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 February, 2017

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

Dear Sir or Madam

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

I 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, 28th February, 2017 at 2.00 pm.

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

Yours faithfully

DAVID W LYNCH

Chief Officer

A G E N D A

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS 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 6th December, 2016 is attached for approval.

4 PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF MEETING OF 17TH JANUARY, 2017, COPY ATTACHED FOR INFORMATION AND RECORD PURPOSES - **Page 7**

(b) AGENDA NOTE - SUMMARY OVERVIEW REPORT BY DOUG CROSS, CHAIR OF THE PERFORMANCE AND AUDIT COMMITTEE

Delegated Decisions taken by the Committee

There were no delegated decisions taken by the Committee at its meeting on 17th January 2017.

Performance Against Workplan

This was the first meeting of the Performance and Audit Committee. The Committee considered the 2016/17 Audit Plan previously approved by the Integration Joint Board. It also scrutinised the Dundee Health and Social Care Partnership Performance Report, noted the outcome of Care Inspectorate inspections and reviewed action plans developed in response to the Audit Scotland Health and Social Care Integration Report and the Annual Internal Audit Report 2015/16. The Committee also reviewed the Partnership's High Level Risk Register.

Any Other Major Issues to highlight to the Board

- Good progress has been made in developing and implementing the Partnership's Performance Framework. The Partnership has access to a comprehensive suite of indicators. This provides a new outward approach for benchmarking performance against national data and should assist the Partnership in identifying the key challenges facing it and the actions to be prioritised. Work is in hand to analyse the findings contained within the performance report and actions have been identified to address the key issues and challenges facing the Partnership with associated links to the Partnership's risk register to be made. An Outcomes and Performance Coordination Group is to be established to support further development of the Framework and assist in the production of quarterly and annual performance reports. It was noted future reports would be structured on a locality basis. Further work is to be undertaken in relation to unscheduled care admissions to hospitals and also finalisation of data into respite care.
- The Committee reviewed the Care Inspection reports following inspections at Oakland Day Centre and older people homes Janet Brougham House and Menzieshill House and were pleased to note the grades awarded to the service, the strengths identified within the service and the very positive comments made by service users and carers. The Committee recorded their appreciation for the contribution and diligence of staff in these establishments in achieving the positive grades and comments.
- The Committee noted the progress made in addressing the issues arising from the Audit Scotland Health and Social Care Integration Report.
- The Committee also noted the progress made against actions arising from the 2015/16 Annual Internal Audit Report.

- The Committee reviewed the current risks and scores contained within the Partnership's High Level Risk Register. The Register will be continually reviewed by the Chief Finance Officer.

The Integration Joint Board is asked to note the content of the note.

5 DO YOU NEED TO TALK? LISTENING SERVICE

(Presentation by Alan Gibbon, Senior Chaplain, NHS Tayside).

6 MEDICINE FOR THE ELDERLY SERVICES - Page 13

(Report No DIJB6-2017 by the Chief Officer, copy attached).

7 DUNDEE HOME AND HOSPITAL TRANSITION PLAN UPDATE - Page 19

(Report No DIJB2-2017 by the Chief Officer, copy attached).

8 FINANCIAL MONITORING POSITION AS AT DECEMBER 2016 - Page 29

(Report No DIJB1-2017 by the Chief Finance Officer, copy attached).

9 FINANCIAL SETTLEMENT 2017/18 OVERVIEW - Page 41

(Report no DIJB5-2017 by the Chief Finance Officer, copy attached).

10 NATIONAL HEALTH AND SOCIAL CARE DELIVERY PLAN - Page 45

(Report No DIJB7-2017 by the Chief Officer, copy attached).

11 DUNDEE MACMILLAN IMPROVING THE CANCER JOURNEY PROJECT - Page101

(Report No DIJB3-2017 by the Chief Officer, copy attached).

12 CLINICAL, CARE AND PROFESSIONAL GOVERNANCE UPDATE - Page 105

(Report No DIJB8-2017 by the Chief Officer, copy attached).

13 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, 25th April, 2017 at 2.00 pm.

At a MEETING of the **DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 6th December, 2016.

Present:-

Members	**Role**
Ken LYNN *(Chairperson)*	Nominated by Dundee City Council (Elected Member)
Stewart HUNTER	Nominated by Dundee City Council (Elected Member)
David BOWES	Nominated by Dundee City Council (Elected Member)
Doug CROSS *(Vice Chairperson)*	Nominated by Health Board (Non Executive Member)
Judith GOLDEN	Nominated by Health Board (Non Executive Member)
Munwar HUSSAIN	Nominated by Health Board (Non Executve Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
Jane MARTIN	Chief Social Work Officer
Frank WEBER	Registered Medical Practitioner (whose name is included in the list of primary medical performers)
Eileen MCKENNA	Registered Nurse
Cesar RODRIGUEZ	Registered Medical Practitioner (not providing primary medical services)
Drew WALKER	Director of Public Health
Raymond MARSHALL	Staff Partnership Representative
Jim MCFARLANE	Trade Union Representative
Christine LOWDEN	Third Sector Representative
Andrew JACK	Service User Representative
Martyn SLOAN	Carer Representative

Also in attendance:-

Diane MCCULLOCH	Head of Community Health and Care Services
Sarah DICKIE	Registered Nurse
Sheila ALLAN	Dundee City Council
Arlene HAY	Dundee Health and Social Care Partnership
David SHAW	Dundee Health and Social Care Partnership
David COULSON	Dundee Health and Social Care Partnership

Ken LYNN, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

There are no apologies for absence.

II DECLARATION OF INTEREST

No declarations of interest were made.

III MINUTE OF PREVIOUS MEETING

The minute of meeting of the Integration Joint Board held on 25th October, 2016 was submitted and approved.

IV MEMBERSHIP – INTEGRATION JOINT BOARD – POSITION OF ASSOCIATE NURSE DIRECTOR

It was reported that following a staffing change Sarah Dickie had been appointed to the position of Associate Nurse Director and as such would replace Eileen McKenna as a member of the Integration Joint Board.

The Integration Joint Board noted the position and welcomed Sarah Dickie to her first meeting and thanked Eileen McKenna for her contribution over the period of her membership.

V PERFORMANCE AND AUDIT COMMITTEE – ADDITIONAL MEMBERSHIP

Reference was made to Article VI of the minute of meeting of the Integration Joint Board held on 25th October, 2016 wherein the membership of the Performance and Audit Committee was agreed.

It was reported that a request had been made to include a staff side/trade union representative as a member of the Performance and Audit Committee and it was recommended that approval be given for one member to attend.

Thereafter, having noted that staff side/trade union representatives on the Integration Joint Board had agreed that Raymond Marshall be put forward for membership of the Performance and Audit Committee in this capacity the Integration Joint Board agreed to him being inducted as a member of the Committee.

VI SOCIAL PRESCRIBING IN DUNDEE

Sheila Allan, Community Health Inequalities Manager gave a presentation on social prescribing in Dundee. It was reported that social prescribing was one means of supporting self-management. It was an approach (or range of approaches) for connecting people with non-medical sources of support or resources within the community which were likely to help with the health problems they were experiencing.

Sheila explained the strategic context to social prescribing and explained the sources of support and the number of referrals received over 2016 and the main goal themes being addressed. Outcomes of referral to external services were outlined. A case study was provided to outline the way in which someone may present themselves to the service and the way their position may be progressed and supported towards assisting a positive outcome for their recovery and continued well-being.

The Integration Joint Board noted the content of the presentation.

VII DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2015/16

There was submitted Report No DIJB47-2016 by the Director of Public Health reporting that the work of the Directorate of Public Health contributed directly to improved healthy life expectancy by supporting people to look after themselves, by contributing to closing the health inequalities gap within a generation, by ensuring that services met minimum quality standards, especially patient experience, and by being cost-effective in all decisions, actions and services. The Director of Public Health also gave a presentation in supplement to their report.

It was reported that the Director of Public Health in each territorial Health Board was required to publish annually an independent report on public health. This report was required to be brought to Tayside NHS Board and made public for use by local stakeholders, including individuals, committees, the third sector, local authorities and NHS partners.

In Tayside the focus had mainly been on the work of the Directorate of Public Health in conjunction with its partner organisations and local communities.

In 2014 a number of people asked for a shorter, more focused and better illustrated report covering fewer topics, so for three years that was what the Directorate of Public Health had provided. Feedback on the reports had been extremely positive. Commissioning, co-ordinating, copy editing

and proofreading of this report and the two previous reports were delegated to Mrs Lesley Marley, Public Health Directorate Manager. The responsible officer was Dr Drew Walker, Director of Public Health.

The Report was accepted by Tayside NHS Board in August 2016. The report was brought to Dundee Health and Social Care Joint Integration Board for information.

The Integration Joint Board agreed to note the presentation, the content of the report and to support the recommendations outlined in the report which was attached as an appendix.

VIII FINANCIAL MONITORING POSITION AS AT OCTOBER, 2016

There was submitted Report No DIJB55-2016 by the Chief Finance Officer providing the Integration Joint Board with an update of the projected financial monitoring position for delegated health and social care services for 2016/17.

The Integration Joint Board agreed:-

(i) to note the overall projected financial position for delegated services as at 31st October, 2016;

(ii) to instruct the Chief Finance Officer to continue to monitor the 2016/17 projected financial outturn and present this to the Integration Joint Board throughout the remainder of the financial year; and

(iii) to note that the format and focus of this financial monitoring would change over time as budgets became more integrated and more closely aligned with the priorities set out within the Strategic and Commissioning Plan.

The Integration Joint Board further agreed that the Chief Finance Officer be instructed to include information on the breakdown of hosted services in future financial reports.

IX MEDICINES MANAGEMENT

There was submitted Report No DIJB56-2016 by the Chief Officer informing the Dundee Integration Joint Board on medicines management activities currently being delivered within Dundee; the plan over the remaining period of financial year 2016/17 and the evolving plans for 2017/18. The report would consider outliers, unexplained prescribing variation, current activities and areas of good performance.

The Integration Joint Board agreed:-

(i) to approve the development of the Tayside Prescribing Management Group as a strategic means to support clinically led quality oriented cost effective prescribing change; and

(ii) to approve the four key priorities of:

- Quality practice visits
- Specific drug projects
- Review of the Tayside formulary
- Prescribing improvement work with individual GP practices and clusters

X INTERNAL AUDIT PLAN 2016/17

There was submitted Report No DIJB60-2016 by the Chief Finance Officer seeking approval of the Annual Audit Plan for Dundee Integration Joint Board for 2016/17.

