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

21st August, 2019

TO: ALL MEMBERS, ELECTED MEMBERS AND OFFICER REPRESENTATIVES OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
(See Distribution List)

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 27th August, 2019 and now enclose the undernoted items of business which were not received at time of issue.

Yours faithfully

DAVID W LYNCH

Chief Officer

A G E N D A

8 THE USE OF ELIGIBILITY CRITERIA TO MAXIMISE AVAILABLE RESOURCES (Page no. 1)

(Report No DIJB45-2019, by the Chief Officer, copy attached).

10 MEMORANDUM OF UNDERSTANDING BETWEEN INTEGRATION JOINT BOARDS AND INDEPENDENT SCOTTISH HOSPICES (Page no. 15)

(Report NO DIJB40-2019, by the Chief Officer, copy attached).

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
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Elected Member (Vice Chairperson)	Councillor Ken Lynn
Elected Member	Councillor Roisin Smith
Elected Member	Bailie Helen Wright
Non Executive Member	Jenny Alexander
Non Executive Member	Professor Nic Beech
NON VOTING MEMBERS	
Chief Social Work Officer	Diane McCulloch
Chief Officer	David W Lynch
Chief Finance Officer (Proper Officer)	Dave Berry
Registered medical practitioner (whose name is included in the list of primary medical services performers)	Dr Frank Weber
Registered nurse	Kathryn Brechin
Registered medical practitioner (not providing primary medical services)	Dr James Cotton
Staff Partnership Representative	Raymond Marshall
Trade Union Representative	Jim McFarlane
Third Sector Representative	Christine Lowden
Service User residing in the area of the local authority	Linda Gray
Person providing unpaid care in the area of the local authority	Martyn Sloan
Director of Public Health	Dr Drew Walker

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Dundee City Council (Members' Support)	Fiona Barty
Dundee City Council (Communications rep)	Steven Bell
Dundee Health and Social Care Partnership (Secretary to Chief Officer and Chief Finance Officer)	Kathleen Sharkey
NHS Tayside (Communications rep)	Jane Duncan
NHS Tayside (PA to Director of Public Health)	Linda Rodger
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
Audit Scotland (Senior Audit Manager)	Bruce Crosbie
Dundee University (PA to Professor Nic Beech)	Lynsey Mcirvine
NHS Tayside (PA to Dr James Cotton)	Jodi Lyon

ITEM No …8……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 AUGUST 2019**

REPORT ON: **THE USE OF ELIGIBILITY CRITERIA TO MAXIMISE AVAILABLE RESOURCES**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB45-2019**

1.0 PURPOSE OF REPORT

1.1 This report sets out the Dundee Health and Social Care Partnership Eligibility Criteria for Adult Social Care services and the financial guidelines to be used to maximise the use of resources across the partnership.

1.2 The report confirms the rationale for applying national eligibility criteria and provides information on the five categories of need that are used to prioritise the provision of service for individuals following assessment. The report also describes the approach taken to maximise the use of available resources to the Partnership.

2.0 RECOMMENDATIONS

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

2.1 Approves the adoption of the Dundee Health and Social Care Partnership eligibility criteria as attached at Appendix 1 and confirms application of this across all Dundee Health and Social Care Partnership social care services (as detailed in section 4.3).

2.2 Notes the intention to prioritise Dundee Health and Social Care Partnership resources at those presenting with Critical and Substantial need (as detailed in section 4.3.6).

2.3 Notes the current arrangements for the financial assessment of social care packages and confirms approval of the upper limit for the funding of social care services for older people living in the community (as detailed in sections 4.1.5/4.4.1).

2.4 Notes that due to the varied levels of needs across younger adults with disabilities a review will be undertaken to ensure spend on adults under the age of 65 years reflects the best use of public resources and that there is further clarity around the allocation of funded support (as detailed in section 4.4.2).

2.5 Notes the intention to review the criteria for the delivery of integrated health and social care services alongside service redesign and implementation (as detailed in section 4.4.3).

3.0 FINANCIAL IMPLICATIONS

3.1 The prioritisation of resources as outlined in this report will ensure funding is available from within the delegated budget to support those most in need.

4.0 MAIN TEXT

4.1 Background

4.1.1 In 2009, the Scottish Government, in agreement with COSLA, introduced guidance which set out the National Eligibility Criteria and Waiting Times for Personal and Nursing Care (2009). The purpose of the guidance was to improve the clarity, presentation and implementation of the Free Personal Care and Nursing Care policy for older people which came into effect in 2002. The national guidance promoted a common eligibility framework, which categorised the needs of individuals and the timescales for delivery of services. In additional to promoting consistent national standards, the guidance asserted key principles, namely:

- the central role of assessment to determine access to social care services;
- the responsibility of local authorities to determine the provision of care services in their areas, taking account of their financial resources and other resources and the cost of service provision; and
- that the prioritisation process should target resources towards responding to people at critical or substantial risk as regards independent living or well-being while not excluding consideration of the benefits of preventative support and less intensive services.

4.1.2 Dundee City Council adopted the national guidance for older people which was to be implemented by December 2009 (Article I of the minute of the Social Work and Health Committee held on 25 January 2010 refers).

4.1.3 The national guidance on Eligibility Criteria and Waiting Times was further reviewed with the introduction of Self Directed Support and this prioritised risk into five bands with assigned priority for responses:

- Critical Risk: Indicates that there are critical risks to an individual's independent living or health and well-being which are likely to call for the immediate provision of social care services (very high priority).
- Substantial Risk: Indicates that there are significant risks to an individual's independence or health and wellbeing and they may require input from Social Work or other partnership services (high priority).
- Moderate Risk: Indicates that there are some risks to an individual's independence or health and wellbeing. These may call for the provision of advice and guidance including signposting to other services or they may simply be manageable over the foreseeable future (medium priority).
- Low Risk: Indicates that there may be some quality of life issues, but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for the provision of social care services.
- No risk: People within this category are those whose assessment of needs indicates there are no risks identified to independence or health and wellbeing. No further advise, action, information, or services require to be arranged or facilitated. However, referral may be made to other services (e.g. NHS, Voluntary Organisations, community groups).

While the original guidance was written for access to older people services, locally it was agreed that the national eligibility criteria framework should apply to all adults. The criteria provided a framework for prioritisation to ensure that resources were allocated on an equitable basis.

4.1.4 Over the last 10 years there has been a shift in the balance of care with a reduction in the number of older people living in care home and hospital long-stay hospital beds and an increase in the number of older people living in the community. To meet the needs of this increasing frail older population requires additional supports and services. As more older people remain at home it was anticipated that requests for larger packages of support would be requested, for some this would be provided as an option through Self Directed Support, including as an Option 1 (Direct Payment). In 2014 it was recognised that there was an increase in requests for 24 hour care to be provided for individuals remaining at home. As the full cost of 24 hour care at home exceeded the costs of a care home placement, requests of this nature were impacting on the ability of the Social Work Department to provide care to the wider older population.

4.1.5 In order to balance the resources available to the Social Work Department, Dundee City Council Policy and Resources Committee set the level of care at home support provided by the Council at 15% above the national care home placement rate resulting in a current maximum cost of up to £822 per week. (Article III of the minute of the meeting held on 13 February 2014 refers). Where the assessment determined that a specialist care placement is required and that this would be financially costed at a higher rate than the national care home rate plus 15%, then the maximum resource available should reflect this additional need and be linked to the specialist care rate.

4.1.6 With the introduction of Self Directed Support, the eligibility criteria for services was reviewed and published by Dundee City Council, a copy of which currently is available on the Dundee Health and Social Care Partnership Website (SDS Eligibility Criteria).

4.1.7 In addition the generic eligibility criteria, local services specific eligibility criteria was established in line with legislation and/or good practice. These eligibility criteria are published by the Dundee Health & Social Care Partnership (the Partnership) and include:

- Community Equipment and Adaptation Criteria (approved at the Social Work and Health Committee, Article III of the minute of the meeting held on 28 March 2016 refers).

- Dundee Adult Carers Eligibility Framework and Eligibility Criteria (approved at the DH&SCP Integrated Joint Board, Article X of the minute of the meeting held on 23 April 2019 refers).

4.1.8 Eligibility has been considered with regard to the Partnership's duties under Equality Act 2010 and our strategic priority to reduce health inequalities. The introduction of clear policy statements regarding eligibility criteria and the maximum level of resources for older people was intended to ensure that decision making was equitable, transparent and support individuals and their families to make informed choices. It would also allow the management of the social work/ social care services in a manner which ensures that more service users will have access to services to enable them to remain at home by maximising the use of available resources to the partnership.

4.2 Strategic Priorities

4.2.1 The Partnership is responsible for delivering person centred adult health and social care services to the people of Dundee who are assessed as needing them. The need for transformational change in the way we provide services is well understood. As a result of improvements in health and care provision people are living longer with more complex needs and demand for services continues to increase. As a result the model is often reactive and crisis driven and health inequalities continue to increase.

4.2.2 As outlined in the Dundee Health and Social Care Strategic and Commissioning Plan 2019-2022, there is a focus on supporting those who are older or have disabilities to maintain as much ability and independence for as long as possible and continue to live in their own home. This will be achieved through the priority areas that are outlined within the Strategy. These priorities are early intervention and prevention, health inequalities, working with localities, and pathways of care.

4.2.3 Over the last decade the demand for services has increased and the Partnership has continued to invest in the growth of social care services. This has enabled the Partnership to manage the growth in demand for social care services, support discharge from hospital and develop new models of care. Despite this use of these additional resources, the overall financial context for public services has meant that the ability to continue to grow the service at the same rate will no longer be possible. The Partnership will be required to take a more targeted approach to ensure that we make best use of the resources available. Equity of care, supporting consistency of service provision in a transparent process and maximising the use of our resources to achieve the best results for the overall population, is key to prioritisation of the resources available to the Partnership.

4.3 Application of the Eligibility Criteria and Prioritisation of Resources

4.3.1 As stated in Section 4.1.1 – 4.1.3, the Scottish Government requires Health and Social Care Partnerships on behalf of local authorities, to publish eligibility criteria to ensure that all adults over 16 needing social care supports have their needs addressed in a fair and transparent way. In applying the national eligibility criteria at a local level, the Partnership will take into account a range of factors, including the needs of our local population through the publication of our Strategic Needs assessment, the overall level of resources available to meet need, the cost of service provision and the demand for individual services.

4.3.2 The Partnership has a devolved duty set in legislation, to assess the needs of any individual in need of social care support. This assessment should be outcome focused, identify the outcomes the person wishes to achieve, consider current informal and formal networks and how the person will be supported to achieve these outcomes. In order to undertake an assessment relevant information about individual circumstances is gathered. This will often include information about activities of daily living, health and the individual's finances. The aim is to get a full picture of the assets available to the individual including those provided from others. Consideration of the four Self Directed Support Options should be introduced at this time.

4.3.3 This assessment will seek to determine whether other supports would be more appropriate as often these will allow the person to continue to manage independently. This may include rehabilitation services, equipment and adaptations or support from the voluntary and independent sector. Where people cannot be supported to retain their independence without additional care and support and are at the greatest risk, it will be essential that they can access this care timeously.

4.3.4 A core component of the assessment process is the identification of informal means of meeting the majority of an individual's identified needs. This will support people to remain independent longer and provide improved personal outcomes. Examples of this may include support from family or signposting towards locality based community services. Social care resources will usually only be provided to individuals who have needs which are assessed as being of a critical or substantial nature and if not met would leave the person at significant risk. This will support us to ensure that financial resources are targeted to those in greatest need.

4.3.5 In circumstances where the person cannot be supported to remain independent in other ways and formal social care services are provided, it will be reviewed on an annual basis. The purpose of a review is to ensure the support is achieving the outcomes agreed at the initial assessment. The review process will consider any significant changes in circumstances and, if necessary, make changes to the support provided. At any time a person in receipt of formal support can ask for a review of their situation.

4.3.6 The partnership is currently experiencing an increase in demand for social care services which outstrip the available resources. Operational experience demonstrates that where we are unable to support individuals with critical or substantial need in the community, there is a higher risk of admission to residential or nursing care. This is borne out by the current increase in admission to care homes. These capacity issues could impact on timely discharge from hospital. A limited benchmarking exercise with other Health and Social Care Partnerships identified that Glasgow, West Lothian, Fife, Aberdeen City, Edinburgh City and Angus all publish eligibility criteria which state they only provide services to individuals who meet the Critical and Substantial eligibility criteria. In order to ensure that resources are used effectively to meet the needs of those most in need, it is proposed that the Partnership prioritises its available resources to support individuals who present with the following levels of risk:

Critical Risk: Indicates that there are critical risks to an individual's independent living or health and well-being which are likely to call for the immediate provision of social care services (very high priority).

Substantial Risk: Indicates that there are significant risks to an individual's independence or health and wellbeing and they may require input from Social Work or other partnership services (high priority).

4.3.7 For those presenting with a moderate, low or no risk (see section 4.1.3 for definition) we will provide information, advice and signposting to individuals. This will include information about access to services through existing arrangements with the third sector and signposting to services that can also provide links to a wide range of relevant opportunities to meet the personal assessed needs of the individual. Where appropriate support will be given to enable or rehabilitate the person to increase their independence and provide a positive, sustainable approach.

4.3.8 The table below sets out the expected timescales for assessment and the provision of social care services in line with the assessed level of risk and the associated level of need.

Level of risk and the associated level of need	Timescale for First Visit	Timescale for Completion of Joint Assessment	Timescale for Provision of Community Care Services
Critical	Same day	Initial screening on same day, and where required a full assessment completed within 7 days	Services may be provided following initial screening, other supports will be delivered within 7 days or earlier if necessary.
Substantial	Within 48 hours	Initial screening within 48 hours, and where required an assessment will be carried out within 14 days	Services may be provided following initial screening and will be delivered within 6 weeks or earlier if necessary.
Moderate	Within 28 days	Assessment will be completed within 28 days of first visit.	Individual will be provided with advice and guidance and signposted to appropriate support services in the community.
Low	Within 12 weeks	Assessment will be completed within 28 days of first visit.	Individual will be provided with advice and guidance and signposted to appropriate support services in the community.
No priority	N/A	N/A	Individual will be provided with advice and guidance and signposted to appropriate support services in the community

4.4 Financial Cost of Packages of Care and Support

4.4.1 Currently packages of care and support are more regularly individually costed for adults at the point of commencement, whereas for older people this tends to be a provision which will grow in line with changing need. With the introduction of the new financial module within the MOSAIC system, we will be able to more easily track the costs for individual packages of care for older people. It is anticipated that this will in turn identify more older people who seek care where the cost of this sits at or above the current threshold (nursing care home rate plus 15%). The current scheme of delegation requires approval by the Chief Officer, Chair of the IJB and/or the Vice Chair of the IJB to support a package of care above the threshold. It is recommended that the Partnership retain the current financial framework as described in section 4.1.5.

4.4.2 Dundee has a proven track record of developing supported accommodation in the community for adults and have reduced the level of care placement significantly. This support is based on individually assessed care and support packages, and given the complex need can result in significant packages of support being provided. As a result of the complexity and variance in need, it has not been possible to set a financial framework for adults. Recent benchmarking has identified that Dundee has a higher spend per population for certain groups of adults. In order to ensure that we are providing support which meets best value it is proposed that we undertake a review of adult care and support, considering both financial and national best practice frameworks to determine the reasons for the difference within Dundee. Following this review our intention is to develop a banded financial framework which provides clarity and equity of provision.

4.4.3 As we continue to develop integrated services and teams, and redesign service delivery models, we anticipate that there will be an overlap in the delivery of tasks which are either provided by both groups of professionals and/or services. To ensure fair and proportionate application of resources and the monitoring of spend, we will continue to review our eligibility criteria and the funding of care packages to ensure a fair and transparent approach is applied to the delivery of individualised packages of support and in recognition of the increasing demands across all partnership approaches. The will not impact on the individual's right to access universal services.

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 application of eligibility criteria may result in people who would have received a service directly from the SH&SCP being signposted elsewhere.
Risk Category	Social
Inherent Risk Level	Likelihood 4 x Impact 3 = 12 (which is a High Risk level)
Mitigating Actions (including timescales and resources)	The service will ensure clarity of application and clear signposting of services and support. Risk will be clearly assessed and acted on. Reviews will ensure that support is managed in according with assessed need and outcomes.
Residual Risk Level	Likelihood 4 x Impact 2 = 8 (which is a High Risk)
Planned Risk Level	Likelihood 4 x Impact 2 = 8 (which is a High Risk)
Assessment of Risk Level	The mitigating actions set out above will ensure people will still be able to access services to support their needs.

7.0 CONSULTATIONS

The Chief Officer, Head of Democratic Services and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

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

As this paper confirms a decision previously made through Dundee City Council, no further directions are required.

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

9.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 12 August 2019

Diane McCulloch
Head of Health and Community Care

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Appendix 1

DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP
ELIGIBILITY CRITERIA AND STANDARD DELIVERY TIMESCALES

1. INTRODUCTION

1.1 The "National Eligibility Criteria and Waiting Times for The Personal and Nursing Care of Older People" was issued jointly by the Scottish Government and COSLA on 28th September 2009. This guidance was adopted by Dundee City Council who applied the new eligibility framework to all community care groups and not solely to the management of older people's care. The criteria was reviewed by the Dundee Health and Social Care Partnership (DH&SCP) and adopted in 2019 as their published criteria.

1.2 The need for a prioritisation framework was and continues to be a direct response to the increasing gap between assessed need and available resources. There are many reasons why this is an increasing issue for health and social care services:

- The impact of demographic change, such as increase in the population of older people and reduction in the number of younger people living in the City;
- Changes in health care which mean, for example, that many more frail, older people are discharged from hospital with high presenting care needs and many children with significant disabilities are not only surviving infancy where they may not previously have done so, but can expect to live with those conditions throughout adulthood;
- The impact of societal changes;
- Rising public expectations and demand for highly personalised services;
- Pressure on core services.

1.3 This prioritisation framework reflects DH&SCP's wish to allocate resources on an equitable basis. This in turn is consistent with the wish of the Scottish Government to see a standardised approach to service eligibility across Scotland.

1.4 DH&SCP's capacity to meet need is and will not be an absolute position. It will vary according to the amount of available resources at any one time, weighed against the amount and type of presenting need. Individual needs change over time and judgements about meeting need are, therefore, made in a constantly changing context. In order to create and deliver the correct balance of service, care and consideration must be applied to ensure that by providing services we are not creating dependencies. For example, an individuals assessed needs may call for the provision of a certain level of services following discharge from hospital, but a different level of service once they are re-established in their own homes. Continual and effective review arrangements are crucial to good effective management and deployment of resources.

1.5 It is also important to recognise that some service delivery interventions are driven by other imperatives, such as statutory responsibilities to a Court Order or an Adult Support and Protection hearing, or local policy decisions to attach resources to designated areas of activity.

1.6 This guidance, as previously noted, is not specific to any single care group. It also acknowledges that where the risk element of the assessment of need applies to the independence or safety of the person concerned, that this is more likely to refer to people with community care needs.

2. PRINCIPLE OF INTENSITY OF RISK AND GREATEST NEED

2.1 The DH&SCP approach to prioritisation is that access to resources should be determined on the basis of comparative intensity of risk and greatest need and not on any other basis, such as, length of waiting time for services. This is consistent with the National Standards noted in the introduction.

2.2 The guidance establishes 5 categories of risk and they are as follows:

- Critical Risk;
- Substantial Risk;
- Moderate Risk;
- Low Risk, and
- No Risk.

It is also important to recognise that risks can be associated with a number of different aspects of life including the following:

- risks relating to neglect or physical or mental health;
- risks relating to personal care/domestic routines/home environment;
- risks relating to participation in the community life;
- risks relating to carers.

For the purposes of this guidance the following definitions have been used to help clarify the 5 categories of risk which have been adopted by the Council:

2.3 **Critical Risk (Highest Priority and Greatest Need)**

People assessed to be within this category are those who will require the immediate or imminent provision of social care service/s. Without intervention there is a major risks to either or both the individual and their Carer's independence or to their health and wellbeing.

These individuals' will require this immediacy of response because they will be or have for example:

- a major or acute health problem/s which cause life threatening harm or danger to themselves, but not necessarily requiring hospitalisation;
- at major risk of serious abuse or neglect including financial abuse and discrimination either having taken place or being strongly suspected (individual may need protective intervention);
- unable to do manage most vital aspects of personal care;
- unable to do the most vital or most aspects of domestic routines;
- unable to sustain vital aspects of work/education/learning;
- unable to sustain their involvement in vital or most aspects of family life/roles and responsibilities;
- unable to sustain their involvement in vital or most aspects of social roles and contacts;
- a Carer of major risk of not being able to continue to provide crucial care and support because of their own major physical/mental health difficulties as a result of their caring role;
- at major risk of becoming unnecessarily delayed in hospital waiting on services.

For older people who have an assessed need for Personal and Nursing Care Services there should be a standard maximum waiting time of 6 weeks (42 calendar days). Adults under 65 years are also entitled to this.

2.4 **Substantial risk (High Priority <u>but not</u> the highest)**

People assessed to be within this category are those whose needs are marginally less than those in the Highest Priority group. The main difference is rather subtle, in that the impact of the non provision of social care services would result in a significant risk as opposed to major risk to either or both the individual or their Carer's independence or to their health and wellbeing. Again, similar to the above, people in this category may also require the immediate or imminent provision of social care service/s.

These individuals' will be or have for example:

- a significant health problem/s which cause life threatening harm or danger to themselves, but will not necessarily require hospitalisation;
- at significant risk of serious abuse or neglect including financial abuse and discrimination either having taken place or being strongly suspected (individual may need protective intervention);
- unable to carry out many aspects of personal care;
- unable to carry out many aspects of domestic routines;
- unable to sustain their involvement in many aspects of family life/roles and responsibilities;
- unable to sustain their involvement in many aspects of social roles and contacts;
- a Carer who is in significant risk of being unable to continue to provide care and support because of their own significant physical/mental health difficulties as a result of their caring role;
- a significant risk of breakdown in the relationship between the individual and their Carer;
- at risk of becoming unnecessarily delayed in hospital waiting on services.

2.5 **Moderate Risk (Medium/Preventative Priority)**

People assessed as being within this category are those whose needs present some risks to the individual or their Carer's independence or health and wellbeing. These may call for the provision of some social care services, managed and prioritised on an ongoing basis or they may simply be manageable over the foreseeable future without service but with appropriate arrangements for review.

These individuals' will be or have for example:

- some health problems indicating some risk to independence, but with potential to maintain independence with minimum intervention;
- a Vulnerable person where there is a need to raise awareness of the potential risk of abuse (individual has capacity);
- unable to do vital or some aspects of personal care;
- able to manage some domestic activities;
- able to manage some aspects of home environment;
- unable to manage several aspects of involvement in work/education/learning;
- able to manage some aspects of family roles and responsibility;
- able to manage some aspects of social roles and contacts;
- a Carer who is unable to manage some aspects of the caring/family /domestic/social roles;
- relationship maintained, although at times under strain, between service user and carer.

2.6 **Low Risk (Low/Preventative Priority)**

People within this category are those whose assessment of need indicate that there may be some quality of life issues, but a low risk to either the individual or their carer's independence, health and wellbeing. The requirement for the provision of social care services, if any, will be very limited. There may be some need for alternative support or advice. However, arrangements must be made to review and monitor any change in order to plan for the foreseeable future or longer term.

The risks these individuals' have are unlikely to cause major harm of danger to either themselves or others. These individuals' will be or have for example:

- few health problems indicating low risk to independence with the potential to maintain health with minimum intervention - self managed care;
- preventative measures including reminders to minimise potential risk of abuse;
- difficulty with one or two aspects of personal care;
- able to manage most aspects of basic domestic activities;
- able to manage most aspects of home environment;
- has difficulty in undertaking one or two aspects of work/education/learning;

- able to manage most aspects of family roles and responsibility;
- able to manage most aspects of social roles and contacts;
- the Carer has difficulty with one or two aspects of their caring/domestic role;
- relationship maintained by limiting some aspects of the caring role.

2.7 **No Priority (No Risk)**

People within this category are those whose assessment of needs indicates there are no risks identified to independence or health and wellbeing. No further advise, action, information, or services require to be arranged or facilitated. However, referral may be made to other services (e.g. NHS, Voluntary Organisations, community groups).

2.8 **Using the Framework**

Using these categories will help to support the fair allocation of resources in order that more significant needs, by definition, will receive priority over less significant needs.

The framework recognises that it is the need and not the person that is categorised by priority. In other words, a person may have a mixture of high and low priority needs, but not all needs would necessarily be met straight away. It also recognises that by providing a specific intervention to meet a significant need may in turn have a sort of domino effect, as by addressing one particular need, the intensity of risks in the other assessed areas may change.

Although not explicit it is important to note that preventative approaches such as self-managed care arrangements/support can help limit the potential needs for service. Again, it is crucial that there are continual and effective review arrangements to support the management and allocation of resources.

2.9 **Timescales**

Linked to the category of intensity of risks the guidance also sets out four sets of timescales by which services should be in place. These are as follows:

- Immediate - required now or within approximately 1-2 weeks;
- Imminent - required within 6 weeks;
- Foreseeable Future - required within the next 6 months;
- Longer Term - required within the next 12 months or subsequently.

2.10 **Eligibility Criteria Summary**

Level of risk and the associated level of need	**Timescale for First Visit**	**Timescale for Completion of Joint Assessment**	**Timescale for Provision of Community Care Services**
Critical	Same day	Initial screening on same day, and where required a full assessment completed within 7 days	Services may be provided following initial screening other supports will be delivered within 7 days or earlier if necessary.
Substantial	Within 48 hours	Initial screening within 48 hours, and where required an assessment will be carried out within 14 days	Services may be provided following initial screening and will be delivered within 6 weeks or earlier if necessary.
Moderate	Within 28 days	Assessment will be completed within 28 days of first visit.	Individual will be provided with advice and guidance and signposted to appropriate support services in the community.
Low	Within 12 weeks	Assessment will be completed within 28 days of first visit.	Individual will be provided with advice and guidance and signposted to appropriate support services in the community.
No priority	N/A	N/A	Individual will be provided with advice and guidance and signposted to appropriate support services in the community

ITEM No …10……..

Dundee Health & Social Care Partnership

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 AUGUST 2019**

REPORT ON: **MEMORANDUM OF UNDERSTANDING BETWEEN INTEGRATION JOINT BOARDS AND INDEPENDENT SCOTTISH HOSPICES**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB40-2019**

1.0 PURPOSE OF REPORT

To make the Integrated Joint Board aware of the Memorandum of Understanding, and to confirm that as the host provider of specialist palliative care, the provision of 'hospice' services are provided within the statutory framework.

2.0 RECOMMENDATIONS

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

2.1 Notes this Memorandum of Understanding.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Background to Memorandum of Understanding (MoU)

4.1.1. This memorandum serves as a framework within which IJBs and independent hospices can collaborate to provide effective support to people with palliative care needs – a copy is attached at Appendix 1.

4.1.2 The Strategic Framework for Action on Palliative and End of Life Care is Scotland's national policy and is a direct response to the resolution passed in 2014 by the World Health Assembly, requiring all governments to recognise palliative care and to make provision for it in their national health policies. By 2021, we should seek to ensure that:

- Everyone who needs palliative care will get hospice, palliative or end of life care;
- All who would benefit from a 'Key Information Summary' will have access to it;
- The availability of care options will be improved by doubling palliative end of life provision in the community, which will result in fewer people dying in a hospital setting.

4.1.3 The environment of strategic commissioning to meet the aims of the Strategic Framework has been developing in an increasingly transactional model between the IJBs and the independent hospices, thereby limiting the potential to meet the aims of the framework.

4.1.4 Over the last 12 months, Ron Culley (Chief Officer, Western Isles) has led a short term working group with representatives from partnerships, the Scottish Hospices Leadership Group and the Scottish Government to develop a memorandum of understanding (MoU). The parties have now

agreed on the content of the MoU and the intention is that this will cover an initial two year period.

