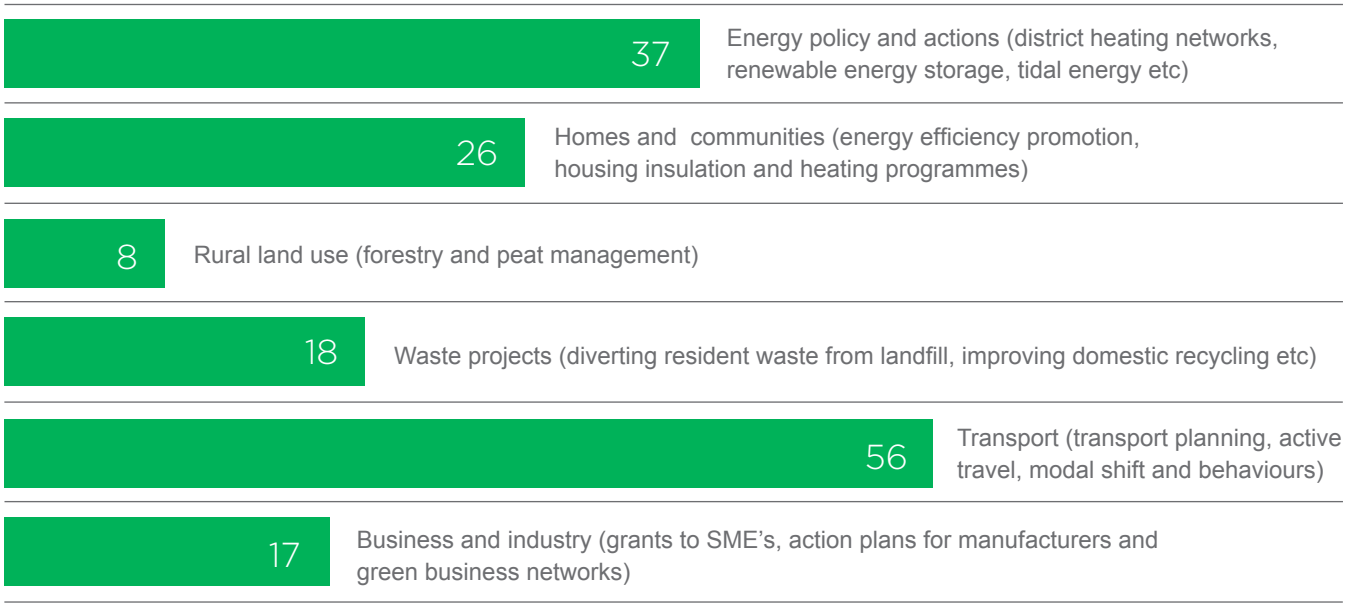
29 local authorities provided details of the dataset they use for setting emission reduction targets and/or tracking emission reduction progress as follows:

Targets to reduce emissions (total overall emissions of sector)

Public bodies were then asked to provide details on any emission reduction targets. The different sectors had the following number of targets:

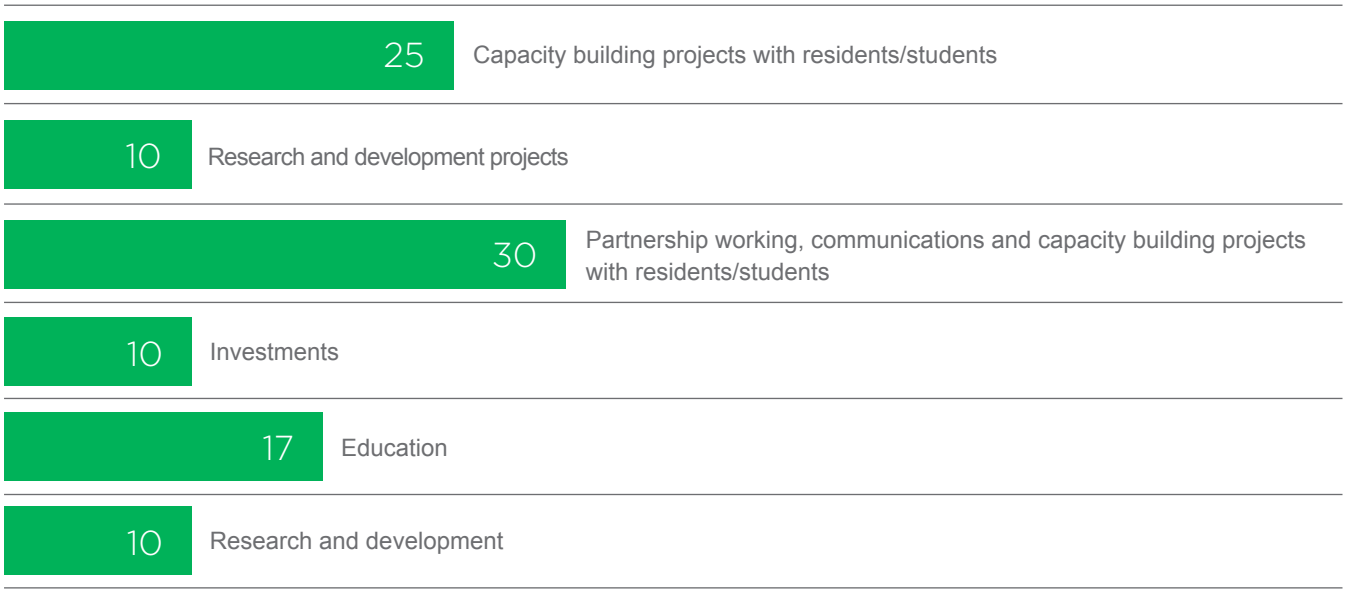
The targets detailed included overall emission targets, specific targets to increase renewable energy capacity or reduce emissions from the energy sector, transport targets to increase active travel, and waste targets to promote household waste reduction and increase recycling rates.

A summary of policies and actions detailed by public sector bodies to meet emission reduction targets



Partnership working, communications and capacity building

Public bodies were asked to provide details on partnership working, communications and capacity building projects. This question is asked to demonstrate links between different public bodies and further work to build capacity with residents/students and the wider community.



Examples of some of the Partnership Working, Communication and Capacity Building projects detailed include:

Inverclyde Council provide energy and climate change lessons in primary schools.

Scottish Borders Council worked with Dundee University, local businesses and the community councils to deliver an extensive programme of community awareness and consultation events in the Scottish Borders were held to increase community awareness of climate change.

Edinburgh College lead a community growing project to supervise food growing with community groups, students and staff.

Aberdeen City Council lead Powering Aberdeen - a Sustainable Energy Action Plan - designed to reduce emissions and find alternative sources of energy across the city. It covers many topics from transport to energy demand management and involves public, private and third sector partner organisations.

Nestrans, Aberdeenshire Council, Aberdeen City Council, NHS Grampian, the James Hutton Institute, the University of Aberdeen, Robert Gordon University and North East Scotland College all work together as part of the North East Scotland Climate Change Partnership.

Scottish Enterprise lead the Scottish Energy Laboratory project to provide a resource to support collaboration and testing of energy technologies.

North Lanarkshire Council support the Phoenix Futures Partnership Project. The project is designed to improve the employability of residents and enhance the network of greenspace and woodland for local communities.

Other notable activity provided in reports

Public bodies were asked to provide further information on relevant projects not included elsewhere in the reporting template.

21	Food and Drink (Food for Life standard, community growing, and local food strategies)
18	Water (water research projects, reducing blockages in drains and sewers, water use campaigns)
56	Biodiversity (habitat restoration, peatland projects, woodland management)
10	Resource Use (donations of furniture to other public bodies and charities, advice to businesses and community to reduce resource use)
5	Procurement

Examples of other notable activity provided in the report

Scottish Canals Canal and North Greenway project to improve green spaces around the Forth and Clyde Canal by creating a local nature reserve and integrating innovative water management solutions.

SNH lead the 4 year EcoCo Life project to enrich and connect wildlife habitats throughout the Central Scotland Green Network, improving the quality of the water environment and providing social and economic benefits throughout the region.

Scottish Environment Protection Agency 12 of their offices have wildflower meadows or semi-natural habitats on their grounds to enrich biodiversity.

Key insights

- It is encouraging that 65 public bodies submitted data on their wider influence, up from 31 in the previous 'trial' year.
- More could be done to support and encourage all Regional Transport Partnerships and National Health Service bodies to report on their wider influence activities.
- Submitted reports contained many blank sections, which suggests the need to simplify and streamline the reporting template.
- Alignment of the wider influence section with the forthcoming Scottish Government Climate Change Plan and related policies will be important.
- Better reporting of wider influence projects could help with the monitoring of Climate Change Plan activity across the public sector.
- There was a high level of biodiversity projects reported, particularly by local authorities.

Section 7: Reporting on wider influence **recommendations**

Improving reported data

- The structure of the wider influence section should be updated to align with the new Climate Change Plan when published.
- SSN to work with key stakeholders in the Regional Transport Partnerships and National Health Service to increase involvement in reporting wider influence activities.
- SSN to work with biodiversity stakeholders to provide improved guidance and direction on biodiversity reporting.

Focussed support to address gaps in performance

- SSN to work with key stakeholders to simplify and streamline wider-influence reporting, and to develop advice and guidance on how public bodies can most efficiently complete the reporting template.
- More guidance and advise should be provided on how best to set targets and report project data so that these provide better quantitative data on emissions reduction and progress towards targets.

Sharing good practice to build capacity

- SSN to collate and promote good practice projects to encourage more public bodies to report their own wider influence activities.

Clearly linking governance and management to projects and targets

- SSN to provide guidance and advice to help simplify the setting and reporting of emission reduction targets
- SSN to work with its Steering Group and partners in the education sector (Environmental Association for Universities and Colleges-Scotland) and the NHS (NHS National Services Scotland) to develop guidance and advice on project-level carbon assessment and reporting.

Recommendations

As part of the continious improvement of the reporting proccess, the following recommendations have been proposed. These recommendations have been based on analysis of the submitted reports as well as feedback from SSN members. We look forward to working with key partners and stakeholders in delivering these going forward.