The Integration Joint Board agreed:-

(i) to approve the proposed Annual Internal Audit Plan for 2016/17;

(ii) to remit to the Performance and Audit Committee to monitor performance against this plan and to consider recommendations arising from the specific reviews within the plan.

XI DISCHARGE MANAGEMENT PERFORMANCE QUARTERLY UPDATE (DECEMBER, 2016)

Reference was made to Articles XIV and XV of the minute of meeting of this Integration Joint Board held on 30 August 2016 wherein the reports on Discharge Management Improvement Plan and Discharge Management Performance were approved.

Reference was also made to Article XII of the minute of meeting of this Integration Joint Board held on 25 October 2016 wherein the report on the Tayside Winter Plan was approved.

There was submitted Report No DIJB57-2016 by the Chief Officer providing an update to the Integration Joint Board on Discharge Management performance in Dundee.

The Integration Joint Board agreed:-

(i) to note the current position in relation to discharge management performance; and

(ii) to note the improvement actions planned to respond to areas of pressure identified.

XII ACCOMMODATION PLANNING FOR ADULTS

There was submitted Report No DIJB58-2016 by the Chief Officer briefing the Integration Joint Board on the progress being made in partnership with colleagues within Neighbourhood Services of Dundee City Council and service providers to drive the development of adapted or supported housing for adults who had particular support needs. The scope of the report covered planning for people with a learning disability and/or autism, adults with a physical disability and adults who had mental health difficulties.

The Integration Joint Board agreed:-

(i) to note the progress being made to improve accommodation options for people who required additional support in Dundee;

(ii) to advise the Chief Officer as to the frequency members would like to receive progress reports about accommodation planning in Dundee; and

(iii) to recommend to Dundee City Council that sufficient provision should be made within future years' Capital Plans to support the investment in accommodation with support for adults.

The Integration Joint Board further agreed that consideration be given to the possibility of inviting representation from Neighbourhood Services of Dundee City Council to future meetings of the Integration Joint Board.

XIII IMPLEMENTATION OF THE STRATEGIC AND COMMISSIONING PLAN

There was submitted Report No DIJB54-2016 by the Chief Officer informing members on progress on the implementation of the Dundee Health and Social Care Strategic and Commissioning Plan with a specific focus on demonstrating progress towards making the strategic shifts that were required to deliver on the eight strategic priorities within the plan.

The Integration Joint Board agreed:-

(i) to note the content of the report and the progress made as described in Appendix 1 of the report; and

(ii) to note the positive investment in services to facilitate the strategic shifts as detailed in paragraph 3.1 of the report.

XIV THE CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2015/16

There was submitted Report No DIJB53-2016 by the Chief Social Work Officer bringing forward for information the Chief Social Work Officer's Annual Report for 2015/16.

The Integration Joint Board agreed to note the content of the Chief Social Work Officer's Annual Report for 2015/16 which was attached to the report as Appendix 1.

The Integration Joint Board further agreed to record their appreciation for the contribution and diligence of social work staff towards making a positive difference to the lives of service users within the auspices of the Dundee Health and Social Care Partnership.

XV DATE OF NEXT MEETING

The Integration Joint Board agreed to note that the next meeting of the Integration Joint Board would be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 28th February, 2017 at 2.00 pm.

Ken LYNN, Chairperson.

6

At a MEETING of the **PERFORMANCE AND AUDIT COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 17th January, 2017.

Present:-

Members	**Role**
Doug CROSS *(Chairperson*)	Nominated by Health Board (Non Executive Member)
Stewart HUNTER	Nominated by Dundee City Council (Elected Member)
David BOWES	Nominated by Dundee City Council (Elected Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
Jane MARTIN	Chief Social Work Officer
Raymond MARSHALL	Staff Partnership Representative

Also in attendance:-

Tony GASKIN	Chief Internal Auditor
Diane McCULLOCH	Dundee Health and Social Care Partnership
Kathryn SHARP	Dundee Health and Social Care Partnership
Lynsey WEBSTER	Dundee Health and Social Care Partnership
Stephen HALCROW	Dundee Health and Social Care Partnership
Anne Marie MACHAN	Audit Scotland

Doug CROSS, Chair, in the Chair.

Prior to commencement of the business the Chair welcomed those in attendance to the first meeting of the Performance and Audit Committee and introductions were made.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Judith Golden, Dr Cesar Rodriguez and Dr Frank Weber.

II DECLARATION OF INTEREST

No declarations of interest were made.

III PERFORMANCE AND AUDIT COMMITTEE – MEMBERSHIP

Reference was made to Article VI of the minute of meeting of the Integration Joint Board held on 25th October, 2016 and Article V of the minute of the meeting of the Integration Joint Board held on 6th December, 2016, wherein the membership of the Performance and Audit Committee was discussed and agreed.

The Committee agreed to note the membership of the Performance and Audit Committee as follows: Doug Cross (Chair); Judith Golden; Councillor David Bowes; Councillor Stewart Hunter; Jane Martin; Dr Cesar Rodriguez or Dr Frank Weber and Raymond Marshall.

IV INTERNAL AUDIT PLAN 2016/17

Reference was made to Article X of the minute of meeting of the Dundee City Health and Social Care Integration Joint Board held on 6th December, 2016 wherein it was agreed to remit to the Performance and Audit Committee to monitor performance against the Internal Audit Plan and to consider recommendations arising from the specific reviews within the plan.

Reference was also made to Article VII of the minute of meeting of Dundee City Health and Social Care Integration Joint Board held on 4th May, 2016 wherein delegated authority was given to the Chief Officer and the Chief Finance Officer to conclude discussions with Fife, Tayside and Forth Valley Management Services and Dundee City Council for the provision of internal audit services for 2016/2017.

There was submitted Report No PAC2-2017 by the Chief Finance Officer advising the Performance and Audit Committee of the Annual Internal Audit Plan for Dundee City Health and Social Care Integration Joint Board for 2016/2017.

The Committee agreed:-

(i) to note the content of the report and the approved Annual Internal Audit Plan for 2016/17; and

(ii) to note the responsibility placed by Dundee City Health and Social Care Integration Joint Board on the Performance and Audit Committee to monitor performance against the Annual Internal Audit Plan and to consider recommendations arising from the specific reviews within the plan.

The Committee further agreed:-

(iii) to note that a report on the outcome of the Audits listed within the plan at paragraph 4.4 would be submitted to the meeting of the Committee to be held on 20th June, 2017; and

(iv) to note that the Chief Internal Auditor expected to be in a position to submit a report on the Audit Universe towards developing an Audit Strategy congruent with the Risk Register of the Integration Joint Board to the meeting of the Committee to be held on 20th June, 2017.

V DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT

Reference was made to Article IX of the minute of meeting of the Dundee City Health and Social Care Integration Joint Board held on 23rd February, 2016 wherein an outline performance framework and reporting cycle was agreed.

Reference was also made to Article IX and Article X of the minute of meeting of the Dundee City Health and Social Care Integration Joint Board held on 30th August, 2016 wherein it was agreed to establish the Performance and Audit Committee and progress in relation to implementing the Dundee Health and Social Care partnerships performance framework was noted and approved.

There was submitted Report No PAC3-2017 by the Chief Finance Officer updating the Performance and Audit Committee on progress in implementing the Partnership's performance framework. The report also brought forward the Quarter 2 Performance Report for 2016/17 for consideration by the Committee.

The Committee agreed:-

(i) to note the progress that had been made in further developing and implementing the performance framework, and supporting structures and systems, since the last update was provided to the Integration Joint Board on 30th August, 2016;

(ii) to note the intention to establish an Outcomes and Performance Co-ordination Group to support the further development and production of annual and quarterly performance reports;

(iii) to note the performance of Dundee Health and Social Care Partnership as outlined in Appendix 1 of the report; and

(iv) to remit the Chief Finance Officer to further develop the performance report which was appended into a performance improvement plan, including timescales for delivery and appropriate links to the Partnership risk register.

The Committee further agreed:-

(v) to note that paragraph 4.2.1 of the report indicated a new outward approach for benchmarking performance against national data within a clinical and care governance perspective and highlighted the fundamental reasons for the introduction of integrated health and social care services and drew out a range of key areas the Dundee Health and Social Care Partnership needed to focus on to improve outcomes for individuals and communities in the future which would assist in the deployment of resources;

(vi) to note that with reference to paragraph 4.1.10 of the report that a report on the range of data which may be obtained through the Source Team and other services within the Partnership to further support the Dundee Health and Social Care Partnership to identify good practice and improvement activities that may impact positively on outcomes for individuals and communities to assist the work of the Committee and the aims of the Partnership would be submitted to the next meeting of the Committee;

(vii) to note that future reports would be based on reporting on a locality structure basis within Dundee;

(viii) to note that further work would be undertaken in relation to analysis and management of data in relation to unscheduled care admission to hospitals;

(ix) that an update report on the finalisation of data in relation to Respite Care would be submitted to the meeting of the Committee to be held on 20th June, 2017.

VI OUTCOME OF CARE INSPECTORATE INSPECTIONS

There was submitted Report No PAC1-2017 by the Chief Finance Officer advising the Performance and Audit Committee of the outcome of the recent Care Inspectorate inspections of Oakland Day Centre and older people homes Janet Brougham House and Menzieshill House.

The Committee agreed:-

(i) to note the content of the report and the content of the inspection reports which were attached as to the report as appendices 1, 2 and 3;

(ii) to note the one recommendation for Menzieshill House as outlined in paragraph 4.3.5 of the report; and

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

The Committee further agreed:-

(iv) to note that contact would be made with the Care Inspectorate in relation to policy issues in relation to the PVG scheme; and

(v) to record their appreciation for the contribution and diligence of staff within the Partnership with responsibility for the individual services referred to in the report towards achieving positive reports from the inspections carried out by the Care Inspectorate.

VII AUDIT SCOTLAND HEALTH AND SOCIAL CARE INTEGRATION REPORT - ACTION PLAN UPDATE

Reference was made to Article VII of the minute of meeting of the Dundee City Health and Social Care Integration Joint Board held on 23rd February, 2016 wherein the content of Audit Scotland's report on progress made in establishing the new Integration Joint Boards following the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 which was published in December 2015 was noted and the action plan to be adopted locally in order to mitigate the identified risks for Dundee Health and Social Care Partnership was set out.