4.2 **Aim of Memorandum of Understanding**

4.2.1 The aim of the MoU is to provide a strategic and financial framework for integration authorities and independent hospices to work in partnership to deliver high quality, responsive and personalised palliative and end of life care. It describes the principles of partnerships that should apply in the development of SLAs, contracts or commissioning plans developed in a local context.

4.2.2 This document refers to independent hospices; this also includes Marie Curie, a UK-wide organisation, which currently runs two hospices in Scotland as part of its wider provision of specialist palliative care services. The MoU does not include provisions made to secure specialist palliative care for children, which is provided by CHAS, and which is subject to separate financial governance arrangements.

4.3 **Summary and Conclusion**

4.3.1 The development of specialist and local palliative care is carried out within the hosted elements of the Dundee IJB, and the hospice element is a key component within the strategic commissioning framework developing across our hospice models in both Perth and Dundee, managed by statutory services. This forms a key component of the local Framework which also includes community developments and linkage of the developing Managed Care Network for End of Life and Palliative Care. As a result, there is no requirement for a MoU for engagement with the independent hospice movement within NHS Tayside.

5.0 POLICY IMPLICATIONS

None.

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 DIRECTIONS

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

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

6.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 5 August 2019

Beth Hamilton
Locality Manager

Appendix 1

Memorandum of Understanding between Integration Joint Boards and Independent Scottish Hospices

Introduction

Across Scotland, Health and Social Care Partnerships and independent hospices are committed to a future which will ensure the provision of high quality and person-centred palliative and end of life care, made available to all who need it, when they need it. This ambition is founded on the following over-arching principles:

- A partnership based on parity of esteem and a commitment to shape palliative care services together;
- A recognition of the importance of financial stability, both within the partnership as a whole and for each independent hospice;
- A commitment to operate openly and transparently, cultivating a position of trust, building strong relationships which are resilient to disagreement and financial pressures;
- A recognition that hospices are autonomous organisations with considerable skills, expertise and charitable income, who nevertheless operate within local health and social care systems and whose aims are aligned to local commissioning strategies.

In approving this Memorandum of Understanding, all parties agree to abide by these principles.

Scope of the Memorandum of Understanding

The principles underpinning the commissioning relationship between NHS Boards and independent hospices specialising in palliative and end of life care in Scotland were set out in a Scottish Government letter to NHS Chief Executives in 2012,[1] commonly referred to as CEL 12. This document has since governed the commissioning relationship between Health Boards and independent hospices.

However, following the Public Bodies (Joint Working) (Scotland) Act 2014, all Health Boards have been required to establish Integration Authorities with their Local Authority partners. Within this context, the functions and resources associated with the provision of palliative and end of life care are now the preserve of Scotland's Integration Authorities.

The terms of CEL 12 do not apply to those Integration Authorities who have established Integration Joint Boards, since in these circumstances the Health Board is no longer the commissioner of palliative and end of life care. By contrast, CEL 12 continues to apply to those Integration Authorities which have elected to establish the NHS Board as a Lead Agency under the 2014 Act. The collaborative commissioning process as set out in CEL 12 has come to fuller fruition in the commissioning process set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

In order to clarify any ambiguities in understanding in the national policy framework, a working group was established to develop a Memorandum of Understanding between Scotland's Integration Joint Boards and Independent Hospices. The Working Group involved representatives of senior management within Integration Authorities, independent hospices, the Scottish Partnership for Palliative Care, Healthcare Improvement Scotland and the Scottish Government. Scotland's independent hospices are represented by the Scottish Hospice

[1] *A Partnership For Better Palliative And End Of Life Care: Creating A New Relationship Between Independent Adult Hospices And NHS Boards In Scotland*

Leadership Group, which has formed to represent the interests of independent hospices at a national level.

This Memorandum of Understanding ("MOU") between Integration Joint Boards and independent hospices builds on the arrangements set out in CEL 12 and represents a wider statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Joint Boards in commissioning palliative care services.

For the purposes of this MOU, we refer to Integration Joint Boards (IJBs) as the responsible party for the planning and commissioning of palliative care services. When the document refers to independent hospices, this also includes Marie Curie, a UK-wide organisation, which currently runs two hospices in Scotland as part of its wider provision of specialist palliative care services. The MOU does not include provisions made to secure specialist palliative care for children, which is provided by CHAS, and which is subject to separate financial governance arrangements.

The MOU will cover an initial two year period (1 April 2019 to 31 March 2021) and is structured to set out the key aspects relevant to facilitating the delivery of effective joint commissioning. It does not impinge on the autonomy of independent hospices as charitable organisations, although it does encourage the establishment and maintenance of Service Level Agreements (SLAs) to govern the relationship between independent hospices and Integration Joint Boards within local systems. SLAs will define mutual expectations and place rights and responsibilities on both parties.

The aim of the MOU is to provide a strategic and financial framework for Integration Authorities and independent hospices to work in partnership to deliver high quality, responsive and personalised palliative and end of life care. It describes the principles of partnership that should apply in the development of SLAs, contracts or commissioning plans developed in a local context.

This MOU will be reviewed and updated by the Scottish Hospice Leadership Group and the IJB Chief Officers parties before 31 March 2021.

Policy Context

The Strategic Framework for Action on Palliative and End of Life Care is Scotland's national policy and is a direct response to the resolution passed in 2014 by the World Health Assembly, requiring all governments to recognise palliative care and to make provision for it in their national health policies.

Launched by Cabinet Secretary for Health, Wellbeing and Sport in December 2015, it outlines the key actions to be taken that will allow everyone in Scotland to receive services that respond to their individual palliative and end of life care needs. The Framework seeks to drive a new culture of openness about death, dying and improvement and sets out to achieve the following outcomes:

- People receive health and social care that supports their wellbeing, irrespective of their diagnosis, age, socio-economic background, care setting or proximity to death.
- People have opportunities to discuss and plan for future possible decline in health, preferably before a crisis occurs, and are supported to retain independence for as long as possible.
- People know how to help and support each other at times of increased health need and in bereavement, recognising the importance of families and communities working alongside formal services.
- People access cultures, resources, systems and processes within health and social care services that empower staff to exercise their skills and provide high quality person-centred care.

The national policy is currently being implemented via a National Implementation and Advisory Group, comprised of representatives of the Scottish Government, Integration Authorities, independent hospices, community care bodies and a range of other stakeholders.

Following the establishment of Integration Authorities, the Scottish Government has also published guidance on a range of subjects, including on strategic commissioning. This was followed up by a specific publication on the commissioning of palliative and end of life care in April 2018.

The guidance describes the key considerations when planning, designing and commissioning palliative and end of life care, including understanding local data and trends around mortality; activity levels and any variation within those; service and support arrangements across the local health and social care system, including any gaps; a map of the total resources available to the partnership - the analysis of which will underpin the key reforms that emerge from local commissioning plans. It will be important that once the total resource is understood (including the total capacity of the hospices), opportunities are taken to reimagine how it can be invested to improve outcomes.

Effective commissioning will result in a comprehensive and cohesive approach to the planning and improvement of palliative and end of life care. It will situate palliative and end of life care as integral aspects of the care delivered by any health or social care professional, focusing on the person, not the disease, and applying a holistic approach to meet the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement.

The following principles should underpin the approach to commissioning:

- transparency and openness
- a focus on system outcomes
- clinical effectiveness
- cost effectiveness
- value for money

It is important that local commissioning plans also consider national priorities. The Scottish Government's national delivery plan sets out a number of high level ambitions to ensure that the right supports and services are in place for people at the end of life. By 2021, we should seek to ensure that:

- Everyone who needs palliative care will get the right care, in the right setting to meet their needs;
- All who would benefit from a 'Key Information Summary' will have access to it;
- The availability of care options will be improved by doubling palliative end of life provision in the community, which will result in fewer people dying in a hospital setting.

Partnerships should consider these priorities within the context of local commissioning plans.

HSCPs should collaborate with independent hospices as *equal partners*, and both parties will actively contribute to the development and delivery of local commissioning strategies. Independent hospices bring considerable expertise, capacity and resource to the commissioning table and this should be recognised in the commissioning relationship. Through their volunteering capacity, charitable income sources, clinical and strategic leadership, hospices have a strong track record of developing personalised, responsive and imaginative palliative care, which will be important to build upon as part of the commissioning process.

Responsibilities (of parties to the MOU)

The respective responsibilities of the parties to this MOU are:

Integration Joint Board responsibilities:

- Planning, design and commissioning of the palliative care functions delegated to them under the 2014 Act based on an assessment of local population needs, in line with the IJB Strategic Plan.
- The development of a local commissioning plan, in partnership with independent hospices and collaborating with other key stakeholders.
- Where there is an independent hospice providing services to more than one IJB, the IJBs will collaborate under Section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that all statutory obligations to people with palliative and end of life care needs are met.
- Ensuring that local SLAs are established and maintained which provide financial stability and which operate on the basis of full cost transparency across both parties.
- Decisions need to be taken in line with all relevant procurement law and strategy.

Independent Hospice responsibilities:

- Contribute to the development of local commissioning strategies underpinning effective palliative and end of life care.
- Work with IJBs to ensure that the hospice's total operating costs are understood within local SLAs.
- Continue to deliver high quality service arrangements, which align with the referral mechanisms and operating systems of local Health and Social Care Partnerships.

Wider Engagement
IJBs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their local strategies and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users.

In relation to the development of local commissioning plans, that would include (but not be limited to): patients, their families and carers; local communities; health and social care professionals; hospices (both NHS and independent); social care providers

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patients' needs, life circumstances and experiences, it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that this engagement is a key part of their local commissioning plans.

Resources
Integration Joint Boards and Scottish Hospices invest millions of pounds annually in the provision of palliative and end of life care. Independent hospices in particular make a significant contribution to Scotland's health economy, generating over £50 million in charitable donations from the public, which supplements core statutory funding. In service to their overall mission, independent hospices will continue to bring these charitable resources to the table.

One of the primary functions of CEL 12 was to outline the financial contribution that Health Boards should make to the running costs of independent hospices. Specifically, it was proposed that 50% of agreed running costs be met by Health Boards, and the CEL 12 letter defined the parameters of what could fall within the scope of agreed costs.

However, this led in some instances to a transactional relationship developing between Health Boards and hospices, which focused on how the agreed costs should be understood. The Scottish Hospice Leadership Group has also produced evidence that the gap between actual and agreed costs has grown over time, thereby eroding the worth of the original commitment.

Within this context, this MOU does not prescribe the proportion of agreed costs to be met by Integration Joint Boards. Rather, it envisages a new relationship developing, based on the following principles:

- A transparent assessment of the *total* resource both parties bring to the table, including charitable income sources;
- A transparent assessment of the *total* costs of service provision, analysed through an "open book" approach between Integration Joint Boards and independent adult hospices
- Value for money and efficiency
- Benchmarking of costs, activity and quality
- Quality outcome measures

This process should avoid the need to debate what counts as *agreed* costs in favour of a relationship that looks at the *total* operating costs of independent hospices, which will include back office costs associated with fundraising, corporate functions, marketing and promotion, volunteering, and management. Within this context it will be important to describe existing patterns of expenditure and impending pressures. National organisations should be transparent in allocating overheads against local hospice running costs. Likewise, there is an expectation that IJBs will provide transparency in respect of their financial position, including the impact of any budgetary adjustments on the palliative care agenda.

In particular, the need for independent hospices to provide pay increases in line with NHS arrangements should be recognised. This further assumes that independent hospices will want to move towards the Agenda for Change pay model. Hospices, IJBs and, where relevant, the Scottish Government, will consider how best to fund any pay increases. These arrangements should be set out within local Service Level Agreements.

There should be a commitment to agree and sign-off Service Level Agreements in a timely fashion, as part of the overall commissioning cycle. A three year agreement is preferred as a means of delivering financial stability, which is especially important during times of service redesign. In the absence of redesign, it is important to note that while this MoU moves away from a specific agreement to meet 50% of agreed costs, individual hospices should not receive a *reduction* in financial support from IJBs against 2018/19 levels, for this could foment the very financial instability that the MoU seeks to protect against. In circumstances where services are being redesigned, overall financial contributions will necessarily be reconsidered, and in these cases, it is important that funding levels are commensurate with the new service provided.

It is also important to note that IJBs do not hold capital budgets and so if hospices want to enter into discussion about accessing capital investment for health and social care buildings, this will require the Health Board and/or Local Authority's participation.

Conflict Resolution

It is important that local provision is made for conflict resolution. Given that the parties to this MoU consistently operate under financial pressure, mechanisms should be in place to remedy disputes. Such disputes may emerge out of the financial or wider commissioning relationship. In the event of any disagreement or dispute between the parties, they will use their best endeavours to reach a resolution without resort to conciliation or mediation. If conciliation or mediation becomes required an independent third party will be sought as deemed acceptable to the NHS Board/HSCP and Partner/Provider.

Oversight

The national working group will monitor the development of local commissioning plans and associated SLA's to consider whether the terms of the MOU are applied consistently and abide by the spirit of partnership.

The benchmarking of the cost, activity and quality of independent adult hospice services should be done at local level but the national working group may also consider this benchmarking to support local partnerships.

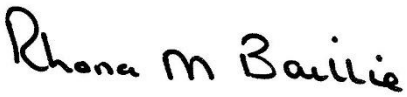
Healthcare Improvement Scotland is available to partnerships to support quality and service improvement.

Signatories

Signed on behalf of IJB Chief Officers

Name: Vicki Irons, Chief Officer, Angus HSCP and Chair, Chief Officers, Health and Social Care Scotland

Signed on behalf of the Scottish Hospice Leadership Group
Name: Rhona Baillie, the Prince & Princess of Wales Hospice and Deputy Chair, Scottish Hospices Leadership Group



Integration Joint Boards	**Independent Hospices**
Aberdeen City	ACCORD Hospice
Aberdeenshire	
Angus	Ardgowan Hospice
Argyll and Bute	
Clackmannanshire and Stirling	Ayrshire Hospice
Dumfries and Galloway	
Dundee City	Bethesda Hospice
East Ayrshire	
East Dunbartonshire	Highland Hospice
East Lothian	
East Renfrewshire	Kilbryde Hospice
Edinburgh City	
Falkirk	
Fife	Marie Curie Hospice
Glasgow City	
Highland	Prince and Princess of Wales Hospice
Inverclyde	
Midlothian	St Andrew's Hospice
Moray	
North Ayrshire	St Columba's Hospice
North Lanarkshire	
Orkney Islands	St Vincent's Hospice
Perth and Kinross	
Renfrewshire	Strathcarron Hospice
Scottish Borders	
Shetland Islands	
South Ayrshire	
South Lanarkshire	
West Dunbartonshire	
Western Isles	
West Lothian	

Annex A: Palliative Care

Palliative Care
Palliative care is defined by the World Health Organisation as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and

impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".

Specialist Palliative Care

Specialist Palliative Care is the active total care of patients with progressive, advanced disease and their families. Care is provided by a multi-professional team who have undergone recognised specialist palliative care training. The aim of the care is to provide physical, psychological, social and spiritual support, and it will involve practitioners with a broad mix of skills. (Tebbit, 1999)

Specialist Palliative Care requires effective multi-professional working within specialist teams and co-ordination across a wide range of professions to ensure that all appropriate patients, including those with non-malignant disease, can access the appropriate service and achieve the best quality of life possible.

These teams work in partnership with those who provide generalist palliative care, to ensure that patients' and families' complex needs are met.

Complex needs are identified as needs that cannot be addressed through simple or routine interventions/care.

Specialist Palliative Care seeks to:

- meet complex needs through a multi-professional team that meets regularly, and where individual team members understand and respect each other's roles and specialist expertise;
- enable team members to be proactive in their contact, assessment and treatment of patients and their families/carers;
- discern, respect and meet the cultural, spiritual and religious needs, traditions and practices of patients and their families/carers;
- recognise the importance of including the needs of families in the patient's care, since good family care improves patients' quality of life and contributes positively to the bereavement process;
- share knowledge and expertise as widely as possible;
- promote and participate in research in order to advance the speciality's knowledge base for the benefit of patients and carers.

A number of essential components make up a specialist palliative care service and the lists below are not exhaustive. These include:

- effective communication
- symptom control
- rehabilitation
- education and training
- research and audit
- continuity of care
- terminal care
- bereavement support for adults, young people and children

The core clinical specialist palliative care services comprise:

- In-Patient care facilities for the purposes of symptom management, rehabilitation and terminal care
- 24 hour access to the In- Patient service which includes specialist medical and adequate specialist nursing cover
- 24 hour telephone advice service for healthcare professionals
- 24 hour telephone support service for known out-patients and their carers
- Day services provided by an out-patient model or day hospice model where patients attend for a determined part of the day (e.g. from 11-3)
- Education programme
- Research and audit undertaken within a framework of clinical governance
- Formalised arrangements for specialist input to local and community hospitals

- Spiritual and psychological/counselling support services'

Key Elements of Specialist Palliative Care within a Specialist Palliative Care Unit

The core team comprises dedicated sessional input from

- Chaplain
- Doctors
- Nurses
- Occupational therapist
- Pharmacist
- Physiotherapist
- Social worker
- Counsellor

The range of integrated service components which can meet patients' needs at different stages of the disease process will include written referral guidelines to;

- Bereavement services
- Community specialist palliative care services
- Complementary therapies
- Counselling services
- Day services
- Hospital specialist palliative care services
- Lymphoedema services
- Patient transport services
- Psychological support services
- Social services
- Spiritual support services

ANNEX B: MEMBERSHIP OF SHORT LIFE WORKING GROUP

- Rhona Baillie, The Prince and Princess of Wales Hospice
- Helen Simpson, Accord Hospice
- Jackie Stone, St Columba's Hospice
- Craig Cunningham, South Lanarkshire HSPC
- Steven Fitzpatrick, Glasgow City HSPC
- Karen Jarvis, Renfrewshire HSPC
- Michael Kellet, Fife HSPC
- Pam Gowans, Moray HSCP
- Ron Culley, Western Isles HSPC (Chair)
- Mark Hazelwood, Scottish Partnership for Palliative Care
- Tim Warren, Scottish Government
- Christina Naismith, Scottish Government
- Diana Hekerem, Healthcare Improvement Scotland

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

(See Distribution List attached)

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

City Chambers
DUNDEE
DD1 3BY

20th August, 2019

Dear Sir or Madam

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

I would like to invite you to attend a meeting of the above Integration Joint Board which is to be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 27th August 2019 at 2.00 pm.

Apologies for absence should be submitted 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/SUBSTITUTIONS

2 DECLARATION OF INTEREST

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

3 MINUTE OF PREVIOUS MEETING - Page 1

The minute of previous meeting of the Integration Joint Board held on 25th June, 2019 is attached for approval.

4 MEMBERSHIP OF DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – THIRD SECTOR REPRESENTATIVE

Reference is made to Article III(c) of the minute of meeting of this Integration Joint Board held on 30th October 2018, wherein it was agreed to appoint Christine Lowden to be a member of the Integration Joint Board in the capacity of Third Sector Representative.

It is reported that Christine Lowden, who is a member of the Integration Joint Board, is to retire from Dundee Voluntary Action on 1st October, 2019. The Third Sector have advised that Eric Knox has been nominated as her replacement to the position of Third Sector Representative.

The Integration Joint Board is asked to agree to the appointment.

5 MEMBERSHIP OF DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – CHIEF SOCIAL WORK OFFICER

It is reported that following the retiral of Jane Martin from the position of Chief Social Work Officer, Diane McCulloch, Head of Health and Community Care will cover all Chief Social Work Officer functions effective from 1st August, 2019,

The Integration Joint Board is asked to note the position.

6 DUNDEE MENTAL HEALTH AND WELLBEING STRATEGIC PLAN 2019-2024 - Page 9

(Report No DIJB44-2019, by the Chief Officer, copy attached).

7 FINANCIAL MONITORING POSITION AS AT JUNE 2019 - Page 31

(Report No DIJB42-2019, by the Chief Finance Officer, copy attached).

8 THE USE OF ELIGIBILITY CRITERIA TO MAXIMISE AVAILABLE RESOURCES

(Report No DIJB45-2019, by the Chief Officer, copy to follow).

9 JOINT INSPECTION (ADULTS): THE EFFECTIVENESS OF STRATEGIC PLANNING IN NORTH AYRSHIRE (MARCH 2018) – DUNDEE POSITION STATEMENT - Page 43

(Report No DIJB41-2019, by the Chief Officer, copy attached).

10 MEMORANDUM OF UNDERSTANDING BETWEEN INTEGRATION JOINT BOARDS AND INDEPENDENT SCOTTISH HOSPICES

(Report No DIJB40-2019 by the Chief Officer, copy to follow).

11 TAYSIDE SEXUAL HEALTH AND REPRODUCTIVE SERVICES UPDATE - Page 95

(Report No DIJB46-2019 by the Chief Officer, copy attached).

12 PUBLICATION OF ANNUAL PERFORMANCE INFORMATION – ANNUAL PERFORMANCE REPORT AND DRAFT ANNUAL ACCOUNTS - DIJB43-2019

On 25th June, 2019 the Integration Joint Board approved the Partnership's Annual Performance Report and Draft Annual Accounts 2018/19 for publication (Articles VIII and XI of the minute refer). Following this statistical advice was issued by National Services Scotland, Information Services Division (NSS, ISD) to all Integration Joint Boards in respect of the quality of data submissions from NHS Boards for the period January to March 2019 in terms of data completeness. NSS, ISD advised IJBs that in relation to inclusion of Scotland level figures and benchmarking information for National Health and Wellbeing Indicators 12 (emergency admissions), 13 (emergency bed days), 14 (readmissions), 16 (falls) and 20 (% of resources spent on hospital stays resulting from emergency admissions) in Annual Performance Reports figures should be presented up to 31st December, 2018 (end of Quarter 3). Furthermore NSS, ISD advised that benchmarking figures for these indicators as at 31st March, 2019 (end of Quarter 4) would give an impression of benchmarked performance that is not reliable and that headline Scotland level figures should not be published if NSS, ISD has not already published equivalent national statistics (in compliance with the UK Code of Practice for Statistics). Consequently the Partnership's annual performance report was amended prior to publication in relation to indicators 12, 13, 14, 16 and 20 to include:

- Dundee level data to 31st March, 2019 (end of Quarter 4); and,
- Benchmarking data that provides a comparison with performance at Scotland level and other Partnerships as at 31st December, 2018 (end of Quarter 3) (with the exception of indicator 20 where benchmarking data is not available and therefore has not been included).

It should be noted that the change in information published does not materially impact on the performance review of the Integration Joint Board however should members wish to view the revised version it can be accessed through the following link:

https://www.dundeehscp.com/publications/dhscp-annual-performance-report-2018-19

At the point at which NSS, ISD publish end of year data for these indicators the Annual Performance Report will be amended and a replacement version uploaded to the Partnership website.

In addition, the Draft Annual Accounts include an extract of performance information as set out in the Annual Performance Report. This document has also now been updated accordingly and can be accessed through the following link

https://www.dundeehscp.com/sites/default/files/publications/annual_accounts_unaudited_2018-19.pdf

13 MEETINGS OF THE INTEGRATION JOINT BOARD 2019 – ATTENDANCES – DIJB21-2019 - Page 101

(A copy of the Attendance Return for meetings of the Integration Joint Board held to date over 2019 is attached for information and record purposes).

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, 29th October, 2019 at 2.00 pm.

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
DISTRIBUTION LIST

(a) DISTRIBUTION - INTEGRATION JOINT BOARD MEMBERS

Role	Recipient
VOTING MEMBERS	
Non Executive Member (Chairperson)	Trudy McLeay
Elected Member (Vice Chairperson)	Councillor Ken Lynn
Elected Member	Councillor Roisin Smith
Elected Member	Bailie Helen Wright
Non Executive Member	Jenny Alexander
Non Executive Member	Professor Nic Beech
NON VOTING MEMBERS	
Chief Social Work Officer	Diane McCulloch
Chief Officer	David W Lynch
Chief Finance Officer (Proper Officer)	Dave Berry
Registered medical practitioner (whose name is included in the list of primary medical services performers)	Dr Frank Weber
Registered nurse	Kathryn Brechin
Registered medical practitioner (not providing primary medical services)	Dr James Cotton
Staff Partnership Representative	Raymond Marshall
Trade Union Representative	Jim McFarlane
Third Sector Representative	Christine Lowden
Service User residing in the area of the local authority	Linda Gray
Person providing unpaid care in the area of the local authority	Martyn Sloan
Director of Public Health	Dr Drew Walker

(b) DISTRIBUTION – FOR INFORMATION ONLY

Organisation	Recipient
NHS Tayside (Chief Executive)	Chief Executive
Dundee City Council (Chief Executive)	David R Martin
Dundee City Council (Head of Democratic and Legal Services)	Roger Mennie
Dundee City Council (Members' Support)	Jayne McConnachie
Dundee City Council (Members' Support)	Dawn Clarke
Dundee City Council (Members' Support)	Fiona Barty
Dundee City Council (Communications rep)	Steven Bell
Dundee Health and Social Care Partnership (Secretary to Chief Officer and Chief Finance Officer)	Kathleen Sharkey
NHS Tayside (Communications rep)	Jane Duncan
NHS Tayside (PA to Director of Public Health)	Linda Rodger
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
Audit Scotland (Senior Audit Manager)	Bruce Crosbie
Dundee University (PA to Professor Nic Beech)	Lynsey Mcirvine
NHS Tayside (PA to Dr James Cotton)	Jodi Lyon

At a MEETING of the **DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 25th June, 2019.

Present:-

Members	**Role**
Trudy McLEAY *(Chairperso*n)	Nominated by Health Board (Non-Executive Member)
Ken LYNN (*Vice Chairperson*)	Nominated by Dundee City Council (Elected Member)
Roisin SMITH	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
Jenny ALEXANDER	Nominated by Health Board (Non-Executive Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
James COTTON	Registered Medical Practitioner (non providing primary medical services)
Sarah DICKIE	Registered Nurse
Jane MARTIN	Chief Social Worker
Drew WALKER	Director of Public Health
Raymond MARSHALL	Staff Partnership Representative
Jim McFARLANE	Trade Union Representative
Christine LOWDEN	Third Sector Representative
Linda GRAY	Service User Representative

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

Diane McCULLOCH	Dundee Health and Social Care Partnership
Dr David SHAW	Dundee Health and Social Care Partnership
Kathryn SHARP	Dundee Health and Social Care Partnership
Shona HYMAN	Dundee Health and Social Care Partnership
Jenny HILL	Dundee Health and Social Care Partnership
Dr Andrew RADLEY	NHS Tayside
Kathryn BRECHIN	NHS Tayside

Trudy McLEAY, Chairperson, in the Chair.

Prior to the commencement of the business, the Chairperson advised of the forthcoming retiral of Jane Martin, Chief Social Work Officer. Both the Chairperson and the Vice Chairperson paid tribute to the contribution Jane Martin had made to the work of Health and Social Care in Dundee over the years in her capacity as a Head of Service with Dundee City Council and her role in furthering this work through the Dundee Health and Social Care Partnership. The Chairperson also took the opportunity to welcome Dr James Cotton to his first meeting of the Integration Joint Board. Tribute was also paid to Sarah Dickie who had now been nominated by NHS Tayside to serve on Perth and Kinross Integration Joint Board and thanks were conveyed for her contribution to the Dundee Integration Joint Board over her period of membership.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of:-

Nic BEECH	Nominated by Health Board (Non-Executive Member)
Frank WEBER	Registered Medical Practitioner (whose name is included in the list of primary medical performers)
Martyn SLOAN	Carer Representative

II DECLARATION 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 23rd April, 2019 was submitted and approved.