Section 1: Profile of reporting bodies recommendations

Sharing good practice to build capacity

- Drawing on information provided in this section, it would be useful to benchmark performance between bodies of similar size and function, to inform and support the sharing of good practice on reporting and climate action.

Section 2: Governance, management and Strategy recommendations

Focussed support to address gaps in performance

- Direct support and training should be offered to those public bodies who do not have a climate change plan or strategy in place, and who need to embed climate change into governance and management structures.

Sharing good practice to build capacity

- There is a need to share good practice on effective governance, management and strategy, including how this relates to the setting and monitoring of climate change targets and relevant projects. More is needed to promote good practice on climate change decision-making, including how this influences finance and investment decisions on projects to meet climate change targets and objectives.
- SSN to produce a register, logging where each public body currently has a project, plan or policy, and logging what they are planning to work on going forward. This will aid the sharing of best practice and resources.

Making better use of existing tools

- Public bodies should make more use of the CCAT Tool to assess their performance and to identify improvement objectives.
- Public bodies should make better use of the ISM framework[1] to help integrate climate change into governance and management structures and drive more coordinated action on climate change.

Clearly linking governance and management to projects and targets

- Many reports would be improved by providing clarity on how governance, management and strategy relates to the setting and monitoring of targets and objectives.
- Reports should aim to explain how governance, management and strategy tracks progress and influences decisions-making to keep projects and initiatives on-track to meet targets and objectives, including how finance and investment decisions are taken to maintain action on climate change.

Section 3: Corporate emissions, targets and projects recommendations

Improving reported data

- There is a need for continuous improvement on data reporting in line with the GHG Protocol key principles of: relevance, completeness, consistency, transparency, and accuracy.
- More attention is needed to ensure that emissions are reported accurately by scope.
- Specific work should be taken forward to improve the reporting of biomass, biofuels and renewables.
- The reporting of projects and targets needs to be improved. Capacity in the public sector needs to be developed to undertake better project level carbon assessment and reporting, and to set, monitor and report progress against more consistent and robust targets. Information on targets and projects needs to be better aligned with information on governance and management.

Focussed support to address gaps in performance

- There is a need to improve reporting of data on emissions from waste, especially outwith local authorities. This includes the need to gather data specifically on corporate waste.
- More attention needs to be given to transport related emissions. This source of emissions requires more attention both at target, and project level and in ensuring that activity and fuel use data is captured and reported.
- In line with developments internationally, there is a need to develop work to better address Scope 3 emissions, most notably on key aspects such as business travel, supply chain and procurement impacts, etc.

Sharing good practice to build capacity

- More should be done to use the climate change reports to identify examples of good practice and to share these across the network to support learning and improvement. This would include work on:
  - Good quality data reporting
  - Examples of good practice in setting and monitoring targets
  - Integrating consideration of behaviour change and how to report this effectively
  - Project or policy theme examples that can be shared across SSN

Making better use of existing tools

- Some public bodies should be making more use of the tools that have been developed to support reporting and climate action. These include the:
  - SSN guidance on reporting, including related training videos
  - Climate Change Assessment Tool
  - ISM (Individual, Social, Material) Behaviours Framework
  - Carbon Project and Footprint Register Tool
  - Adaptation Scotland's Five Steps to Climate Adaptation guidance

Clearly linking governance and management to projects and targets

- More should be done to improve the setting of corporate emission reduction targets, and to develop and maintain project registers that are adequate for meeting targets.
- More should be done to demonstrate a clearer link between targets and projects and corporate governance and management structures and processes. This should more clearly demonstrate how management and governance arrangements track progress and make decisions based on project delivery and performance information.
- Reports could be improved if organisations communicated more clearly whether they are on track or not to meet their targets, and how they plan to respond if progress is not on track.

Section 4: Adaptation recommendations

Improving reported data

- SSN will work with public bodies and enhance guidance documents to improve the standard of information submitted on adaptation actions in Climate Change Reports.
- Further collaboration is required between SSN, Adaptation Scotland, the Scottish Government and the listed accountable public bodies within Scotland's Climate Change Adaptation Programme (SCCAP), to reduce duplication for public bodies who report as part of SCCAP.

Focussed support to address gaps in performance

- SSN and Adaptation Scotland should collaborate to use the information in the reports to better target the public bodies most in need of support. Efforts should be focussed on those bodies who have not assessed current or future climate change risks and are at the earlier stages of climate change adaptation work.

Clearly linking governance and management to projects and targets

- More should be done to improve the setting of corporate adaptation objectives, and to develop project and policy registers that are adequate for meeting objectives.
- More should be done to demonstrate a clearer link between objectives, policies and projects and corporate governance and management structures and processes. This should more clearly demonstrate how management and governance arrangements of adaptation track progress and make decisions based on performance information.

Section 5: Procurement recommendations

Improving reported data

- Public bodies should seek to better articulate the specific climate change relevant objectives and impacts of their procurement activities. A more direct link to climate change project registers and project funding would be useful, as would the articulation of how procurement is specifically contributing to the reduction of emissions or adapting to a changing climate.

Focussed support to address gaps in performance

- More is needed to address gaps in understanding, methods and data availability for specifically assessing the climate change implications and opportunities of procurement. This work relates to the need for more support in addressing Scope 3 emissions noted in Section 3 of this report. This will require the gathering of good practice examples and evolving professional standards, the development of guidance and support tools, and support to improve reporting. This will require the collaboration of key stakeholders with expertise in climate change data, public sector climate action, and public procurement.

Sharing good practice to build capacity

- More should be done to promote and enable learning from examples of good procurement practice contained in the climate change reports. Opportunities for collaborative procurement and for mainstreaming innovative procurement examples should be explored, involving all relevant stakeholders from climate change and procurement areas of expertise.

Section 6: Validation recommendations

Focussed Support to Address Gaps in Performance

- Build up a map of existing external validation which is adequate, and work to develop effective peer to peer and external validation approaches on other areas. Improve the quality and scope of validation across the reports, while avoiding duplication of validation already in place.
- SSN to explore options to provide cost effective support for peer-to-peer external validation support for public bodies.

Sharing Good Practice to Build Capacity

- SSN to provide a 'match making' service to assist those who do not have a peer review process in place to match with bodies with similar estates / functions.

Section 7: Reporting on wider influence recommendations

Improving reported data

- The structure of the wider influence section should be updated to align with the new Climate Change Plan when published.
- SSN to work with key stakeholders in the Regional Transport partnerships and National Health Service to increase involvement in reporting wider influence activities.
- SSN to work with biodiversity stakeholders to provide improved guidance and direction on biodiversity reporting.

Focussed support to address gaps in performance

- SSN to work with key stakeholders to simplify and streamline wider-influence reporting, and to develop advice and guidance on how public bodies can most efficiently complete the reporting template.
- More guidance and advise should be provided on how best to set targets and report project data so that these provide better quantitative data on emissions reduction and progress towards targets.

Sharing good practice to build capacity

- SSN to collate and promote good practice projects to encourage more public bodies to report their own wider influence activities.

Clearly linking governance and management to projects and targets

- SSN to provide guidance and advice to help simplify the setting and reporting of emission reduction targets
- SSN to work with its Steering Group and partners in the education sector (Environmental Association for Universities and Colleges-Scotland) and the NHS (NHS National Services Scotland) to develop guidance and advice on project-level carbon assessment and reporting.

Keep Scotland Beautiful is the charity that enables action on sustainable development by working with organisations and communities to change behaviour to reduce carbon emissions and environmental impact. It's part of our work to make Scotland clean, green and more sustainable.

Keep Scotland Beautiful

Supported by the Scottish Government

The Scottish Government

T: 01786 471333 **E:** ssn@keepscotlandbeautiful.org

facebook.com/KSBScotland @KSBScotland

www.keepscotlandbeautiful.org

THE BRITISH ASSESSMENT BUREAU ISO14001 UKAS MANAGEMENT SYSTEMS 8289

ISO 14001:2015 Certification No.208826

FSC RECYCLED Paper FSC® C017120

ITEM No …12…….

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

REPORT ON: **MEASURING PERFORMANCE UNDER INTEGRATION - 2018/19 SUBMISSION**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB11-2018**

1.0 PURPOSE OF REPORT

The purpose of this report is to seek approval of the 2018/19 submission made by the Partnership to the Ministerial Strategic Group for Health and Community Care (MSG) as part of the Measuring Performance under Integration work stream.

2.0 RECOMMENDATIONS

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

2.1 Notes the summary table of targets under each service delivery area (Appendix 1).

2.2 Approves the 2018/19 submission to the MSG (Appendix 2).

2.3 Notes the methodology used to develop proposed targets for submission to the Ministerial Strategic Group (sections 4.2.3 and 4.2.4 and Appendix 3).

2.4 Notes that 2018/19 targets will remain in draft until such times as the Integration Joint Board budget for 2018/19 has been confirmed (section 4.2.5).

3.0 FINANCIAL IMPLICATIONS

None.

4.0 BACKGROUND

4.1 Measuring Performance under Integration – 2017/18 Request, Submission and Performance

4.1.1 In mid-January 2017 the Scottish Government and COSLA, on behalf of the MSG, wrote to all Health and Social Care Partnerships to invite them to set out local objectives, trajectories and performance targets for 2017/18 under the following six key service delivery areas:

- Unplanned admissions;
- Occupied bed days for unscheduled care;
- A&E performance;
- Delayed discharges;
- End of Life care: and,
- The balance of spend across institutional and community services.

4.1.2 In February 2017 the Dundee Partnership provided an initial response to the Scottish Government for consideration by the MSG. In each service area the response set out:

- What available data was telling us about local performance;
- What we had achieved to date through commissioning and delivery activity;
- What more we planned to do to impact on each area of service delivery; and,
- How we planned to measure improvement, including setting out trajectories and performance targets.

Report DIJB20-2017 (Measuring Performance Under Integration) provides detailed information regarding the request and response submitted. The submission from Dundee was identified by MSG as a particularly high quality submission.