There was submitted Report No PAC5-2017 by the Chief Finance Officer providing an update to the Performance and Audit Committee of the actions identified to mitigate the risks highlighted by Audit Scotland following their review of Health and Social Care Integration in December 2015.

The Committee agreed to note the progress of the key actions identified as a response to the recommendations arising from the Audit Scotland Report on Health and Social Care Integration.

The Committee further agreed to note that a development session around governance would be arranged for the membership of the Integration Joint Board, to assist their awareness and understanding of governance issues, later in the year.

VIII ANNUAL INTERNAL AUDIT REPORT – 2015/16 ACTIONS UPDATE

Reference was made to Article VI of the minute of meeting of the Dundee City Health and Social Care Integration Joint Board held on 28th June 2016 wherein the content of the Annual Internal Audit report on the internal control framework for the Integration Joint Board for the financial year 2015/2016 was noted and it was agreed that an action plan be developed in relation to address areas recommended for improvement.

There was submitted Report No PAC4-2017 by the Chief Finance Officer updating the Performance and Audit Committee of progress in responding to the required actions highlighted within the Chief Internal Auditor's Annual Internal Audit Report 2015/16.

The Committee agreed:-

(i) to note the progress made against the actions highlighted in Appendix 1 of the report; and

(ii) to remit the Chief Finance Officer to bring a further progress report to the Performance and Audit Committee to conclude the 2015/16 action plan.

IX HIGH LEVEL RISK REGISTER - UPDATE

Reference was made to Article VIII of the minute of meeting of the Dundee City Health and Social Care Integration Joint Board held on 30th August 2016 wherein the High Level Risk Register for the Integration Joint Board was approved.

There was submitted Report No PAC6-2017 by the Chief Finance Officer updating the Performance and Audit Committee of the status of Dundee Health and Social Care Partnership's High Level Risk Register.

The Committee agreed:-

(i) to note the current risk levels associated with the risk categories as set out in Appendix 1 of the report; and

(ii) to remit the Chief Finance Officer to continually review the risk register in line with any areas of concern identified within future Dundee Health and Social Care Partnership performance reports.

X PROGRAMME OF MEETINGS 2017

The Committee agreed that the programme of meetings of the Performance and Audit Committee for the remainder of 2017 be as follows:-

Date	Venue	Time
Tuesday, 14th March, 2017	Committee Room 1, 14 City Square, Dundee	2.00 pm
Tuesday, 20th June, 2017	Committee Room 1, 14 City Square, Dundee	2.00 pm
Tuesday, 12th September, 2017	Committee Room 1, 14 City Square, Dundee	2.00 pm
Tuesday, 28th November, 2017	Committee Room 1, 14 City Square, Dundee	2.00 pm

XI DATE OF NEXT MEETING

The Committee noted that the next meeting of the Committee would be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 14th March, 2017 at 2.00 pm.

Doug CROSS, Chairperson.

REPORT TO: HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 FEBRUARY 2017

REPORT ON: MEDICINE FOR THE ELDERLY SERVICES

REPORT BY: CHIEF OFFICER

REPORT NO: DIJB6-2017

1.0 PURPOSE OF REPORT

The purpose of the report is to update the Integration Joint Board (IJB) on the progress of work to reshape inpatient, outpatient and community Medicine for the Elderly Services in Dundee to respond to the changing needs and demographics of the population and in line with the strategic direction for older people clinical services of Dundee Health and Social Care Partnership. The current and proposed remodelling described within the report puts in place a range of service improvements which will enhance the quality of care afforded to older people and support older people to receive both health and social care closer to home.

2.0 RECOMMENDATIONS

It is recommended that the IJB:

2.1 Notes the progress made and future planned developments in:

- The creation of a specialist stroke rehabilitation unit in Dundee;
- The remodelling or rehabilitation and assessment wards in Royal Victoria Hospital (RVH);
- The developments in step down assessment and rehabilitation resources in the community;
- The development of multidisciplinary team working (Enhanced Community Support) in the community; and
- The improved liaison between community services and Ninewells.

2.2 Endorses the principle that any resources released as a result of the proposed changes outlined in this report are reinvested in community based services;

3.0 FINANCIAL IMPLICATIONS

The financial plan associated with the proposed changes is currently being developed and identified resources released as a result of the changes outlined in this report will support a shift in the balance of care through the reinvestment in community based services.

4.0 MAIN TEXT

4.1 Background

4.1.1 The Dundee Health and Social Care Strategic and Commissioning Plan 2016-21 outlines the intention of the partnership to redesign the way in which services are provided to Older People to meet the health and wellbeing outcomes of that population. People will have services provided closer to where they stay which will enable them to stay in their own home for as long as possible. Where they do require hospital treatment they will be able to return to a homelike setting as soon as possible.

4.1.2 A number of different work streams are in progress to achieve this redesign under the project Reshaping Care for Older People in Dundee. One of these work streams supports the redesign of Medicine for the Elderly Services. This report will update the IJB regarding progress of this work stream and the planned future developments. The remodelling is

summarised in the table below. In addition an update is provided in relation to other work which supports these developments.

4.1.3 The current bed model within RVH supports:

- 22 transitional beds for those who are deemed medically fit for discharge and for whom arrangements are being made and/or those who are not medically stable enough to be discharged

Within the community there are currently:

- 30 step down intermediate care places within a care home. These are supported by a multidisciplinary team including Social Work, Community Rehab Team and the Peripatetic Nursing Team;
- 2 housing with care step down places for people whose own accommodation does not meet their needs.

The following table provides the current bed base modelling for RVH and sets out the step changes across two phases to reach the desired bed modelling. This modelling describes an increase in community resources which supports step down from hospital.

Bed Base at RVH/Accommodation with Support

	Ward 3	Ward 6	Ward 4	Ward 5	Ward 7	Ward 8	Community	total
Current	8 transitional	14 transitional	14 Rehabilitation and Assessment	15 Rehabilitation and Assessment	22 Rehabilitation and Assessment	21 Rehabilitation and Assessment	32 30 care home 2 housing	126
Phase one	Non operational	14 transitional	16 14 stroke 2 swing	23 Rehabilitation and Assessment	22 Rehabilitation and Assessment	21 Rehabilitation and Assessment	36 32 care home 4 housing	132
Phase 2	Non operational	Non operational	16 14stroke 2 swing	23 Rehabilitation and Assessment	22 Rehabilitation and Assessment	21 Rehabilitation and Assessment	44 32 care home 4 housing 8 intensive care at home	126

4.2 Stroke Rehabilitation In-patient Services

4.2.1 Stroke is the third commonest cause of death and the most frequent cause of severe adult disability in Scotland. Evidence from a systematic review of a wide range of trials or organised stroke unit care indicates that stroke patients have a range of better outcomes in terms of survival, returning home and independence if they are managed in a stroke unit rather than admitted to a general ward. A Cochrane review of the benefits of a stroke unit found that there was:

- an 18% relative reduction in death
- a 20% relative reduction in death or institutional care
- 22% relative reduction in death or dependency

4.2.2 While acute stroke inpatient service for Dundee and Angus patients is located in Ninewells Hospital, there are currently 14 stroke rehabilitation older patients at any one time in RVH for patients from Dundee. Work is underway to redesign the way in which stroke rehabilitation services are provided to people in Dundee. The intention is to create a new specialist mixed sex unit in Ward 4 RVH. Currently this is provided in the four rehabilitation and assessment wards. The stroke rehabilitation unit will be a mixed sex unit and with 14 beds and 2 swing beds that will comply with NHS Tayside Single Sex Accommodation Policy ("*single sex accommodation for this policy is defined as when a room or bay is specifically for one sex with washing facilities also available solely for this one sex*"). The swing beds will be used more flexibly according to need. The service will include the development of a multidisciplinary team, and the identified wards will require some environmental improvements. It is anticipated this project will be complete by May 2017.

4.3 Rehabilitation and Assessment

4.3.1 Work is underway to improve the way in which more general rehabilitation and assessment is provided to older people in Dundee. Currently RVH has six wards. There are four rehabilitation and assessment wards and two transitional care wards. Transitional wards accommodate people who are not medically stable enough to be discharged and those who are fit for discharge and for whom arrangements are being made. In future models the needs of these patients will be met within the rehabilitation and assessment wards. The improvements contained within this report have resulted in less demand for transitional beds.

4.3.2 The needs of older people who do require to be in hospital have become increasingly complex and as a result the environments are no longer fit for purpose. In addition staffing levels will need to be adapted to support the changing complexity. There is a need to remodel to meet the needs of the population.

4.3.3 Following the described remodelling, provision for rehabilitation and assessment will be in three wards within RVH which can accommodate up to 66 people. These wards will have more appropriate environments and a higher staffing ratio. Staff will be redeployed between the stroke rehabilitation unit and these wards from the non-operational ward. Initially there will be a minimal overall reduction in bed numbers with a temporary reduction of one bed.

4.3.4 This work will take place in two stages as community models continue to be developed through shifting resources from in-patient to community services. This will include an increase in community capacity with the development of step down rehabilitation in care homes and dedicated housing with care. As a result of this increase in community options, stage one will see the retraction of one transitional ward and phase two will see the retraction of another transitional ward with redistribution of beds across both the in-patient and community setting. Bed usage over the past year confirms this can be achieved. The anticipated timescale for these changes is April 2017 for phase one and November 2017 for phase two as community services discussed below develop.

4.3.5 There have been a number of developments of community based assessment and rehabilitation resources which have supported the remodelling of inpatient resources. It is recognised that hospital is not the best environment for people who are medically fit for discharge and it is also not a good environment in which to conduct an assessment of the person's need for ongoing support. As a result there has been significant developments of resources to support people at home or if that is not possible a homelike environment.

4.3.6 These developments are supported and underpinned by a range of improvements in the way services are delivered. These include developments in the intermediate care, acute frailty team, community rehabilitation services, Enhanced Community Support (ECS) which is community based multidisciplinary working including the need for an additional Rapid Response arm, support to care homes, poly-pharmacy review and social care. Links between Ninewells and the community have been improved as have those between Acute Frailty and other departments in Ninewells.

4.3.7 The capacity of the intermediate care unit, contracted in a local Nursing Home, has been increased from 23 to 28 and there are a further two beds made available in step down care and two in a housing environment. Medicine for the Elderly team will transfer some of the workforce to support the team in Intermediate Care. This is predicted to increase patient throughput by a minimum of 15% and create additional capacity. Availability will be increased further over the next six months to include two further care home spaces, two housing with care spaces and on average eight people being supported at home by a specialist intensive social care team.