IV PERFORMANCE AND AUDIT COMMIITTEE

(a) MINUTE OF PREVIOUS MEETING OF 28TH MAY, 2019

The minute of the previous meeting of the Performance and Audit Committee held on 28th May, 2019 was submitted and noted for information and record purposes.

(b) CHAIR'S ASSURANCE REPORT

There was submitted Report No DIJB38-2019 by Ken Lynn, Chairperson of the Performance and Audit Committee, providing an Assurance Report to the Integration Joint Board on the work of the Performance and Audit Committee.

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

V MEMBERSHIP OF DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – REGISTERED NURSE

Reference was made to Article III(c) of the minute of meeting of this Integration Joint Board held on 30th October, 2018, wherein it was noted that NHS Tayside had nominated Sarah Dickie to be a member of the Integration Joint Board in the capacity of Registered Nurse.

It was reported that NHS Tayside had now nominated Sarah Dickie to serve on Perth and Kinross Integration Joint Board and that Kathryn Brechin, Associate Nurse Director Designate had been nominated as her replacement to the position of Registered Nurse on Dundee Integration Joint Board effective from 1st August, 2019.

The Integration Joint Board agreed to note the appointment.

VI PRESENTATION – THE FAIRNESS COMMISSION'S MENTAL HEALTH RECOMMENDATIONS

A joint presentation was made by former Commissioners of the Dundee Fairness Commission. The presentation covered Mental Health recommendations that came out of the research during the Commission which took place over 2018 including the need for a 24/7 Mental Health drop-in service in collaboration with beneficiaries and offering clinical, non-clinical, therapeutic and peer support and training for service providers and frontline staff (including GP Surgeries) to:-

- raise awareness of the impact of poverty on mental health
- improve interactions with service users
- support prevention and early intervention
- increase referrals/signposting to non-clinical mental health support

The Integration Joint Board noted the content of the presentation and, following questions and answers, thanked the presenters for their contribution.

VII SELF EVALUATION FOR THE REVIEW OF PROGRESS WITH INTEGRATION OF HEALTH AND SOCIAL CARE

Reference was made to Article VI of the minute of meeting of this Integration Joint Board held on 26th February, 2019 wherein the update progress report on Audit Scotland Health and Social Care Integration was submitted.

There was submitted Report No DIJB27-2019 by the Chief Officer presenting the self-evaluation of the current position in Dundee in relation to the Ministerial Strategic Group for Health and Community Care's report on review of progress with integration.

The Integration Joint Board agreed:-

(i) to approve the final self-evaluation document which was attached to the report as Appendix 1 and instruct the Chief Officer to submit the document to the Ministerial Strategic Group;

(ii) to note that a draft self-evaluation was previously submitted to the Ministerial Strategic Group to comply with the deadline for return of 15th May, 2019 as outlined in section 4.3 of the report; and

(iii) to instruct the Chief Finance Officer, as Chair of the Integration Strategic Planning Group, to take forward the improvement actions with dates identified through the self-evaluation process in partnership with Dundee City Council and NHS Tayside and report progress to the Integration Joint Board no later than 17th December, 2019.

VIII ANNUAL PERFORMANCE REPORT 2018/19

There was submitted Report No DIJB24-2019 by the Chief Officer submitting the Health and Social Care Partnership Annual Performance Report 2018/19 for approval.

The Integration Joint Board agreed:-

(i) to note the updates provided, including that a summary version of the Annual Performance Report 2018/19 would be produced for publication;

(ii) to approve the Annual Performance Report 2018/19 which was attached to the report as Appendix 1; and

(iii) to approve the planned approach to formatting, publication and distribution as outlined in sections 4.2.3 and 4.2.4 of the report.

IX FINANCIAL MONITORING YEAR END POSITION

Reference was made to Article XIII of the minute of meeting of this Integration Joint Board held on 28th August, 2018 wherein the report on Dundee Integration Joint Board 2018/2019 Budget for Delegated Services was submitted.

There was submitted Report No DIJB34-2019 by the Chief Finance Officer providing an overview of the final financial position for delegated health and social care services for 2018/2019.

The Integration Joint Board agreed to note the content of the report including the year end outturn for delegated services to the 2018/2019 financial year end as at 31st March, 2019 as outlined in Appendices 1, 2 and 3 of the report.

X DUNDEE INTEGRATION JOINT BOARD ANNUAL INTERNAL AUDIT REPORT 2018/2019

Reference was made to Article XI of the minute of meeting of the Performance and Audit Committee of 31st July, 2018 wherein the report on Dundee Integration Joint Board Annual Internal Audit Report 2017/2018 and Annual Governance Statement was submitted.

There was submitted Report No DIJB35-2019 by the Chief Finance Officer advising of the outcome of the Chief Internal Auditor's report on the Integration Joint Board's internal control framework for the financial year 2018/2019.

The Integration Joint Board agreed:-

(i) to note the content and findings of the Annual Audit Report 2018/2019 which was attached to the report as Appendix 1; and

(ii) to instruct the Chief Finance Officer to incorporate the recommendations of the report into the Integration Joint Board's Governance Action Plan, presented to and monitored by the Performance and Audit Committee.

XI DRAFT ANNUAL ACCOUNTS 2018/2019

There was submitted Report No DIJB30-2019 by the Chief Finance Officer presenting the Integration Joint Board's Draft Annual Statement of Accounts 2018/2019 for approval to initiate the external audit process.

The Integration Joint Board agreed:-

(i) the content of the Draft Final Accounts Funding Variations as outlined in Appendix 1 of the report;

(ii) to approve the Draft Dundee Integration Joint Board Annual Corporate Governance Statement as outlined in Appendix 2 of the report;

(iii) to note the Integration Joint Board's Draft Annual Statement of Accounts 2018/2019 as outlined in Appendix 3 of the report;

(iv) to note the application of reserves during 2018/2019 to meet the Integration Joint Board's liabilities and support its activities during the financial year as outlined in 4.1.3. of the report; and

(v) to instruct the Chief Finance Officer to submit the Accounts to the Integration Joint Board's External Auditors (Audit Scotland) to enable the audit process to commence.

XII DUNDEE INTEGRATION JOINT BOARD FINAL 2019/2020 BUDGET

Reference was made to Article VI of the minute of meeting of this Integration Joint Board of 29th March, 2019 wherein the report on Dundee Integration Joint Board 2019/2020 Budget was submitted.

There was submitted Report No DIJB31-2019 by the Chief Finance Officer presenting NHS Tayside's formal budget offer to Dundee Integration Joint Board in relation to the delegated budget 2019/2020 and setting out the implications of this and Dundee City Council's budget offer on the Integration Joint Board's final 2019/2020 budget.

The Integration Joint Board agreed:-

(i) to note and adopt the formal delegated budget offer to Dundee Health and Social Care Partnership from NHS Tayside as set out in sections 4.2 to 4.6 of the report;

(ii) to instruct the Chief Officer and Chief Finance Officer to continue discussions with the Chief Executive and Director of Finance of NHS Tayside in relation to Dundee's prescribing budget allocation as set out in section 4.3 of the report;

(iii) to note the total value of Dundee Integration Joint Board's delegated budget for 2019/2020 as set out in Table 3 of the report;

(iv) to note the Dundee share of additional Scottish Government funding for Mental Health and Primary Care Transformation Funding as set out in section 4.6 of the report;

(v) to note the level of unidentified savings within the delegated budget as an implication of the level of resources provided by NHS Tayside and Dundee City Council for 2019/2020 set against anticipated financial pressures remained at £546k as set out in section 4.1.1 of the report and instruct the Chief Finance Officer to reflect the ongoing financial position through the financial monitoring reports presented to the Integration Joint Board throughout the financial year;

(vi) to instruct the Chief Finance Officer to inform Dundee City Council and NHS Tayside of the significant risk of the Integration Joint Board being unable to deliver a balanced budget by the year ended 31st March, 2020 as set out in section 3.0 of the report;

(vii) to note the Dundee share of additional Scottish Government funding for Mental Health and Primary Care Transformation Funding as set out in section 4.6 of the report; and

(viii) to remit the Chief Officer to issue directions to Dundee City Council and NHS Tayside as indicated in section 6 and the appendix to the report.

XIII DUNDEE PRIMARY CARE IMPROVEMENT PLAN – UPDATE

Reference was made to Article IX of the minute of meeting of this Integration Joint Board of 28th August, 2018 wherein an update report was submitted on the Dundee Primary Care Improvement Plan.

There was submitted Report No DIJB33-2019 by the Chief Officer providing an update on the implementation of the Dundee Primary Care Improvement Plan for 2018/2019 and seeking approval for the implementation of the Dundee Primary Care Improvement Plan for 2019/2020.

The Integration Joint Board agreed:-

(i) to note the positive progress to implement the Dundee Primary Care Improvement Plan 2018/2019 in the first year of delivery which was attached to the report as Appendix 1 and noted in section 4.3 of this report;

(ii) to approve the proposed actions for Dundee Health and Social Care Partnership for 2019/2020 as described in Appendix 1 of the report and note the proposed allocation of funding as detailed in section 3 of the report;

(iii) to instruct the Chief Officer to issue directions to NHS Tayside to implement with immediate effect the specific actions relevant to them as outlined in Appendix 1 of the report;

(iv) to note the previous agreement to delegate the monitoring of the Dundee allocation of the Primary Care Improvement Fund as noted in section 4.2 of the report;

(v) to instruct the Chief Officer to provide a further report on progress made in the second year of delivering the Dundee Primary Care Improvement Plan to a future meeting of the Integration Joint Board; and

(vi) to note that a Tayside Primary Care Improvement Plan 2019/2020, incorporating the Dundee Primary Care Improvement Plan, would be submitted to the Scottish Government following approval by the relevant parties including Dundee Integration Joint Board.

XIV CARERS (SCOTLAND) ACT FUNDING INVESTMENT PLAN 2019/2021

Reference was made to Article XIV of the minute of meeting of this Integration Joint Board of 18th December, 2018 wherein an update report was submitted in relation to progress in implementing the Carers (Scotland) Act 2016 and Carers Investment Plan 2018/2019.

There was submitted Report No DIJB28-2019 by the Chief Officer providing information about progress with implementation of the Carers Strategic Plan, Carers (Scotland) Act 2016 and seeking approval for the Carers (Scotland) Act Investment Plan 2019/2021.

The Integration Joint Board agreed:-

(i) to note progress made in implementing the Carers Strategic Plan as outlined in section 4.1.3 of the report;

(ii) to note the intention for the use of the Carers (Scotland) Act Funding 2019/2020 as described in sections 4.2 and 4.3 of the report;

(iii) to approve the Carers (Scotland) Act Funding 2019/2020 Investment Plan for 2019/2020 which was attached to the report as Appendix 2; and

(iv) to remit the Chief Officer to issue the directions to Dundee City Council and NHS Tayside as set out in section 8.0 of the report and as attached at Appendix 1 of the report.

XV PROPOSAL TO DEVELOP A DUNDEE AND ANGUS COMMUNITY AND SCHOOLS EQUIPMENT LOAN SERVICE

There was submitted Report No DIJB26-2019 by the Chief Officer providing information about the Dundee and Angus Community Equipment Loan Service and the proposal to further develop the service to a Dundee and Angus Community and Schools Equipment Loan Service;

The Integration Joint Board agreed:-

(i) to approve, in principle, the proposal to proceed with development of a Dundee and Angus Community and Schools Equipment Loan Service; and

(ii) to instruct the Chief Officer to further progress discussions with Dundee and Angus Council, on the development of a Dundee and Angus Community and Schools Equipment Loan Service and to report back to a meeting of the Integration Joint Board for a decision to be made on the outcome of discussions.

XVI SUBSTANCE MISUSE SERVICE REDESIGN UPDATE

Reference was made to Article XIII of the minute of meeting of this Integration Joint Board of 18th December, 2018 wherein the Substance Misuse Redesign Plan was approved and it was agreed that an update report on progress be submitted to this meeting of the Integration Joint Board.

There was submitted Report No DIJB25-2019 by the Chief Officer providing an update about the progress with the redesign of Substance Misuse Services.

The Integration Joint Board agreed:-

(i) to note the Substance Misuse Service Redesign progress described at section 4 of the report; and

(ii) to request a report on progress with the redesign programme be submitted to the meeting of the Integration Joint Board to be held on 29th October 2019.

XVII PROPOSED MODEL OF CARE FOR OLDER PEOPLE WITH MENTAL HEALTH NEEDS – BUSINESS CASE

Reference was made to Article VIII of the minute of meeting of this Integration Joint Board held on 27th June, 2017 wherein the report on Remodelling of Care for Older People was submitted.

There was submitted Report No DIJB29-2019 by the Chief Officer providing the business case for the proposed model of care for older people with mental health needs, including dementia, that was outlined in the Remodelling Care for Older People report presented to the Integration Joint Board on 27th June, 2017. The national strategic direction for these changes was outlined in the Scottish Government's Reshaping Care for Older People policy, Scotland's National Dementia Strategy (2017-2020) and The Future Model of Residential Care for Older People (2014) with the local strategic direction set through the Dundee Frailty Strategic Planning Group.

The Integration Joint Board agreed:-

(i) to note the content of the report and the remodelling which had taken place to support older people with mental health needs, including dementia, as described in section 4.1 of the report; and

(ii) to approve the business case as outlined in section 4.2 of the report and the associated financial framework as noted in section 3.0 of the report.

XVIII UPDATE ON DELAYED DISCHARGE, UNSCHEDULED CARE AND WINTER PRESSURES IMPROVEMENT PROGRAMMES

There was submitted Report No DIJB36-2019 by the Chief Officer detailing the progress made against the Home and Hospital Transition Improvement Plan 2018/2019 and providing an update on the work of the Unscheduled Care Board. In addition the paper reported on the performance to manage patient flow during the winter period and seeking agreement to sign off the Tayside area report to the Scottish Government which described the Tayside Performance during the winter period 1st November, 2018 to 31st March, 2019.

The Integration Joint Board agreed:-

(i) to note progress made against the 2018/2019 Home and Hospital Transition Improvement Plan as reported in section 4.2 and as detailed in Appendix 1 of the report;

(ii) to note the work of the Unscheduled Care Board during the previous financial year and the change projects associated with this work-stream as detailed in section 4.3 of the report;

(iii) to note the progress made in implementing the winter plan during 2018/2019 as detailed in section 4.4 and Appendix 2 of the report;

(iv) to note the requirement to produce a winter plan for 2019/2020 and request that this be submitted to a meeting of the Integration Joint Board for consideration prior to submission to the Scottish Government; and

(v) to approve the report on the progress made across Tayside during the winter period 2018/2019 as attached at Appendix 2 of the report and confirm agreement for the report to be signed off for submission to the Scottish Government.

XIX ANNUAL REPORT OF THE DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP CLINICAL, CARE AND PROFESSIONAL GOVERNANCE GROUP

There was submitted Report No DIJB32-2019 by the Chief Officer providing information to the Integration Joint Board regarding matters of Clinical, Care and Professional Governance. In addition, the report provided information on the business of the Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group, previously known as R2, and to outline the ongoing planned developments to enhance the effectiveness of the group.

The Integration Joint Board agreed:-

(i) to note the content of the report;

(ii) to note the progress made against the Annual Work Plan as attached at Appendix 1 of the report; and

(iii) to note the work undertaken by the Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group (R2) from April, 2018 to April, 2019 to seek assurance regarding matters of Clinical, Care and Professional Governance as outlined in sections 4.2 to 4.5 of the report.

XX MEETINGS OF THE INTEGRATION JOINT BOARD 2019 – ATTENDANCES

There was submitted Agenda Note DIJB37-2019 providing a copy of the attendance return for meetings of the Integration Joint Board held to date over 2019.

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

XXI DATE OF NEXT MEETING

The Integration Joint Board agreed to note that the next meeting of the Integration Joint Board would be held in Committee Room 1, 14 City Square, Dundee on 27th August, 2019.

Trudy McLEAY, Chairperson.

ITEM No …6……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 AUGUST 2019**

REPORT ON: **DUNDEE MENTAL HEALTH AND WELLBEING STRATEGIC PLAN 2019-2024**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB44-2019**

1.0 PURPOSE OF REPORT

To brief the Integration Joint Board on the consultation about the draft Dundee Mental Health and Wellbeing Strategic Plan and seek approval to publish and implement the attached final version of the Plan.

2.0 RECOMMENDATIONS

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

2.1 Notes the outcomes of the consultation undertaken about the draft Dundee Mental Health and Wellbeing Strategic Plan (the Strategic Plan) as outlined in Sections 4.2.1 – 4.2.6.

2.2 Approves the publication of the revised Strategic Plan attached as Appendix 1 by 1 September 2019 on the Dundee Health and Social Care Partnership website.

2.3 Approves the financial framework embedded within the Strategic Plan at pages 11 to 13 (of the Strategic Plan).

2.4 Approves the accompanying Dundee Mental Health and Wellbeing Commissioning Framework (2019 – 2024) attached at Appendix 2.

2.5 Instructs the Chief Officer to present a 6 monthly performance report to the Integrated Strategic Planning Group that incorporates all priority areas for improvement, as set by both Dundee Mental Health and Wellbeing Strategic and Commissioning Group and Tayside Mental Health Alliance.

3.0 FINANCIAL IMPLICATIONS

3.1 Dundee Mental Health and Wellbeing Strategic Plan will be implemented within the available financial resources of Dundee Health and Social Care Partnership.

4.0 MAIN TEXT

4.1 Report DIJB64-2018 “Dundee Mental Health and Wellbeing Strategic Plan 2019-2024” was endorsed by Dundee Health and Social Care Integration Board in December 2018 (Article VII of the minute refers). The report outlined the intended strategic direction for mental health and wellbeing developments in Dundee and sought authority to progress the finalisation of the Strategic Plan in collaboration with key stakeholders.

4.2.1 A consultation process was agreed by Dundee Mental Health and Wellbeing Strategic and Commissioning Group (MHWSCG) in February 2019 and was undertaken between 27th March 2019 and 26th April 2019 via the Dundee Health and Social Care Partnership website. The consultation was reopened for a further period between 10th May and 20th May to ensure that people who had expressed an interest had ample opportunity to comment. The link to the consultation document was distributed widely to key stakeholders.

4.2.2 131 responses in total were received. Of these, 32 were completed fully, 5 were completed bar some elements of 1 question and 94 were completed in part.

4.2.3 The questions asked as part of the consultation included:

- Did respondents live/work in Dundee?
- Were respondents carers?
- Did respondents feel that the 4 priorities within the Strategic Plan are the right ones?
- What were respondents' views about the actions outlined within each priority area?
- Did respondents feel the Strategic Plan will have an impact for people with protected characteristics or who experience socio-economic disadvantage?

4.2.4 Overall, the majority of the feedback received was very positive and reaffirming with regard to the content and proposed direction and actions set out within the Strategic Plan.

4.2.5 The MHWSCG convened an extraordinary meeting in May to consider the analysed results of the consultation. The focus of the meeting was to consider the results and ascertain whether changes or additions should be made to the Strategic Plan. A number of additions were agreed upon.

4.2.6 The main areas that have been strengthened/ added within the Strategic Plan:

- Links to other strategies, for example Children and Families/ Substance Misuse;
- Use of information technology to support clinical interventions from a person's home or community base added as a further example of agreed priority;;
- Collaborative work with hospital based colleagues, for example to improve unscheduled care arrangements added as a further example of agreed priority;
- Demographic information added to and presentation of the same improved
- Focus on Wellness Recovery Action Plans and Advanced Statements added specifically;
- A recognition of the importance of improving the mental wellbeing of all citizens, including our own workforce;
- An emphasis on understanding the links between trauma and poor mental health and the consequent need to provide trauma sensitive and trauma informed care.

4.3 A financial framework is now incorporated within the Strategic Plan. This will enable the MHWSCG to track desired shifts in investment to more preventative, community based supports and to a range of earlier interventions as part of an already evolving primary care model of Mental Health and Wellbeing interventions and support.

4.4 Dundee Mental Health and Wellbeing Commissioning Framework (2019 – 2024) accompanies the Strategic Plan at Appendix 2. This Commissioning Framework confirms all overarching areas for action, and governance arrangements, as agreed by both the MHWSCG and Tayside Mental Health Alliance. The Commissioning Framework will remain dynamic and workstreams and associated actions will continue to develop in response to emerging evidence based best practice, local and national drivers and any relevant reports.

4.5 A Tayside Mental Health Alliance has been formed to ensure strong leadership of, and a collaborative approach is taken to, both local and Tayside wide Mental Health and Wellbeing developments. The core Alliance membership represents all the 3 Health and Social Care Partnerships across Tayside in terms of their delegated duties as well as Mental Health services retained by NHS Tayside. The Mental Health Alliance, following a number of preparatory workshops/ discussions, has formally established and is meeting monthly to ensure progress is made at pace.

4.6 A Clinical Lead with responsibility for Dundee Mental Health and Learning Disability has recently been appointed. The post holder will provide clinical leadership across all community mental health services in Dundee and will work in conjunction with the Locality Manager and others to ensure that strategic and operational plans are clinically led. The Clinical Lead will also become a member of the Tayside Mental Health Alliance.

4.7 An Improvement Advisor for Mental Health has also been appointed within the Partnership. The postholder joined the team at the end of July and brings a range of clinical and quality improvement experience both in Scotland and abroad, this including the development and implementation of an integrated mental health/substance misuse pathway. The Improvement Advisor has already joined Tayside Mental Health Alliance.

4.8 An Independent Inquiry into Mental Health Services in Tayside continues to progress. An Interim Report was produced by Chair of the Inquiry David Strang in May this year, "The Independent Inquiry into Mental Health Services in Tayside, Interim Report, Inquiry Update and Emergent Key Themes: Capturing Experiences of Mental Health Services in Tayside", May 2019. The report focussed largely on the evidence that has been gathered thus far from a range of key participants, most importantly citizens of Dundee. Mr Strang's Interim report has been welcomed by the MHWSCG and it is hoped that the Inquiry will request further explorative discussion with members of the Group. The themes of concern arising within the Interim report are consistent with those already understood by MHWSCG, and it is envisaged that the Inquiry will now wish to have further, and ongoing, communication about Dundee improvements and the progress/ pace of the work of the Tayside Mental Health Alliance prior to final recommendations being made by Mr Strang over the coming months.

4.9 Report DIJB64 – 2018 outlined a process of co-production that led to the production of the draft Dundee Mental Health and Wellbeing Strategic Plan. The MHWSCG are confident that the final draft is reflective of the key areas for action that will lead to improved mental health and wellbeing for Dundee citizens and a reduction in mental health inequalities.

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	That the Strategic Plan is not fully implemented and therefore does not achieve the desired outcomes.
Risk Category	Operational
Inherent Risk Level	Likelihood (3) x Impact (4) = Risk Scoring (12)
Mitigating Actions (including timescales and resources)	Progress is already being made in respect of some of the priority areas set out within this Strategic Plan. Dundee MHWSCG and the Tayside wide Mental Health Alliance will own the local and pan Tayside improvement, commissioning and governance arrangements associated with this Strategic Plan respectively.
Residual Risk Level	Likelihood (2) x Impact (3) = Risk Scoring (6)
Planned Risk Level	Likelihood (2) x Impact (3) = Risk Scoring (6)
Approval recommendation	That the risk should be accepted.

7.0 CONSULTATIONS

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

8.0 DIRECTIONS

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

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

9.0 BACKGROUND PAPERS

Report DIJB64–2018, Dundee Mental Health and Wellbeing Strategic Plan 2019-2024.

David Lynch
Chief Officer

DATE: 5 August 2019

Arlene Mitchell
Locality Manager

Appendix 1

Dundee Mental Health and Wellbeing Strategic Plan 2019-2024

Introduction

Our vision is that the people of Dundee will have positive wellbeing and a good quality of life to help prevent mental health problems occurring, and that those with mental ill health will get the respect, support, treatment and care they require to recover without fear of discrimination or stigma.

Mental health and wellbeing is a priority locally, nationally and globally. We know that mental health inequalities are a more significant challenge in Dundee in comparison to most other areas of Scotland.

Dundee Mental Health and Wellbeing Strategic and Commissioning Group (MHWSCG) has produced this Plan to support the improvement of mental health and the reduction of mental health inequalities, predominantly for adults, over the next 5 years in the city.

What is Mental Health and Wellbeing?

Mental health and wellbeing is how we feel, think and behave as well as how fit we are in body and mind. Happiness and satisfaction, ability to cope when things get hard, and feeling optimistic about the future are features of positive mental health and wellbeing. If we have a sense of belonging, meaning and purpose in life, good physical health, and can look after ourselves and control what happens to us, we are more likely to be resilient and experience good mental health and wellbeing.

What affects Mental Health and Wellbeing?

Mental health and wellbeing is complex. Having close friends and family can promote positive wellbeing and protect us when things go wrong; however, someone with good mental wellbeing may find it easier to be sociable and connect with others than a person who has poor mental health. Equally, unemployment, poverty, disability or being a carer can lead to poor mental health, but can also make it difficult for a person to find or hold down a job that could improve their life circumstances and impact positively on their wellbeing.

The connections and differences between mental wellbeing and mental illness are debatable. Health professionals may see mental illness as disease, which requires medical treatment and intervention. Others see mental illness as a natural reaction to life circumstances best treated by dealing with the root causes of the person's distress, for example bereavement, trauma, relationship breakdown, or chronic pain. The issue is further complicated by the fact that being mentally unwell does not always result in clinical diagnosis of mental illness, and that people living with mental illness can and do often experience positive wellbeing.

Why Mental Wellbeing Matters

Poor mental health and wellbeing are linked with a wide range of negative factors such as unhealthy lifestyles, poor physical health, unemployment and deprivation. On the other hand, good mental health and wellbeing have been shown to lead to better health and social outcomes. The impacts of poor mental health, and mental ill health, are significant and have implications for a range of public services such as the NHS, Criminal Justice and local authorities. In recognition of this, mental health and wellbeing is a priority for the Scottish Government and locally for Dundee Partnership and the Health and Social Care Partnership. Tackling poor mental health involves improving mental wellbeing for the whole population as well as preventing and reducing mental illness.

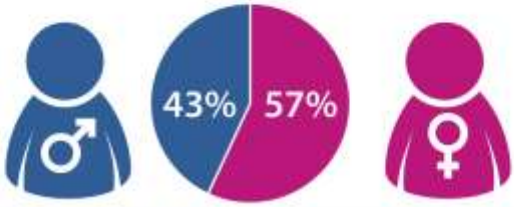
Mental Health Inequalities

In working together to improve mental health and wellbeing, we recognise that mental ill health affects some people more than others. Using a range of data sources, we know that:

In Dundee, more adults aged 16 – 64 have a mental health condition than the Scottish average. This equates to 6,319 people in the city.

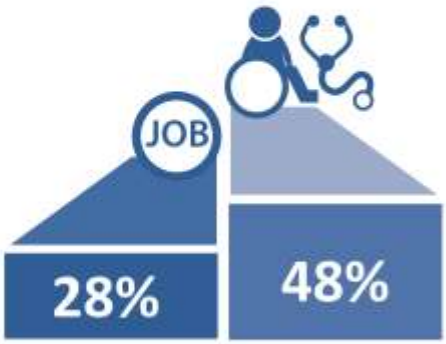
For adults in Dundee reporting a mental health condition, the highest rate can be found for women aged 35-49 years.

For every age group, women are more likely to have mental health conditions than men. The gender ratio for Dundee is 57% females and 43% for males, which is similar to the position in the rest of Scotland.



Populations living in poorer socio-economic circumstances are at increased risk of poorer mental health, depression and lower subjective wellbeing. Those living in the poorest areas are twice as likely to develop mental health problems as those on average incomes.

The 2011 Census showed that, of the 8 wards within the city, the East End, Lochee and Coldside wards have the highest rate per 1,000 people with a mental health condition. All areas of Dundee, except for the West End and The Ferry, have a higher rate than the national average per 1,000 adults aged 16-64 reporting a mental health condition.