4.1.3 During 2017/18 the Scottish Government, via National Services Scotland Information Service Division, has provided a quarterly Measuring Performance under Integration dataset to all Partnerships for each of the indicators within the MSG submission for which data is available. To date information has been provided up to October 2017.

4.1.4 At a local level performance against targets set out in the 2017/18 submission has been reported as part of the regular Quarterly Performance Reports submitted to the Performance and Audit Committee (PAC). Report PAC32-2017 (Dundee Health & Social Care Partnership Performance Report – Quarter 2) includes the position in Dundee at end of quarter 2, 2017/18. In summary, there has been positive performance against 2017/18 interim targets; three areas have exceeded interim targets for the period (unplanned admissions, occupied bed days for unscheduled care and A&E performance) and one area partially met the interim targets (delayed discharges). For two areas (end of life care and the balance of spend) data is not available monthly or quarterly to allow for performance monitoring. Delayed discharges due to complex reasons has consistently not met the interim target.

4.2 Measuring Performance under Integration – 2018/19 Request and Submission

4.2.1 In late November 2017 the Scottish Government and COSLA, on behalf of the MSG, sent an update to Partnerships regarding progress made in considering how best to provide regular updates to MSG (Appendix 4). This followed a broader stakeholder consultation event hosted by COSLA in 2017 at which the expectations of MSG were discussed alongside local performance management systems and resources, from which a working group of Chief Finance Officers, data analysts, Scottish Government representatives and Integration Managers was formed to develop a proposed framework for sharing progress under the six service delivery areas with MSG.

4.2.2 Whilst the details of the proposed framework are further considered and developed by MSG, supported by the working group, the Scottish Government and COSLA have agreed it would be helpful for MSG to have an updated overview of local objectives and ambitions in each of the six service delivery areas. To that end an invitation was extended to the Partnership to submit objectives, trajectories and targets for 2018/19 on a standardised format by 31 January 2018.

4.2.3 It should be noted that the 2017 Measuring Performance Under Integration submission to MSG included targets under each service delivery area for all ages. The guidance issued alongside the November 2017 letter recognises that local arrangements mean that not all Partnerships have delegated children's services functions and therefore their work does not directly impact on performance across all age groups. For the 2018 submission there is an option to submit targets for 18+ only; this is the approach that has been taken in Dundee in line with the scope of the IJB's delegated functions. This change of approach means that targets and data included in performance reports relating to Measuring Performance Under Integration until the 31 March 2018 will refer to data for all ages, whilst targets included in this report and in performance reports from 1 April 2018 will refer to data for 18+.

4.2.4 Targets agreed in the February 2017 response were applied to the data for aged 18+ and data was analysed. The following trends were assessed and used in preparation of the current submission:

- 15/16 baseline data;
- 15/16 based projections for 17/18 and 18/19;

- Trajectories / targets submitted in the February 2017 response for 17/18 and 18/19;
- Actual data from 1 April 2017 – 31 October 2017 and estimated data from 1 November 2017 – 31 March 2018 to estimate the 17/18 position; and
- 18/19 trajectories / targets based on the 17/18 estimated position.

Where special cause variation, for example improvement work to reduce delayed discharges or the flu epidemic, caused extraordinary data results, subsequent year targets were adjusted so that the same rate of increase or decrease was not expected in subsequent years. 18/19 targets for A+E attendances and delayed discharge bed days lost were adjusted for these reasons.

Appendix 1 is a summary table of the 32 indicators which correspond to the six key service delivery areas.

Appendix 2 contains the template provided by the Scottish Government. This has been completed and will form the entire Dundee submission.

Appendix 3 was used in preparation of the submissions and has been included as supplementary information. Charts and methodologies have been provided. It should be noted that for some indicators, such as emergency admissions, proposed targets reflect projected declining performance after taking account of demographic growth and its resultant impact on demand as well as past performance trends, however the target rate of decline will be less than the projected rate of decline.

4.2.5 An interim submission has been made to the Scottish Government to meet the 31 January 2018 deadline following consultation with the Chief Officer and Heads of Service. At this time it was highlighted that the submission would be subject to revision following the PAC on 13 February 2018 and the IJB on 27 February 2018. In addition it was noted that the targets contained within the submission for 2018/19 cannot be confirmed until such times as the 2018/19 IJB budget has been finalised and an assessment made of the adequacy of resources to deliver planned improvement actions factored in to the calculation of targets.

4.2.6 Performance against targets (for both 2017/18 and 2018/19) will continue to be reported as part of the quarterly performance reports submitted to PAC. Targets will also be integrated into the Partnership's 2018/19 delivery plan, where the principles of the approach utilised for submissions will be expanded to encompass additional service delivery areas.

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 risk of not meeting targets against national indicators could affect outcomes for individuals and their carers and not make the best use of resources.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 4 x Impact 3 = Risk Scoring 12 (High)
Mitigating Actions (including timescales and resources)	- Continue to develop a reporting framework which identifies performance against Measuring Performance under Integration targets. - Continue to report data quarterly to the PAC to highlight areas of poor performance. - Continue to support operational managers by providing in depth analysis regarding areas of poor performance, such as complex delayed discharges. - Continue to ensure that data informs operational practices and improvements and also that operational activities and priorities are used to interpret trends shown by the data.

Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (High)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (Moderate)
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable.

7.0 CONSULTATIONS

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

8.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 31 January 2018

Kathryn Sharp
Senior Manager

Appendix 1

			15/16 baseline	17/18 Projection (15/16 based)	17/18 Trajectory agreed Feb 17	17/18 Actual and Estimated	18/19 Trajectory agreed Jan 18	% Change (15/16 baseline to 18/19 trajectory
Unplanned admissions								
1.	Number of emergency admissions	submitted	14,125	15,168	15,153	15,122	15,464	+9.5%
2.	Number of emergency admissions from A+E	submitted	6,483	7,345	6,797	7,616	7,616	+17.5%
3.	A+E conversion rate (%)	to be developed						
Occupied bed days for unscheduled care								
4.	Number of emergency bed days	submitted	120,989	115,305	114,132	111,893	108,129	-10.6%
5.	Number of emergency bed days ; geriatric long stay	to be developed						
6.	Number of emergency bed days; mental health specialities	to be developed						
A+E Performance								
7.	Number of A+E attendances	submitted	23,437	23,336	22,686	26,562	26,562	+13.3%
8.	A+E % seen within 4 hours	to be developed						

			15/16 baseline	17/18 Projection (15/16 based)	17/18 Trajectory agreed Feb 17	17/18 Actual and Estimated	18/19 Trajectory agreed Jan 18	% Change (15/16 baseline to 18/19 trajectory
Delayed Discharges								
9.	Number of bed days lost – standard and code 9	submitted	15,050	14,502	14,042	12,480	11,856	-21.2%
10.	Number of bed days lost – code 9	Not submitted	6,668	7,740	7,740	6,273	6,461	-3.1%
11.	Number of bed days lost – Health and Social Care Reasons	No data provided from ISD						
12.	Number of bed days lost – Patients/Carer/Family related reasons	No data provided from ISD						
End of Life Care ***based on 16/17 deaths but will change in 17/18 and 18/19 as % proportions are applied to the total number of deaths in each year**								
13.	% of last 6 months of life in community	submitted	86.9%		88%		89%	+2.1%
14.	% of last 6 months of life in hospice / palliative care unit	submitted	1.4%		2%		3%	+1.6%
15.	% of last 6 months of life in community hospital	Not applicable						
16.	% of last 6 months of life in large hospital	submitted	11.7%		10%		8%	-3.5%
17.	Number of days of last 6 months of life in community	submitted	252,351		252,275*		255,143*	n/a as no. of deaths each year varies
18.	Number of days of last 6 months of life in hospice / palliative care unit	submitted	3,965		5,733*		8,600*	n/a as no. of deaths each year varies
19.	Number of days of last 6 months of life in community hospital	not applicable						
20.	Number of days of last 6 months of life in large hospital	submitted	34,042		28,668*		22,934*	n/a as no. of deaths each year varies

			15/16 baseline	17/18 Projection (15/16 based)	17/18 Trajectory agreed Feb 17	17/18 Actual and Estimated	18/19 Trajectory agreed Jan 18	% Change (15/16 baseline to 18/19 trajectory
Balance of Care								
21.	% of population living at home (unsupported) – All ages	submitted	97.7%		97.6%			
22.	% of population living at home (supported) – All ages	submitted	1.3%		1.5%			
23.	% of population living in a care home – All ages	submitted	0.7%		0.5%			
24.	% of population living in hospice / palliative care unit – All ages	to be developed						
25.	% of population living in community hospital – All ages	submitted	0%		0%			
26.	% of population living in large hospital – All ages	submitted	0.4%		0.4%			
27.	% of population living at home (unsupported) – 75+	submitted	79.8%		80%			
28.	% of population living at home (supported) – 75+	submitted	11.3%		11.6%			
29.	% of population living in a care home – 75+	submitted	6.8%		6.7%			
30.	% of population living in hospice / palliative care unit – 75+	to be developed						
31.	% of population living in community hospital – 75+	submitted	0%		0%			
32.	% of population living in large hospital – 75+	submitted	2%		1.7%			