4.4 Acute Frailty Team

4.4.1 Developments in the Acute Frailty Team have significantly reduced the pressure on Ninewells Acute Medical Unit and Medicine Directorate, with 3-fold reduction in the length of time frail people spend in the Medical Assessment Unit and an increase in the numbers of frail patients being discharged from Ninewells front-door to home and community facilities. A current limitation is that this model is a five day service. In addition the Orthogeriatric and surgical

liaison service has had a significant impact on the length of stay for frail older people in surgical wards. It is proposed to build on this development to create a designated seven day Acute Frailty service as recommended by the National Clinical Strategy 2016.

4.5 Community Services

4.5.1 Dundee has made significant progress in relation to community multidisciplinary working. There are four GP cluster arrangements which are aligned to Medicine for the Elderly Consultant teams, Social Work Teams, Community Nursing Teams and the Community Rehabilitation Team. The day hospital is a key part of this and work will be undertaken to develop the services provided. Three further work streams are in place to develop this model and include: how the Psychiatry of Old Age Community Mental Health teams interface with these teams, how services are provided out of hours and how support is provided for people with a range of complex needs at home.

4.5.2 It is also evident that rapid response and triage by specialist Medicine for the Elderly teams in the community is required to bolster Enhanced Community Support model in order to avoid unnecessary hospital admissions in times of quick patient decompensation. Clinicians feel that there is a need to shift a rapid Comprehensive Geriatric Assessment from the acute hospital to the community. Discussions around this model are currently taking place and further details will be presented in due course. A model is aimed to be in-situ by November 2017 to improve community capability and capacity to care for more frail patients at home. Clinicians believe that in addition to numerous benefits to Dundee people that a reduction on the reliance of hospital beds can be realised, maybe in nature of 10%. This project in conjunction with others in paper will support Phase 2 of RVH bed model redesign.

4.5.3 A number of supports to care homes have been developed as many people were coming into hospital from these environments. These include a peripatetic team, a psychiatric care home liaison team, an Older People's review team and the support of an Advance nurse practitioner. Further development is underway to review the medical model of support and to move towards more integrated ways of working. The role of the advanced nurse practitioner is further being developed. Following successful pilot work pharmacy are working to implement a medicine review for people moving into care homes, supported by locality Medicine for the Elderly Consultants. This is a key priority as we look to reduce medication induced harm as well as look to address Primary Care medication spend.

4.5.4 Social care is a key component of the support needed by frail older people and a number of developments have happened. These include introducing a Contract Framework, commissioning a specialist palliative care service, introducing electronic scheduling and a new rota for home care staff to increase capacity. Community Social Work teams have been remodelled to promote assessment in the community and enablement support workers have been employed to ensure the flow through the enablement service works effectively for rapid services.

4.5.5 Effective communication is vital to improving services and a number of practice developments have been introduced to improve working relationships between the community and Ninewells. These include development of Ninewells Discharge Hub that houses both Dundee Discharge Team and hospital based care managers and the discharge process for frail people being centred around multidisciplinary team setting of Planned Dates for Discharge (PDD).This process involves real time communication with social work and allows patients to access necessary care packages to facilitate discharge at the point they are medically fit. This has already halved delays since winter 2015. New guidance for staff regarding people who may need Guardianship and transfer documentation will also reduce hospital delays.

4.6 Conclusion

4.6.1 In conclusion, there is the need to remodel non-acute inpatient services to meet the complex needs of the population. The Partnership is in the process of creating a dedicated stroke unit and rehabilitation and assessment ward in an appropriate environment with appropriate levels of staffing. There have been a number of developments across community based assessment and rehabilitation resources which have supported the remodelling of inpatient services. It is recognised that hospital is not the best environment for people who are medically fit for discharge and is also not a good environment in which to conduct an assessment of the

person's need for ongoing support. Both the current and planned developments will support older people to only be admitted to hospital where required, minimise delays to discharge and meet their health and social care needs in the community for as long as possible.

4.6.2 It is anticipated that this model of care delivery for frail older people in Dundee will achieve the Dundee Health and Social Care Partnership's commitments in relation to the recently published national Health and Social Care Delivery Plan.

5.0 POLICY IMPLICATIONS

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

6.0 CONSULTATIONS

The Chief Finance Officer, Associate Medical Director (Older People), Clinical Lead Consultant (Medicine for the Elderly) and the Clerk were consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 7 February 2017

ITEM No …7……….

REPORT TO:	**HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 FEBRUARY 2017**
REPORT ON:	**DUNDEE HOME AND HOSPITAL TRANSITION PLAN UPDATE**
REPORT BY:	**CHIEF OFFICER**
REPORT NO:	**DIJB2-2017**

1.0 PURPOSE OF REPORT

1.1 To provide an update to the Health and Social Care Integration Joint Board of the outcome and progress of actions and arrangements put in place across the Partnership to respond to discharge management.

2.0 RECOMMENDATIONS

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

2.1 Notes the content of the report and progress in relation to the Dundee Discharge Management Improvement Plan (attached as Appendix 1).

3.0 FINANCIAL IMPLICATIONS

3.1 The expenditure noted in this report is funded from Delayed Discharge Funds which form part of Dundee Health and Social Care Partnership's recurring budgeted resources.

4.0 MAIN TEXT

4.1 Background to Discharge Management

4.1.1 A delayed discharge is a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date. (ISD Delayed Discharges Definitions and Data Recording Manual).

4.1.2 The focus on effective discharge management is reflected through the National Health and Wellbeing Outcomes and their indicators. There are two indicators that relate directly to effective discharge management:

- National Indicator 19: Number of days people spend in hospital when they are ready to be discharged;
- National Indicator 22: Percentage of people who are discharged from hospital within 72 hours of being ready.

4.1.3 There are a number of other indicators which indirectly relate to discharge management and admission to hospital. These are percentage of people admitted to hospital from home during the year, who are discharged to a care home; percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency; readmission to hospital within 28 days; emergency admission rate and emergency bed day rate.

4.2 Governance and Monitoring Arrangements

4.2.1 Within Dundee a Home and Hospital Transitions Group, chaired by the Head of Service, Health and Community Care, oversees performance and improvement actions in relation to Discharge Management. The Group aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be.

4.2.2 On a weekly basis, an update is provided to the Chief Officer, Director of Acute Services and key Home and Hospital Transitions Group members on delay position. This information is used to maintain an ongoing focus on enabling patients to be discharged from hospital when they are ready as well as to inform improvements.

5.0 DISCHARGE MANAGEMENT IMPROVEMENT PLAN

5.1 Home and Hospital Transition Improvement Plan

5.1.1 The Home and Hospital Transitions Group, chaired by the Head of Service, Health and Community Care, aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be.

5.1.2 This ambition is reflective of the National Health and Wellbeing Outcomes and their Indicators and the strategic ambitions set out within Dundee Health and Social Care Partnership Strategic and Commissioning Plan. In particular it focuses on prevention of emergency admission and readmission to hospital, supporting people to live at home and be discharged when they are ready.

5.1.3 To support achievement of this ambition, contribute to the Dundee Health and Social Care Partnership Strategic and Commissioning Plan and evidence progress against National Health and Wellbeing Outcome Indicators, a Home and Hospital Transition Improvement Plan was developed and approved by the Integrated Joint Board on 24 August 2016.

5.2 Home and Hospital Transition Plan Project Progress

5.2.1 The Dundee Health and Social Care Partnership has invested in additional capacity in the Health, Social Care and third sector workforce through Change Fund, Integrated Care Fund and latterly the Delayed Discharge funding streams to support both the unnecessary admission to hospital and prevention of discharge delay.

5.2.2 The Discharge Monies have supported the Dundee Partnership to further develop a number of initiatives and build capacity within our workforce that have contributed to enabling citizens of Dundee to be supported at home, but when people do have to go to hospital they are only there as long as they need to be. Progress against key actions is below.

5.2.3 Care at Home Service, Home Care and Resource Matching Unit: - The Resource Matching Unit is now established and along with the increase resource provision from the discharge funding has increased capacity and efficiency of the care at home service. A further piece of improvement activity has been carried out to improve communication between the Discharge Hub and the Resource Matching Unit, in order to achieve our aim of achieving discharge on the planned date of discharge for all patients. It is planned that this work will contribute to a reduction in number of delays due to patients awaiting a care package.

5.2.4 Care Home Placements: - The Discharge Monies funded an additional five Care Home placements which generated additional capacity within the service. To support winter planning, a further additional five Care Home placements were future funded to enable service users to be able to leave hospital into a homely setting. We have put a number of resource in place to support assessment for 24 hour care to take place in a more homely setting as it is recognized that hospital is not an appropriate place to do this. Currently there are nine places available in care homes. Two further places will be developed over the next six months in housing with care and a social care service is being commissioned to allow intensive support for an assessment to be done at home.

5.2.5 Discharge Management Team and Integrated Discharge Hub – The increased AHP and Nursing input into the Discharge Team has increased its capacity to co-ordinate discharges and contribute to the development of an Integrated Health and Social Care Discharge Hub. An integrated Social Work and Health Discharge Hub was implemented on 3 December 2015. This Hub has established a single route for referrals, reduced duplication between social work and health teams and established a shared ethos on person centered discharge planning within a multi-disciplinary team approach. In line with the Home and Hospital Transition Plan, work is now underway to further develop this Hub into a fully integrated team to increase capacity of the service and enhance and further develop opportunity for discharge assessment for all patients at Ninewells.

5.2.6 Guardianship – The additional hours to the Mental Health Officer (MHO) Service has significantly increased capacity of the MHO Service to respond to requests for Guardianship reports. This has resulted in a timely completion of reports and reduction in bed days lost as a result of waiting for an MHO.

5.2.7 Power of Attorney Campaign – A further Power of Attorney campaign took place during the winter period and included provision of information about becoming a Power of Attorney on social media, newsletters, television advertising and a dedicated website. The funding through the discharge monies has supported this to happen. It is organized that this will be followed up by promotional events during 2017 and through further communication and campaign work. It is planned that by increasing the number of Power of Attorneys this will reduce number of bed days lost through people awaiting application for Guardianship.

5.2.8 Carers – A Strategic Plan for Supporting Carers has been drafted and formal consultation took place on the Plan between November 2016 and January 2017. Through the strategic plan, Dundee Health and Social Care Partnership aim to achieve a *caring Dundee in which all Carers feel listened to, valued and supported so that they feel well and are able to live a life alongside caring.* In relation to discharge management, work is underway to develop and implement a pathway for involving Carers in the discharge planning process, so that Carers feel listened to, valued and supported.