The 2011 census indicated that people who identified themselves as having mental health conditions were less likely to be in work than Dundee's general population. Only 28% are in employment, 48% are either long term sick or disabled.

Prevalence figures from Mental Health (MH) registers for all Dundee Practices have demonstrated a year on year increase in the number of people on the register. In the last 5 years the change in the number of people on the MH register has increased by 8.8%.

Mental Disorders are strongly related to suicides. Dundee has a slightly above average suicide rate compared to the rest of Scotland.

What's Happening in Dundee?

Mental health and wellbeing is identified as a priority in all relevant policies and plans in the city. In Dundee's City Plan it is one of the top three issues in the Health, Care and Wellbeing theme, alongside obesity and substance misuse. The MHWSCG, which involves a wide range of statutory and non-statutory service providers and community/ service user/ advocacy perspectives, has produced this Strategic Plan and a more detailed action plan to address many of the most important challenges facing Dundee's people in obtaining good mental health and wellbeing. This Strategic Plan has a strong interface with a range of other strategic plans and commissioning statements which recognise, and impact on, the mental health and wellbeing of specific population groups in the city. These include the Tayside Plan for Children, the Substance Misuse Strategic and Commissioning Plan for Dundee 2018-2021, A Caring Dundee: A Strategic Plan for Supporting Carers in Dundee and Dundee Suicide Prevention Strategic Plan for Dundee.

These plans are interconnected, reflect and put into action, the strategic priorities implemented by Scottish Government at a national level in terms of improving health and reducing health inequalities for the population as a whole.

The views and perspectives of those who provide mental health support and services in Dundee are listened to and acted upon when redesigning or restructuring how we do our business. Most importantly, this Strategic Plan and the more detailed action plan incorporate the views, suggestions and ideas of local people and service users about what matters most to them in terms of improving and protecting their mental health and wellbeing, as well as reflecting their experiences of mental ill health, services and recovery. These measures ensure that this Strategic Plan, and current and subsequent actions, are genuinely co-produced by those who have a stake in its development and delivery.

Principles to Guide Improvement

Delivering the vision for mental health and wellbeing in the city requires underpinning principles that direct the approach and all activity of the MHWSCG and its partners. The following 3 overarching principles have been adopted:

An integrated approach that brings together medical and social models of mental health.

An upstream approach that is focused on mental health promotion, prevention and early intervention, as well as services focussed on treatment and care.

A person-centred and strengths based approach which focuses on recovery, assets, quality of life and hope rather than the deficits and problems of individuals and communities.

Strategic Priorities

The MHWSCG has agreed 4 key strategic priorities to underpin and define its work in Dundee moving forward. These are:

- Reducing Health Inequalities

- Prevention and Early Intervention
- Getting the Right Support at the Right Time
- Focus on Recovery

The priorities agreed upon carry equal importance and there is an inter relationship between these. The 4 priorities will be used to track performance and improvement over time as well as to identify areas where activity may need to be accelerated.

To support these priorities we will strive to ensure that people who work within health and social care services, and partners, feel engaged in the work they do and are supported to continuously improve the information, support, care and treatment they provide.

A Good Practice Example

Sources of Support social prescribing link workers service (SOS)

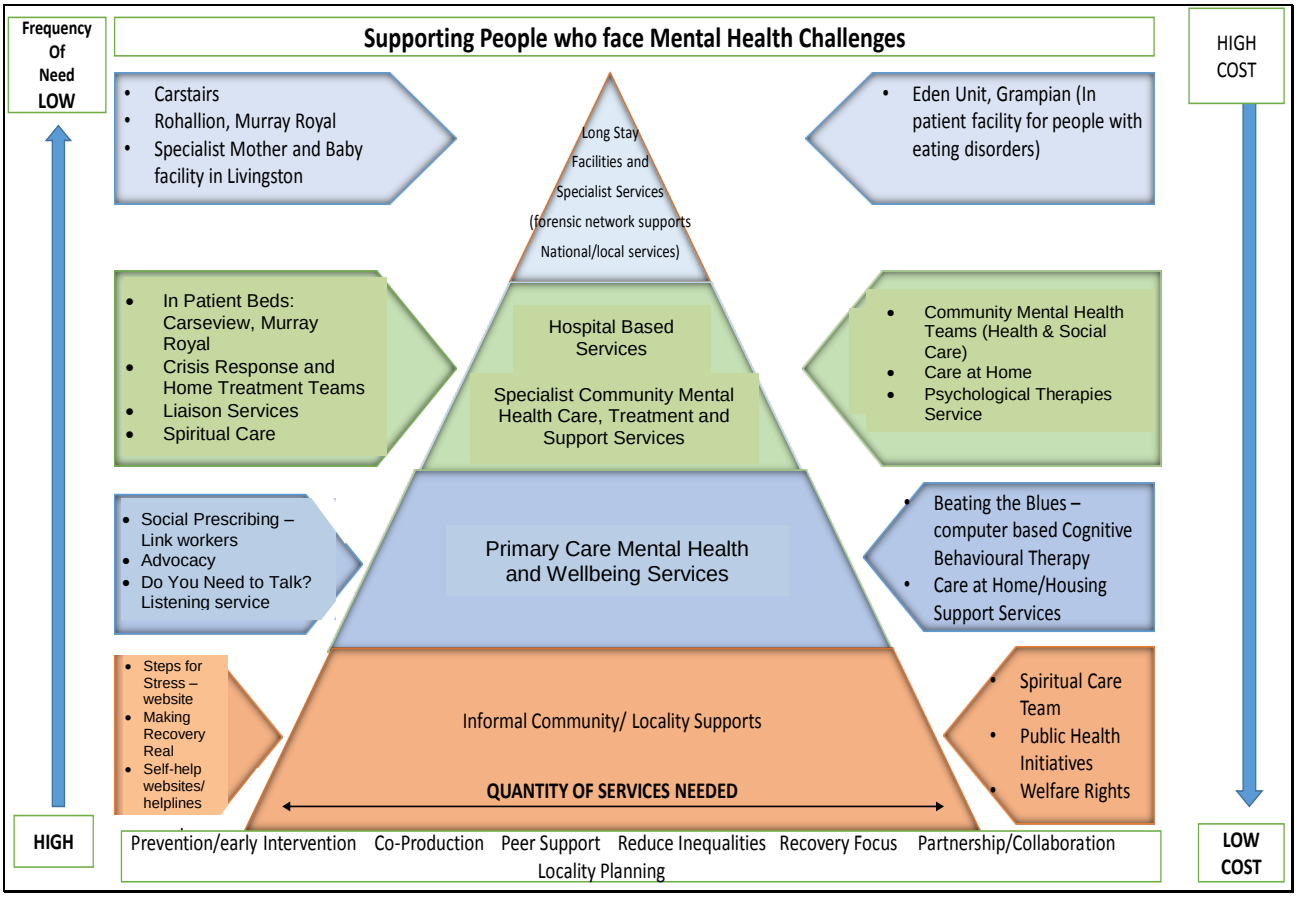
SOS was piloted on a small scale and scaled up incrementally to the current position of 10 social prescribing link workers across 15 GP practices as part of the Scottish Government national Community Link Worker Programme, and more recently in the context of the Tayside Primary Care Improvement Plan and Action 15 of the national Mental Health Strategy.
Link workers take referrals from GPs and other health professionals for adult patients with poor mental health and wellbeing affected by their social circumstances. The SOS service sits within Dundee's integrated Health Inequalities Service.
An external evaluation demonstrated that the service had positive impacts on clients and GPs. Data showed a fairly even gender split and mixed age range. Over half of those referred were single, 92% had a mental health issue, the majority were unemployed and/or unfit to work, in receipt of welfare benefits, and living in the most deprived areas. 59% of patients required assisted visits to support them to access services; reasons included chronic anxiety, mobility issues, and financial constraints. Over 70% of those referred engaged with the scheme, 65% of goals were met fully and 84% had some positive outcome. Outcomes included increased access to services and activities, decreased social isolation, improved or new housing, benefits issues being addressed, new sense of purpose, and increased confidence. Outcomes for GPs included reduced patient contact, more options for patients, raised awareness of non-clinical services, and increased productivity. The role of the link worker was shown to be sophisticated and complex, using skills such as negotiation, facilitation, research, networking and advocacy.
This effective and impactful model provides a synergy between medical and social models of mental health and wellbeing, focusing on social determinants and providing positive links for vulnerable people with a wide range of community based services and activities that can help improve life circumstances and quality of life.

Quotes:

"…when I first began I rarely went out… it kind of gave me a boost to go and do things with the kids and I was always kind of worried about money, so she put me onto places that didn't cost too much or were free".

"Quite often as a GP you do realise effectively what you can do is not very much. Life and circumstances and all sorts of things affect people's mental health and all you can do is give them 10 minutes of your time and probably send them away with a prescription".

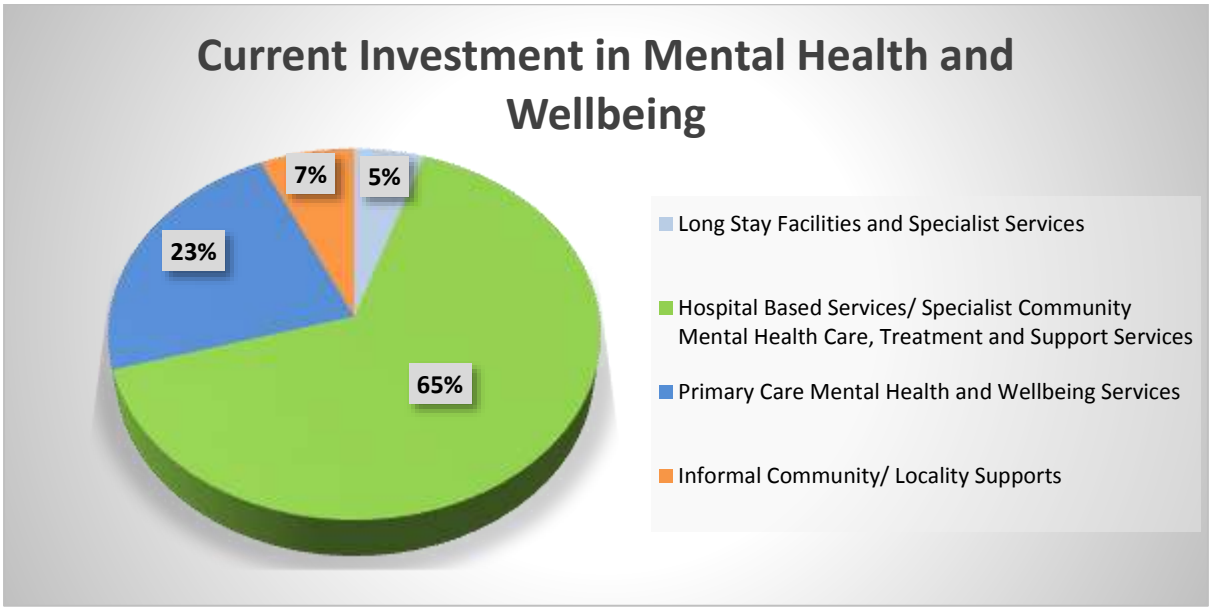
Mental Health and Wellbeing Model



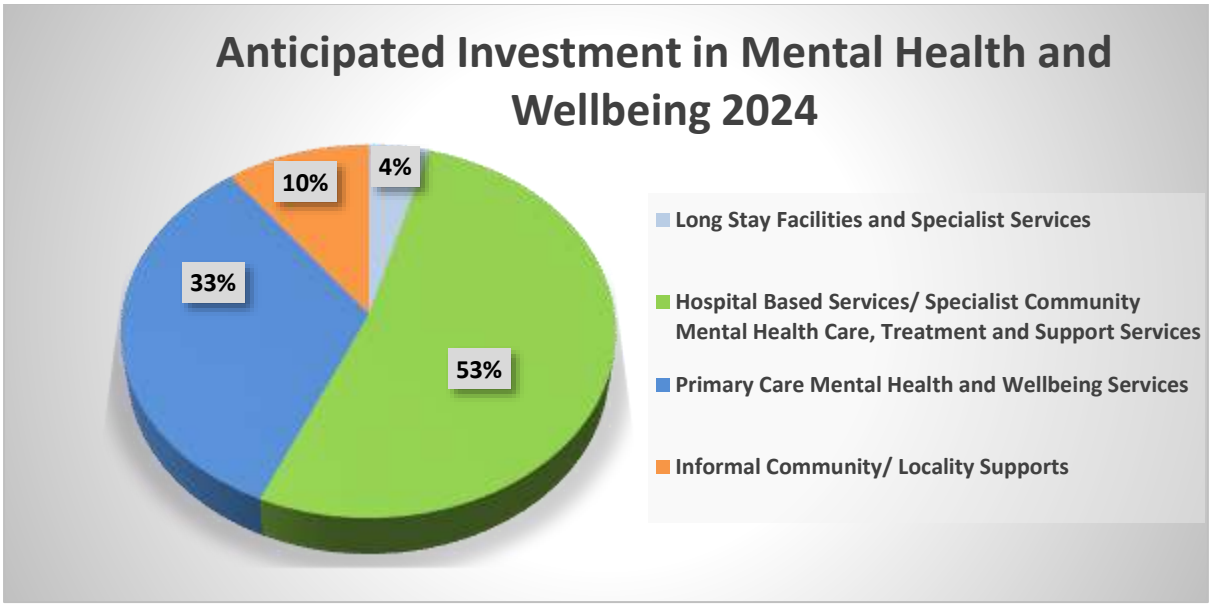
The pyramid above has been adapted from a model produced by the World Health Organisation and can be used to help organisations analyse the balance between varying levels of support within a mental health context.

The model illustrates some examples of mental health and wellbeing support that is currently available in the city and will be used to track progress against strategic priorities throughout the life of the Plan. In order to improve mental wellbeing and reduce mental health inequalities, it is anticipated that the level of informal/ locality based supports will continue to increase. As a result, the reliance on the current level of in patient provision will decrease as more preventative supports are made available.

A financial framework has been developed as part of this model to track disinvestment/investment across the different levels of mental health and wellbeing support. This will enable the MHWSCG to evidence shifts in investment and the best use of overall available resources.

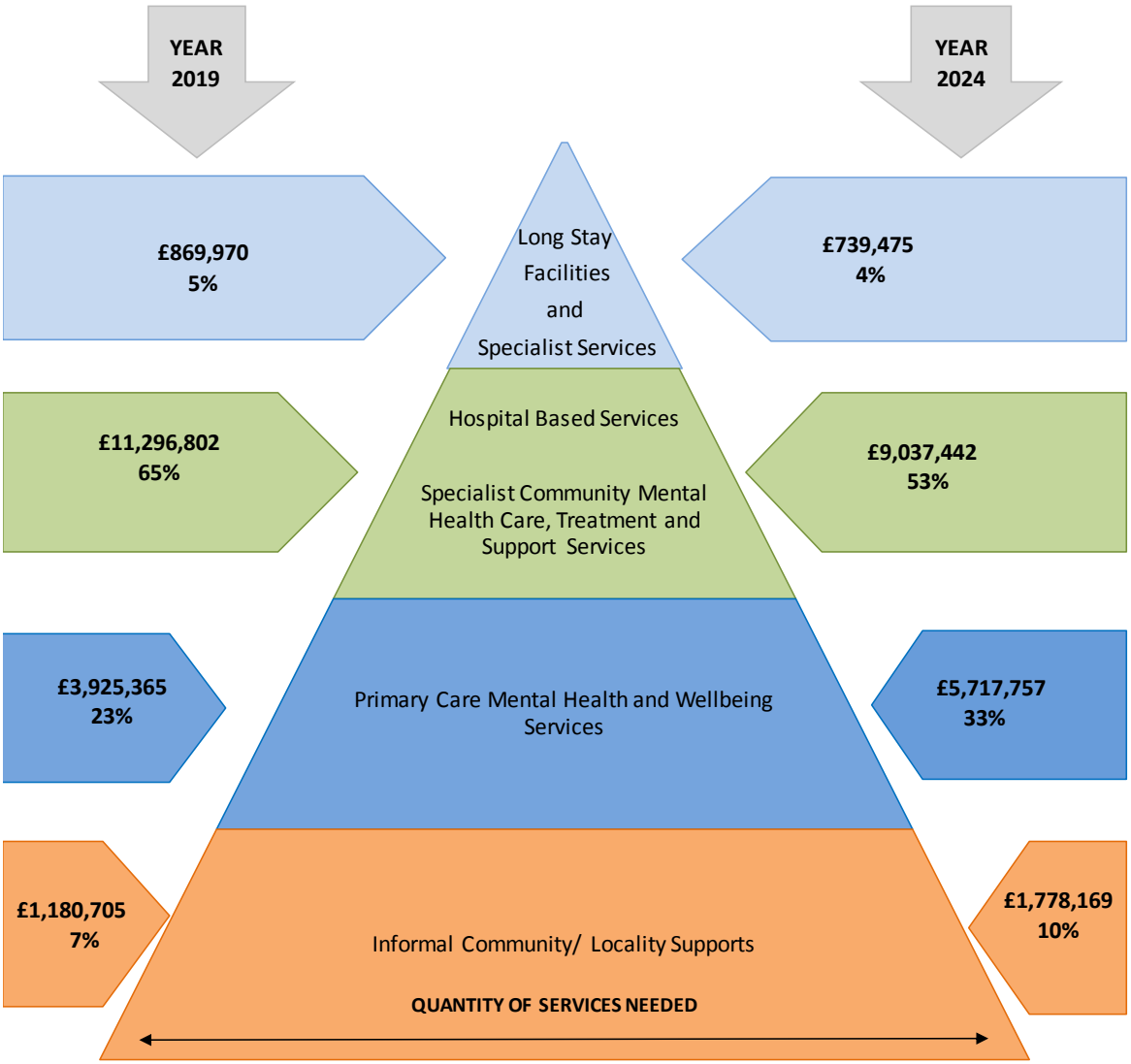


The above chart shows the current balance of investment of Dundee Health and Social Care resources in Mental Health and Wellbeing.



The above chart shows an anticipated shift in the balance of financial investment over the life of this Strategic Plan.

Anticipated Shifts in Investment
2019-2024



The MHWSCG will use the above financial framework as a baseline from which to evidence desired shifts to more preventative, locality based support for the people of Dundee.

The model shows the anticipated impact of a redesign of Mental Health and Wellbeing Supports in Dundee. Financial planning will also require to take account of demographic factors and available financial resources between 2019 – 2024.

Good Practice Example

Making Recovery Real (MRR) is a multi-agency cross sector initiative supported by the Scottish Recovery Network.

The aim of the initiative is to shift the balance of power at all levels towards people with lived experience of mental health challenges.

Extensive and ongoing engagement tells us that what best supports recovery is:

- Being heard and understood, particularly by others who have lived experience.
- Sharing recovery stories.
- Being able to support others who have similar experiences.

In the 3 years that Making Recovery Real has been in place in Dundee we have:

- Created films and workshops to help share recovery stories with the public, service providers, and decision-makers.
- Held events to share the learning.
- Delivered Peer 2 Peer training courses.

Some of the impacts that have been evidenced so far:

- Creation of more peer recovery roles, both voluntary and paid positions in a variety of settings.
- Establishment of a Peer Recovery Network for mutual support and ongoing development.
- Of 24 peer graduates, 6 regularly deliver story sharing workshops and participate in events; 5 have progressed into further training or personal development courses, 5 have taken up volunteering opportunities, 3 went on to University courses, and 3 are now in employment.

Strategic Priority 1 - Reducing Health Inequalities

Some people are more likely to have poor mental health than others. For example, someone living on a low income is much more likely to become mentally unwell than someone who is better off. Someone who completes suicide is three times more likely to come from a poorer community than a more affluent one. These are unacceptable facts of life in Dundee. The strategy aims to reduce health inequalities by:

- Developing a framework of assessment, intervention, and support to address health inequalities experienced by people with mental health challenges.

- Targeting outreach work for better outcomes in localities with higher incidences of poor mental health, including providing mental health training.

- Working with people with mental health challenges to improve their physical health, for example including targeted smoking cessation programmes in conjunction with Public Health colleagues.

- Working with people with chronic physical conditions to improve their mental health and wellbeing.

- Working with people within the Criminal Justice Service to improve their mental health and wellbeing.

- Providing appropriate housing for people with mental health challenges.

- Provide more co-ordinated responses for people facing mental health and substance misuse challenges.

Strategic Priority 2 - Prevention and Early Intervention

The best way of ensuring that people enjoy good mental health and wellbeing is to prevent problems from arising in the first place. When problems do arise, they are best resolved when dealt with as quickly as possible. The strategy will therefore deliver support that is open to all, helping people to look after their own mental health and wellbeing. Other actions are included to keep people who live with ongoing mental health challenges as well as possible and prevent relapse. To these ends we will:

- Increase awareness of mental health issues across communities, schools, and workplaces, reducing stigma and discrimination.

- Make health and wellbeing information easier to find and understand.

- Make non-medical and social prescribing more widely available.

- Increase the number of short breaks to help sustain relationships between people with mental health issues and their unpaid carers.

- Provide evening and weekend access to facilities at Dundonald Centre for local mental health focussed care providers and voluntary organisations.

- Provide more low intensity psychological support at earlier stages in the patient journey.

Strategic Priority 3 - Getting the Right Support at the Right Time

People with mental health challenges, and their carers, have reported that it can be difficult to get the right help at the right time. However, getting the right help usually results in better outcomes. That's why we intend to broaden the range of available supports, and to make supports more accessible. Some of the changes we shall introduce are:

- Expanding the "Do you need to Talk?" Listening Service.

- Delivering Mental Health and wellbeing short courses in community settings.

- Increasing capacity within psychological therapies services.

- Introduction of specialist mental health assessment and liaison service within GP cluster areas to speed up access to appropriate mental health support.

- Strengthening support for people who live with substance misuse as well as mental health issues.

- Improving our response to people experiencing distress. We shall introduce a model of care and support that compliments existing services and is available at all times of the day and night.

We will also:

- Collaborate to improve pathways between acute care, primary care, community care and community based mental health and wellbeing supports.

- Ensure the pathway and transition planning is a collaborative process involving all stakeholders supporting children, young people, adults and older people who face mental health challenges.

- Work in partnership to provide 7-day community mental health support.

- Collaborate with hospital based mental health services to ensure smooth transitions between home and hospital and ensure that person centred treatment and recovery plans are followed.

- Build capacity within the third sector to strengthen services and supports within communities.

- Build capacity within the community pharmacy service to provide expert advice and guidance on mental wellbeing.

- Improve availability of Welfare Rights advice and information within all settings to support people experiencing mental health challenges to navigate the current welfare system.

- Enhance the accessibility of services by promoting the use of technology to allow people to consult with specialist services from their own home or local community bases.

- Work to ensure that people offering care, treatment and support are familiar with the effects of trauma and fully understand the longer-term impact of adverse childhood experiences such as sexual and/or physical abuse.

Strategic Priority 4 - Focus on Recovery

People can and do successfully recover from mental ill health, but recovery is personal and means different things to different people. We will continue to learn together about recovery and what best supports it, keeping lived experiences of recovery at the forefront of all we do. We will:

- Encourage people to hold recovery conversations in communities, sharing recovery stories, and celebrating successes.
- Develop the workforce, extending and broadening understanding of recovery.
- Create more peer recovery roles, both paid and voluntary, across the system and support a network for people involved in peer recovery.
- Emphasise the social components of recovery alongside reduced clinical symptoms n all care, treatment, and support provided.
- Provide 1:1 support and group activities in topics such as goal setting, personal reflection, mindfulness, and self-management.
- Review the use of anti-psychotic medications and poly pharmacy in acute and primary care settings.
- Continue to work in partnership with a range of others to improve employers' knowledge about mental health and wellbeing and their capacity to support people within, and back to, the workplace.
- Ensure appropriate access to the right care and/or support should a person relapse: Maintain a hopeful stance throughout this period, care planning around Wellness Recovery Action Plans and Advanced Statement.

Co-Production

The priorities and actions within this Plan have been strongly influenced by the voice of people in Dundee who have experience of mental health challenges. The MHWSCG has developed positive, and possibly unique, relationships with vulnerable groups and localities in the context of strategic planning and commissioning processes. In addition to important but more traditional models of linking with service user groups and forums, strategic officers have developed meaningful connections with people and communities most at risk of developing poor mental health.

The work of the Poverty Truth Commission Mental Health Sub Group has been fed into the MHWSCG at every stage and this dialogue and collaboration has ensured that the recommendations from the sub group on what needs to change strengthen and are consistent with the actions in the strategic commissioning plan. The following is a quote from one of the Commissioners:

"Recently the mental health working group had the opportunity to present our research findings and recommendations to the strategic planning group. For me personally it was really empowering to share the voice of some of the most disenfranchised people in our city. I felt like the group listened with open minds and were really receptive to our recommendations. Although some of what we shared made difficult listening everyone engaged with the discussion. I feel more confident that our voices have been heard and will form part of the conversation around the development of mental health services having shared our research and recommendations with the group."

A Health Issues group in the East End of the city performed its drama on suicide and self-harm to the MHWSCG followed by focused discussions on how local people with lived experience can provide support to others in the same situation in their own communities. The group helped design a mental health briefing to share at a local level the work of the strategic commissioning group and continue to work tirelessly to improve the mental health of those in need.

Dundee Service User Network (SUN) continue to seek the views of people with lived experience and are represented on the MHWSCG.

These processes demonstrate that the MHWSCG is genuinely coproducing its strategy and associated actions by working alongside those most affected and using their experience and evidence to agree what a framework of support will look like.

The MHWSCG will continue to listen to people through existing, well established communication networks and will strive to make new connections with, and fully involve, a range of people and interest groups across the city.

The outcomes of processes that provide external scrutiny will continue to be incorporated within strategic planning throughout the life of this Plan.

Governance

The Mental Health and Wellbeing Strategic and Commissioning Group (MHWSCG) will take responsibility for, and provide leadership on, all matters relating to mental health and wellbeing strategic planning and commissioning for adults within the city.

A Commissioning and Financial Framework which includes anticipated timescales against actions will accompany this Plan.

A reporting framework is being produced to track progress against the priority areas outlined within this Plan and against the more detailed set of actions already identified by the MHWSCG.

Links to Related Policy/Strategy Documents

Improving mental health is a priority for the Scottish Government.

The SG website includes information about the activity that the Scottish Government is currently undertaking and provides links to further information about Mental Health and Wellbeing.

Mental Health policy in Scotland encompasses a number of discrete strategies including Mental Health Strategy and Suicide Prevention Strategy. It is recognised that the determinants and effects of mental health cross a wide variety of other policy areas such as substance misuse, early years, public health, acute physical illness and the interdependence of mental and physical health.

'What Research Matters for Mental Health Policy in Scotland' (2015.) The research priorities outlined in this paper were developed by the Mental Health and Protection of Rights Division of the Scottish Government to support 5 key policy objectives articulated through the Mental Health Strategy 2012-2015 and the Suicide Prevention Strategy 2013-2016.

Although both strategies were coming to an end, the paper included emerging sentiments about the direction of travel for the next strategies.

The Mental Health Strategy 2017 – 2027 was published on 30 March, 2017, and is the centrepiece for the Government's focus on improving Mental Health. It contains 40 specific actions, each intended to tackle a specific issue. The strategy includes a focus on prevention and early intervention, accessible services, physical wellbeing of people with mental health problems, rights and information.

'Every Life Matters' – Scotland's Suicide Prevention Action Plan (2017 - 2022) lists the actions which leaders nationally and locally must take to transform society's response and attitudes towards suicide and these actions extend beyond health and social care.

The City Plan for Dundee 2017 – 2026 builds on a series of Dundee Outcomes which reflect and contribute to the national ambitions for Scotland. It has 5 strategic priorities one of which is to improve the mental health and wellbeing of the people of Dundee.

Dundee Health and Social Care Partnership Strategic and Commissioning Plan 2016 - 2021

Tayside Primary Care Improvement Plan

The National Health and Wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services.