Appendix 2

Dundee	Unplanned admissions 18+	Unplanned bed days 18+	A&E attendances 18+	Delayed discharge bed days 18+	Last 6 months of life	Balance of Care
Baseline	2016/17 change from 2015/16:	2016/17 change from 2015/16:	2016/17 change from 2015/16:	2016/17 change from 2015/16:	2016/17 change from 2015/16:	2016/17 change from 2015/16:
				All delays	**Last 6 months community (inc care homes)**	2016/17 data not yet available
15/16 (baseline)	14,125	120,989	23,437 A+E attendances and 6,483 admissions from A+E	15,050	0.8% decrease (250,272) in number of days spent in the community for people who died between 15/16 and 16/17.	
16/17	14,500	117,304	23,388 A+E attendances and 6,936 admissions from A+E	14,627	**Last 6 months hospice palliative care unit**	
Difference	+375	-3,685	-49 A+E attendances and +453 admissions from A+E	-423	10.8% decrease (3,537) in number of days spent in hospice / palliative care for people who died between 15/16 and 16/17.	
% Difference	+2.5%	-3%	-0.2% A+E attendances and +7% admissions from A+E	-2.8%	**Last 6 months large hospital**	
					3.4% decrease (32,868) in number of bed days for people who died in large hospital between 15/16 and 16/17.	
Objective	17/18 target	17/18 target	17/18 target	17/18 target	17/18 target	16/17 Targets
	Increase by 4.3%	**Decrease by 4.6%**	**Increase in A+E attendances by 15%**	**All delays**	Number of days of last 6 months of life spent in community - increase by **2% (255,277)**	**Supported At Home**
	17/18 target admissions – 15,122 17/18 target rate per 100,000 – 12,436	17/18 target bed days – 111,893 17/18 target rate per 100,000 – 92,018	17/18 target A+E attendances – 26,562	**Decrease bed days lost due to delayed discharges by 14.7%** 17/18 target bed days lost – 12,480 17/18 target rate per 100,000 – 103	Number of days of last 6 months of life spent in hospice / palliative care unit – increase by **2% (3,608)**	All Ages – 1.5% of the population supported at home. 75+ - 11.6% of the population supported at home
	The 17/18 target rate is 0.4% lower than the expected 17/18 rate based on 15/16 projections. This is a reduction of 46 emergency admissions compared with the 15/16 projection.	The 17/18 rate is 3% lower than the expected 17/18 rate based on 15/16 projections. This is a reduction of 3,412 emergency bed days compared with the 15/16 projection.	The 17/18 rate is 14% higher than the expected 17/18 rate based on 15/16 projections. This is an increase of 3,225 A+E attendances compared with the 15/16 projection.	The 17/18 rate is 13.9% lower than the expected 17/18 rate based on 15/16 projections. This is a decrease of 2,022 bed days lost due to delayed discharges compared with the 15/16 projection.	Number of Bed Days of Last 6 Months of Life Spent in Large Hospital – decrease by **13% (28,595)**	**Unsupported At Home** All Ages – 97.6% of the population unsupported at home. 75+ - 80% of the population unsupported at home.
	2018/19 target	2018/19 target	**Increase A+E admissions by 10%**	2018/19 target	2018/19 change:	**Living in Care Homes**
	Increase by 2.3%	**Decrease by 3.4%**	17/18 target A+E admissions – 7,616 17/18 target A+E admissions rate - 287	Decrease bed days lost due to delayed discharges by 5%	Number of Bed Days of Last 6 Months of Life Spent in Community- increase by **2% (260,383)**	All Ages – 0.5% of the population living in care homes.

	18/19 target admissions – 15,464 18/19 target rate per 100,000 – 12,710 The 18/19 target rate is 2.4% lower than the expected 18/19 rate based on 15/16 projections. This is a reduction of 363 emergency admissions compared with the 15/16 projection.	18/19 target bed days – 108,129 18/19 target rate per 100,000 – 88,875 The 18/19 rate is 4.5% lower than the expected 18/19 rate based on 15/16 projections. This is a reduction of 4,957 emergency bed days compared with the 15/16 projection.	The 17/18 rate is 3.7% lower than the expected 17/18 rate based on 15/16 projections. This is a reduction of 271 A+E admissions compared with the 15/16 projection. 2018/19 target **Decrease A+E attendances by 0%** 18/19 target A+E attendances – 26,562 The 18/19 rate is 14% higher than the expected 18/19 rate based on 15/16 projections. This is an increase of 3,225 A+E attendances compared with the 15/16 projection. **Decrease A+E admissions by 2%** 18/19 target A+E admissions – 7,616 18/19 target A+E admissions rate – 281 The 18/19 rate is 16% lower than the expected 18/19 rate based on 15/16 projections. This is a reduction of 176 A+E admissions compared with the 15/16 projection.	18/19 target bed days lost – 11,856 18/19 target bed days lost rate - 97 The 18/19 rate is 18.2% lower than the expected 17/18 rate based on 15/16 projections. This is a decrease of 2,646 bed days lost due to delayed discharges compared with the 15/16 projection.	Number of Bed Days of Last 6 Months of Life Spent in Hospice / Palliative Care Unit – increase by **2% (3,680)** Number of Bed Days of Last 6 Months of Life Spent in Large Hospital – decrease by **13% (24,878)**	75+ - 6.7% of the population living in care homes. **Large Hospital** All Ages – 0.4% of the population in large hospital. 75+ - 1.7% of the population living in large hospital.
How will it be achieved	-Further development of Enhanced Community Support, including acute. - Implement 7 day targeted working (EA5-USC) - Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit. - Implement an improvement plan relating to re-admission to hospital within 28	- Continue to review in patient models in line with community change. - Further implement planned date of discharge model. - Further develop discharge planning arrangements for adults with a learning disability and / or autism, mental ill-health, physical disability and acquired brain injury. - Increase investment in intermediate forms of care. - Co-locate the Learning Disability Acute Liaison Service within the Hospital	-Further development of Enhanced Community Support, including acute - Implement 7 day targeted working (EA5-USC) - Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit. - Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan. - Implement the Tayside Falls Prevention and	-Increased investment in intermediate forms of care. - Remodel care at home services and provide more flexible responses. - Further invest in social care infrastructure, including consolidating current tests of change through third sector partnerships. - Further development of Community Rehabilitation. - Review discharge management procedures and guidance.	-PEOLC test site for dementia - Expand the use of Palliative Care Tool Bundle and Response Standards in use across community based health and social care services. -Fully implement the Macmillan Improving the Cancer Project. - PEOLC Managed Clinical Network in place, to focus on non-specialist palliative care. - Increased availability of Key Information Summaries and ACPs. - Learning disability community nursing team will work with MacMillan nurses to improve methods of communication.	-Further develop Enhanced Community Support, including acute. - Develop a model of support for carers in line with the Carers Act. - Continue to review in patient models in line with community change. -Increase investment in models that support adults within their own homes. - increase investment and improve capacity in social care. - Continue to develop step down to assess model. - Increase the range of accommodation with support for people with complex needs.

	days of discharge analysis and improvement plan. - Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway. - Transformation of work with primary care and the implementation of the new GP contract. - Development of locality based out-patient clinics. Development of integrated care homes.	Discharge Team base at Ninewells Hospital - Increase investment in resources which support assessment for 24 hour care taking place at home or home like settings. - Implement a pathway for people with substance misuse problems and who have multiple morbidities. - Hold Power of Attorney local campaigns. - Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016. - Integrated pathways are being developed across care home teams, ortho geriatrics and older people psychiatry. - Remodel AHP services within acute settings to improve pathways. - Further remodel integrated discharge hubs which will improve joint working arrangements.	Management Framework (2017-20) and refresh DHSCP falls pathway. - - Implement a pathway for people with substance misuse problems and who have multiple morbidities. - Transformation of work with primary care and the implementation of the new GP contract. - Remodelling of polypharmacy. - Further remodel integrated discharge hubs which will improve joint working arrangements.	- Develop a statement and pathway for involving carers in discharge planning process. - Extend the range of third sector supports for adults transitioning from hospital back to the community. - Develop a step down and assessment model for residential care. - Hold Power of Attorney local campaigns. - Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2000. - Establish an integrated model of support for people with a learning disability and / or autism who also have extremely complex health and care support needs. - Implement home and hospital discharge plan.		- Increase social prescribing and improve self-care. - Further develop accommodation with support models in the community for adults. - Remodel the stroke pathway. - Further develop short breaks and respite opportunities.
Progress (updated by ISD)						
Notes			The attendance trajectories are a result of the flu virus epidemic which hit Tayside severely over the autumn / winter of 17/18 and also an increase in fractures due to adverse weather causing falls. The admission rates appear good due to the high number of attendances		Accidental deaths excluded	

Appendix 3

Measuring Performance Under Integration Charts and Methodologies

Introduction

This report provides key information to assist with the interpretation of the Dundee submission to the Ministerial Strategic Group regarding 'Measuring Performance under Integration'.

Under each of the six high level service delivery areas is a chart which illustrates

- 'Projections submitted in Feb 17' (blue line) – projected performance based on 2015/16 baseline data. The projection is produced by NSS ISD using the Arima model, taking into account past performance, demographic growth and the resultant impact on demand, and assuming that health and social care systems and interventions continue to function 'as is'. This projection was included as part of the February 2017 submission.

- 'Trajectories submitted in Feb 17' (orange line) which is the projection (blue line) plus / minus the target applied for 2017/18. This illustrates the intended level of performance in 2017/18 taking into account planned changes in systems and interventions during the year.

- 'Dundee Actual (Up to Oct 17) and Expected (Oct 17 to Mar 18)' (grey line) illustrates the most current actual data available and an estimate for the remaining months up to March 18. This demonstrates actual performance and when compared against the projection (blue line) and intended/target level of performance (orange line), demonstrates the impact of the HSCP since the 15/16 baseline.

- 'Trajectories agreed in Jan 18 for 18/19' (yellow line) illustrates the intended level of performance in 2018/19. This takes into account the projected performance (blue line) and actual performance in 2017/18 (grey line), as well as planned changes in systems and interventions for 2018/19.