5.2.9 Prevention of Admission - To support our focus on prevention of admission, a review of information and data will be undertaken over the next three months to understand reasons for emergency admission, admission and readmission to hospital within 28 days of discharge so that this informs improvement activity in relation to these areas.

6.0 POLICY IMPLICATIONS

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

7.0 CONSULTATIONS

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

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 3 February 2016

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National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
National Outcome 1: Healthier Living **and** **National Outcome 5: Reduce Health Inequalities**	• **National Indicator 1**: % of adults able to look after their health very well or quite well • **National Indicator 12**: Emergency Admission Rate (per 100,000 people aged 18+) • **National Indicator 13**: Rate of emergency bed days for adults	Review reasons for emergency admission across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will contribute to a reduction in emergency admission to hospital (NI 12,13)	Locality Manager
		Further develop use of technology enabled care as a means of enabling people to live independently and look after their own health. (NI 1, 12,13)	Locality Manager
		Further embed Enhanced Community Model for support for Older Adults and introduce the Community Model for Support with Adults as a means of reducing emergency admissions and enabling people to live independently and look after their health in their own home or homely setting. (NI 1, 12,13)	Locality Manager
		Further develop awareness and use of anticipatory care plans for all Adults where a plan would be of benefit to the Adult. (NI 1, 12,13)	Nurse Consultant
		Prioritise and invest in models of support that help to support life style changes which improve health through Care Group Strategic Planning Groups. (NI 1, Dundee Health and Social Care Partnership Strategic Plan)	SPG Leads
		Embed health checks as a means to engage people in the health and wellbeing agenda, to increase self-care, and avoid longer term ill health. (NI 1, 12, 13, Dundee Health and Social Care Partnership Strategic Plan)	SPG Leads
		Develop shared training programmes for frontline staff to support awareness and understanding of sensory impairment including signposting; sensory health checks and support. (NI 1, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
National Outcome 2: Independent Living	• **National Indicator 18**: % of adults with intensive care needs receiving care at home • **National Indicator 15**: Proportion of last 6 months of life spent at home or in a community setting • **National Indicator 19:** Number of days people spend in hospital when they are ready to be discharged • **National Indicator 21**: % of people admitted to hospital from home during the year, who are discharged to a care home • **National Indicator 22**: % of people discharged from hospital within 72	Support more people to be assessed at home or a homely setting rather than in hospital by completing and evaluating the 'Moving Assessment into the Community' project for older people and resource the proposed change. (NI 19, 21, 22, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways. (NI 19, 21, 22, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Increase our investment in intermediate forms of care such as step up/step down accommodation and support for all adults. (NI 19, 22, 21, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Further develop discharge planning arrangements for adults with mental ill-health, physical disability and acquired brain injury. (NI 19, 22, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Invest in resources which support assessment for 24 hour care taking place at home or home like settings (NI 18, 19, 21, 22, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager
		Redesign services to ensure rapid access to palliative services (NI 15, 18, 19, Dundee Health & Social Care Partnership Strategic Plan).	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
	hours of being ready	Review access to end of life services so that people are supported in their place of choice (NI 15, 18, 19)	Locality Manager
		Review patient pathways between Carseview Hospital and the community. (NI 18, 19, 21, 22, Dundee Health & Social Care Partnership Strategic Plan)	Locality Manager
		Embed within care group strategic commissioning plans the development of a range of community resources and supports which facilitate community based assessment, enable people to remain in their own home and be discharged from hospital when they are ready. (NI 15, 18, 19, 21, 22)	SPG Leads
		Further develop earlier identification of requirement for measures under Adults With Incapacity (Scotland) Act 2016 so that people are not waiting for completion of formal measures within a hospital setting. (NI 19, 21, 22)	Localty Manager
		Promote Power of Attorney through local campaigns as a means of increasing number of Power of Attorneys so that Adults are not waiting in hospital settings for decisions about their care upon discharge. (NI 19, 21, 22)	Locality Manager
		Review and remodel care at home services to provide more flexible responses. (NI 15, 18, 19, 21, 22)	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
		Lead a review, with partners, of the current Learning Disability acute liaison service and develop a future model (NI 5, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager
		Further develop models of Community Rehabilitation to support transitions between home and hospital (NI 15, 18, 19, 21, 22, Dundee Health and Social Care Strategic Plan)	Locality Manager
National Outcome 3: Positive Experiences and Outcomes	• **National Indicator 5**: % of adults receiving any care or support who rate it as excellent or good	Implement IRISS home from hospital research findings (NI 5)	Locality Manager
		Develop and implement discharge management procedures and guidance to promote consistency in practice in relation to discharge management and use of planned date of discharge. (All Indicators)	Locality Manager
		Establish and implement a Discharge Management Learning Framework and Learning Networks as a means of promoting and enabling consistency in practice and ensuring effective person centred communication during transition between hospital and home. (NI 5)	Locality Manager
		Develop an 'early indicator of deteriorating health and well-being tool', for use by front line social care staff to reduce the instances of hospital admissions, increase the use of preventative interventions, and assist people to look after their health and well-being (NI 1,5)	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
National Outcome 6: Carers are Supported	• **National Indicator 8**: % of carers who feel supported to continue in their caring role	Implement a statement and pathway for involving Carers in discharge planning process in line with section 28 of the Carers (Scotland) Act 2016 in partnership with Carers and Carers Organisations (NI 8, Carers (Scotland) Act 2016, Dundee Health and Social Care Strategic Plan)	Locality Manager
		Embed the statement and pathway for involving Carers in discharge planning within discharge guidance, planned date of discharge guidance, multi-agency Carer's guidance and a learning and workforce development framework. (NI, Carers (Scotland) Act 2016, Dundee Health and Social Care Strategic Plan)	Locality Manager
		Embed Equal Partners in Care Learning Framework and Carers Learning Networks to enable the Health and Social Care Workforce to enable Carers to feel identified and supported.	Locality Manager
		Develop a Strategic Commissioning Statement for Carers with input/involvement from carers' groups and carer' partnerships and implement this. (NI 8, Carers (Scotland) Act 2016, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager
National Outcome 7: People are Safe	• **National Indicator 14**: readmission to hospital within 28 days • **National Indicator 16:** Falls rate per 1,000 population in over 65's	Further implement the planned date of discharge model so that patients , carers are involved in a well-planned discharge and have coordinated follow up care where required upon discharge (NI 21, 22, 14)	Locality Manager
		Further develop post discharge support to people with long term conditions in order to contribute to a reduction in emergency hospital admission and readmission to hospital. (NI 14)	Locality Manager

National Health And Wellbeing Outcomes	Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes.	Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator.	Lead
		Further develop local fall pathway initiatives to reduce risk of falls (NI 16)	Locality Manager
National Outcome 9: Resources are used Efficiently and Effectively	**National Indicator 20**: % of health and care resources spent on hospital stays where the patient was admitted in an emergency.	Extend the co- location of teams with common purpose and broaden the definition of integration to include all sectors (health, social work, third sector, independent sector). (NI 20, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager
		Implement a fully Integrated Discharge Management Team to increase capacity of the service and enhance and further develop opportunity for discharge assessment for all patients at Ninewells. (NI 20, Dundee Health and Social Care Partnership Strategic Plan)	Locality Manager
		Establish integrated systems and processes which support information sharing and improved communication (All Indicators)	Locality Manager
		Review the systems and mechanisms for reporting around discharge management (All Indicators)	Locality Manager

ITEM No …8……….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 FEBRUARY 2017**

REPORT ON: **FINANCIAL MONITORING POSITION AS AT DECEMBER 2016**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB1-2017**

1.0 PURPOSE OF REPORT

1.1 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 2016/17.

2.0 RECOMMENDATIONS

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

2.1 Notes the overall projected financial position for delegated services as at 31 December 2016;

2.2 Instructs the Chief Finance Officer to continue to monitor the 2016/17 projected financial outturn and brings to the attention of the IJB any areas of concern arising between the December 2016 position and the end of the financial year;

2.3 Instructs the Chief Finance Officer to seek information from Angus and Perth & Kinross Health and Social Care Partnerships on their plans for cost containment and reduction in relation to overspent services hosted by them on behalf of Dundee Health and Social Care Partnership and to report these back to the IJB.

3.0 FINANCIAL IMPLICATIONS

3.1 The financial monitoring position for Dundee Health and Social Care Partnership based on expenditure to 31 December 2016 shows a net projected overspend position of £2,321k which is an improvement on the previously reported figure of an overspend totalling £2,435k as at 31 October 2016. Services delegated from NHS Tayside (excluding prescribing but including Family Health Services (FHS) and General Medical Services (GMS)) are estimated to be in an overspend position of around £304k by the end of the financial year, down from a previously reported overspend of £754k. As with prescribing, these overspends are subject to the risk sharing arrangement outlined in the Integration Scheme whereby responsibility for meeting the shortfall in resources remains with NHS Tayside.

Services delegated from Dundee City Council are anticipated to be in an underspend position of approximately £297k at the 31 March 2017 which is less of an underspend projected in the previous period.

3.2 In relation to services hosted by Perth and Kinross and Angus IJB's on behalf of Dundee IJB, Dundee's share of overspends from these services are expected to be to the value of £1,248k. The net transfer of anticipated service costs hosted by Dundee IJB on behalf of Angus and Perth and Kinross IJB's is expected to result in a further overspend to Dundee of around £100k. This total anticipated overspend is also subject to the risk sharing arrangement therefore will remain with NHS Tayside.

4.0 MAIN TEXT

4.1 Background

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

4.1.2 The IJB confirmed the overall budgeted resources for delegated services at its meeting in June 2016 with associated savings and efficiency targets to be achieved through the delivery of a local transformation programme for these delegated services. The detail of this is outlined in a separate report on this agenda. Members of the IJB will recall that as part of the Due Diligence process reported to the IJB in March 2016, a number of risks associated with the resources delegated by Dundee City Council and NHS Tayside to the IJB, including anticipated levels of savings, were highlighted. This financial monitoring position reflects the status of these risks as they display within cost centre budgets.

4.1.3 The current financial position as at 31 December 2016 is shown in Appendix 1. Members of the IJB will note that the presentation of the budgets and projected expenditure position to March 2017 continues to be more aligned than integrated however, this will evolve as the transition to new locality based integrated service structures progresses.