The Carers (Scotland) Act 2016 is designed to support carers' health and wellbeing and to help make caring more sustainable.

Appendix 2

Dundee Mental Health & Wellbeing Commissioning Framework (2019-2024)

Aim	Priorities	Outcomes	Workstream/ Redesign Group	Governance	Funding Stream
To support the improvement of mental health & wellbeing & reduce mental health inequalities for the citizens of Dundee	Reducing Health Inequalities	National Health and Wellbeing Outcomes	Primary Care Model Supporting Mental Health and Wellbeing	Dundee Mental Health and Wellbeing Strategic and Commissioning Group	• Dundee Health & Social Care Partnership (HSCP) Revenue Budget • Action 15 Funding / Primary Care Investment
			Locality based Early intervention / Preventative Mental Health and Wellbeing Support	Dundee Mental Health and Wellbeing Strategic and Commissioning Group	• Dundee HSCP Revenue Budget • Action 15 Funding / Primary Care Investment
			Clinical Care Pathways	Tayside Mental Health Alliance	• Dundee HSCP Revenue Budget • Perth & Kinross HSCP (hosted inpatient) budget
	Prevention & Early Intervention	Mental Health Quality Outcomes: Timely, Safe, Person Centred, Effective, Efficient, Equitable and Trauma Informed	Unscheduled Care Pathways	Tayside Mental Health Alliance	• Dundee HSCP Revenue Budget • Perth & Kinross HSCP (hosted inpatient) budget
			Accommodation with Support	Dundee Mental Health and Wellbeing Strategic and Commissioning Group	• Dundee HSCP Revenue Budget • Dundee City Council General Services Capital Plan • Affordable Housing Supply Programme (AHSP) Grant, Scottish Government
	Right Support at the Right Time		Child to Adult Transition Pathways	Tayside Mental Health Alliance	• NHS Tayside • Dundee City Council • Dundee HSCP Revenue Budget • Perth & Kinross HSCP (hosted inpatient) budget
			Integrated Pathway – Mental Health / Substance Misuse	Dundee Mental Health and Wellbeing Strategic and Commissioning Group	• Dundee Health & Social Care Partnership Revenue Budget
	Focus on Recovery	Actions from National Mental Health Strategy 2017 - 2027	Support for People Experiencing Distress	Dundee Mental Health and Wellbeing Strategic and Commissioning Group	• Dundee Health & Social Care Partnership Revenue Budget • Action 15 Funding
			Workforce Planning	Dundee Mental Health and Wellbeing Strategic and Commissioning Group	• Dundee HSCP Revenue Budget • Perth & Kinross HSCP (hosted inpatient) budget
			Suicide Prevention	Dundee Suicide Prevention Strategic Planning Group	• Dundee Health & Social Care Partnership Revenue Budget

Co-production — Human Rights Approach — Collaboration

Workstream / Redesign Group	Action	Timescale
Primary Care Model Supporting Mental Health and Wellbeing	Extend Patient Assessment, Liaison and Management Service (PALMS) to all 4 GP Cluster areas	Full implementation in one cluster area by December 2019. All 4 cluster areas to be operational by 2021.
Locality based Early intervention / Preventative Mental Health and Wellbeing Support	Invest further in preventative locality based support, targeting communities in greatest need Improve access to information through existing community networks and further develop collaborative approaches to the co-production and dissemination of information, including the use of information technology Build on existing co-production mechanisms, co-ordinated and led by Dundee Voluntary Action	The Mental Health and Wellbeing Strategic Commissioning Group will review progress to date, discuss and agree future actions and timescales for completion. The Mental Health and Wellbeing Strategic Commissioning Group will review progress to date, discuss and agree future actions and timescales for completion. Ongoing throughout life of Strategic Plan
Clinical Care Pathways	Design / Review and Implement revised Clinical Pathways, including but not limited to: • Emotionally Unstable Personality Disorder • Bipolar Disorder / Psychosis • Depression • Autism • Trauma	To be confirmed by Tayside Mental Health Alliance.
Unscheduled Care Pathways	Review Crisis Resolution / Intensive Home Treatment Pathways Establish 24/7 Community Mental Health support	Initial Stakeholder Event in Spring 2019 identified priorities for redesign. Redesign group will determine the scale and pace of developments and timescale for completion.
Accommodation and Support	Implement Strategic Housing Investment Plan priorities for people who experience mental health challenges	Additional 18 units (houses) by early 2020. A further 7 units during 2021. Requirements from 2021 – 2024 yet to be confirmed / commissioned.

Workstream / Redesign Group	Action	Timescale
Child to Adult Transition Pathways	Implement Scottish Government Transitional Care Plan (Child and Adolescent Mental Health Services to Adult Community Mental Health Services) Broaden the multi disciplinary and multi agency scope of local transition planning protocol (This is a local to Dundee Action)	To be confirmed by Tayside Mental Health Alliance Completion by end of 2019
Integrated Pathway – Mental Health / Substance Misuse	Design and implement unified pathways for people with significant mental health and substance misuse challenges (incorporating any recommendations from Mental Health Inquiry / Drugs Commission). This may include: • Specialist Assessment • Supporting a Case Management approach • A decision making protocol that will incorporate a mechanism for resolving differences in opinion between services	Programme Plan to be confirmed between September and December 2019
Support for People Experiencing Distress	Develop triage response with Ambulance Service / Police / Accident & Emergency Department, including out of hours Commission 2 properties with availability and provision of 24/7 short term mental health support Create further opportunities for people to access tailored support when needed using a drop in approach	Phased implementation from early 2020 Summer/Autumn 2020 Phased implementation from early 2020

Workstream / Redesign Group	Action	Timescale
Workforce Planning	Establish 2/3 Advanced Nurse Practitioner posts (who can prescribe) Implement a medication concordance and medication review model to reduce poly pharmacy issues Establish skill mix and ensure learning opportunities to support multi disciplinary locality working Embed peer recovery support model in a range of cross sector settings and establish a local Peer Recovery Network led by Dundee Voluntary Action to provide governance framework Continue to develop a Trauma Informed workforce	Recruitment by Spring 2020 Anticipated phased implementation from Summer 2020 Ongoing throughout life of Strategic Plan, linked to each workstream / redesign group Network is established, further additional peer recovery support posts are being recruited to by end of 2019 Ongoing throughout life of Strategic Plan
Suicide Prevention	Enhance collaboration between Tayside Suicide Review Group, Tayside Drugs Death Review Group and Dundee Mental Health and Learning Disability Adverse Event Management Group	Formal links already established. Principles of information sharing agreed, shared work plan to be agreed by end of 2019.

ITEM No …7……..

REPORT TO: **DUNDEE HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 AUGUST 2019**

REPORT ON: **FINANCIAL MONITORING POSITION AS AT JUNE 2019**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB42-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board with an update of the projected financial monitoring position for delegated health and social care services for 2019/20.

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 2019/20 financial year end as at 30 June 2019 as outlined in Appendices 1, 2 and 3 of this report.

2.2 Notes that officers within the Health and Social Care Partnership will assess a number of actions required to effect a recovery plan which will be reflected in the August financial monitoring report to be presented at the IJB meeting of the 29th October 2019 as outlined in section 4.7.1 of this report.

3.0 FINANCIAL IMPLICATIONS

3.1 The financial monitoring position for Dundee Health and Social Care Partnership based on expenditure to 30 June 2019 shows a net projected overspend position at the year end of £2,316k. As a result of this projected position, officers within the Health and Social Care Partnership will assess a number of actions required to effect a recovery plan.

4.0 MAIN TEXT

4.1 Background

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

4.1.2 The IJB set out its final budget for delegated services at its meeting of the 25 June 2019 following receipt of confirmation of NHS Tayside's budget (DIJB31-2019). Within this report, the risks around the prescribing budget were reiterated after being formally noted in the budget report presented to a meeting of the IJB held on 29 March 2019 (Article VI of the minute refers).

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

4.1.4 Under the terms of the Integration Scheme, the risk sharing arrangements in relation to any residual overspends incurred by the end of the financial year will be met proportionately by the Council and NHS Tayside. Discussions will be ongoing throughout the financial year with both parties to consider the implications of this should an overspend arise. Officers within the partnership will however continue to explore areas to control expenditure and achieve the savings targets identified.

4.2 Projected Outturn Position – Key Areas

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

4.3 Services Delegated from NHS Tayside

4.3.1 The financial projection for services delegated from NHS Tayside to the IJB indicates a projected overspend of around £459k by the end of the financial year. Community based health services managed directly by Dundee Health and Social Care Partnership are projected to be underspent by approximately (£373k), while GP prescribing is projected to be overspent by £364k. A further overspend of £249k relates to General Medical /Family Health services and an overspend of £219k as a result of the net effect of hosted services risk sharing.

4.3.2 Service underspends are reported within Allied Health Professionals (£288k), Keep Well (£175k) and hosted services such as Psychology (£550k) and Sexual & Reproductive Health (£150k) mainly as a result of staff vacancies.

4.3.3 Service overspends are anticipated in Continuing Care £640k, Psychiatry of Old Age £163k and Intermediate Care £101k and Medicine for the Elderly £380k. These are associated with the Delayed Discharge issues highlighted at section 4.4.2 below. Community Mental Health services are also anticipated to be overspent by £215k. Additional staffing pressures have contributed to the adverse position within these services through ensuring safe staffing levels in accordance with the National Nursing and Midwifery workload tools requirements.

4.3.4 The Family Health Services prescribing budget currently projects a shortfall totalling £364k based on the expenditure trends to date. General Medical Services forecast an overspend of £247k.

4.3.5 Members of the IJB will also be aware that Angus and Perth and Kinross IJBs host delegated services on behalf of Dundee IJB and a number of services are hosted by Dundee on behalf of Angus and Perth and Kinross. These are subject to a risk sharing agreement whereby any over or underspends are reallocated across the three Tayside IJBs at the end of the financial year. The financial monitoring position of these services in their totality are reflected in each of the IJB's financial monitoring reports and for information purposes the projected net impact of these services on each IJB's budgeted bottom line figure is noted. More detail of the recharges from Angus and Perth and Kinross IJBs to Dundee IJB are noted in Appendix 3. This shows net overspends to the value of £276k being recharged with the net impact of hosted services to Dundee being an overspend of £219k.

4.3.6 As with 2018/19, the financial position of Dundee City IJB continues to be impacted upon by the significant overspend in the Mental Health Inpatient service which is hosted by Perth & Kinross IJB. Perth and Kinross IJB has continued to utilise cost pressure funding and apply other interventions to reduce the overspend position in respect of this service provision. This has resulted in Dundee City IJB reducing its share of the estimated overspend to £296k, compared to the year-end overspend for 18/19 of £473k. This position is driven by undelivered savings carried forward from previous years, medical locum costs and nursing costs in General Adult Psychiatry. Plans to reduce and offset costs through savings anticipated from Mental Health, Learning Difficulties, Inpatient and the Transformation Programme will to be monitored closely over 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 shows an anticipated overspend of £1,857k based on the expenditure position to date.

4.4.2 A significant financial challenge facing the IJB's delegated budget continues to be the provision of home and community based social care at a sufficient level to meet increasing demographic demand and reduce delayed discharges in hospital while balancing financial resources. At this stage of the financial year, the activity in this area is at such a level that a significant overspend is projected across a range of services. An overspend of approximately £600k is anticipated within externally purchased care at home services while expenditure on private and voluntary sector care homes is significantly higher than projected with an increased number of placements compared to the previous year's position and anticipated trajectory resulting in a further overspend of around £450k. In addition, expenditure on respite care is higher than budget by around £145k again mainly due to high levels of demand. Furthermore, expenditure on the Assessment at Home Service, an essential part of the multi-disciplinary Enhanced Community Support Service was originally planned to be funded through reserves as part of transitional arrangements leading to a further overspend of £824k, however current reserve balances set aside for this purpose are no longer sufficient to support this level of spend.

4.4.3 A range of underspends within Learning Disabilities, Substance Misuse and Mental Health functions partly arising from staff turnover as well as slippage in the development of new services are currently projected to partly offset these budget pressure areas.

4.5 Reserves Position

4.5.1 The IJB's reserves position was adversely affected at the year ended 31st March 2019 as a result of a greater than anticipated overspend incurred during last financial year. The reserves position is noted below and is subject to the audit of the 2018/19 annual accounts.

	Opening Balance £000	**Anticipated Commitments**	**Projected Net Position at Year end**
Non-Earmarked Reserves	561	-	561
Earmarked Reserves – Transformation	400	(300)	100
Earmarked Reserves – Specific*	1,805	(1,805)	-
Total	2,766	(2,105)	661

*These balances mainly consist of Primary Care, ADP and Mental Health Action 15 Scottish Government Funds which must be spent on the purposes for which they were provided for. In addition, a balance of funding of around £300k is to be used to support the assessment at home service.

4.6 Savings and Transformation Plan

4.6.1 The IJB agreed a savings and transformation programme at its meeting of 29th March 2019 to the value of approximately £5.4m which was around £500k short of the required target to fully balance the budget. This shortfall is included within the projections contained within this report.

4.6.2 A risk assessment has been made of the full delivery of the savings as follows:

Risk Category	**Value of Savings £000k**
Green	2,558
Amber	932
Red	1,900
Total	5,390

In respect of the red categorised savings, £500k relates to the planned private and voluntary care home placements reduction included in the overspend above with the balance also reflected in the overall projected overspend position. These savings will continue to be progressed and monitored closely over the remainder of the financial year.

4.7 Recovery Action

4.7.1 Given the level of overspend projected and continued increasing demand for services officers from the Health and Social Care Partnership have commenced assessing a number of actions required to reduce expenditure. The implications of these will be reported in full at the IJB meeting of the 29th October 2019 and will include:

- Review of health and care pathways to reduce hospital stays including delayed discharge to ensure any system blockages are cleared and systems and processes are working at their optimum level.
- Continuous scrutiny of staff vacancies and managing these effectively where safe to do so
- Continuous review of discretionary spend across all service areas
- Review of specific expenditure areas such as Learning Disability Services
- Work with partners to ensure resources are maximised across the whole system supporting health and social care
- Review of progress of previously agreed savings proposals
- Options around use of remaining reserves

5.0 POLICY IMPLICATIONS

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

6.0 RISK ASSESSMENT

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

7.0 CONSULTATIONS

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

8.0 DIRECTIONS

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

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

9.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 5 August 2019

Appendix 1

DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP - FINANCE REPORT 2019/20 **Jun-19**

	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	40,842	1,938	15,777	1,206	56,619	3,144
Mental Health	3,867	(196)	3,559	120	7,426	(76)
Learning Disability	23,738	(270)	1,409	40	25,147	(230)
Physical Disabilities	6,118	281	0	0	6,118	281
Substance Misuse	1,883	(199)	2,824	55	4,707	(144)
Community Nurse Services/AHP/Other Adult	966	88	12,449	(393)	13,415	(305)
Hosted Services	0	0	20,018	(384)	20,018	(384)
Other Dundee Services / Support / Mgmt	-366	215	25,704	(353)	25,337	(138)
Centrally Managed Budgets	0		-1,427	(664)	(1,427)	(664)
Total Health and Community Care Services	**77,047**	**1,857**	**80,313**	**(373)**	**157,360**	**1,484**
Prescribing (FHS)	0	0	32,569	364	32,569	364
Other FHS Prescribing	0	0	830	0	830	0
General Medical Services	0	0	24,939	247	24,939	247
FHS - Cash Limited & Non Cash Limited	0	0	18,165	2	18,165	2
Grand Total	**77,047**	**1,857**	**156,816**	**240**	**233,863**	**2,097**
Net Effect of Hosted Services*			6,074	219	6,074	219
Grand Total	77,047	1,857	162,890	459	239,937	2,316
Less: Planned Draw Down From Reserve Balances		0				0
Grand Total	**77,047**	**1,857**	**162,890**	**459**	**239,937**	**2,316**

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

Appendix 2

Dundee City Integration Joint Board – Health and Social Care Partnership – Finance Report June 2019

	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)			4,863	163	4,863	163
Older People Serv. – Ecs			37	0	37	0
Older Peoples Services -Community			510	0	511	0
Continuing Care			1,025	640	1,025	640
Medicine for the Elderly			5,274	380	5,274	380
Medical (POA)			668	0	668	0
Psychiatry Of Old Age (POA) - Community			1,972	(175)	1,972	(175)
Intermediate Care			(44)	101	(44)	101
Dundee- Supp People At Home			0	0	0	0
Medical (MFE)			1,472	98	1,472	98
Older People Services	40,842	1,983			40,842	1,938
Older Peoples Services	40,842	1,983	15,777	1206	56,619	3,144
General Adult Psychiatry			3,559	120	3,559	120
Mental Health Services	3,867	(196)			3,867	(196)
Mental Health	3,867	(196)	3,559	120	7,426	(76)
Learning Disability (Dundee)	23,738	(270)	1,409	40	25,147	(230)
Learning Disability	23,738	(270)	1,409	40	25,147	(230)

	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	6,118	281			6,118	281
Physical Disabilities	6,118	281	0	0	6,118	281
Substance Misuse	1,883	(199)	2,824	55	4,707	(144)
Substance Misuse	1,883	(199)	2,824	55	4,707	(144)
A.H.P. Admin			406	(12)	406	(12)
Physiotherapy			3,777	(160)	3,777	(160)
Occupational Therapy			1,454	(116)	1,454	(116)
Nursing Services (Adult)			6,262	0	6,262	0
Community Supplies - Adult			155	(25)	155	(25)
Anticoagulation			394	(80)	394	(80)
Joint Community Loan Store			0	0	0	0
Intake/Other Adult Services	966	88			966	88
Community Nurse Services / AHP / Intake / Other Adult Services	966	88	12,449	(393)	13,415	(305)

	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			2,774	0	2,774	0
Palliative Care – Medical			1,152	10	1,152	10
Palliative Care – Angus			348	0	348	0
Palliative Care – Perth			1,730	150	1,730	150
Brain Injury			1,710	200	1,710	200
Dietetics (Tayside)			3,001	(20)	3,001	(20)
Sexual and Reproductive Health			2,175	(150)	2,175	(150)
Medical Advisory Service			160	(88)	160	(88)
Homeopathy			28	4	28	4
Tayside Health Arts Trust			62	0	62	0
Psychology			5,190	(550)	5,190	(550)
Psychotherapy (Tayside)			863	120	863	120
Learning Disability (Tayside AHP)			825	(60)	825	(60)
Hosted Services	0	0	20,018	(384)	20,018	(384)
Working Health Services			0	0	0	0
The Corner			416	(8)	416	(8)
Grants Voluntary Bodies Dundee			84	0	84	0
IJB Management			807	(100)	807	(100)
Partnership Funding			22,768	0	22,768	0
Urgent Care			0	0	0	0
Public Health			469	0	469	0
Keep Well			630	(175)	630	(175)
Primary Care			529	(70)	529	(70)
Support Services/Management Costs	(366)	215			(366)	(215)
Other Dundee Services / Support / Mgmt	(366)	215	25,704	(353)	25,337	(138)

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Centrally Managed Budgets			(1,427)	(664)	(1427)	(664)
Total Health and Community Care Services	**77,047**	**1,857**	**80,313**	**(373)**	**157,360**	**1,484**
Other Contractors						
Prescribing (FHS)			32,569	364	32,569	364
Other FHS Prescribing			830	0	830	0
General Medical Services			24,939	247	24,939	247
FHS - Cash Limited and Non Cash Limited			18,165	2	18,165	2
Grand Total HSCP	**77,047**	**1,857**	**156,816**	**240**	**233,863**	**2,097**
Hosted Recharges Out			(11,887)	(58)	(11,887)	(58)
Hosted Recharges In			17,961	276	17,961	276
Hosted Services - Net Impact of Risk Sharing Adjustment			**6,074**	**219**	**6,074**	**219**
Less: Planned Draw Down from Reserves						
Total	**77,047**	**1,857**	**162,890**	**459**	**239,937**	**2,316**

Appendix 3

NHS Tayside - Services Hosted by Integrated Joint Boards - Charge to Dundee IJB
Risk Sharing Agreement - June 2019

Services Hosted in Angus	Annual Budget	Forecast Over (Underspend)	Dundee Allocation
Forensic Service	991,113	(95,000)	(37,430)
Out of Hours	7,443,345	(33,000)	(13,002)
Tayside Continence Service	1,440,352	(33,000)	(13,002)
Ang-loc Pharmacy	1,850,651	0	0
Speech Therapy (Tayside)	1,128,661	(39,500)	(15,563)
Hosted Services	**12,854,122**	**(200,500)**	**(78,997)**
Apprenticeship Levy	41,188	704	277
Balance of Savings Target	-109,308	109,308	43,067
Grand Total Hosted Services	**12,786,002**	**(90,488)**	**(35,652)**
Services Hosted in Perth			
Angus Gap Inpatients	2,095,480	275,000	108,350
Dundee Gap Inpatients	6,078,856	337,500	132,975
Dundee Gap Snr Medical	2,032,833	25,000	9,850
P+K Gap Inpatients	5,771,043	50,000	19,700
Learning Disability (Tayside)	6,418,630	65,000	25,610
T.A.P.S.	704,868	(7,500)	(2,955)
Tayside Drug Problem Services	830,784	(50,000)	(19,700)
Prison Health Services	3,926,385	(38,500)	(15,169)
Public Dental Service	2,115,396	(6,500)	(2,561)
Podiatry (Tayside)	3,035,794	(186,000)	(73,284)
Hosted Services	**33,010,069**	**464,000**	**182,816**
Apprenticeship Levy - Others	41,700	304	120
Apprenticeship Levy - IPMH	76,600	(1,064)	(419)
Balance of Savings Target	(36,894)	291,765	114,955
Balance of Savings Target - IPMH	(291,765)	36,894	14,536
Grand Total Hosted Services	**32,799,710**	**791,899**	**312,008**
Total Hosted Services	**45,585,712**	**701,411**	**276,356**

ITEM No …9……..

Dundee Health & Social Care Partnership

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 27 AUGUST 2019**

REPORT ON: **JOINT INSPECTION (ADULTS): THE EFFECTIVENESS OF STRATEGIC PLANNING IN NORTH AYRSHIRE (MARCH 2018) – DUNDEE POSITION STATEMENT**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB41-2019**

1.0 PURPOSE OF REPORT

To inform the Integration Joint Board (IJB) of the published inspection report of strategic planning within North Ayrshire Health and Social Care Partnership. As part of our commitment to continuous improvement this report also highlights areas for learning for the Dundee Health and Social Care Partnership.

2.0 RECOMMENDATIONS

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

2.1 Note the content of this report and the North Ayrshire inspection report published by the Care Inspectorate and Healthcare Improvement Scotland (attached as Appendix 1).

2.2 Note the Dundee position as assessed against the North Ayrshire report (section 4.2.1 and Appendix 2).

2.3 Instructs the Head of Service, Finance and Strategic Planning to develop an action plan to address priority areas for improvement (section 4.2.2) and submit this to the Performance and Audit Committee for approval no later than 26 November 2019.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Inspection of Services

4.1.1 As part of the statutory programme of inspection activity for Health and Social Care Partnerships across Scotland Scottish Minister have asked the Care Inspectorate and Healthcare Improvement Scotland to jointly report on the effectiveness of strategic planning by Integration Authorities. Joint inspections of strategic planning have within their scope how Integration Authorities plan, commission and deliver high-quality services in a co-ordinated and sustainable way.

4.1.2 Joint inspections of strategic planning focus on three key areas:

- How well the partnership has improved performance in both health and social care;
- How well the partnership has developed and implemented operational and strategic planning arrangements and commissioning arrangements; and,
- How well the partnership has established a vision, values and aims across the partnership and the leadership of strategy and direction.

4.1.3 The inspection of strategic planning in North Ayrshire took place between August and December 2018, with the inspection report published in March 2019:

http://www.careinspectorate.com/images/documents/4860/Joint%20inspection%20adults%20strategic%20planning%20report%20for%20North%20Ayrshire.pdf

This was the 4th joint inspection of strategic planning since the integration of health and social care supports and services. North Ayrshire is part of Dundee's Local Government Benchmarking Framework 'family group' meaning that it has a similar socio-demographic profile to Dundee. Considering the results of inspections from Partnerships within our 'family group' is particularly relevant in contributing to continuous improvement, as the challenges the Partnership faces in delivering good performance are likely to be similar to our own.

4.2 Dundee Position Statement

4.2.1 Appendix 2 contains a high level assessment of the Dundee position against the evaluation of North Ayrshire contained within the inspection report. It highlights key strengths and areas for improvement. Key areas for improvement have been identified across 14 of the 17 areas of focus within the inspection activity.

4.2.2 Whilst all identified areas for improvement offer valuable learning to the Partnership and will be considered for future action, areas for improvement have been allocated a relative priority for action. The priority level takes account of the gap between the expectations of scrutiny bodies and the current Dundee position, as well as whether or not work is currently ongoing to address the issues identified and whether or not adequate resources are currently available to drive forward improvements. This has resulted in 4 areas being identified as a high priority for improvement:

- Performance: including systems for robust reporting against local indicators and aggregate individual outcome information, as well as arrangements to ensure the right performance information is available to the right people within the Partnership at the right time.
- Priorities / Commissioning Intentions: including developing financial frameworks and detailed commissioning intentions to support the implementation of strategic plans and alignment of strategic plans to ensure a whole systems approach.
- Asset Based Approaches: including improving performance in relation to Self-Directed Support and increasing the pace of work to embedded personalisation in practice.
- Financial Position / Sustainability: including the range of issues recently identified through the internal audit report on Transformation (Article X of the minute of the IJB meeting held on 25 June 2019 refers).

4.2.3 It is intended that the Head of Service for Finance and Strategic Planning will, along with his Management Team, consider the high priority areas and develop an action plan to address these. In some areas, such as for issues relating to personalisation, action plans are already in place; these will now be reviewed and update to reflect any further learning available from North Ayrshire's inspection report.

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 does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

The Head of Service – Finance and Strategic Planning, Head of Service - Health and Community Care and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

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

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

9.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 5 August 2019

Kathryn Sharp
Senior Manager, Strategy and Performance

Healthcare Improvement Scotland

care inspectorate

JOINT INSPECTION (ADULTS)
The effectiveness of strategic planning in
North Ayrshire Partnership

JOINT INSPECTION (ADULTS)

The effectiveness of strategic planning in North Ayrshire Partnership

March 2019

The Care Inspectorate is the official body responsible for inspecting standards of care in Scotland. That means we regulate and inspect care services to make sure they meet the right standards. We also carry out joint inspections with other bodies to check how well different organisations in local areas are working to support adults and children. We help ensure social work, including criminal justice social work, meets high standards.

Healthcare Improvement Scotland works with healthcare providers across Scotland to drive improvement and help them deliver high quality, evidence-based, safe, effective and person-centred care. It also inspects services to provide public assurance about the quality and safety of that care.

We can also provide this report:

- by email
- in large print
- on audio tape or CD
- in Braille (English only)
- in languages spoken by minority ethnic groups.

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1. About this inspection

Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to report on the effectiveness of strategic planning by integration authorities. This includes how integration authorities plan, commission and deliver high-quality services in a co-ordinated and sustainable way.

In this inspection the focus was on how well the partnership has:

- improved performance in both health and social care
- developed and implemented operational and strategic planning arrangements and commissioning arrangements,
- established a vision, values and aims across the partnership and the leadership of strategy and direction.

To do this we assessed the vision, values and culture across the partnership, including leadership of strategy and direction. We evaluated the operational and strategic planning arrangements (including progress towards effective joint commissioning) and we assessed the improvements the partnership has made in health and social care services that are provided for all adults.

Integration brings changes in service delivery but we recognise that it takes time for this to work through into better outcomes. Indeed, at this early stage of integration, we would expect to see data showing some room for improvement in the outcomes for people using health and care services, even where leadership is effective and planning robust. In these inspections of strategic planning we do not set out to evaluate people's experience of services in their area. Our aim is to assess the extent to which the Health and Social Care Partnership (HSCP) is making progress in its journey towards efficient, effective and integrated services that are likely to lead to better experiences and improved outcomes over time.