Emergency Admissions

Chart 1: Emergency Admissions 18+ as a Rate per 100,000 Population in Dundee

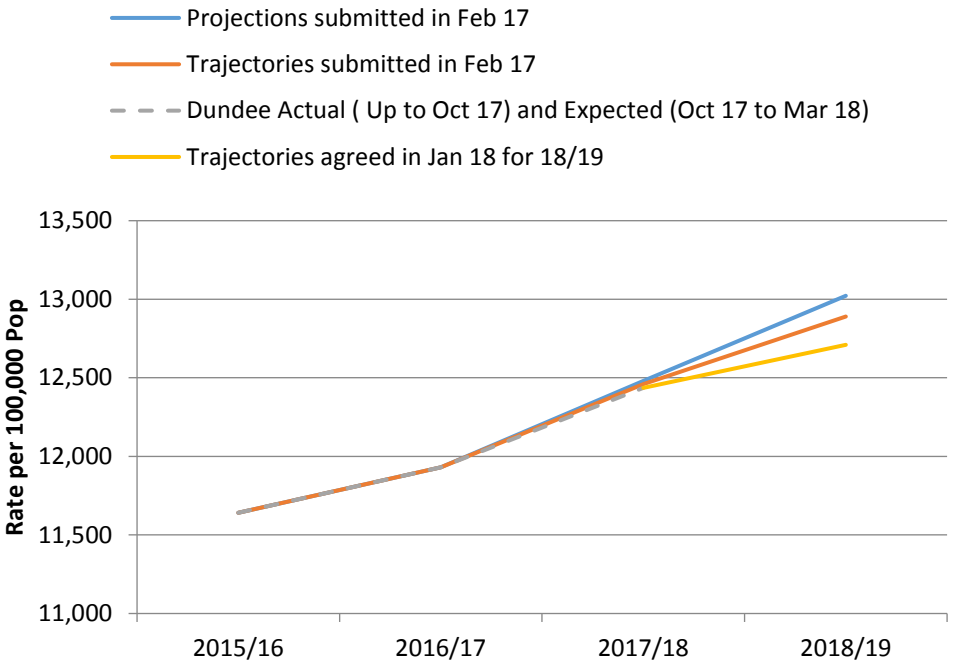
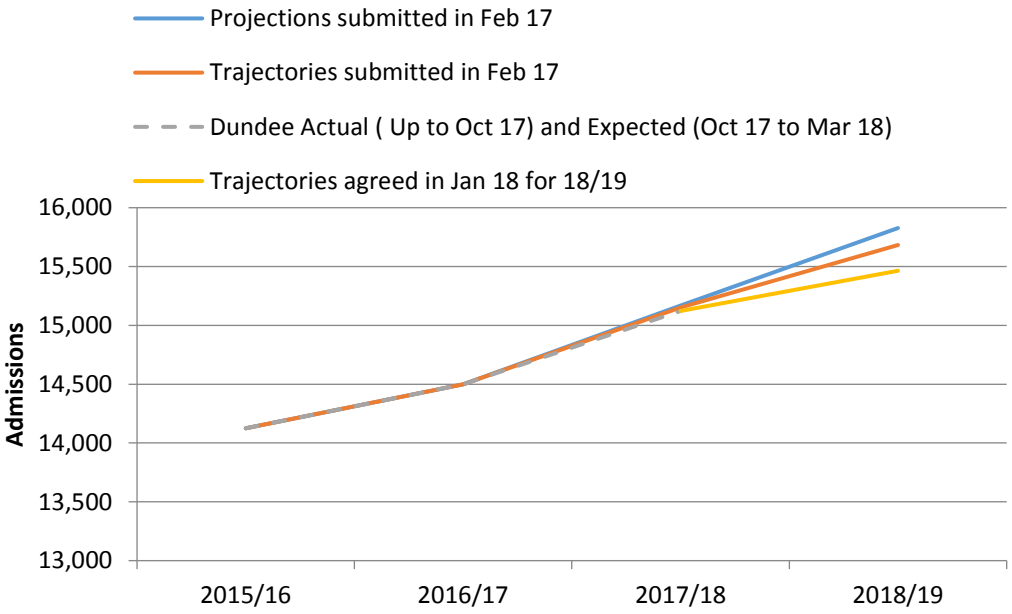


Chart 2: Emergency Admission Numbers 18+



What is the data telling us?

- 17/18 estimated and actual performance is better than the 15/16 based projection for 17/18 and the 17/18 trajectory (target) set in February 17.
- Emergency admissions were projected to increase in 17/18 (15,168 – 15/16 based projection) and the trajectory set in Feb 17 for 17/18 was for emergency admissions to increase at a slower rate than the projection (15,153).

- The actual and estimated data for 17/18 shows that Dundee is likely to perform even better and there will be approximately 15,122 emergency admissions.

How was the 18/19 target developed?

- The 15/16 based projection for 18/19 was that emergency admissions would increase from 15,168 in 17/18 to 15,827 in 18/19. The 18/19 trajectory submitted February 17 was to reduce the rate of this increase to 15,683.
- The 18/19 target is to further increase emergency admissions from the 17/18 actual and estimate by 4.3% to 15,464 emergency admissions. This represent a slower rate of increase than has been projected based on both 15/16 projections and 17/18 actual and estimated performance.

How will trajectories agreed in Jan 18 for 18/19 be achieved?

- Further development of Enhanced Community Support, including acute.
- Implement 7 day targeted working (EA5-USC)
- Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.
- Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.
- Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.
- Transformation of work with primary care and the implementation of the new GP contract.
- Development of locality based out- patient clinics.
- Development of integrated care homes.

Emergency Bed Days

Chart 3: Emergency Bed Days 18+ as a Rate per 100,000 Population in Dundee

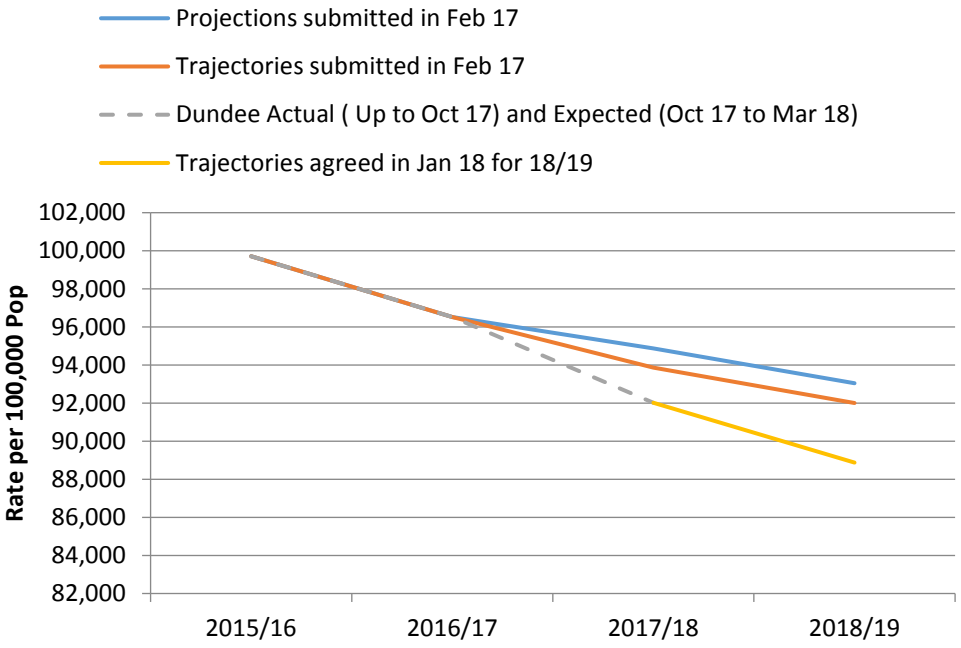
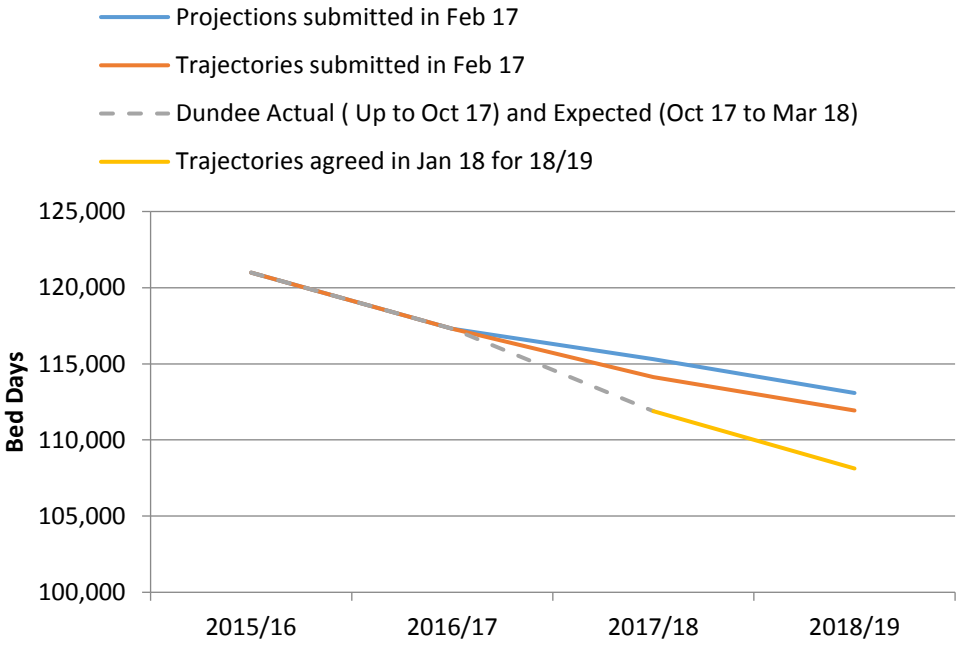


Chart 4: Emergency Bed Day Numbers 18+



What is the data telling us?

- 17/18 estimated and actual performance is better than the 15/16 based projection for 17/18 and the 17/18 trajectory (target) set in February 17.
- Emergency bed days were projected to decrease in 17/18 (115,305 – 15/16 based projection) and the trajectory set in Feb 17 for 17/18 was for emergency bed days to decrease further than the projection (114,132).

- The actual and estimated data for 17/18 shows that Dundee is likely to perform even better and there will be approximately 111,893 emergency bed days.

How was the 18/19 target developed?

- The 15/16 based projection for 18/19 was that emergency bed days would decrease from 115,305 in 17/18 to 113,085 in 18/19. The 18/19 trajectory submitted February 17 was for there to be a further decrease to 111,935 emergency bed days.
- The 18/19 target is to further reduce emergency admissions from the 17/18 actual and estimate by 3.4% to 108,129 emergency bed days.

How will trajectories agreed in Jan 18 for 18/19 be achieved?