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

4.2 Projected Outturn Position – Key Areas

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

4.3 Services Delegated from NHS Tayside

4.3.1 Members will recall from the Due Diligence process that there were a number of significant risks and challenges highlighted within delegated budgets from NHS Tayside. This included a testing savings target across services as a reflection of the overall financial challenges facing NHS Tayside. This overall financial challenge has resulted in NHS Tayside embarking on a comprehensive Transformation Programme to deliver service efficiencies and improvement. A number of the workstreams within this programme have been applied to delegated services, which combined with local service delivery efficiencies, constitutes Dundee Health and Social Care Partnership's Transformation Programme. These efficiencies have been incorporated into service budgets where identifiable and the financial projections take into account the anticipated achievement of a number of these savings.

4.3.2 The financial projection for services delegated from NHS Tayside to the IJB indicates a projected overspend of around £304k by the end of the financial year excluding the prescribing budget but including FHS and GMS. This is a significant reduction in the previous projected overspend of £754k and moves the expenditure position for these services closer to the expected financial position outlined following consideration of the range of service redesign initiatives outlined in the IJB's Transformation Programme.

4.3.3 A number of service underspends are noted within Mental Health, Community Nursing and Allied Health Professionals primarily as a result of staff vacancies. This is additional to staff slippage / vacancy factors incorporated into the base budget for these services and therefore provides an additional contribution to achieving the overall savings target. It should be noted however that a significant element of the efficiency savings target remains within the Other Dundee Services / Support / Management heading resulting in this service reflecting an adverse financial position.

4.3.4 Staff cost pressures exist in a number of other services such as Continuing Care and Palliative Care where the use of nursing bank and agency costs, although reducing from previous years, results in increased costs. Initiatives planned within the Transformation Programme will reduce the impact of these in due course. The mid-year transfer of the Medicine for the Elderly service to the IJB with a corresponding overspend of around £475k has added to the range of pressures being faced within the delegated budget.

4.3.5 A projected shortfall totalling £2,313k remains in the prescribing budget which is a deterioration of around £79k from the previously reported figure. A number of initiatives continue to be developed through NHS Tayside's Transformation Programme supported by the Prescribing Management Group (PMG). The PMG function as a collaborative with delegated authority from the three Tayside IJBs and NHS Tayside Board, to allocate, monitor and agree actions to make optimal use of the prescribing budget. The PMG will deliver a whole system approach to developing prescribing action plans, implementation of prescribing projects and monitoring, identification and management of financial risks within prescribing. Dundee HSCP contributes to the PMG and will continue to explore innovative ways of safely delivering services in a more cost effective manner. Members will recall that the IJB agreed to invoke the risk sharing arrangement with NHS Tayside in relation to this budget whereby the leadership of delivery of efficiency savings within this budget remains the responsibility of NHS Tayside.

4.3.6 Members of the IJB will also be aware that Angus and Perth and Kinross IJB's 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 IJB's 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. The net impact to Dundee IJB of hosted services is a further projected overspend of £1,348k.

4.4 Services Delegated from Dundee City Council

4.4.1 Due to the nature of the local government budget process, an efficiency savings plan for services delegated by Dundee City Council was in place prior to services becoming delegated to Dundee Integration Joint Board. These efficiencies are embedded within service budgets and the financial monitoring reflects performance in achieving these. Risks associated with these budgets were also reflected in the Due Diligence process with the challenge of achieving staff slippage targets being the major concern. These are also embedded in the cost centre budgets therefore the financial monitoring position reflects the level of risk still anticipated against this.

4.4.2 The financial projection for services delegated from Dundee City Council to the IJB notes an overall projected underspend of around £297k which is a deterioration from a previously reported underspend of £553k. Within this overall position, a number of pressure areas continue to emerge. Over the last few months, the financial position has continued to reflect the impact of responding to the challenge of reducing delayed discharges through investment in additional capacity above planned levels for care at home services and care home placements to the value of approximately £865k. This has been funded through the ability of the IJB to respond quickly to shift resources within the current 2016/17 budget and this will require further consideration as part of the 2017/18 budget process.

4.4.3 The areas of underspend mainly appear in budgeted resources allocated to further develop accommodation with support services. This is mainly as a result of a difference in timing between the investment made by Dundee City Council in budgeted resources to meet anticipated demographic pressures within the adult care budget and the commissioning and development of additional services and capacity to provide the infrastructure to meet projected demand. It is anticipated that this investment will be fully committed during 2017/18. At this stage of the financial year, staff costs within Older People's services are anticipated to fall short of meeting set slippage targets, partly due to delays in achieving planned service efficiencies and this will continue to be closely monitored throughout the year.

4.5 Transformation Programme Innovation and Development Funding

4.5.1 Dundee IJB agreed Report DIJB15-2016 (Planning for Additional Resources) at its meeting on 4 May 2016 which set out the planned investment of additional funding from the Scottish Government with further investment reflected in Report DIJB50 approved at the October meeting. The original planning assumptions around the commitment of these resources reflected in Report DIJB15-2016 was for additional spend of £5.844m on initiatives to support the priorities set out within the Strategic and Commissioning Plan in 2016/17 (excluding contingencies). The latest financial monitoring position notes this is likely to be approximately £5.161m with the reduction mainly due to slippage in some of the large scale projects such as Enhanced Community Support and less commitment to new initiatives in 2016/17. However this increases the value of anticipated carry forward of resources to £3.403m in order to sustain innovation investment in future years.

5.0 POLICY IMPLICATIONS

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

6.0 CONSULTATIONS

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

7.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 6 February 2017

Appendix 1

DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP - FINANCE REPORT 2016/17 AS AT DECEMBER 2016

	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	41,521	1,468	14,021	453	55,542	1,920
Mental Health	1,615	-373	3,557	-300	5,172	-673
Learning Disability	23,056	-390	1,241	-95	24,297	-485
Physical Disabilities	5,578	-669	0	0	5,578	-669
Substance Misuse	783	21	2,356	-8	3,139	13
Community Nurse Services / AHP / Other Adult	5,051	-262	10,934	-288	15,984	-550
Hosted Services	0	0	18,349	-760	18,349	-760
Other Dundee Services / Support / Mgmt*	1,312	-90	21,446	1,481	22,758	1,390
Total Health and Community Care Services	**78,915**	**-297**	**71,903**	**483**	**150,818**	**187**
Prescribing (FHS)	0	0	33,197	2,313	33,197	2,313
General Medical Services	0	0	24,668	-82	24,668	-82
FHS - Cash Limited & Non Cash Limited	0	0	20,199	-97	20,199	-97
Grand Total	**78,915**	**-297**	**149,967**	**2,617**	**228,882**	**2,321**
Hosted Services - Net Impact of Risk Sharing Adjustment			4,632	1,348	4,632	1,348

* Includes NHST budgeted efficiency savings target of £1,717k not yet allocated to specific cost centres.

APPENDIX 2

DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP – FINANCE REPORT

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Psych Of Old Age (In Pat)			4,558	-30	4,558	--30
Older Peoples Serv. -Community			456	-5	456	-5
Continuing Care			2,396	55	2,396	55
Medicine for the Elderly			3,585	475	3,585	475
Medical (P.O.A)			607	3	607	3
Psy Of Old Age - Community			1,487	-45	1,487	-45
Intermediate Care			933	0	933	0
Staff	18,719	565			18,719	565
Supplies & Services / Transport etc	1,904				1,904	0
Property	1,489				1,489	0
Care Home Placements	20,606	267			20,606	267
Day Opportunities / Enabler	225				225	0
Respite	854	165			854	165
Domiciliary Care	5,820	598			5,820	598
Other Third Party Payments	1,610				1,610	0
Sheltered / Very Sheltered	684				684	0
Income	-10,389	-127			-10,389	-127
Older Peoples Services	41,521	1,468	14,021	453	55,542	1,920

	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
General Adult Psychiatry			3,557	-300	3,557	-300
Staff	633	-33			633	-33
Supplies & Services / Transport etc	9				9	0
Accommodation with Support	2,395	-244			2,395	-244
Care Home Placements	515				515	0
Day Opportunities / Enabler	249				249	0
Respite	19				19	0
Domiciliary Care	38				38	0
Housing Support	418				418	0
Sheltered / Very Sheltered	216				216	0
Income	-2,876	-96			-2,876	-96
Mental Health	1,615	-373	3,557	-300	5,172	-673
Learning Disability (Dundee)			1,241	-95	1,241	-95
Staff	6,596	--64			6,596	-64
Supplies & Services / Transport etc	294				294	0
Property	287				287	0
Accommodation with Support	11,205	-326			11,205	-326
Care Home Placements	2,277				2,277	0
Day Opportunities / Enabler	1,518				1,518	0
Respite	124				124	0
Domiciliary Care	0				0	0
Housing Support	401				401	0
Other Third Party Payments	1,241				1,241	0
Sheltered / Very Sheltered	2,833				2,833	0
Income	-3,719				-3,719	0
Learning Disability	23,056	-390	1,241	-95	24,297	-485

	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
Staff	1,442	22			1,442	22
Supplies & Services / Transport etc	100				100	0
Property	140				140	0
Accommodation with Support	986	-692			986	-692
Care Home Placements	1,923				1,923	0
Respite	38				38	0
Domiciliary Care	20				20	0
Other Third Party Payments	1,421				1,421	0
Sheltered / Very Sheltered	116				116	0
Income	-608				-608	0
Physical Disabilities	5,578	-669	0	0	5,578	-669
Alcohol Problems Services			470	-3	470	-3
Drug Problems Services			1,886	-5	1,886	-5
Staff	544	-44			544	-44
Supplies & Services / Transport etc	10				10	0
Accommodation with Support	239	65			239	65
Care Home Placements	149				149	0
Respite	0				0	0
Housing Support	37				37	0
Other Third Party Payments	32				32	0
Income	-228				-228	0
Substance Misuse	783	21	2,356	-8	3,139	13

	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
A.H.P.S Admin			387	-9	387	-9
Physiotherapy			3,171	-125	3,171	-125
Occupational Therapy			1,379	-60	1,379	-60
Nursing Services (Adult)			5,127	-100	5,127	-100
Community Supplies - Adult			130	0	130	0
Anticoagulation			369	6	369	6
Joint Community Loan Store			371	0	371	0
Staff	2,404	-262			2,404	-262
Supplies & Services / Transport etc	587				587	0
Property	148				148	0
Care Home Placements	-119				-119	0
Accommodation with support	0				0	0
Day Opportunities / Enabler	0				0	0
Respite	364				364	0
Housing Support	363				363	0
Other Third Party Payments	172				172	0
Sheltered / Very Sheltered	2,139				2,139	0
Income	-1,007				-1,007	0
Community Nurse Services / AHP / Intake / Other Adult Services	5,051	-262	10,934	-288	15,984	-550