Both the Care Inspectorate and Healthcare Improvement Scotland undertake a variety of other scrutiny and improvement activities, in collaboration with other scrutiny bodies, which provides assurance about the quality of services and the difference those services are making to people in communities across Scotland.

North Ayrshire Partnership is a joint venture between North Ayrshire Council and NHS Ayrshire & Arran and is referred to as the partnership throughout this report. This inspection took place between August and December 2018. The conclusions within this report reflect our findings during the period of inspection. There is a summary of the methodology in Appendix 2. In order that our joint inspections remain relevant and add value, we may refine our scrutiny methods and tools as we learn from each inspection.

2. The North Ayrshire context

[Context provided by North Ayrshire Partnership within Position Statement received 19 September 2018.]

Geographical
North Ayrshire is located in the west of Scotland covering 885 kilometres square, and borders the areas of Inverclyde to the north, Renfrewshire to the northeast and East Ayrshire and South Ayrshire to the east and south respectively.

Demographic
In 2016 the National Register for Scotland captured that the total population of North Ayrshire was 135,890. The working age population (16-64 years) was 60.5% of the population (85,535). A total of 39.5% of the population were out with working age with 17.2% being children and young people (0 – 15 years) and 22.3% older people (65+).

Demographic projections
North Ayrshire's population is expected to both decrease and shift in composition over the coming years. North Ayrshire's total population is expected to drop by 3%, from 135,950 in 2017 to 132,092 in 2027. A decrease is predicted in the 0–15 years age group (from 17.2% of the population in 2017, to 16.8% in 2027) and the working age group (from 60.5% in 2017 to 55.8% in 2027). Over the same period, an increase of over 5% in the over 65s population is predicted (increasing from 22.3% of the population in 2017 to 27.5% in 2027).

Service demand impacts
The growing proportion of older people is likely to result in greater demands on adult health and social care services, alongside a reduced working age population and shift in composition over the coming years. New models of care are needed that focus on preventing ill health and where possible reducing the need for hospital based care. According to information provided by the Scottish Public Health Observatory, between 2015 and 2017, 6,277 (per 100,000 population) people in North Ayrshire aged 65 or over experience two or more emergency hospital admissions. This is above the Scotland average of 5,422.

In addition, demand for mental health treatment continues to increase, with over a fifth (20.6%) of the North Ayrshire population being prescribed drugs for anxiety, depression or psychosis. This compares with the national percentage of 18.5%. In 2016/17 North Ayrshire also had a higher rate of Alcohol and Drug related hospital stays than the Scotland average. There were 898.6 (per 100,000) alcohol related stays, significantly above the Scotland average of 690.8, with 342.3 (per 100,000) drug related stays, significantly higher than the Scotland figure of 146.9. In 2016, there were 35 drug related deaths in North Ayrshire, representing a significant increase on the year before and highlighting an area of concern for the partnership. In 2015, North Ayrshire had over 14,000 unpaid carers (roughly 10% of the

population), who delivered care, estimated to be worth approximately £321m. The support provided by local carers is invaluable and without available support provided by health and social care services, the demands placed on unpaid carers will increase. The partnership will continue to nurture carers in their supporting roles.

Political
North Ayrshire Council area contains 10 electoral wards and has 33 local councillors. Since 4 May 2017, North Ayrshire Council has been governed by a minority Labour Party administration. There are 11 Labour councillors, 11 SNP councillors, 7 Conservative councillors and 4 Independent councillors.

At the Scottish Parliament, North Ayrshire is represented by two Constituency seats, Cunninghame North and Cunninghame South, both represented by the SNP. At the UK Parliament level, North Ayrshire rests within two constituency areas, Central Ayrshire and North Ayrshire and Arran, again both are represented by the SNP.

Economic
North Ayrshire's current employment rate is 8% higher than its recessionary low point, and is 2% below its all-time (15-year) high. At 68%, North Ayrshire's employment rate is below that of Scotland (74%).

Inequalities
North Ayrshire is a place of sharp inequalities. Some residents experience high levels of deprivation and poor health. According to the Scottish Index of Multiple Deprivation (SIMD) 2016, 39% of the area's population live in areas identified as among the most deprived in Scotland. This equates to almost 53,000 people. These inequalities between communities are in part responsible for the significant health inequalities that exist locally.

In terms of overall life expectancy, men in North Ayrshire can expect to live to 76 years, this is around six months less than the Scotland average. The life expectancy for women in North Ayrshire is similar to that of the national average. However, within North Ayrshire, there are great variations in life expectancy for both men and women across localities.

Individuals living in an area of high deprivation are more likely to experience poor health over the long term compared to individuals in a less deprived area. In North Ayrshire there is a gap in male life expectancy of 18 years between deprived and more affluent areas. In North Ayrshire, levels of multiple -morbidity are higher in deprived areas. Levels of multiple-morbidity in localities with the highest level of deprivation are three times higher than in the most affluent localities.

Governance
The Integration Joint Board (IJB) is formed by four North Ayrshire Council Elected members and four NHSAA Non-Executive members. The IJB has a legal responsibility for the planning and resourcing of a range of delegated services as

detailed in the Integration Scheme. North Ayrshire HSCP has the lead partnership role for Mental Health inpatient services.

Financial position

The partnership is not alone in facing significant financial challenges. Services are delivered from a budget of £230m. Financial pressures in relation to health and social care services due to demographic growth and sustainability issues of traditional models of service delivery continue. In a number of areas demand is outstripping available resources, requiring a significant change agenda to be delivered by the integration of services, to meet demand, alongside constraints on financial resources. The change programme in 2018-19 alone required to deliver £6.6million of savings. These financial pressures are expected to continue in future years and are anticipated to direct the pace at which service change requires to be implemented.

It was against this backdrop, that North Ayrshire became the first formalised HSCP in Scotland on 2 April 2015.

3. Performance

North Ayrshire Partnership had made some progress in developing a performance reporting framework, informed by national and local indicators and aligned to the partnership's five strategic priorities. Performance information, including finance, were regularly reported to the partnership's senior management teams and the IJB. Operational performance was not presented in as much detail as financial performance and the reports received by the IJB did not include data on aggregated individual outcomes. A sub-group of the IJB was responsible for monitoring performance and highlighting areas where there was improvement or action required.

While it was evident that the partnership had made progress in developing its performance reporting structures, the system of reporting was not consistently found to support the use of some performance data to enable this to be integral to drive improvement. This was evidenced through managers and staff reporting that there was generally a lack of impact measurements to evidence positive personal outcomes for people receiving health and social care services in North Ayrshire.

The partnership was part of a National Health and Wellbeing Indicators 'family group'. The partnership had identified an improvement in its ranking from 2013/14 in seven of the nine measures and against all authorities in six out of the nine measures. However during our inspection, the partnership's performance within the family group was found to be relatively poor on more than half the comparative indicators. There was also no clear indication as to how the partnership was using this benchmarking to enhance performance. A well-established system of identifying baseline measurements and setting targets could improve performance tracking against the partnership's strategic intent and allow North Ayrshire to better identify areas where action should be focused.

The need for improvement in the use of data had been identified by the partnership and was being addressed through the Transformational Change Programme. The partnership had enlisted support from Information Services Division (ISD) and the Local Intelligence Support Team (LIST) in developing baseline measurements. These are aimed at improving how they could better understand and translate the national outcome measures into delivering improved outcomes for individuals. This was a positive development to support the use of performance data across the partnership.

There was duplication in performance monitoring and governance arrangements because of different reporting systems between health and social care services. To improve the effective sharing of information and to reduce risk from this, the partnership had developed the All Service Performance Information Review and Evaluation (ASPIRE) process. However, ASPIRE did not include performance data from the third and independent sectors, which was monitored through a separate

contract management process. The lack of this information was recognised and ASPIRE was reported to us as being a 'work in progress'. There was evidence of ASPIRE being used to provide a comprehensive performance monitoring process in the North Ayrshire Drug and Alcohol Recovery Service (NADARS). Performance data for all NADARS services or projects across all sectors were supplied to one central group. Outcomes were agreed and linked into the strategic plan. The central group screened performance data and provided feedback. This was a helpful structure which has the potential to provide a more comprehensive systematic approach to inform monitoring of performance of other services.

In conjunction with the National Health and Wellbeing Outcomes[1], the Scottish Government published a core suite of integration indicators[2] in 2017. These indicators were determined by asking for feedback from people who use services and also by looking at performance indicators. An example is the rate of delayed discharge. Against these criteria, the partnership had a number of performance measures indicating a very mixed performance compared to Scotland as a whole and measures where performance was either in line with or poorer than the Scotland average.

Emergency admission rates for adults aged 20-64 years was increasing; the rate of bed days used for admissions in this age group was worse than the Scotland average. There had been a less significant increase in emergency admissions for people aged over 65.

Bed days lost to delayed discharge in the 12 months to August 2018 increased for all adults to the highest level since 2012. The primary reasons for delay were the partnership being unable to meet the health and social care needs (over 75s) and being unable to make the necessary care arrangements and delays in securing funding (18-74 age group).

Delays due to adults awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, known as Code 9 delays, had also increased and remained higher among the 18–74 age group. Improving this was a priority within the plan for intermediate care which is covered in more depth later in this report.

A significant challenge was the prevention of unscheduled admissions to hospital and in achieving timely discharge from hospital once a patient was declared medically fit. The partnership had identified the provision of care at home as a major factor required to support an improvement in performance in both prevention of admission and reduction in delays in discharge. It was addressing this through a number of measures. For example, in an effort to reduce delays caused by waiting for care at home provision, daily monitoring of people in hospital awaiting this service

[1] https://www2.gov.scot/Resource/0047/00473516.pdf
[2] https://www2.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes

had been introduced to improve communication between hospital and community services. A further effort to improve performance was the introduction of hospital discharge meetings. Managers and staff reflected that the implementation of these measures as well as collaborative working had resulted in improvements in the management of admission and discharge. Staff can now plan for discharge as part of the admission. Staff told us these initiatives have had a positive impact on reducing the number of patients waiting for care at home.

The rate of care at home provided by the partnership was good for the 18–64 age group where the rate of the population receiving care at home and intensive homecare were both higher than the Scotland average. Care at home and intensive homecare varied for the over 65 age group. The population of the over 65 age group receiving homecare was higher than the Scotland average and those (over 65) receiving intensive homecare was lower than the Scotland average.

There was evidence of investment by the partnership to support people to stay at home which included the use of tele-care[3]. The partnership provided better levels of community alarms and technology-assisted healthcare to older people than the Scotland average. To promote the independence of people with learning disabilities, there had been a successful pilot in the use of technology to inform the redesign of the overnight support service. There had also been an expansion of community link workers in GP practices to enable people to access a wider range of support options. Community hubs had also been developed in two sheltered housing schemes.

It was evident that the use of performance data within the partnership to drive improvement had progressed. However, we identified weaknesses in the funding approval process. For example the system to gain approval for funding was subject to delays both for discharge from hospital and to provide care at the right time. Staff told us that when funding was delayed this resulted in individuals deteriorating from the point of assessment with the consequence of requiring a higher level of service provision.

Planning and development of new ways of working was taking place across the partnership to improve performance in the delivery of national outcomes and indicators. There was evidence of progress and development in the reporting and use of data both at a service level and to measure effectiveness of strategic plans. The impact of these plans had not fully translated into improved performance at this stage.

[3] Tele-care is a system used to support independence at home. https://www.gov.scot/publications/supporting-empowering-scotlands-citizens-national-action-plan-technology-enabled-care/

4. Policy development and planning

Strategic planning

North Ayrshire IJB has the lead role for mental health and learning disability services across Ayrshire. It also holds responsibility for health and community care, primary care, children, families and criminal justice services in North Ayrshire. The partnership acknowledged that going forward, delivering services in the same way will not be financially or operationally sustainable. We found that the most developed areas in terms of strategy and operational shift were in mental health, learning disability and addictions. These developments had included consultation with stakeholders. The strategic intent for services, for which the lead role had been delegated to other IJBs in Ayrshire, was not as well developed. For example, we were less confident about the approach being taken on the development of services for older adults. There was evidence of progress within individual work streams but, overall, the strategic shift for services for older adults was not as well developed as those where services were led by the partnership.

The partnership has a shared vision that: “All people who live in North Ayrshire are able to live a safe, healthy and active life.” This vision was informed by an overarching strategic commissioning plan which sets out the partnership’s five strategic priorities. The strategic commissioning plan outlines the actions and developments the partnership has agreed to implement during 2018–2021 to achieve each strategic priority[4]. These commissioning intentions were also grouped according to the broad service areas that the partnership is responsible for delivering. This structure provided a framework that had supported the development of clear, wide-ranging and diverse commissioning intentions against the wider vision and the partnership’s strategic priorities across the health and social care system in North Ayrshire. These included primary prevention and promoting self-management to improving primary care and social care, development of multidisciplinary teams, self-directed support (SDS) and specialist services.

The partnership took proactive steps to make sure that the strategic commissioning plan was co-produced. It was developed by a sub-group of the Strategic Planning Group (SPG) which included representation from a broad range of stakeholders. It had also been informed by a public engagement exercise. This engagement and consultation had supported the decision to carry forward the same strategic commissioning priorities from the 2015–2018 plan to the 2018-2021 plan.

The housing contribution statement demonstrated that there was an understanding of the importance of housing in achieving the partnership’s strategic priorities. The HSCP’s Director participated in the Homelessness Task Force which demonstrated the level of commitment to this work. During our inspection, it was highlighted that there was a gap in how housing was represented on the SPG. The local authority

[4] https://www.north-ayrshire.gov.uk/Documents/CorporateServices/ChiefExecutive/PolicyandPerformance/directorate-plan/2018/Strategic-Plan.pdf

housing service was represented on the SPG but the Registered Social Landlords (RSLs) had not been invited to join the SPG. At the time of our inspection, we were advised that an RSL representative had been sought to join the SPG by senior managers in the partnership. There was evidence of difficulty in establishing a constructive dialogue between the partnership and the RSLs with a commitment to improve this expressed by both sides.

We could see the strategic plan had evolved over time. The plan was updated in 2016 and this had informed the development of the current plan. The partnership's performance and audit sub-committee monitors and evaluates implementation of the strategic commissioning plan. The absence of SMART[5] objectives meant there was difficulty in determining if actions were delivered within intended timescales, were achievable, led to measurable improvements and were realistic.

Strategic needs assessment

The partnership's strategic needs assessment consisted of several discrete needs assessments. These had the advantage of ensuring that detailed and focused assessments informed particular developments such as rehabilitation and intermediate care. There was sufficient high-level population-based needs assessment to support the overall strategic priorities. The partnership had improved the strategic needs assessment which informed the strategic commissioning plan for 2018–2021. The updated version included greater analysis of service performance, demand and resources.

The partnership had not produced and published a single strategic needs assessment that pulled together all of the data used to inform the strategic commissioning plan. This increased the risk that the discrete strategic needs assessments would not be systematically updated within consistent time periods or in response to specific changes in demographic, demand or performance trends. It also limited the potential for this information to be used by partners, including the third and independent sectors, to inform the development of their services.

Strategic commissioning priorities in the strategic commissioning plan reflect key themes within the partnership's strategic needs assessment. The use of key themes within the strategic commissioning plan and improvement in the detail within the strategic needs assessment were good. This could be further strengthened through a single strategic needs assessment supported by a system to provide regular updates. The key themes included the area's relatively high levels of deprivation, increasing numbers of older people with complex needs and reductions in workforce and funding. These priorities were reflected in key high-level strategies such as 'bringing services together' and 'early intervention and prevention'. These are essential for health and social care integration to support improved outcomes, changes in workforce profile and available resources.

[5] Smart, Measurable, Achievable, Realistic and Time-bound.

Locality planning

The partnership had progressed locality planning by establishing six localities in 2016. Locality Planning Forums (LPFs) existed in each of these and included members of the IJB who were also part of the SPG. This had the benefit of ensuring that localities could directly feed into the partnership's strategic commissioning processes. Each LPF had identified priorities for their locality and these were included in the partnership's strategic commissioning plan.

Locality priorities had been informed by high-level analysis of the health and wellbeing of each locality's population. This process had been successful in demonstrating important and significant differences in the characteristics of each locality and the need to develop local planning processes to respond to these. The partnership recognised locality planning would be better informed through the provision of information on service activity, performance and resources at locality level. This process was under development at the time of our inspection.

There was commitment to widening participation within the localities. There had been positive progress with a pilot of the new roles of Locality Engagement Champions and Locality Communication Champions. Public engagement pilots for locality forums over the period from November 2018 to April 2020 were planned.

The Community Planning Partnership (CPP) was well established prior to the formation of the partnership and its localities. There was some duplication across these forums which were under review. There was a clear recognition that each LPF had a distinct role to identify health and social care priorities within both the partnership and CPP. The third and independent sectors were represented on the CPP, but there were a range of views on the effectiveness of locality planning at the current stage of development. For example, we heard from some service users and carers that where there had been pan Ayrshire condition specific groups, these were perceived as having a stronger voice. At the current stage of development, the engagement with different care groups has not established confidence in representing all relevant interests at this time.

The partnership showed a commitment to supporting the role of LPFs and an increase of awareness through a planned process of engagement and provision of information. This was a positive approach and recognised the variations across Localities.

Priorities

The priorities of the partnership were clear at all levels and aligned with local authority and NHS board priorities. An example of this was the alignment of the partnership's strategic planning priorities with the CPP's Local Outcomes Improvement Plan. However, the commissioning intentions were not sufficiently aligned with the financial plans. Closer alignment would inform decisions relating to investment and disinvestment as they implement their plans.

Commissioning intentions

Strategic planning and commissioning processes for mental health services were well developed. The partnership has lead responsibility for mental health services across Ayrshire. This had supported successful developments such as the Woodland View mental health inpatient facility and the integrated NADARS. The partnership was working with the other Ayrshire HSCPs to develop and implement a pan Ayrshire mental health strategy to deliver the Scottish Mental Health Strategy 2017-2027.

The strategy for services for people with learning disabilities was also well developed. This included the challenges of increasing demand, limited resources and the importance of redesign and development of traditional services to support sustainable outcomes. One example of this was the successful pilot of the use of technology to support the independence of people with learning disabilities to redesign support during the night.

Good practice example – service redesign

Trindlemoss was a good example of shared investment to redesign services, as the capital funding required was agreed jointly between NHS Ayrshire & Arran and North Ayrshire Council. In addition, it was evident that there had been a proactive approach to involving people using services in the development of the project. This reinforced our analysis that the partnership has a strong commitment to engagement and consultation with stakeholders and feedback is being used to inform strategic planning and decision making.

Both the mental health and learning disability strategies were supported through the partnership's Commissioning Strategy Community Support 2018-2021 for people with learning disabilities, physical disabilities and mental health needs. This included a comprehensive and well-developed approach to evolving more personalised services. Overall, these detailed plans demonstrate a positive and coherent whole system strategy to provide more personalised services. The plan lacked detailed financial planning and did not identify areas of investment and disinvestment.

The strongest examples of effective strategic planning and commissioning of services for older people had been taken forward on a pan Ayrshire basis. These plans had been developed by a change team based in North Ayrshire Partnership and demonstrated that the partnership has developed capacity to deliver effective strategic planning and commissioning. The combination of a focus on a programme of discrete pan Ayrshire plans and an under-developed whole system perspective to support pan Ayrshire planning for older adults increased some challenges and risks in the partnership's ability to integrate processes with services and activities that operate at a partnership level. Examples included care at home and reablement services, equipment and adaptations, and third sector and community resources.

Care at home is covered in greater depth later in this report. Falls prevention is also relevant and is delivered on a pan Ayrshire basis and was described in the partnership's strategic commissioning plan as requiring further development. The partnership had challenges in maximising the potential benefits of providing equipment and adaptations. The plans in relation to the examples stated, were not developed to demonstrate clarity in terms of the assessment of need, demand, capacity and option appraisal, including modelling of different cost scenarios, expected outcomes and timescales for implementation. As a result of a lack of a whole system approach to older adult services there was no comprehensive or coherent strategy evident for older adult services.

The partnership had some commissioning intentions that were not clearly set out in the strategic commissioning plan or other detailed plans. The decision to maintain the majority of care at home provision in-house was an example of a decision that was prompted by five external providers exiting the North Ayrshire market. However, there was no evidence that this decision was supported by detailed financial planning, option appraisal (including adequate comparison with the costs of external provision) and risk assessment. Its absence from the strategic commissioning plan meant that there was no explanation as to how it would contribute to the partnership's overall strategy for older people.

An example of this was the waiting list for care home placements. One of the biggest areas of overspend incurred by the IJB was care home placements. Waiting lists were being used as a means of reducing this overspend. The impact of this was not fully risk assessed or evaluated to include impact on outcomes for individuals and the whole system. This demonstrated a lack of budget management strategies linked to strategic planning and commissioning processes which had led to the impacts of these budget strategies not being utilised to inform and refine future strategy. There was evidence that the financial implications of commissioning approaches and strategies had been factored into the medium-term financial plan.

Plans for care at home and care homes were not developed sufficiently to provide clarity in terms of the assessment of need, demand, and capacity and option appraisal, including modelling of different cost scenarios, expected outcomes and timescales for implementation. This approach had missed an opportunity to identify where individuals could have potentially been supported by alternative services and responses such as reablement, technology or intensive care at home or extra care housing. There were positive steps evident to develop a commissioning strategy for care homes with providers involved in this process. This work was at an early stage.

Early intervention and prevention

There was acknowledgement from senior managers that progress in the area of prevention had been limited. Although this was recognised as a strategic priority, it was difficult to focus on and we heard from senior staff that this was due to financial limitations. One example where further development was acknowledged as required

in the partnership's strategic commissioning plan was falls prevention which was delivered on a pan Ayrshire basis.

There was evidence of a positive development where a procurement and commissioning exercise was being undertaken for addictions services to work with the third sector to deliver early intervention and prevention. Third sector provision of early intervention had reduced due to a withdrawal of support of the Integrated Care Fund (ICF). Some services had been replaced with in-house services, including 'money matters'. The availability of link workers within GP practices was described as a positive resource in identifying resources within the community at an early stage.

The challenge of continuing to meet critical needs while identifying resources to invest in early intervention and prevention, as in other partnerships across the country, was recognised during our inspection as being a significant one which requires time to demonstrate. This applied to the rehabilitation and intermediate care development detailed below.

Rehabilitation and intermediate care

An area where there was evidence of good integrated planning and commissioning was the pan Ayrshire development of rehabilitation and intermediate care. Additional investment from the NHS board of £2.5m had been provided to enable a shift in the balance of care from hospital by investing in a new model for community services to prevent avoidable admissions. This model had been developed following a review of the evidence base for reducing emergency admission rates in Ayrshire. Plans described how development of rehabilitation and intermediate care services would deliver this. These plans provided a coherent description of how investment contributes to an integrated approach to the needs of older people and people with complex needs. The levels of investment were clearly identified with projections of the net levels of avoidable costs and clear time-specific implementation plans. Development of rehabilitation and intermediate care had also been designed to interface with the pan Ayrshire Primary Care Improvement Plan. This was a strength in terms of ensuring a consistent approach across primary care and rehabilitation and intermediate care.

Rehabilitation and intermediate care fit within a clearly defined vision for a comprehensive tiered model of support in the community.

Starting with the provision of community resources, other aspects of the model included:

- leisure activities
- technology enabled care
- exercise to support self-management
- anticipatory care.

At the next level were:

- multidisciplinary teams (organised around GP practices and clusters)
- community rehabilitation
- equipment adaptations
- intensive homecare
- enhanced intermediate care teams
- community hospitals
- step up/step down provision.

The final tier progression was to acute hospital care. This was a well-developed plan at the time of our inspection where the development of rehabilitation and intermediate care was focused on the reduction of emergency admissions and delays in discharge by investing in community services. There was a lack of detail and analysis evident on the effect of this plan on the delivery of long term care service delivery across the partnership. These services included care at home and care home provision. For both of these services there was insufficient detail evident to inform development. A specific example was the potential impacts of transition of an individual to receiving a long-term care at service. This was applicable where there was a need identified for a move to long-term care for an individual at the completion of a period of rehabilitation, having achieved their optimal level of independence. There was also an absence of clear identification of the potential risks to resources, skills and expertise within intermediate care and rehabilitation being used inefficiently, if they are required to continue to support people while waiting for long term support to be organised.

Pan Ayrshire plans for rehabilitation, intermediate, palliative and end of life care contained strategic commitments to develop joint plans in the future for community hospitals, frail older people and long term care in care homes. An example of a comprehensive approach was the palliative and end of life care plan which is under development and requires agreement by the three Ayrshire Integration Authorities. These were clear examples of commissioning intentions being underpinned by detailed plans and informed by a whole system approach. This programme approach was deliberate to mitigate the risk of progress being lost because plans were too complex.

Engagement and involvement

A focus on engagement and communication was evident and the strategy built on an earlier review of learning disability services and appreciative enquiry processes with staff. The partnership had agreed plans for the redevelopment of a significant proportion of its day services for people with learning disabilities, together with supported accommodation on a single site in Irvine called Trindlemoss, which we identified as an example of good practice during this inspection. Capital investment from both North Ayrshire Council and NHS Ayrshire & Arran had been aligned and

this reflected a collaborative approach that was evident in many areas of development.

Engagement with care home providers that continue to offer services in the partnership has followed a period of sudden change in this market and was viewed by some providers as reactive due to imminent reductions in capacity. The timing of this illustrated a lack of a whole system perspective which resulted in a loss of opportunity to identify the fundamental strategic risk to care home sustainability at an earlier point in time. For example we heard there had not been engagement to identify potential impacts and risks from the perspective of providers when the partnership took the decision to manage demand for places through waiting lists. At the time of the inspection, the partnership had made a positive commitment to begin to work with care home providers to address this.

Housing

There were well-developed commitments in the Strategic Housing Investment Plan (SHIP). These were developed and aligned with the partnership's strategic commissioning plan for supported housing for adults. Commitments in relation to adults included the promotion of independence, assisting in preventing demand for care and support services and realising financial savings for the partnership. The development of community hubs in existing sheltered schemes had progressed and presented a good opportunity to enhance prevention and early intervention. This was viewed as a positive development by staff. Senior managers indicated that the redevelopment of sheltered schemes and the development of supported housing for adults, with adjacent staff bases, had resulted in the potential for extra care housing for older people to be considered. This would exceed the current housing commitments in relation to older people and were focused on the redevelopment of sheltered housing. The contribution of housing was reflected in general terms within the strategic plan. More detail on the recognition of the need to support the partnership's vision and outcomes was evident within the Housing Contribution Statement and SHIP. This includes the role of housing in planning through representation at the SPG as discussed earlier in this report.

Asset based approach

Senior managers identified that moving to an asset based approach[6] was essential to make sure that outcomes were maintained as demand increased faster than the available resources.

The asset based approach was consistent with partnership strategic plans relating to adults with learning disability, physical disabilities and mental health needs. It was less clear as to how it would fit into the range of strategies and initiatives that the partnership was developing in relation to older people. Staff told us about an example of where community assets had been identified to support people who were

[6] "An asset based approach is strength based practice. It is practice based on a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets." https://www.scie.org.uk/strengths-based-approaches/guidance

waiting for a care at home service. However, while these were valued, there was no formal evaluation, assessment or monitoring of risk applied to community-based services. There was a lack of evidence of a link between the pan Ayrshire intermediate care strategy with partnership planning for community support.