- Continue to review in patient models in line with community change.
- Further implement planned date of discharge model.
- Further develop discharge planning arrangements for adults with a learning disability and / or autism, mental ill-health, physical disability and acquired brain injury.
- Increase investment in intermediate forms of care.
- Co-locate the Learning Disability Acute Liaison Service within the Hospital Discharge Team base at Ninewells Hospital
- Increase investment in resources which support assessment for 24 hour care taking place at home or home like settings.
- Implement a pathway for people with substance misuse problems and who have multiple morbidities.
- Hold Power of Attorney local campaigns.
- Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.
- Integrated pathways are being developed across care home teams, ortho geriatrics and older people psychiatry.
- Remodel AHP services within acute settings to improve pathways.
- Further remodel integrated discharge hubs which will improve joint working arrangements.

A&E Performance

Chart 5: Number of Attendances at A+E

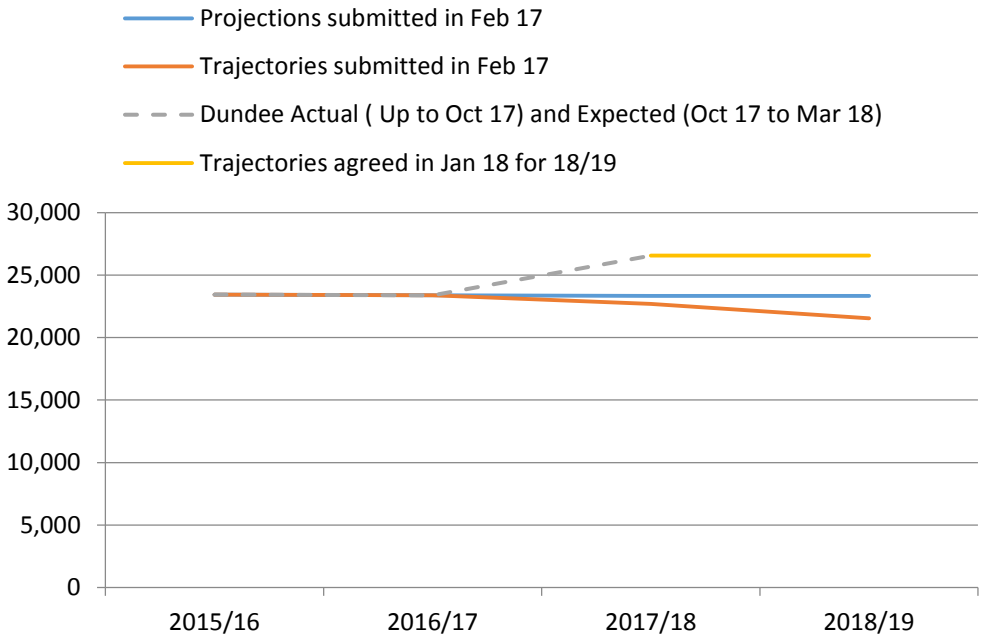


Chart 6: Number of 18+ Admissions from A+E

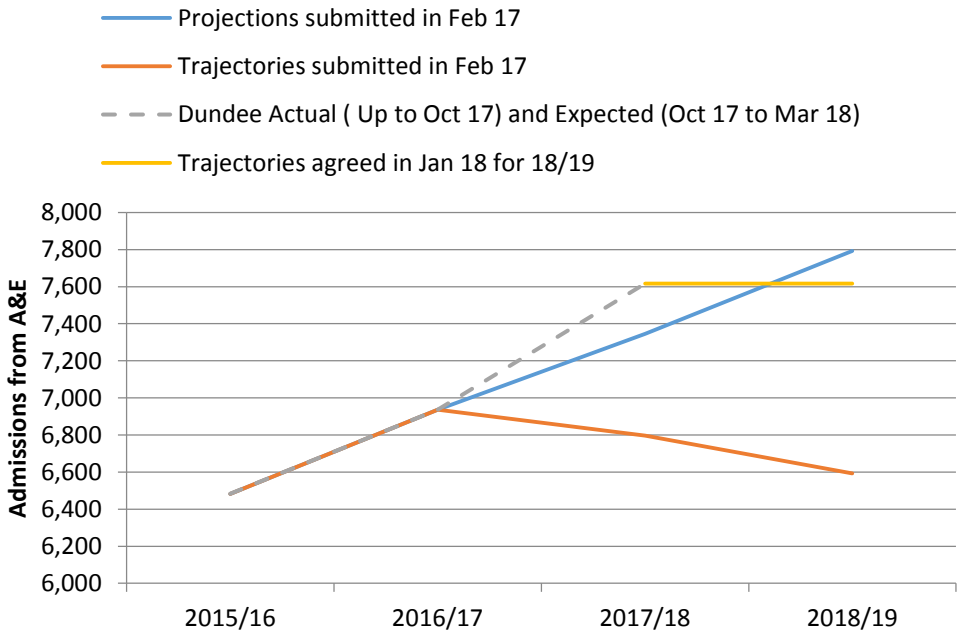
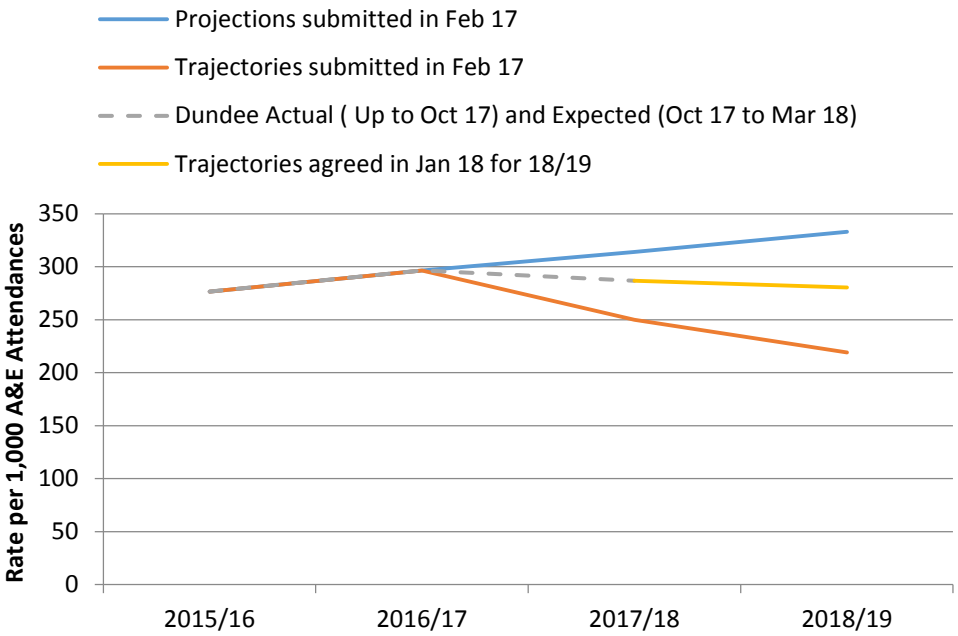


Chart 7: Admissions from A&E 18+ as a Rate per 1,000 Attendances



What is the data telling us?

- 17/18 estimated and actual performance is poorer than both the 15/16 based 17/18 projection for A+E attendances and better than the 15/16 based 17/18 projection and worse that the 17/18 trajectory (target) set in February 17 for A+E admissions.
- A+E attendances were projected to increase in 17/18 (23,336 – 15/16 based) and the trajectory set in Feb 17 for 17/18 was for A+E attendances to decrease further than the projection to 22,686, however the actual and estimated 17/18 data will be approximately 26,562.
- A+E admissions were projected to increase in 17/18 (7,345 – 15/16 based) and the trajectory set in Feb 17 for 17/18 was for A+E admissions to decrease further that the projection to 6,797, however the actual and estimated 17/18 data will be approximately 7,616.

How was the 18/19 target developed?

- The target for number of A+E attendances is to maintain the number at the same as 17/18 (26,562).
- The reasons for the number of A+E attendances in 17/18 being higher than the projection are mainly due to the higher than normal pressures on acute systems due to the flu epidemic and fractures cause by falls in the adverse weather.
- The 15/16 projection suggested that there would be zero change between 17/18 actual performance and 18/19 performance and therefore this has been applied to the 18/19 trajectory.

How will trajectories agreed in Jan 18 for 18/19 be achieved?

- Further development of Enhanced Community Support, including acute
- Implement 7 day targeted working (EA5-USC)
- Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.
- Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.
- Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.

- Implement a pathway for people with substance misuse problems and who have multiple morbidities.
- Transformation of work with primary care and the implementation of the new GP contract.
- Remodelling of polypharmacy.
- Further remodel integrated discharge hubs which will improve joint working arrangements.

Delayed Discharge

Chart 5: Bed Days Lost to Delayed Discharge 18+ as a Rate per 1,000 Population in Dundee