	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			2,462	33	2,462	33
Palliative Care - Medical			998	18	998	18
Palliative Care - Angus			336	-48	336	-48
Palliative Care - Perth			1,457	138	1,457	138
Brain Injury			1,571	25	1,571	25
Dietetics (Tayside)			2,507	-145	2,507	-145
Sexual & Reproductive Health			1,962	-68	1,962	-68
Medical Advisory Service			150	-28	150	-28
Homeopathy			26	3	26	3
Tayside Health Arts Trust			57	0	57	0
Psychology			4,481	-547	4,481	-547
Eating Disorders			287	-28	287	-28
Psychotherapy (Tayside)			957	-25	957	-25
Learning Disability (Tay Ahp)			714	-23	714	-23
Keep Well			385	-65	385	-65
Hosted Services	0	0	18,349	-760	18,349	-760
Working Health Services			0	0	0	0
The Corner			390	-12	390	-12
Resource Transfer - Dcc			8,578	0	8,578	0
Dundee- Supp People At Home			0	0	0	0
Grants Voluntary Bodies Dundee			190	-20	190	-20
C.H.P. Management			686	-38	686	-38
Partnership Funding			11,649	0	11,649	0
Carers Strategy - Dundee			166	0	166	0
Public Health			486	-15	486	-15
Primary Care			871	-120	871	-120
Centrally Managed Budgets			-1,570	1,685	-1,570	1,685
Staff	934	-90			934	-90
Supplies & Services / Transport etc	94				94	0
Property	284				284	0
Income	0				0	0
Other Dundee Services / Support / Mgmt	1,312	-90	21,446	1,481	22,758	1,390

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Total Health and Community Care Services	**78,915**	**-297**	**71,903**	**483**	**150,818**	**187**
Other Contractors						
Prescribing (FHS)			33,197	2,313	33,197	2,313
General Medical Services			24,668	-82	24,668	-82
FHS - Cash Limited & Non Cash Limited			20,199	-97	20,199	-97
Grand Total H&SCP	**78,915**	**-297**	**149,967**	**2,617**	**228,882**	**2,321**
Hosted Recharges Out			-10,759	100	-10,759	100
Hosted Recharges In			15,391	1,248	15,335	1,248
Hosted Services - Net Impact of Risk Sharing Adjustment			**4,632**	**1,348**	**4,632**	**1,348**
Large Hospital Set Aside			**21,000**	**0**	**21,000**	**0**

ITEM No …9………..

REPORT TO:	**HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 FEBRUARY 2017**
REPORT ON:	**FINANCE SETTLEMENT 2017/18 OVERVIEW**
REPORT BY:	**CHIEF FINANCE OFFICER**
REPORT NO:	**DIJB5-2017**

1.0 PURPOSE OF REPORT

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

2.0 RECOMMENDATIONS

It is recommended that the IJB:

2.1 Notes the content of the Scottish Government's Draft Budget as it relates to health and social care partnerships;

2.2 Notes the further transfer of resources from NHS Boards to Integration Authorities to invest in social care of £107m taking the total transfer of resources to support health and social care integration to £357m over 2016/17 and 2017/18;

2.3 Notes the potential implications of this to Dundee Integration Joint Board's delegated budget;

2.4 Remits to the Chief Finance Officer to bring forward a proposed budget for 2017/18 in relation to delegated services for consideration by the IJB.

3.0 FINANCIAL IMPLICATIONS

3.1 The full financial implications of the finance settlement and outcome of subsequent negotiations with Dundee City Council and NHS Tayside will be presented to the IJB at a special Budget meeting in March 2017 as part of the IJB's financial planning and budget setting process. This will include an overview of anticipated financial pressures over 2017/18 and associated Transformation Programme to mitigate these.

4.0 MAIN TEXT

4.1 The Cabinet Secretary for Finance and the Constitution announced the Scottish Draft Budget in December 2016. Since then, the Scottish Government has sought to provide clarity to Health and Social Care Partnerships, Local Authorities and NHS Boards on the detail behind the announcements in the settlement as they relate to health and social care. This report provides an overview of these announcements and outlines the impact they are likely to have on Dundee IJB's delegated budget for 2017/18.

4.2 Additional Investment in Health and Social Care

4.2.1 In 2017/18 an additional £107m will be transferred from NHS Boards to Integration Authorities to invest in social care. Of this, £100m is to support the continued delivery of the Living Wage, sleepovers and sustainability in the care sector and £7m to disregarding the value of war pensions from financial assessments for social care charging and pre-implementation work in respect of new carer's legislation. This is additional to the £250m added in to the 2016/17 budget in support of health and social care integration. Dundee's share of the additional £100m is £3.04m and this is required to fund the full year effect of ensuring all adult social care workers receive the living wage, a further increase in the living wage from £8.25 per hour to £8.45 per hour, ensuring sleepover payments meet statutory minimum payments and to support the financial sustainability of the social care sector. Dundee's share of the additional £7m is £0.21m, consisting of £150k in relation to loss of income through disregarding war pensions and £60k as part of Carers Act pre-implementation. Detailed work is currently being undertaken to estimate the projected cost of these commitments to services provided by Dundee Health and Social Care Partnership and this will be presented to Dundee IJB as part of the 2017/18 detailed Budget proposals.

4.2.2 The Draft Scottish Budget also sets out an investment programme to be allocated to NHS Boards as part of investment in reform with some of this relating to delegated services to Integration Authorities and will be channelled through Health and Social Care Partnerships. This includes additional investment in Primary Care nationally of £27m (taking the total reform investment to £60m) and Mental Health Services of £11m (taking total Mental Health Reform investment to £30m). Discussions are currently taking place with NHS Tayside to determine the scale of this resource locally and how it will be allocated.

4.2.3 For Primary Care it is identified that particular focus should be given to developing and expanding multi-disciplinary teams; sustainability of provision; development of GP clusters; and responsiveness to a new GP contract. For mental health, particular focus should be given to developing new models of care and support for mental health in primary care settings, improving the physical health of people with mental health problems, and improving mental health outcomes for people with physical health conditions, reducing unwarranted variation in access and assuring timely access; and developing services that focus on the mental health and wellbeing of children, young people and families, including improved access to perinatal mental health services. This investment will facilitate the commitment to shift the balance of care, so that by 2021/22 more than half of the NHS frontline spending will be in Community Health Services.

4.3 Impact of Local Authority Finance Settlement

4.3.1 As part of the finance settlement, Local Authorities will be able to adjust their allocations to Integration Authorities in 2017/18 by up to their share of £80 million below the level of budget agreed with their Integration Authority for 2016/17. In relation to Dundee City Council, this "share" based on a composite indicator of Grant Aided Expenditure (GAE) and NHS Scotland Resource Allocation Committee (NRAC), totals £2.44m. Dundee City Council has indicated its intention to apply the full reduction to the delegated budget as set out above although this position will be confirmed at the Council's budget setting meeting on the 23 February 2017.

4.3.2 As part of the budget negotiations with Dundee City Council, the 2017/18 delegated budget to Dundee IJB will include an uplift to cover the anticipated pay award for the year in addition to an uplift in relation to the National Care Home Contract. These uplifts are currently being negotiated nationally and therefore at this stage the outcome of these are unknown.

4.4 Impact of NHS Finance Settlement

4.4.1 The finance settlement in relation to NHS Boards stipulates that NHS contributions to Integration Authorities for delegated health functions will be maintained at least at 2016/17 cash levels. This has been clarified by the Scottish Government in that budgets to Integration Authorities for 2017/18 must be at least equal to the current recurring budget allocations in 2016/17. The net uplift to NHS Tayside's baseline budget following the transfer to Integration Authorities for delivery of improved outcomes in social care and support the delivery of the living wage to adult social care workers equates to 0.4%. Discussions are ongoing between the Chief Officer and Chief Finance Officer and NHS Tayside with regards to the implications of the settlement including consideration of the various cost pressures identified through the Due Diligence process.

4.4.2 As part of the NHS finance settlement, funding for Alcohol and Drugs Partnerships (ADP) to support delivery of agreed service levels will transfer to NHS Board baselines for delegation to Integration Authorities. The national value of this is £53.8 million with an NHS Tayside allocation of £4.159m. In 2016/17, ADP funding provided nationally was supplemented from the NHS Tayside revenue uplift to the extent of £1.2m in order to maintain the overall spending in addressing alcohol and substance misuse and maintaining alcohol and drugs treatment performance at existing levels across ADP areas. At this stage, it is unclear whether Tayside Health Board will commit this further level of discretionary funding in 2017/18.

4.4.3 The Scottish Government has also outlined its intention to review the effectiveness of the current arrangements with respect to hospital budget delegation to Integration Authorities, including "set aside" budgets. The three Tayside health and social care partnerships are currently piloting an approach with support from the Scottish Government to develop the commissioning model in relation to the large hospital set aside and gain a better understanding of the set aside value and implications of health and social care partnership's varying the scale of occupied bed days for their local population.

4.5 Health and Social Care Partnership Priorities

4.5.1 In setting out its ambitions for Integration Authorities within the finance settlement, the Scottish Government has reiterated the priorities health and social care partnerships are expected to achieve over the short to medium term. These are noted as follows:

Integration Authorities are responsible for planning and provision of social care, primary care and community healthcare and unscheduled hospital care for adults. Integration priorities are to:

1. Reduce occupied hospital bed days associated with avoidable admissions and delayed discharges, focussing investment in care alternatives that can help people to continue living independently in their own homes and communities for as long as possible.

2. Increase provision of good quality, appropriate palliative and end of life care, particularly in people's own homes and communities and also, where appropriate, in hospices, so that people who would benefit from such care access it.

3. Enhance primary care provision, with particular focus on developing and expanding multi-disciplinary teams; sustainability of provision; development of GP clusters; and responsiveness to a new GP contract.

4. Reflect delivery of the new Mental Health Strategy, with particular focus on developing new models of care and support for mental health in primary care settings; improving the physical health of people with mental health problems, and improving mental health outcomes for people with physical health conditions; reducing unwarranted variation in access and assuring timely access; and developing services that focus on the mental health and wellbeing of children, young people and families, including improved access to perinatal mental health services.