There was no evidence of a systematic approach to mapping community assets in order to make sure that there would be sufficient capacity to support the development of an asset based approach. Senior managers planned to engage with the partnership's staff first to develop the asset based approach and then involve the third sector and other stakeholders. Involving the third sector and other stakeholders in this process at a later stage than staff potentially risks a lack of expertise and ownership from the third sector organisations in the development of the approach. Feedback from third sector organisations was mixed. They appreciated the opportunity for involvement in the SPG and IJB but they told us that there had been a reduction of services within the third sector as a result of reduced resources. Despite this there was capacity within communities that could be further utilised to support this approach.

While the commitment to an asset based approach was articulated across a range of staff groups and senior managers, the expectation and understanding was varied. There was a lack of evidence of information detailing what the approach will involve or how it will support greater sustainability. To address this, plans were being developed for an engagement programme to inform stakeholders.

There was a positive approach to delivering better personal outcomes through a move to an asset based approach. This was at an early stage within the partnership.

Developing more personalised services and maximising the flexibilities available through self-directed support was central to successfully moving from traditional service responses to an asset based approach. The partnership's strategic plan commits to; "help individuals to have better choice and personal control of their support at an early stage by reinvigorating self-directed support and the Partnership Charging Policy. "An implementation plan was agreed by the partnership's senior management team in 2017, including additional staffing for the self-directed support team. Senior managers highlighted that self-directed support has not been given significant priority up to now and opportunities to progress developments which could enable progress towards an asset based approach had been limited.

Financial position and sustainability

The IJB faced a significant funding challenge. Contributing factors included an ageing population, real term funding reductions and a history of overspending. There was a total deficit of £5.807m at the end of March 2018.

Following a financial review in August 2018, the IJB projected an overspend of £1.247m during 2018/19. In light of this projection, a financial recovery plan had been implemented with the intention of balancing funding and expenditure by the

year end. However, this depends on achieving all the savings identified in the savings plan in the year. This will require regular monitoring by the IJB. If the planned savings are not achieved there is a risk that any further actions taken to address any overspend will adversely affect service quality and performance.

The IJB had implemented a challenge fund to support service redesign. This funded a programme that created opportunities for services to make transformational changes to realise both the required North Ayrshire Council savings target and additional savings which could be re-invested in their newly designed service. The original projected level of gross savings of £6.416m by the end of March 2019 will not be achieved. The expected gross savings for phase one of the programme were £1.657m. Whilst the challenge fund did not create the level of savings originally desired, it was a positive step in creating more efficient services, financial savings and creating more sustainable service models. The fund allowed the partnership the freedom to trial new ideas and improvements with the ability to discontinue any projects that would not produce the required savings.

The partnership had made considerable improvements in ensuring that its activities would be financially viable through the development of its current Medium-Term Financial Strategy (2017/18 and 2019/20). The strategy and the five work streams that it was based on were included in the partnership's current strategic commissioning plan. The partnership recognised the need to refresh the Medium-Term Financial Plan from 2019/20 onwards and finance officers recognised the need for greater alignment with its strategic priorities and strategic commissioning intentions.

The IJB implemented a new financial framework for council budgets which provided more effective budget management. Variances in the budget were monitored monthly and areas where focus and intervention was required could be identified quickly. This was a positive step towards effective budget monitoring and financial sustainability. The framework was for application only for social care budgets in order to address concerns about the financial risk of volatile demand-driven social care services. While there are different challenges in relation to NHS budgets, further work was required to also improve the monitoring of these budgets.

It was intended that the greatest impact on the financial sustainability of the partnership would be the transformational change programme. The programme was led by the Chief Finance Officer in the role of Chief Finance and Transformation Officer. Having the Chief Financial Officer lead on transformation intended to demonstrate a commitment to the programme, together with a recognition that financial and service sustainability are inextricably linked. It was recognised that the post had been filled shortly before our inspection and the impact of this approach was not fully evident.

Over the next three years, the IJB intends to repay £1.5m to reduce the existing council deficit of £5.807m. If this plan to repay the debt is successful, along with the savings plan in place for 2018/19, then the financial position of the IJB will significantly improve. As with the 2018/19 savings plan, achieving this depends on regular monitoring and implementing contingency measures if monitoring shows the planned levels of savings are not being achieved. The plan is also dependent on the IJB having detailed financial and strategic plans in place to prevent future overspend and continue investment in service development.

Contract management, procurement and market facilitation

We learned that there were no service level agreements in place for NHS-hosted services, for example cancer care. The partnership relies on each NHS service for the provision of clinical and care governance arrangements and audit reports and there was no evidence of a system of assurance within the partnership for hosted services.

The partnership had agreed arrangements for ensuring contract management and continuous improvement of social care services procured from external providers. These functions were delivered by the procurement and contract management team, based in North Ayrshire Council. This team was valued by commissioners, managers and providers. The team assisted commissioners to develop effective service specifications. Team members had constructive working relationships with staff within the partnership who had commissioning responsibilities. The partnership's ability to support these integrated approaches was enhanced by the secondment of experienced NHS staff (with experience and responsibility for NHS third sector funding) to the North Ayrshire Council procurement and contract management team.

The contract management team had systematic monitoring arrangements in place. At the point of a contract being implemented, a contract management framework was put in place. The level of review was determined by the size of the service and the level of spend incurred. Six-monthly self-assessments were followed by annual visits by the contracts team to validate the self-assessment data. Contact with providers would be more frequent if, for example, there was a concern about the quality of the service being provided. Where concerns were identified through regulatory inspection, improvement plans were put in place and monitored by the contracts team.

An understanding of the potential issues and risks from a provider's perspective was not always translated from the contract management team to more senior managers in the partnership who attend the IJB. This increased the risk of the partnership's strategic commissioning plan and other plans not being informed by a whole system approach.

Positively, the partnership was delivering its immediate commissioning intentions effectively. The contract management team produces a market analysis to support each procurement exercise. There was a lack of evidence that the partnership had

yet undertaken market facilitation activities to develop its external markets to better meet the needs of its population in the future, either directly or through North Ayrshire Council. Further evidence of this was the absence of a market position statement to facilitate and encourage providers to develop their services on the basis of shared understanding of local markets and the needs and characteristics of the population.

The partnership had begun to identify information to develop market facilitation only with care home providers. This limited the partnership's ability to offer choice to older adults requiring care at home, the lack of a commissioning strategy for community supports also reduced choice for all adults.

Self-evaluation and quality assurance

The partnership had undertaken a range of self-evaluation activities from appreciative enquiry to specific evaluations of service developments. These activities varied considerably in terms of the scale, detail and comprehensiveness of the evaluation. There was limited evidence to demonstrate that these self-evaluation activities were consistently informing strategic plans through application of the findings and recommendations. Examples within learning disability services included evaluation of tests of change in respite provision and the care at home/tele-care pilot in learning disability services. This evaluation of tele-care demonstrated a reduction in the need for sleepovers and was reported to have been effective in empowering service users. There was ongoing evaluation being facilitated through assignment of a project manager.

It was positive that outcomes for addiction services linked back into the strategic plan and that the performance data was supplied to a central group which screened the data and provided feedback on the quality. We noted some concern from third sector representatives about the allocation of monies from the Integrated Care Fund and, in particular, the rationale behind the decision to cease projects and move services in-house. There had been representation in this process and representatives of the third sector service providers from the third sector interface (TACT) were positive about being involved.

There was evidence of a lack of comprehensive self-evaluation of services for older people. The information provided on the evaluation of step up/step down provision in a care home had a limited scope and lacked content. There was no information on the costs of running the service and minimal qualitative data on outcomes. While the evaluation indicated that the views of some staff were that the project had been successful in providing temporary residential accommodation for people who would benefit from reablement, the majority of people using the service were admitted to the care home on a permanent basis. As the partnership intends to use this evaluation to inform discussions that have just begun with care home providers to develop new models of provision, there needs to be greater clarity about the key

success measures of such projects as well as the costs and expected efficiency savings.

There were a number of feedback and consultation mechanisms being used by the partnership. This included information from complaints, the Care Opinion website, adverse events monitoring and contract monitoring.

Governance arrangements for managing performance and risk

The IJB performance and audit sub-committee was chaired by an elected member who also sits on the IJB. The partnership was subject to audits by the council, the NHS board and external audit. An annual audit programme had been identified with the internal auditor for North Ayrshire Council and the IJB. The Head of Finance and Transformation was involved in this process. Performance of commissioned services provided by the third and independent sectors was being reported to the governance committee. While this is positive, as noted above, different performance management arrangements for in-house and external provision limited the extent that performance and risk are managed from a whole system perspective for some functions that rely on a mix of in-house and external provision, for example care at home.

There were some examples of the partnership successfully developing processes to manage risk. These included the strategic risk register (SRR) which is a comprehensive document linked to the delivery of the strategic plan. Reports are provided to the IJB on a six-monthly basis and monitored on a more frequent basis by the senior management team. The financial position of the partnership is entered as a risk on the SSR, signalling its priority. The partnership acknowledged that an integrated approach to risk management was still being developed.

The IJB was receiving budget monitoring reports on a monthly basis together with a RAG[7] status and active discussion was taking place on areas of concern.

The IJB received reports on operational performance but these did not drill down to provide information on personal outcomes. The partnership was beginning to work towards processes to achieve this with assistance from ISD analysts.

Financial governance was being supported by the implementation of a budget holder's charter. The partnership had carried out a budget holder's audit and held development sessions with teams in support of their responsibilities for managing the budget.

The effectiveness of the partnership's risk management was limited in some areas. Improvements were needed to make sure that the strategic commissioning plan was informed by a whole system approach that describes all of the commissioning intentions the partnership is delivering. It should also be aligned with the

[7] The **RAG** system is a popular project management method of rating for issues or status reports, based on Red, Amber (yellow) and Green colours used in a traffic light rating system.

partnership's financial planning as this limits the effectiveness of risk management in some areas. For example, performance information from contract monitoring of external providers was not reported to the IJB and information on external services and internal provision was not combined or compared to give an effective overview of service areas such as care at home. Failure to include strategies such as the operation of waiting lists to manage budgets and aligning strategic commissioning intentions with financial plans means that any risks to individual or whole system outcomes arising from these actions had not been identified, monitored and actions taken to mitigate them.

Performance information provided to the IJB was not detailed enough to show why there were delays for people who had been assessed as having "critical and substantial" levels of need but who had not received a service in response to this assessment because they were on a waiting list for a care home. The partnership's risk register presented to the IJB in May 2018 described this risk in terms of lack of funding leading to service users' assessed needs being not met and classified it as high risk. However, the mitigation and control measures it described relied on professional judgement.

Mitigation and control measures had not included processes to collect data systematically on outcomes from which the overall risk management strategy can be evaluated. As part of this inspection we requested data on waiting lists. The information provided by the partnership gave no detail on outcomes for those waiting. Instead, it provided quantitative data only which showed that at the end of August 2018, 78 people were waiting for a care home placement, 36 of whom were waiting in hospital. There was no information provided on the length of wait, or the circumstances of those people waiting for care. In the same month, 20 people were waiting on a package of care in the community. Consideration of strategic risks to the sustainability of provision and whole system impacts such as increased levels of delayed discharge were not identified.

Senior staff acknowledged that, overall, a more integrated approach to performance monitoring needed to be developed. It was positive that discussions had started with the aim of supporting the SPG to monitor the performance of the strategic plan.

Involvement of stakeholders

The partnership was committed to stakeholder involvement and had made significant efforts to make sure that it engaged with a range of stakeholders and used their views to influence and inform its strategic commissioning activities. It continued to seek opportunities to develop and improve how it engaged with service users, carers and the wider public. "Doing what matters together" is the partnership's participation and engagement strategy for 2018-2021. Whilst the partnership acknowledged that they still had work to do to fully implement this strategy and maximise the contribution of LPFs, it was commendable that they had set up the Engagement and

Development Group in 2017 to support the review of the processes and structures for participation and engagement with a view to improving their approach.

We noted that there was an ongoing investment in improving approaches to engagement. The partnership had learned from previous engagement events and acknowledged that there was a need to provide engagement that is best suited to the needs of different audiences. There was a genuine commitment to listening to communities, but at the same time an acknowledgement by the partnership that it was developing its approaches going forward. An example of an approach where the views of stakeholders had influenced strategic commissioning was in the redesign of NADARS. This resulted in an agreement to make sure that the employment of people with a lived experience would be part of the specification for services that will be commissioned for people with an addiction.

The partnership had a range of systems and processes for quality assurance, self-evaluation and improvement. One of these "You said, we did and we didn't", was a record of suggestions and comments received from the consultation process undertaken on the new strategic plan (2018–2021). The consultation phase took place during January and February 2018. It was positive that the partnership was making the investment to provide feedback from a consultation exercise in this way. Carer representatives indicated that the partnership had historically consulted carers about issues of service improvement and this positive relationship was continuing to develop.

Overall, the evidence gathered during our inspection about the relationship between the partnership and service providers was mixed. The third sector interface told us that planning forums exist at an operational level, with the sector conveying a sense of positive relationships up to senior management level. The third and independent sectors had a well-established seat on the IJB and SPG and there was evidence of a good level of challenge from and debate with representatives from the sectors. The independent sector indicated that they had been involved at the highest level within the partnership prior to the IJB being formed.

The provider forum was a robust, self-managed group which provided opportunities for joint working across sectors. Third sector representatives reported that quality and procurement issues as well as the strategic plan were discussed at the provider's forum. However, some providers were less positive about the frequency and value of these forums. Some indicated that they had lost trust in the partnership over recent years and did not feel valued or fully and meaningfully engaged. Not all third sector providers were invited to provider forums, with some expressing criticism of the level of communication afforded to them by the partnership and how this was impacting on their working relationship and their engagement in discussions about service planning. Some independent sector providers shared a similar view and voiced concern that the challenging financial position for the partnership had impacted on their working relationship with the partnership.

We learned from some independent sector representatives that the care home providers forum was rarely held, with attendance at this having decreased. Similarly, the care at home providers forum had been suspended whilst tendering was undertaken and meetings had not been reinstated.

The partnership had begun dialogue with independent sector care home providers about the re-modelling of care home provision. However, there was no evidence provided by the partnership of a strategy or financial plan having been developed to inform or support these discussions. Neither was there a proposal in place, as we were advised by senior staff that a process of data collection was under way to inform the longer term strategy, and that a report is planned to be submitted to the IJB early in 2019.

We noted from our staff survey, which was issued to staff across the partnership, that not all staff felt engaged in strategic planning. Responses showed that 48% of staff disagreed or strongly disagreed that their views are fully taken into account when services are being planned at a strategic level. The partnership had already developed its second strategic plan and had made a firm commitment to engagement and consultation in this plan.

It was positive to hear from those who represented the voice of mental health service users that there had been meaningful engagement with them by the partnership, including discussion about the development of the strategic plan and service changes. Feedback had been used to inform change, which was a positive reflection of engagement. Communication from the partnership to the community about the changes to mental health services was not perceived as successful by some stakeholders.

Integrated team working was most evident in addiction services. The intermediate care team was a further example of integrated working, having been developed to support avoidance of unnecessary hospital admissions. The partnership was also taking action to enable the mental health team to be co-located, with the aim of having a central point of contact for people who may need to access support. Plans for the co-location of some learning disability services had also lost momentum and the co-location of justice services had not been as positive as originally anticipated. These plans to integrate and co-locate teams were reflected as positive by staff, however there were concerns expressed that progress was slower than anticipated.

‘Public Health’ is part of the partnership’s senior management team and a member of the team attends regular meetings to provide input to the health and care governance group. They also contribute to emergency planning and resilience, including winter planning. Their membership of the SPG was positive and enabled ongoing communication and information sharing, although there was little detailed evidence on how Public Health had informed the development of the strategic plan, beyond the production of elements of the strategic needs assessment.

We have indicated in this report that where North Ayrshire has lead responsibility across the whole of Ayrshire for a specific care group, we have seen evidence of an approach to strategic planning and service delivery which has a clear focus on improving personal outcomes. We considered that the development at Trindlemoss in Irvine was a good example of a planned and collaborative approach to service change.

Trindlemoss was designed to support adults with complex mental health issues and learning disabilities and was being developed from a site vacated in 2015 by a third sector provider. The model includes supported accommodation, day support, rehabilitation and long stay care. The ethos is to promote community inclusion and independent living, in part by ensuring that individuals will be able to be supported as close as possible to their home area and out with a hospital environment.

5. Leadership and direction

Vision and values

The partnership's vision, "All people who live in North Ayrshire are able to have a safe, healthy and active life", was outlined within the strategic plan 2016–2018. It was evident that the aims of the partnership were consistent, shared and well understood. We surveyed the staff in the partnership and 86% of those responding were aware of the partnership's vision. During the inspection, we found that tackling inequalities and improving mental health and wellbeing were the elements most evident and consistently described. Positively there was evidence of collaboration on developments which reinforced the vision. The SPG reflected that there was "a continuing journey with a shared vision and passion, trying to reduce inequalities."

The collaborative leadership of the partnership demonstrated a clear vision and intent for delivery of services in North Ayrshire which was evident and understood across a range of stakeholders.

Culture and standards

There was a culture of collaboration and continued strengthening of integrated working to improve standards evident across the partnership. This culture was well supported by managers, professional leads, elected and Board members. The positive support for integration within the partnership was reflected by the results in our staff survey and during our inspection from a range of staff groups.

The partnership's iMatter survey in 2017 and 2018 reported that some staff did not know who senior managers were. In our survey of staff, 47% disagreed/strongly disagreed that senior managers communicate well with frontline staff and 45% disagreed/strongly disagreed that 'Leaders are visible'. Efforts to improve communication were evident. Senior managers and elected members told us of an ongoing commitment to connect with staff. This was done through walk rounds, team events, site visits, service visits and iMatter events. The weekly email update sent by the HSCP Director was popular across a range of staff. It was evident that the partnership has a system of capturing staff opinion, and we would expect to see improvement in staff satisfaction with communication from senior managers.

Collaboration

At a senior level there was evidence of collaborative leadership across the partnership and involvement in decision making at a pan-Ayrshire level. This was evident through the Senior Partnership Operational Group (SPOG).

Where agreement was reached at SPOG, decision and approval was then sought from the SPG and IJB. Examples of this process included plans for the continuation of a police and crisis service collaboration for winter planning and people attending A&E with mental health concerns. Sharing work across the other Ayrshire HSCPs was another benefit of this collaborative senior forum.

An example of sharing good practice was the contribution of the partnership's change team in supporting the other Ayrshire partnership areas to address pressure on care homes and care at home teams after this had been identified at SPOG.

The partnership's management structure was supporting collaborative leadership in North Ayrshire and pan-Ayrshire. The ability to deliver services and work collectively were described positively and supported by senior managers and by the IJB. One advantage was the ability to share and resolve similar issues across the three partnerships which were discussed then shared with the respective IJBs.

IJB members worked well together, with members actively questioning and seeking additional detail to make sure they had a full understanding of the issues being discussed. They were actively and fully engaged in the integration agenda and supportive of progressing integration. This was evident for financial reporting and management of budgets and, through minutes and directions, the expectations of North Ayrshire Council and NHS Ayrshire & Arran were clear.

The partnership's senior managers who were involved in decisions at a pan Ayrshire level were clear how work was progressing. Confidence and understanding of developments for services where the partnership has a lead role, for example mental health and learning disability, were demonstrated during our inspection. Clarity across all stakeholders in relation to services for older adult services was not evident. Some staff told us that there were limited options available to older people receiving services in the partnership and were unclear about the progress of developments. Senior managers expressed confidence that the work streams associated with older people's services were making progress. There was acknowledgement that there were several work streams associated with older adult services in development, and communication on progress could be strengthened.

Good examples that demonstrated the strength in collaborative decision making and resource allocation were evident. These include the joint purchase and funding of Trindlemoss and development of the intermediate care and rehabilitation service with additional funding from NHS Ayrshire & Arran. Senior managers expressed confidence in the strength of collaborative working and the ability at HSCP Director level to develop and deliver services both for pan-Ayrshire and North Ayrshire.

Integration had brought changes which included the co-location of senior management from health and social care across two sites. This was a change that required adjustment but this move to co-location had brought benefits. These were described as an increased understanding of roles of others, better communication and an enhanced team identity which has supported the delivery of strategic objectives. This is further described in the section on workforce.

At a senior management level, co-location had enabled improved networking and an increased sense of a partnership approach. The introduction and implementation of an integrated supervision policy had been regarded as a success. As in other

integration authorities, the lack of integrated IT systems was an ongoing challenge. There was an acknowledgement that the integration of teams required further development and support.

Priorities

The intention to reduce inequalities was clearly evidenced during our inspection as being integral to improving the quality of life for everyone. This was recognised by senior management and was shared and supported by staff working across the partnership. Senior managers sought the assistance of NHS Health Scotland in completing the strategic needs assessment to inform the 2018–2021 strategic plan. The valued role of NHS Health Scotland to advise and provide evidence strengthened this work and supported the partnership staff in understanding the issues and factors which contribute to inequalities. This work was positively perceived across the partnership.

The partnership had developed five strategic priorities for their first strategic plan 2015–2018:

- tackling inequalities
- engaging communities
- bringing services together
- prevention and early intervention, and
- improved mental health and wellbeing.

The decision to retain these five strategic priorities in the 2018–2021 strategic plan had been based on extensive consultation with stakeholders. This consultation had resulted in a consensus that these remained the right priorities and were agreed by the SPG and supported by senior managers as being integral to realising the partnership's vision.

Locality priorities

There was evidence of value being placed on identifying need at locality level. This was demonstrated through a revision of the original locality profiles being undertaken. This work was supported by ISD in providing an analysis of performance against the Ministerial Strategy Group (MSG) indicators[8]. This detailed analysis was a positive move that provided profiles to inform all stakeholders and support decision making around planning locality priorities and the strategic objectives of the partnership.

[8] The Ministerial Strategy Group for Health and Community Care (MSG) monitor a suite of indicators to measure the impact of integration. The MSG was established in 2008 to provide a forum in which leaders from health and social care could meet to discuss matters of mutual interest and to provide leadership, direction and support in working across organisational and structural boundaries. It assumed overall responsibility for policy matters that crossed the local government/NHSScotland interface and is a key forum for taking forward COSLA and the Scottish Government's joint political leadership of health and social care integration. http://www.cosla.gov.uk

Work to identify and determine local needs had begun to be developed through the locality forums. The level of confidence expressed in the effectiveness of the LPFs was found to be mixed across staff groups. Changes to support the structure and functions of LPFs had been identified and there was support at senior level for the development of these forums within localities.

These changes comprised of revising the Terms of Reference to include regular updates on reports on achievements, performance and progress made against priorities at local level and inclusion of third sector representation across all forums. The experience of representatives of TACT and other areas of third and independent sector in locality planning was described as mixed.

A process for raising questions with the IJB was demonstrated. For example, a question had been raised about the use of funds from the Carers Act monies to support respite. We saw that carers groups across the localities were valued and we evidenced a request for views on types and need for respite from carers to be gathered and fed back to the IJB. These routes for questions and the highlighting of issues were both positive and demonstrated good communication between the IJB and carers forums.

New roles had been created for Locality Engagement Champions and Locality Communication Champions. These had been designed to extend engagement at locality level and are planned to be introduced through a pilot in Kilwinning, commencing October 2018, followed by the North Coast in November 2018.

A public engagement pilot for LPFs had been planned from November 2018 to April 2020 and was seen as “an important step forward.” The timescales for the introduction of these pilots were over an 18-month period across six localities. As a result of this time commitment, evaluation and evidence of any benefit will not be measurable in the short term to inform planning. Sharing of learning and communication of progress will be required to inform stakeholders across North Ayrshire of the work of the LPFs. These measures demonstrated a commitment by the partnership to improve engagement and communication and sharing of performance information to inform the effectiveness of planning at a locality level.

These developments demonstrated a positive effort on the part of the partnership to improve and support the function and the engagement and effectiveness of the LPFs. The value placed on support for developing LPFs and carers groups was a strength for the partnership.

Workforce

A key issue facing all IJBs was workforce planning. The IJB was in the draft stages of workforce planning. It had not prioritised the development of a comprehensive approach to workforce planning in the past.

The partnership's requirement for a workforce able to meet the demands of the service to deliver the strategic plan was reflected in the draft Joint Workforce Development Strategy. The plan is still under development and the intention is to take it to the Staff Partnership Forum in March 2019 and IJB in April 2019. The plan acknowledges the different terms and conditions that exist and that this position would be unchanged over the period of the plan.

We heard from staff who thought the variation in terms and conditions between NHS and council staff was a barrier to integration. There was a historical issue of separate roles and responsibilities for local authority and NHS occupational therapists and, despite integration, this had not been resolved. There was evidence of a lack of an integrated approach for the recruitment of an occupational therapist responsible for assessment of individuals requiring aid and adaptations. Although there were efforts being made to recruit, this was a situation that was impacting on the delivery of this service. There was a positive example of an integrated workforce development by the recruitment of generic technical instructors in the intermediate care team, which was described as having a positive effect within this service. A decision had been taken to delegate the responsibilities of the allied health professional to the partnership, this was a change which offered the potential to create opportunities of integrated working for occupational therapists.

Positive changes in working and a greater understanding of roles were described as a benefit of integration across health and social care staff and this was reflected in the staff survey. Most staff indicated that they were supported and encouraged to "work collaboratively to support meaningful integrated working and good practice."

A profile of the partnership workforce was being developed and this work was at an early stage. The partnership recognised the need to have this information to support work to determine future staffing requirements, and inform recruitment requirements, training needs and projected costs.

There was no evidence of development for management roles within the partnership. We heard from some groups that this limited opportunities for progression. Where there were absences at a senior management level these were covered from within the team.

NADARS was the only fully integrated adult service within the partnership that had brought both staff together and improved access through a single point of referral. Integration of the mental health team was planned but had been delayed at the time of our inspection. Multidisciplinary team working was being piloted as part of the Primary Care Improvement Plan.

The commitment to integrated working was evident but while this was seen within some areas of service there was no clear link between individual areas of service or development and the partnership workforce plan evident at the time of our inspection.

Clinical and professional governance

Clinical and professional governance and leadership was in place and although it was robust, the structure in place for the partnership was supplemented by additional pan Ayrshire professional groups. There was continued support for these professional forums, including social work, allied health professions, learning disability services and mental health services. There was evidence of a review of the effectiveness of one of these groups which indicated meeting as professional groups was valued by participants. However, this review was limited and did not demonstrate any benefit to the partnership's workforce. Senior managers reflected that pan-Ayrshire approaches benefited all three HSCPs, for example dissemination of good practice and sharing learning from adverse events.

Increased links between health and social care had supported learning from adverse events and reduced the number of investigations. The partnership had invested in root cause analysis training[9]. This had enabled a wide staff group to apply this standardised approach to investigation. The benefits of this investment was not yet apparent. There was an increased representation of health and local authority at recent governance group meetings and work had been done to align processes. Over the last six months of 2018, recording of adverse events from NHS board and local authority systems had been captured. However, the recording systems are separate. This is an issue nationally.

There has been a review of the health and care governance group's Terms of Reference to improve its effectiveness. Undertaking this demonstrated the development of this group to meet the requirements of the Health and Social Care Governance Framework. These requirements were being met within the current structure for governance and provided assurance to the NHS board, council and IJB.

The partnership highlighted the example of the mental health adverse events review group as good practice. This was a pan Ayrshire weekly forum where all mental health-related incidents that meet an agreed criteria are reported. A second group was in place which is for North Ayrshire only. The purpose of this group was cited as providing the NHS board, council and IJB with assurance in respect of professional standards of those staff working in integrated teams, reviewing significant and adverse events, improving the quality of care and ensuring the views of people using services are sought. We considered it was positive that this reporting structure was in place.

A pan Ayrshire clinical and care governance framework had been in place since 2017 and an established governance framework for the North Ayrshire IJB had been in operation since 2015. Social work staff had access to the Chief Social Work Officer for any professional issues. Governance structures for health and social care integration were continuing to develop with service change. Senior staff voiced some concern in respect of the capacity of mental health officers to support out-of-hours

[9] Root cause analysis (RCA) is a method of problem solving used for identifying the root causes of faults or problems.

services which were hosted out of East Ayrshire and run pan Ayrshire and that there was pressure in the form of increasing demand for guardianship and financial intervention. Work to address this included a new governance framework agreed by the senior management team to protect mental health officers' time to deliver statutory services. This will be considered further as part of a wider review of community care services.