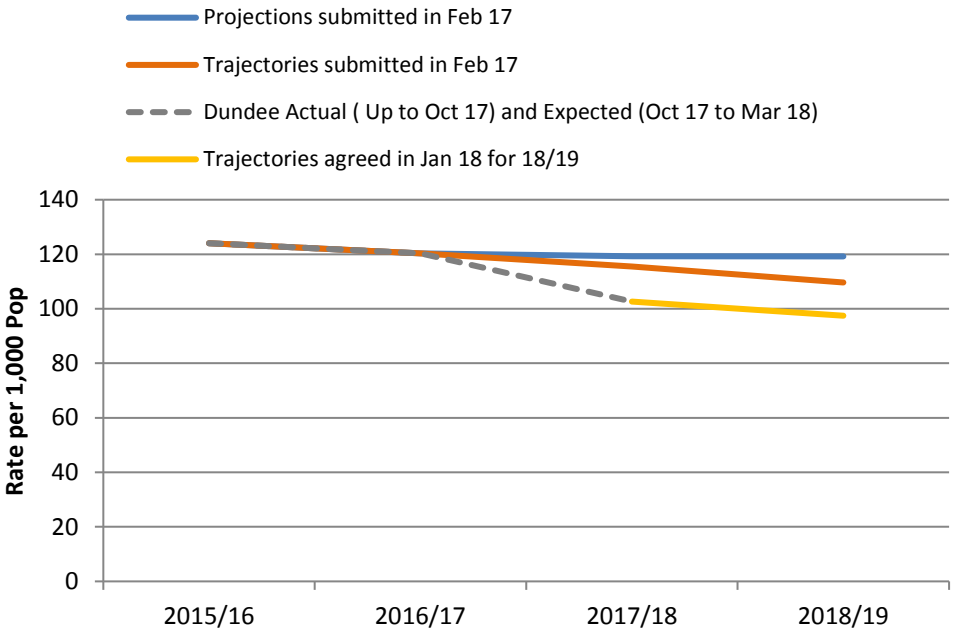
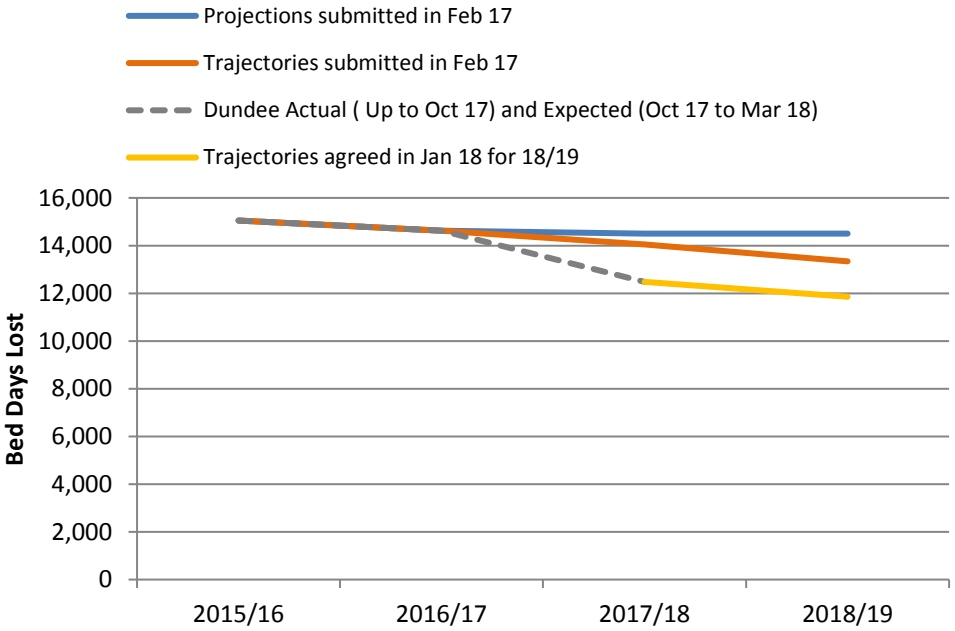


Chart 6: Number of Bed Days Lost to Delayed Discharges 18+



What is the data telling us?

- 17/18 estimated and actual performance is better than the 15/16 based projection for 17/18 and the 17/18 trajectory (target) set in February 17.
- Bed days lost to delayed discharge were projected to decrease in 17/18 to14,502 and the trajectory set in Feb 17 for 17/18 was for emergency bed days to decrease further than the projection (14,042).
- The actual and estimated data for 17/18 shows that Dundee is likely to perform even better and there will be approximately 12,480 bed days lost. This is a further improvement of 1,562 bed days compared with the 17/18 trajectory set in February 17.

How was the 18/19 target developed?

- The 15/16 based projection for 18/19 was that bed days lost would be maintained at the same number as 17/18 (14,502). The 18/19 trajectory submitted February 17 was for there to be a decrease to 13,340 bed days lost.
- The 18/19 target is to further reduce bed days lost from the 17/18 actual and estimate by 5% to 11,856 bed days lost.

How will trajectories agreed in Jan 18 for 18/19 be achieved?

- Increased investment in intermediate forms of care.
- Remodel care at home services and provide more flexible responses.
- Further invest in social care infrastructure, including consolidating current tests of change through third sector partnerships.
- Further development of Community Rehabilitation.
- Review discharge management procedures and guidance.
- Develop a statement and pathway for involving carers in discharge planning process.
- Extend the range of third sector supports for adults transitioning from hospital back to the community.
- Develop a step down and assessment model for residential care.
- Hold Power of Attorney local campaigns.
- Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.
- Establish an integrated model of support for people with a learning disability and / or autism who also have extremely complex health and care support needs.
- Implement home and hospital discharge plan.

Last 6 months of life

What is the data telling us?

The 16/17 target was to increase the number of days of the last 6 months of life spent in the community, increase the number of days in a hospice / palliative care by 2% and increase the number of days spent in a large hospital by 13%.

These targets were not met as between 15/16 and 16/17 the number of people who died in the community decreased by 0.8%, the number of people who died in a hospice / palliative care unit decreased by 10.8% and the number of people who died in a large hospital decreased by 3.4%.

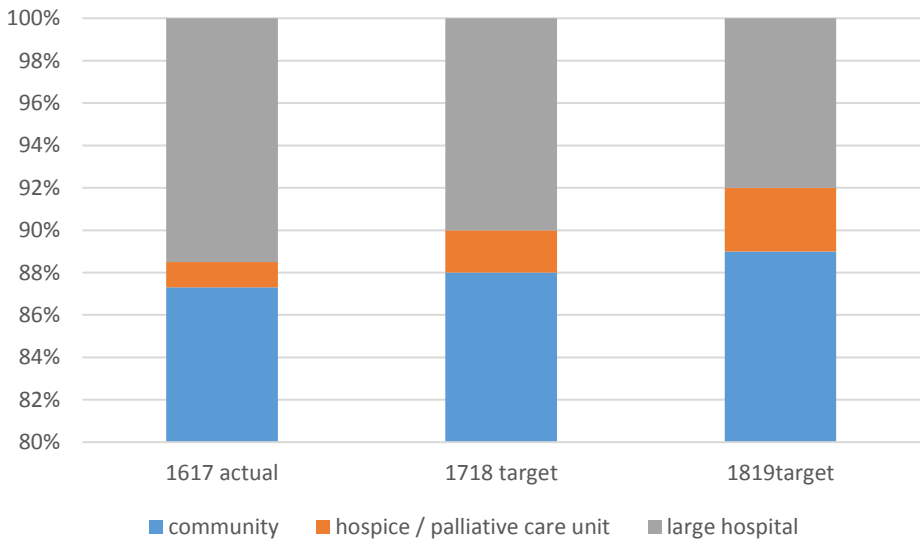
How was the 18/19 targets developed?

When interpreting this data it became apparent that the % change is determined by the total number of deaths in a year and if the number of deaths is less than the baseline year then targets may not be met. Common sense tells us that reduced numbers of deaths cannot be regarded as negative.

It has therefore been agreed that instead of % changes compared with the previous year that it would be more sensible to set ratio based targets.

Chart 7 illustrates the actual 16/17 ratio and the target ratios for 17/18 and 18/19

Chart 7: % of days spent in last 6 months of life by location



How will trajectories agreed in Jan 18 for 18/19 be achieved?

-PEOLC test site for dementia
- Expand the use of Palliative Care Tool Bundle and Response Standards in use across community based health and social care services.
-Fully implement the Macmillan Improving the Cancer Project.
- PEOLC Managed Clinical Network in place, to focus on non-specialist palliative care.
- Increased availability of Key Information Summaries and ACPs.
- Learning disability community nursing team will work with MacMillan nurses to improve methods of communication.

Balance of Care

Data to measure performance against the 16/17 targets is not currently available from NSS ISD therefore it is not currently possible to measure performance.

The targets set in the February 2017 submission were:

Supported At Home

All Ages – 1.5% of the population supported at home.

75+ - 11.6% of the population supported at home

Unsupported At Home

All Ages – 97.6% of the population unsupported at home.

75+ - 80% of the population unsupported at home.

Living in Care Homes

All Ages – 0.5% of the population living in care homes.

75+ - 6.7% of the population living in care homes.

Large Hospital

All Ages – 0.4% of the population in large hospital.

75+ - 1.7% of the population living in large hospital.

Health and Social Care Integration Directorate
Integration Division

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 5453

COSLA

To: Chief Officers Integration Authorities

22 November 2017

Dear Colleagues

UNDERSTANDING PROGRESS UNDER INTEGRATION

We are writing to provide you with an update on our work to develop a plan for sharing progress updates on integration with the Ministerial Strategic Group for Health and Community Care (MSG).

We wanted firstly to thank you for sharing your local objectives on the initial six indicators in February. As you know, we used this information to provide MSG with a summary overview of Integration Authority ambitions around these indicators, progress to date and some of the challenges facing Integration Authorities in delivering on their objectives. MSG appreciated the time you took in developing and sharing your local objectives to support them in their role in providing political leadership for, and oversight of, integration.

Since then we have been considering how best to provide regular progress updates to MSG. With the agreement of the Chief Officer network, we established a small working group comprising lead officers for strategic commissioning and performance in Integration Authorities, Chief Finance Officers, data analysts and SG officials. The group has met three times to discuss possible approaches and suggested a potential framework for providing future updates to the MSG. This framework is outlined below.

During our discussions, we've reflected in some detail on a number of issues, for instance, how best to balance the presentation of a manageable number of common data points for all areas with more bespoke narrative insights that can help to draw out the richness of local variation; how to explore specific themes such as end of life care; how to explore the quality of service user experience; how best to recognise normal fluctuations in performance, particularly between frequent reporting dates. We've also shared experiences on setting local objectives.

Based on the these discussions, the working group has suggested the following outline framework for sharing regular progress updates with MSG based on four key elements:

a) Quarterly data on the six indicators but in time building on these indicators for example to reflect the contribution of primary and social care.
b) Comparison between progress in Integration Authorities and projections set out in local plans, and also with the likely result had no changes been made
c) Overarching narrative summary, drawing out emerging themes from across Integration Authorities
d) Local illustrations, inviting individual Integration Authorities to contextualise their progress with a presentation to the group and opportunity for discussion. Over time we aim to involve a wide range of Integration Authorities depending on the purpose / theme of the MSG meeting.

Taking account of the proposed framework, we have agreed with the working group and Chief Officers that we will co-produce a paper providing an update on progress for the next MSG meeting on 13 December, drawing on the recent annual performance reports, and will invite one or two partnerships to present at the meeting.