6. Summary and conclusion

By taking appropriate action to further develop the plans and structures currently in place and ensuring a proactive approach to the management of operational performance, we are confident that North Ayrshire Partnership will continue to move forward with the integration of health and social care.

Our evaluation of quality indicators 1, 6 and 9

The Care Inspectorate and Healthcare Improvement Scotland, together with key stakeholders, have developed a set of quality indicators and illustrations to support partnerships to evaluate and improve the quality of work and the outcomes they are achieving for individuals, carers and communities. Inspection teams use this same set of indicators and illustrations to support their assessments of quality and what needs to be improved. During these inspections, we agreed to focus particularly on three of the indicators (quality indicators 1, 6 and 9) and to publish an evaluation of these quality indicators (Appendix 1) using a six-point scale.

Quality indicator 1: Key performance outcomes

1.1 Improvements in partnership performance in both healthcare and social care

The partnership had developed its performance reporting framework to monitor performance of health and social care services in North Ayrshire. It demonstrated that extensive reporting structures to collate and analyse data from across the partnership had been developed. This was mapped against national and local indicators and aligned to the partnership's strategic priorities.

Review of national and local performance data in terms of key outcome areas for adults showed a number of performance measures that indicated a mixed performance compared to Scotland as a whole. A number of measures showed performance was worse than the Scotland average.

The partnership benchmarked its performance against its National Health and Wellbeing Indicators family group. The partnership's performance was worse than the comparison group on more than half of the comparative indicators. There was no demonstrable use of this information to improve performance.

Monitoring and reporting of performance had not impacted on continuous improvement. This had been recognised by the partnership which had enlisted ISD and LIST support to work on developing baseline measurements aimed at improving how the partnership translates national outcomes to delivering better outcomes for the people of North Ayrshire.

The delivery of care at home provision was a major factor in supporting the partnership's attempts to improve performance. Data showed that progress had been made towards shifting the balance of care to enabling more people to stay at home. Whilst North Ayrshire was performing well for those aged 18–64, the

partnership's performance for intensive homecare for those aged over 65 was lower than the Scotland average.

Overall, North Ayrshire had made progress in developing its performance framework and was clear on the outcomes required of services to deliver for the people of North Ayrshire. However, a systematic approach to utilising data was not demonstrated. Development in the use of performance data to drive improvement in key outcome areas needs to be progressed in order to clearly demonstrate how this information is contributing to positive experiences and outcomes for people.

Evaluation: Adequate

Quality indicator 6: Policy development and plans to support improvement in service

6.1 Operational and strategic planning arrangements
6.5 Commissioning arrangements

The partnership's operational and strategic planning arrangements had a number of strengths. There was clear evidence of an integrated approach to the planning, development and delivery of services, particularly in relation to mental health, learning disability and drug and alcohol services. They included a clear vision supported by a wide range of commissioning intentions to achieve strategic priorities across the range of service areas that it is responsible for and a commitment to involving stakeholders and using feedback from communities, service users and their carers to inform strategic planning. The partnership had been proactive in the development of localities, including consideration of current and future service performance, demand and resource usage to inform its strategic needs assessment and financial planning. Members of the IJB had developed very positive constructive working relationships with opportunities for respectful questioning and challenge. There was a clear commitment to managing budget pressures and regular reporting of financial performance. Self-evaluation was particularly strong in learning disability and addictions services and good progress had been made to develop processes to manage risk, including financial pressures.

The extent to which strategic plans were informed by a whole system approach and aligned to financial planning was less evident, as is the extent to which the plans can be monitored against SMART criteria. Planning for older adults was less robust than for other care groups. The partnership's approach to promoting a mixed economy of care in consultation with the third and independent sectors was not well defined. There was some evidence to indicate that the partnership needed to invest more time in developing stronger relationships with the third and independent sectors, with the aim of continuing to shift the balance of care, particularly for older adults.

Evaluation: Good

Quality indicator 9: Leadership and direction that promotes partnership

9.1 Vision, values and culture across the partnership
9.2 Leadership of strategy and direction

A vision for services to meet the needs of the people of North Ayrshire that reflects strategic priorities to reduce inequalities was evident, widely understood and supported across the partnership.

The intention to reduce inequalities was clearly evidenced during our inspection as being integral to and recognised by the senior management of the partnership. This was shared and supported by staff working across the partnership.

At senior level, there was collaborative leadership across the partnership and involvement in decision making at a pan-Ayrshire level. It was evident that the discussion and agreement reached was shared, and approved, through the IJB and provided a strong basis for sharing approaches.

There had been a review of the health and care governance group's Terms of Reference to improve its effectiveness. Undertaking this demonstrated the development of this group to meet the requirements of the Health and Social Care Governance Framework. These requirements were being met within the current structure for governance and provided assurance to the NHS board, council and IJB.

Where North Ayrshire had a lead for pan Ayrshire mental health and learning disability services, there was evidence of a confidence and understanding of the developments for these services demonstrated during our inspection. However, for older adult services, staff and external stakeholders were unclear about the progress of developments and told us that there were limited options available to older people receiving services in the partnership. Senior managers expressed confidence that the work streams associated with older adult services were making progress. There was acknowledgement that there were several work streams associated with older adult services development and communication on progress could be strengthened.

A profile of the partnership workforce was being developed and this work was at an early stage. The partnership recognised the need to have this information to support work to determine future staffing requirements, inform recruitment requirements, training needs and projected costs.

There was no evidence of development for management roles within the partnership. We heard from some groups that this limited opportunities for progression.

Evaluation: Good

7. Areas for improvement

1 The partnership should evaluate how well ASPIRE is delivering its intended outcomes.

2 The partnership should improve its systems for measuring individual service user outcomes and the system of reporting to the IJB and other stakeholders to inform improvements in service delivery.

3 The partnership should proactively review each of its commissioning plans and intentions from a whole system perspective to identify and address impacts on other parts of the health and social care system. This review should make sure that financial plans and strategies are aligned with the strategic commissioning plan and progress investment or disinvestment needed to achieve strategic priorities. This includes reviewing existing commissioning intentions to make sure they are underpinned by robust financial planning.

4 The partnership should make sure its commissioning intentions work together to improve and sustain outcomes for people who use services in each service area and in each locality. Detailed information should be routinely presented to the IJB about outcomes for people who use services and include the impact of delays.

5 The partnership should further develop preventative services and self-directed support implementation to support its objective of moving to an asset based approach. All health and social care services delivered directly or by external providers should take account of the national health and social care standards. To support this approach, the partnership should take steps to engage more proactively with providers and staff.

6 The partnership should identify the workforce requirements to meet the delivery of services through linking all workforce developments to identify the recruitment, training and development needs for the partnership.

7 The partnership should ensure pan-Ayrshire planning and development of older adult services is communicated across staff and relevant stakeholders in the partnership.

Appendix 1 – Quality Improvement Framework

1. Key performance outcomes	4. Impact on the community	6. Policy development and plans to support improvement in service	7. Management and support of staff	9. Leadership and direction that promotes partnership
We assessed 1.1 Improvements in partnership performance in both healthcare and social care	4.1 Public confidence in community services and community engagement	**We assessed 6.1** Operational and strategic planning arrangements	7.1 Recruitment and retention	**We assessed** 9.1 Vision, values and culture across the partnership
1.2 Improvements in the health and wellbeing and outcomes for people, carers and families	**5. Delivery of key processes**	6.2 Partnership development of a range of early intervention and support services	7.2 Deployment, joint working and team work	**We assessed** 9.2 Leadership of strategy and direction
2. Getting help at the right time	5.1 Access to support	**We assessed 6.1** Quality assurance, self-evaluation and improvement	7.3 Training, development and support	9.3 Leadership of people across the partnership
2.1 Experience of individuals and carers of improved health, wellbeing, care and support	5.2 Assessing need, planning for individuals and delivering care and support	6.4 Involving individuals who use services, carers and other stakeholders	8. Partnership working	9.4 Leadership of change and improvement
2.2 Prevention, early identification and intervention at the right time	5.3 Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks	**We assessed** 6.5 Commissioning arrangements	8.1 Management of resources	**10. Capacity for improvement**
2.3 Access to information about support options including self directed support	5.4 Involvement of individuals and carers in directing their own support		8.2 Information systems	10.1 Judgement based on an evaluation of performance against the quality indicators
3. Impact on staff			8.3 Partnership arrangements	
3.1 Staff motivation and support				

What is our capacity for improvement?

Appendix 2 – Methodology

Our inspection of the North Ayrshire health and social care partnership was carried out over three phases:

Phase 1 – Planning and information gathering
The inspection team collated and analysed information requested from the partnership. The inspection team sourced other information before the inspection started. Additional information was provided during fieldwork.

Phase 2 – Staff survey and fieldwork
We issued a survey to 556 staff. Of those, 418 (75%) responded, with 360 (65%) of the total issued completed the full survey. We also carried out fieldwork activity over 9 days, during which we interviewed a number of people who hold a range of responsibilities across the partnership. The partnership offered a number of observational sessions, which inspectors attended where they had capacity.

Phase 3 – Reporting
The Care Inspectorate and Healthcare Improvement Scotland jointly publish an inspection report. The report format for this inspection focuses on strategic planning and commissioning and links this to evidence gathered on current performance and the development of the integrated leadership team. Unlike previous joint reports, comment is provided on our level of confidence in respect of the partnership's ability to successfully take forward its strategic plans from intentions to changes in operational delivery.

To find out more visit www.careinspectorate.com or www.healthcareimprovementscotland.org

care inspectorate

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.

Appendix 2

THE EFFECTIVENESS OF STRATEGIC PLANNING IN NORTH AYRSHIRE

DUNDEE COMPARATIVE ASSESSMENT

SPECIFIC AREA OF FOCUS	DUNDEE STRENGTHS	DUNDEE AREAS FOR IMPROVEMENT	PRIORITY FOR IMPROVEMENT
Performance	Robust and regular performance reporting against national indicators Financial performance reporting to IJB and Senior Management Teams Performance and Audit Committee scrutiny of performance Use of benchmarking information, including family group data and target setting (Local Government Benchmarking Framework and Measuring Performance Under Integration indicators) Use of LIST Team to analyse national data to inform improvement Central operational performance group considering performance data Good benchmarked performance in relation to emergency bed days and delayed discharge	Robust and regular performance reporting against local indicators Collated, regular performance reporting to Senior Management Teams against operational performance indicators Reporting of data regarding aggregate individual outcomes Target setting for indicators outwith those in Local Government Benchmarking Framework and Measuring Performance Under Integration Clarity regarding the role of performance information within the Partnership's Transformation Programme Inclusion of information from contract monitoring arrangements with third and independent sector not fully integrated within performance reporting arrangements Poor benchmarked performance for readmissions and falls	HIGH
Strategic Planning	Co-production of Strategic and Commissioning Plan	Assurance regarding robustness of strategic planning arrangements in place for hosted services led by other Partnerships	MEDIUM

SPECIFIC AREA OF FOCUS	DUNDEE STRENGTHS	DUNDEE AREAS FOR IMPROVEMENT	PRIORITY FOR IMPROVEMENT
	Housing Contribution Statement and evidence of joint working with Neighbourhood Services and other housing sector partners Well-developed vision and strategic priorities in a number of service areas developed through SPG structures	Gaps in representation / attendance at the Integrated Strategic Planning Group Delivery plan to support implementation and tracking of progress against Strategic and Commissioning Plan	
Strategic Needs Assessment	Up-to-date strategic needs assessment Supplementary strategic needs assessments for localities and some areas of service delivery Strategic needs assessments published and available to all partners Key messages from strategic needs assessment have informed strategic priorities		n/a
Locality Planning and Priorities	Locality needs and performance profiles in place Detailed locality analysis reports being developed Range of examples of locality engagement through wider Community Planning structures Commitment to strengthen locality engagement arrangements further Good alignment between City Plan and DHSCP Strategic and Commissioning Plan Strong and inclusive Community Planning Partnership	No Partnership specific strategic planning forums for specific localities / service delivery areas Limited supporting infrastructure to enable locality engagement and planning	MEDIUM
Priorities / Commissioning Intentions	Partnership priorities aligned to City Plan, local authority and NHS Board priorities Some strong examples of whole systems planning – for example unscheduled care work across Tayside	Financial frameworks and detailed commissioning intentions not yet in place to support delivery of all strategic plans Alignment of all commissioning plans and intentions to provide a whole systems perspective	HIGH

SPECIFIC AREA OF FOCUS	DUNDEE STRENGTHS	DUNDEE AREAS FOR IMPROVEMENT	PRIORITY FOR IMPROVEMENT
	Service redesign plans and strategies contain clear assessment of need, demand, capacity and option appraisals Focus on tackling inequalities		
Early Intervention and Prevention	Evidence in strategic plans of intended shift to early intervention and prevention Some evidence in commissioning and redesign of shift of resources to early intervention and prevention		n/a
Asset Based Approach	Commitment to asset –based approach Investment in Third Sector Interface and through commissioning of third sector services Meaningful participation of Third Sector within strategic and commissioning processes	Limited impact of Personalisation Delivery Plan on performance for Self-Directed Support and embedding culture of personalisation	HIGH
Financial Position and Sustainability	Maintenance of Integrated Care Fund to support tests of change and focused improvement projects Commitment to strengthen arrangements for medium and long-term financial planning Integrated budget management and reporting	Issues raised within recent internal audit report regarding Transformation Programme and dependency on this programme to deliver savings	HIGH
Contract Management, Procurement and Market Facilitation	Strong Social Care Contracts Team based within the Partnership Robust contract monitoring arrangements for externally procured services Robust arrangements for involvement of operational managers in contracting process and for escalation of risks to senior managers Dedicated Social Care Contracts Team supports whole system approach to commissioning across HSCP and Children and Families	No Service Level Agreements in place for NHS-hosted services Market Facilitation Strategy requires review and is not detailed enough / specific enough about commissioning intentions Limited market facilitation activity	MEDIUM

SPECIFIC AREA OF FOCUS	DUNDEE STRENGTHS	DUNDEE AREAS FOR IMPROVEMENT	PRIORITY FOR IMPROVEMENT
Self Evaluation and Quality Assurance	Range of activities progressed at team, service and organisational level Range of feedback and consultation mechanisms in place at team, service and organisational level	Outcomes of activity does not consistently inform strategic and improvement planning	MEDIUM
Governance Arrangements for Managing Performance and Risk	Performance and Audit Committee in place Internal audit plan and activity Annual report on inspection gradings High level risk register in place Financial monitoring in place	Integrated approach to risk management across the whole system Need to strengthen links between strategic planning, risk and financial information Linking the impact of identified risks and risk management strategies to impact on outcomes for individuals Need to strengthen the role of the ISPG in monitoring the effectiveness of the Strategic and Commissioning Plan	MEDIUM
Involvement of Stakeholders	Commitment to inclusive stakeholder engagement Involvement of people with lived experience in Strategic Planning Groups and wider development of strategic plans Strong arrangements for involvement of carers representatives Strong Third Sector involvement in the work of the Partnership Providers Forums operating well in some service areas Progress in the implementation of integrated teams in a number of service areas	Engagement and Participation Strategy requires refresh and supporting infrastructure to enable implementation Need to strengthen involvement of independent sector in strategic planning activities Staff surveys indicate staff do not feel fully informed and engaged with change processes Challenges progressing co-location of teams in localities at pace Public Health representation on the ISPG	MEDIUM
Vision and Values	Clear vision, understood across stakeholder groups		n/a

SPECIFIC AREA OF FOCUS	DUNDEE STRENGTHS	DUNDEE AREAS FOR IMPROVEMENT	PRIORITY FOR IMPROVEMENT
Culture and Standards	iMatters system in place to capture feedback from staff IJB members strongly support strengthening of integration arrangements	Need to maintain workforce communication and engagement on a consistent basis	MEDIUM
Collaboration	Some examples of strong collaboration arrangements across Tayside – for example unscheduled care, Mental Health Alliance Active IJB members Commitment to robust support and supervision arrangements across the workforce	Induction and continuous development support for IJB members Significant potential to further expand Tayside wide collaboration, including joint commissioning Lack of current building capacity to enable co-location of senior managements teams Lack of integrated IT systems	MEDIUM
Workforce	Developing integrated recruitment approach and integrated posts Leadership development opportunities available across the workforce Range of integrated teams in place	Workforce Plan requires to be updated	MEDIUM
Clinical and Professional Governance	Internal audit report and recommendations informing changes in structures Clear commitment to clinical and professional governance Regular reporting to IJB Service specific and Tayside wide structures support Dundee level arrangements	Work required to further strengthen adverse event processes and links to Significant Case Review processes	LOW

ITEM No …11……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD - 27 AUGUST 2019**

REPORT ON: **TAYSIDE SEXUAL HEALTH AND REPRODUCTIVE SERVICES UPDATE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB46-2019**

1.0 PURPOSE OF REPORT

1.1 To provide an update about the progress with the redesign of Tayside Sexual and Reproductive Health Services.

2.0 RECOMMENDATIONS

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

2.1 Notes the Tayside Sexual and Reproductive Health Services Redesign progress described at section 4 of this report.

2.2 Approves the proposed partnership arrangement between NHS Tayside Elective Medicine and Dundee Integrated Joint Board Tayside Sexual and Reproductive Health Services regarding the delivery of services for people living with HIV as reflected in Section 4.5.

3.0 FINANCIAL IMPLICATIONS

3.1 The expenditure noted in this report is funded from within resources available to Dundee Health and Social Care Partnership.

4.0 MAIN TEXT

4.1 Background to Tayside Sexual and Reproductive Health Services

4.1.1 It is our ambition that citizens of Tayside are enabled to have the information, advice, support they need to live a healthy and fulfilled life. Tayside Sexual and Reproductive Health Service (TSRHS) provides specialist sexual and reproductive health services across Tayside which aims to achieve that ambition through early intervention to prevent infection where possible.

4.1.2 Upon transfer of responsibilities for Tayside Sexual Health and Reproductive Services to the Dundee Integrated Joint Board in 2017, an evaluation of the performance, risks, operating model and culture took place. The evaluation informed a redesign programme so that we can achieve our ambition. To support effective delivery and development of partnership arrangements the redesign was implemented through three projects:

Project 1 – Corner Review
Project 2 – HIV Organisational Model Review
Project 3 – Specialist Sexual Health Services Review

4.1.3 A summary of the service improvement themes and redesign progress were reported to the Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group during the periods 2018 and 2019. The redesign programme was subsequently added as an action within the Dundee Health and Social Health Partnership Strategic Commissioning Plan 2019 – 2022.

4.2 Progress with the Service Redesign

4.2.1 Over the past two years, the focus has been on establishing the organisational conditions that will support and enable the service to achieve its ambitions and in doing so contribute to Integrated Joint Boards and NHS Tayside strategic priorities. This has included strengthening operational leadership arrangements within the service and use of evidenced based practice, and clinical governance to underpin the service developments. An overview of progress against each project is set out at sections 4.3 to 4.5.

4.3 Project 1 – The Corner

4.3.1 The Corner is a successful service which works in partnership with a range of agencies to deliver a wide range of services for young people including sexual and reproductive health drop in clinical services; mental health and wellbeing services; support around substance use; support around online safety and the law; counseling; health and wellbeing workers based in the 8 Dundee secondary schools; and outreach services to a range of organisations and individuals including schools, third sector and other professionals https://www.thecorner.co.uk/index.php

4.3.2 A review of the Corner Model was undertaken between March 2018 and January 2019 as a partnership with Dundee City Council to ensure the Corner is best place to deliver on key priorities and demonstrate its significant contribution moving forward

4.3.3 Following on from the review, the Corner has refreshed its service delivery priorities, strengthened leadership arrangements and implemented value management as a continuous improvement and workforce development programme to achieve its aim to enable young people to look after and improve their own health and wellbeing.

4.3.4 Through this the Corner intends to deliver the services below: -

- Corner Core Services – Delivery of asymptomatic, non-complex Sexual and Reproductive Health Services, mental health and wellbeing support and counseling services delivered from the Corner hub.
- Corner Outreach Service - Targeted health and wellbeing interventions to vulnerable young people and young carers across Dundee.
- Corner Early Intervention Service - Accessible support to young people in their communities across Dundee inclusive of counselling and sexual health advice.
- Corner Digital Advice and Development Service - A digital service which provides online access to counselling and Sexual Health and Wellbeing advice and information.

4.3.5 The Corner intends to provide annual reports on its performance including its impact on young people as part of the service ongoing continuous improvement approach.

4.4 Project 2 – Specialist Sexual and Reproductive Health Services

4.4.1 Specialist Sexual and Reproductive Health Services are delivered by Tayside Sexual and Reproductive Health Service (TSRHS), which provides a wide range of specialist care and treatment to people across Tayside. This includes complex contraception, complex genito-urinary medicine, specialist menopause care, sexual problems, HIV pre-exposure prophylaxis (PrEP), procedures including the removal of deep sub-dermal implants and sexual and reproductive health care.

4.4.2 A review of the specialist sexual and reproductive health services model and organisational structure was undertaken during the period 2018 in response to reduced capacity within specialist services, to improve the patient access pathways and to promote improved outcomes for citizens across Tayside.

4.4.3 Following on from the review, the Service has refreshed its service delivery priorities and arrangements and implemented further use of technology to improve efficiency and access of the service to citizens across Tayside. In addition it has strengthened leadership arrangements by implementing a new organisational structure which provides operational management at a local level across Tayside, as well as focusing on developing clinical practice and ensuring business and clinical care governance to enable a robust approach to continuous improvement.

4.4.5 In going forward, the service aims to work with partners across Tayside to develop a model which builds sexual and reproductive health capacity outwith TSRHS, supporting workforce development to facilitate implementation of the model developed, and enhances support available across Dundee, Angus and Perth and Kinross by aligning specialist sexual and reproductive health capacity more closely with service user need.

4.5 Project 3 – HIV Services

4.5.1 Delivery of services to people living with HIV is currently undertaken as a partnership between staff within NHS Tayside Elective Medicine and Tayside Sexual and Reproductive Health Services whilst the prevention of HIV is undertaken by Tayside Sexual and Reproductive Health Services.

4.5.2 During 2018, an options appraisal was undertaken to review and agree an organisational model which would support implementation of United Nations, NHS Tayside and DHSCP ambitions to become a Fast Track City and through this achieve: -

- 90 per cent of people living with HIV knowing their status;
- 90 per cent of people with diagnosed HIV on treatment;
- 90 per cent of people on treatment with suppressed viral loads.

4.5.3 The options appraisal was completed and it was agreed between clinicians and strategic leaders from NHS Tayside Elective Medicine, TSRHS and the Sexual Health and BBV MCN that the following arrangements would be implemented from 1st September 2019: -

- TSRHS will continue to lead on the prevention of HIV using a range of approaches including through the delivery of HIV pre-exposure prophylaxis (PrEP) and partner notification as part of specialist sexual health services provision.
- NHS Tayside Elective Medicine will lead of the treatment and support to people living with HIV and through this the nursing resource currently aligned to Tayside Sexual and Reproductive Health Services to deliver a service to people living with HIV will transfer NHS Tayside Elective Medicine from 1st September to enable cohesive service delivery.

4.5.4 A Partnership agreement has been developed to provide governance and oversight of this new arrangement between NHS Tayside Elective Medicine and Dundee IJB Tayside Sexual and Reproductive Health Services and to ensure that the requirements of both organisations are met.

4.6 Future Priorities

4.6.1 The changes made over the last two years have demonstrated that increased access and choices of treatment and support can deliver improved outcomes. The priorities over the next two years are to focus on: -

- Reviewing learning and recommendations from research and performance information to inform continuous improvement of sexual and reproductive health services.

- Building workforce capacity through workforce planning. This will set out workforce projections, workforce development and skills mix needed to deliver Tayside Sexual Health and Reproductive Services.
- Coproducing with stakeholders across Tayside a developing model for specialist sexual health services which continues to promote early intervention and prevention and enables development of services in localities across Tayside, with a particular focus on supporting people at high risk of poor sexual and reproductive health.
- Continuing to use realistic medicine, evidenced based practice, and clinical governance to underpin the clinical service deliver.
- Further developing partnership arrangements and pathways with partners across Tayside which includes primary care, prisons, children & families, neighbourhood services and wider third sector.

4.7 Summary and Conclusion

4.7.1 A redesign of Tayside Sexual and Reproductive Health Services has been implemented to support our ambition that citizens across Tayside will have access to the information and support that they need to live a fulfilled life.

4.7.2 Over the past year, the focus has been on establishing the organisational and cultural conditions that will support the redesign. This has included strengthening leadership, governance, development of multi-disciplinary working and review current operating models.

4.7.3 The focus for 2019 – 2020 will be to further implement the redesign programme with a particular focus on prevention and early intervention and supporting people at high risk of poor sexual and reproductive health.

5.0 POLICY IMPLICATIONS

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

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that current funding will be insufficient to undertake the redesign
Risk Category	Financial
Inherent Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is High Risk Level)
Mitigating Actions (including timescales and resources)	Securing multi-agency agreement on the actions required.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (which is a High Risk Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	Given the risk mitigation actions in place the risk is deemed to be manageable and should be accepted.

Risk 2 Description	There is a risk that suitably qualified and skilled staff are unable to be recruited to deliver the service required.
Risk Category	Workforce
Inherent Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is High Risk Level)
Mitigating Actions (including timescales and resources)	Securing stakeholder agreement on the actions required.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (which is a High Risk Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	To note the risk

7.0 CONSULTATIONS

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

8.0 DIRECTIONS

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

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

9.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 5 August 2019

Alexis Chappell
Locality Manager

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DIJB21-2019

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD - ATTENDANCES - JANUARY 2019 TO DECEMBER 2019

Organisation	Member	Meeting Dates January 2019 to December 2019						
		26/2	29/3	23/4	25/6	27/8	29/10	17/12
Dundee City Council (Elected Member)	Cllr Ken Lynn	√	√	√	√			
Dundee City Council (Elected Member)	Cllr Roisin Smith	√	√	√	√			
Dundee City Council (Elected Member)	Bailie Helen Wright	√	√	√	√			
NHS Tayside (Non Executive Member)	Trudy McLeay	√	√	√	√			
NHS Tayside (Non Executive Member)	Jenny Alexander	A	√	A	√			
NHS Tayside (Non Executive Member)	Dr Norman Pratt	√	√					
NHS Tayside (Non Executive Member)	Professor Nic Beech			A	A			
Dundee City Council (Chief Social Work Officer)	Jane Martin	√	√	√	√			
Chief Officer	David W Lynch	√	√	√	√			
Chief Finance Officer	Dave Berry	√	√	√	√			
NHS Tayside (Registered Medical Practitioner (whose name is included in the list of primary medical performers)	Dr Frank Weber	A	A	A	A			
NHS Tayside (Registered Nurse)	Sarah Dickie	√	√	A	√			
NHS Tayside (Registered Medical Practitioner (not providing primary medical services)	Dr Cesar Rodriguez	√	√					
NHS Tayside (Registered Medical Practitioner (not providing primary medical services)	Dr James Cotton			A	√			
Trade Union Representative	Jim McFarlane	√	A	√	√			
NHS Tayside (Staff Partnership Representative)	Raymond Marshall	√	√	√	√			
Voluntary Sector Representative	Christine Lowden	√	√	√	√			
Service User Representative	Linda Gray	√	√	√	√			
Carer Representative	Martyn Sloan	√	√	√	A			
NHS Tayside (Director of Public Health)	Dr Drew Walker	√	A	√	√			

✓ Attended
A Submitted Apologies
A/S Submitted Apologies and was Substituted
No Longer a Member and has been replaced / Was not a Member at the Time