Beyond this meeting, we have agreed with the working group and Chief Officers that it would be helpful to provide MSG with an updated overview of local objectives and ambitions relating to the six indicators. We are aware that some Integration Authorities will have reviewed and updated their objectives since sharing them in February. You are therefore each invited to share your updated objectives for 2018/19 by 31 January 2018, following which we will provide an overview, with input and support from the working group and partnerships, for MSG for their meeting on 21 March 2018. We recognise that, as before, you will want to engage a range of partners in this process.

To support the process, we have developed draft guidance and a suggested format for sharing objectives with advice from the working group, ISD and others. This should help to simplify the task locally and will provide consistency across information shared. As before we would anticipate that there would be local support for developing objectives from the LIST team and other local analysts drawing on collective advice on best practice around developing objectives.

We will work with the working group and Chief Officers to expand the range of indicators used going forward. In view of the move to a single national social care dataset, we have agreed with the working group that we should feed in views around about the social care data collected to ensure that it provides intelligence which supports the planning and delivery of integrated services.

We would be grateful if you would provide your updated 2018/19 local objectives for MSG by 31 January 2018 to be sent to NSS.Source@nhs.net. We recognise that you will want to agree these objectives with your IJB, so if that is not possible within the timescale, we would be happy to accept interim objectives. We would welcome any feedback on this approach and the guidance – please contact my colleague Fee Hodgkiss fiona.hodgkiss@gov.scot or 0131 244 5429.

Yours faithfully

Alison Taylor Paula McLeay

Alison Taylor
Deputy Director
Integration Division

Paula McLeay
Chief Officer Health and Social Care
COSLA

ITEM No …13……..

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

REPORT ON: **TARGETS AND INDICATORS IN HEALTH AND SOCIAL CARE: A REVIEW**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB7-2018**

1.0 PURPOSE OF REPORT

To inform the Integration Joint Board of the key points and recommendations from 'Targets and Indicators in Health and Social Care: A Review' (Professor Sir Harry Burns, November, 2017) To inform members of the potential implications for the Dundee Health and Social Care Partnership should the Scottish Government decide to implement the recommendations within the review.

2.0 RECOMMENDATIONS

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

2.1 Notes the key points and recommendations from 'Targets and Indicators in Health and Social Care: A Review' as summarised within this report.

2.2 Notes the potential implications for the Dundee Heath and Social Care Partnership of any future implementation of the recommendations made within the review by the Scottish Government (section 4.6).

2.3 Instructs the Chief Finance Officer to bring forward a full report on local implications if, following consideration of the review, the Scottish Government proceeds to implement any of the recommendations made by Professor Sir Harry Burns.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 BACKGROUND

4.1 In November 2017 the Scottish Government published Professor Sir Harry Burns' review of Targets and Indicators in Health and Social Care in Scotland. The review had been commissioned by the Scottish Government to inform its approach to target setting for health and social care, assess how well targets align to Scottish Government strategy for the future of the NHS and social care services and comment on whether targets support the best possible use of public resources. The remit of the review included consideration of the relevance to health and social care of the 30 National Performance Framework indicators, 19 Local Delivery Plan standards and 23 National Health and Wellbeing indicators.

4.2 The review highlights the need for a continued focus on inequality, both in terms of outcome inequality (for example, life expectancy) and inequality of opportunity. Whilst the importance of public health approaches, such as smoking cessation, are acknowledged significant emphasis is placed on drugs, alcohol, suicide, accidents and violence as the factors which are the greatest cause of inequalities amongst younger people. Professor Burns highlights that these factors require attention to emotional, social and psychological needs of people alongside medical interventions and promotes a life-course approach to improving health and wellbeing, promoting

social justice and contributing to sustainable development, inclusive growth and wealth. This may be particularly challenging for Integration Authorities, such as Dundee, where the scope of delegated functions does not cover the whole life-course and will require co-operation across Community Planning structures and organisational boundaries.

4.3 Whilst the review acknowledges clear evidence that setting targets can produce improvements in the process targeted, it also identifies a number of risks associated with target setting:

- a tendency to focus on those things most easily measured;
- fostering complacency amongst providers already achieving targets and defensiveness from those who are not;
- potential adverse effect of national targets on local priorities;
- neglect of un-targeted activities;
- risk of targets widening inequalities in deprived populations if they are unrealistic and unattainable; and,
- targets set beyond the capacity of the system to cope diverting organisational attention to meeting deadlines rather than whole systems improvement.

In addition to these risks, the complexity of the public sector is highlighted and it is suggested that there is a need to focus on indicators before target setting is considered. Professor Burns writes:

> "*Experience suggests that with complex systems, what can be measured is often not sufficiently detailed to allow for meaningful performance monitoring. The result is often oversimplification of the system to a set of numbers which do not provide adequate information to allow improvement of the outcomes of the complex system. As a result opportunities for performance improvement across the whole system are often missed.*"

4.4 Having highlighted some of the potential risks and challenges regarding indicators and targets in complex health and social care systems, Professor Burns goes go on to acknowledge the usefulness of targets in setting a direction against which progress can be measured over time. He suggests that a thorough understanding of the aims and envisioned outcomes of the system can support identification of new indicators that meet three key principles:

- are pragmatic and co-produced;
- are subject to regular review to ensure ongoing relevance; and,
- provide information on the whole performance of the system, rather than just a snapshot of one aspect.

The potential risks outlined in section 4.4 and the key principles suggested within the review will be taken into account as the Partnership continues to develop and implement its multi-tiered performance framework.

4.5 In considering the current set of national indicators and standards against the risks and key principles outlined above, the review sets out the inadequacies of the current approach at a national level:

- they do not always adhere to the principles of good design for indicators and targets;
- there are three separate sets of indicators with different organisations accountable for delivery, which does not support systems thinking;
- for many indicators no routine data collection takes place;
- mechanisms for reporting performance tend to result in public debate focusing on specific parts of the system in isolation;
- accurate reporting requires appreciation of context and the social context of different organisations is not always clear enough;
- there is not enough focus on continuous progress;
- there is a need to consider alternative measures of economic growth that are more relevant to population wellbeing; and,
- targets and indicators need to encourage joint working across agencies and communities to tackle social and economic conditions in which people make decisions about maintaining or improving their health.

Professor Burns also suggests that assurances that specific processes are in place to connect performance reporting to improvement processes that deliver continuous improvement in indicators would resolve many of the issues he identifies within the current system.

4.6 Recommendations in Specific Service Delivery Areas

4.6.1 Professor Burns makes a number of recommendations in relation to service delivery areas within the scope of the IJB. The Scottish Government is currently considering the review content and has not yet made any formal response to the recommendations made. If the Scottish Government at any point in the future decides to progress with implementation of any of the recommendations made, a full assessment of local implications will be made and submitted to the IJB. An initial assessment of potential implications for the IJB, should they be implemented in the future, are summarised below.

4.6.2 Access to Emergency Care Indicators

- *Information on A&E attendance, referral pathways, length of time spent in A&E, admissions from A&E, length of hospital stay and outcomes should be reported, alongside bed availability as a determinant of A&E waiting times*; currently only attendance, admissions and waiting times at A&E are regularly reported to the Performance and Audit Committee therefore revision to local datasets and information flows would be required.
- *Each GP practice should receive regular information about how many patients attend A&E, including self-referrals*; whilst GPs receive some information from emergency summaries more work may be required to support information sharing as part of the implementation of the GP contract.

4.6.3 Healthcare Indicators

- *Waiting time targets, including those for mental health, should be subject to clinical prioritization. The Scottish Government should consider removing the 18 week referral to treatment standard and devolve this matter to local systems*; local decisions would require to be made regarding approaches to prioritization and replacement local standards.
- *Trial decision support tools which have been proven to enhance patient confidence in clinical advice, with a view to roll out if evidence supports this*; the use of tools would require incorporation into local policy and practice, with potential implications for learning and workforce development.

4.6.4 Socioeconomic Indicators

- *The Scottish Government should work closely with public sector bodies to commission interventions aimed at testing new ways of meeting needs of families living in difficult circumstances with a view to assessing cost-effectiveness and transformational potential*; links are increasingly being made across the life-span and whole family approaches through joint work between the Community Planning Partnership Executive Boards for Children and Families and Health, Care and Wellbeing however this work may require to be accelerated and expanded in scope.

4.6.5 Opinion Indicators (including measures from the national health and social care experience survey)

- *More regular assessment of service utilisation and effectiveness is required, including effective means of collecting people's views on services and mechanisms for rapid feedback*; it is clear that such mechanisms would require to be implemented at a local level and whilst a number of services have developed innovative practices in this regard there is improvement work required in some service areas (for example, there is ongoing work within the Integrated Substance Misuse Service) to ensure effective self-evaluation and quality assurance approaches as part of the overall Clinical, Care and Professional Governance framework
- *Elements of the national experience survey where there is wide variation should be developed to allow more detailed data collection and analysis*; this would provide very helpful supplementary information to inform local improvement planning processes and enhance the level of detail available to identify and plan improvements.

4.6.6 Place of Care and Independent Living Indicators

- *Those responsible for delivering support to elderly and disabled people should carry out a needs assessment for their area, including co-production of any service responses*

required; there is further work planned in this regard as part of the development of locality needs assessment and service delivery models. This may also require further work to improve collection and reporting of equality monitoring data.

4.6.7 End of Life Care Indicators

- *Integration Authorities should receive data on palliative and end of life care provision and service quality, including the impact of guidelines for benchmarking and good clinical practice*; this level of data is being developed for reporting at the Palliative and End of Life Care Managed Clinical Network data/audit group and connections will be made through the Partnership's multi-tiered performance framework to higher level datasets.
- *Key Information Summaries might be a useful driver for 'what matters to you' discussions that support shared decision making between patients and those providing care*; IT systems supporting Key Information Summaries are GP input only at the present time therefore local approaches to support input from patients and other stakeholders would require to be developed, possibly through Anticipatory Care Plans.

5.0 POLICY IMPLICATIONS

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

6.0 RISK ASSESSMENT

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

7.0 CONSULTATIONS

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

8.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 31 January 2018

Kathryn Sharp
Senior Manager