5. Where children's services are integrated, continue to invest in prevention and early intervention, particularly in the early years, with the expectation that work will continue to deliver 500 more health visitors by 2018.

6. Support delivery of agreed service levels for Alcohol and Drugs Partnerships' work, in support of which £53.8m is transferring to NHS Board baselines for delegation to Integration Authorities.

7. Ensure provision of the living wage to adult care workers and plan for sustainability of social care provision.

8. Continue implementation of Self Directed Support.

9. Prepare for commencement of the Carers (Scotland) Act 2016 on 1 April 2018.

4.5.2 In relation to measuring performance against these priorities under integration, the Ministerial Strategic Group for Health and Community Care (MSG) has agreed to track the following indicators:

(1) unplanned admissions;

(2) occupied bed days for unscheduled care;

(3) A&E performance;

(4) delayed discharges;

(5) end of life care; and

(6) the balance of spend across institutional and community services.

Integration Authorities have been invited to set out their local objectives and ambitions in relation to these by the end of February 2017.

4.6 Dundee IJB Budget

4.6.1 The full implications and outcomes of the finance settlement and subsequent negotiations with Dundee City Council and NHS Tayside will be presented to Dundee IJB at a special budget meeting in March 2017 where the proposed budget for delegated services will be presented. This will include consideration of the anticipated financial pressures and corresponding actions as expressed as the IJB's Transformation Programme.

5.0 POLICY IMPLICATIONS

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

6.0 CONSULTATION

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

7.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 6 February 2017

ITEM No …10……..….

REPORT TO:	**HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 FEBRUARY 2017**
REPORT ON:	**NATIONAL HEALTH AND SOCIAL CARE DELIVERY PLAN**
REPORT BY:	**CHIEF OFFICER**
REPORT NO:	**DIJB7-2017**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board (IJB) with an overview of the recently published national Health and Social Care Delivery Plan, and to set out how requirements relevant to the Health and Social Care Partnership (HSCP) are being addressed.

2.0 RECOMMENDATIONS

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

2.1 Notes the content of the national Health and Social Care Delivery Plan (attached as appendix 1) and local arrangements for responding to this.

2.2 Remits to the Integrated Strategic Planning Group (ISPG) to confirm that the detailed commitments made within the delivery plan are fully reflected within the Partnership's Strategic and Commissioning Plan and Strategic Planning Group Commissioning Statements.

2.3 Remits to the Chief Finance Officer to ensure that future performance reports submitted to the Performance and Audit Committee fully incorporate the local improvement objectives in relation to the six areas of performance set out at 4.3.4.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Health and Social Care Delivery Plan Overview

4.1.1 In December 2016 the Scottish Government published the national Health and Social Care Delivery Plan, which sets out a programme of work to further enhance health and social care services towards the aim of "*a Scotland with high quality services, that have a focus on prevention, early intervention and supported self-management*." The plan sets out expectations of significant step-change towards transformation of health and social care services by 2021.

4.1.2 Whilst the delivery plan has a focus on health services, it also recognises that for the Government's aspirations to be delivered that "*change must take place at pace and in collaboration with partners across and outside of the public sector, and that partnership working is essential for planning that will deliver the actions described.*" The plan recognises that capacity, focus and an appropriately skilled workforce will be required to address the increasing pressures on health and social care services stemming from our changing society, particularly those pressures associated with more people living longer and with long-term conditions.

4.1.3 The delivery plan sets out the Government's intention to focus on three areas which it believes will have the greatest impact on delivery and achieve transformational change over the next five

year period. The 'triple aim' of 'better care', 'better health' and 'better value' is to be delivered through four major programmes of linked activity: health and social care integration; the National Clinical Strategy; public health improvement; and, NHS Board reform. An integrated performance framework is to be developed early in 2017 for the different component parts of the delivery plan.

4.1.4 **Better care** is focused on improving quality of care by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all. This approach seeks to ensure that people get the right help at the right time, are involved in all aspects of their care through person-centred, safe and effective services. Better care also places an emphasis on care planning that anticipates health and social care needs, focuses on prevention and early intervention and further enhances the role of Community Health Services. Better care is aligned to the Partnership's strategic priorities and shifts for early intervention / prevention, person centred care and support, models of support / pathways of care and managing our resources effectively.

4.1.5 **Better health** is focused on improving health and wellbeing by promoting and supporting healthier lives, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management. This includes equal importance being placed on physical and mental health and approaches that promote key public sector services (such as health, social care and education) working together systematically to create a culture in which healthy behaviours are the norm. Better health is aligned to the Partnership's strategic priorities and shifts for health inequalities, and early intervention and prevention.

4.1.6 **Better value** is focused on increasing value from, and financial sustainability of, care by making effective use of available resources and efficient and consistent delivery that focuses resource on where it achieves most and on prevention and early intervention. This approach seeks to promote a culture of improvement, innovation and accountability and to ensure that services are organised and delivered at the level where they can provide the best, most effective services for individuals, including shifting the balance of services towards the community. Better value is aligned to the Partnership's strategic priorities and shifts for early intervention and prevention, and managing our resources effectively.

4.2 Key Implications for Health and Social Care Partnerships

4.2.1 The delivery plan sets out wide ranging ambitions and commitments under the four major programmes of work identified at 4.1.3, all of which have implications for the functions delegated to the Partnership. The delivery plan is directed to driving forward step-change at a national and local level in the integration of health and social care services.

4.2.2 The delivery plan sets out the expectation that Health and Social Care Partnerships will continue to plan and deliver well co-ordinated care that is timely and appropriate to people's needs, with care needs being better anticipated in order that fewer people are inappropriately admitted to hospital or long-term care. In support of this the delivery plan identifies three specific areas of focus for which Partnerships will be accountable for:

1. Reducing inappropriate use of hospital services
    - Unscheduled care and delayed discharge:
        - Making full use of powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings;
        - Raising performance across the whole of Scotland on delayed discharge to the performance of the top quartile of local areas, as a step to eliminating delayed discharge, reducing unscheduled hospital care and shifting resources into primary and community care;
        - By 2018, reducing unscheduled bed-days in hospital care by up to 10% by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital.

    - Palliative care:

- o By 2021, ensuring that everyone who needs palliative care will get hospice, palliative or end of life care, all who would benefit from a 'key information summary' receive one, and more people will have the opportunity to develop personalised care and support plans;
- o By 2021, doubling palliative and end of life provisions in the community, resulting in fewer people dying in a hospital setting.

2. Shifting resources to the community:
   - By 2021, increase Partnerships spending on primary care services to 11% of the frontline NHS Scotland budget.

3. Supporting the capacity of community care:
   - Continuing the programme of work to deliver change in adult social care sector with COSLA and other partners through work to reform the National Care Home Contract, social care workforce issues and new models of care and support in home care.

4.2.3 The programme of work under the National Clinical Care Strategy aims to achieve an integrated, re-balanced service that is more responsive and supportive to the needs of individuals. In primary and community care activity is focused on building capacity (particularly in GP practices and the associated multi-disciplinary workforce) and supporting the development of new models of care within GP provision, out-of-hours provision and mental health. Similarly to the areas of focus for health and social care integration (see 4.2.1) in secondary and acute care the National Clinical Strategy focuses on reducing unscheduled care, improving scheduled care and improving outpatients.

4.2.4 The delivery plan recognises the challenges to public health that arise from lifestyle behaviour, the modern environment and wider social-cultural factors that act to prevent positive health choices being made and sustained. The plan sets out work that will be undertaken to support a new set of national priorities and support key public health issues (particularly smoking, alcohol, obesity and physical activity). This includes a specific focus on improving access to mental health support by increasing capacity and reducing waiting times, and on the effectiveness and sustainability of models of supporting mental health in primary care.

4.3 Local Response to the Delivery Plan

4.3.1 The aims and priorities set out in the delivery plan are strongly reflected in the Partnership's Strategic and Commissioning Plan as described at 4.1.4 to 4.1.6. Strategic Planning Groups (SPGs) across the Partnership will undertake a further exercise, under the direction of the Integrated Strategic Planning Group (ISPG), to confirm that the detailed commitments made within the delivery plan are fully reflected within their own strategic commissioning statements.

4.3.2 During 2017 the delivery plan indicates that there will be new/refreshed national strategies, plans and/or guidance for: oral health; health literacy; alcohol; mental health; digital health and social care; and, physical activity and health and social care workforce planning. As these emerge Strategic Planning Groups will review their content to ensure appropriate alignment with strategic and commissioning plans (both Partnership wide and for specific SPGs), reporting back to the ISPG as required.

4.3.3 The delivery plan sets out a clear commitment to enhance services and improve performance in relation to unplanned admissions, unscheduled care, delayed discharges, end of life care, and the balance of spend across institutional and community services. National benchmarking data and the Partnership performance information for 2016/17 quarter 2 indicates that Dundee is currently demonstrating variable performance across national indicators in these areas (see appendix 2 attached and Performance & Audit Committee Report PAC3-2017).

4.3.4 In January 2017 the Scottish Government wrote to Partnership Chief Officers to indicate that the Ministerial Strategic Group for Health and Community Care has agreed that during 2017/18 Partnership performance in relation to unplanned admissions; occupied bed days for unscheduled care; A&E performance; delayed discharges; end of life care; and, the balance of spend across institutional and community services will be tracked (see appendix 2 – Measuring Performance Under Integration letter from the Scottish Government & Cosla dated 19 January 2017). Each Partnership has been invited to set out local objectives against indicators for each

area by the end of February. Officers are currently developing a response to this request and it is proposed that a detailed report setting out improvement targets and timescales will be submitted to the Performance and Audit Committee in due course. This will include how the Partnership will meet the improvement targets set out within the national delivery plan for delayed discharge, unscheduled bed days, end of life care and the balance of spend.

4.3.5 A set of statements is provided (in appendix 1 of the delivery plan) articulating what will be different at an individual, community, regional and national level in a transformed health and social care system. These will be considered within ongoing discussions regarding the development of local outcomes and indicators within the Partnerships' multi-tiered performance framework.

5.0 POLICY IMPLICATIONS

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

6.0 CONSULTATIONS

The Chief Finance Officer, Professional Advisors to the Integration Joint Board and the Clerk were consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 6 February 2017

Health and Social Care Delivery Plan

December 2016

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Introduction

1. Our aim[1] is a Scotland with high quality services, that have a focus on prevention, early intervention and supported self-management. Where people need hospital care, our aim is for day surgery to be the norm, and when stays must be longer, our aim is for people to be discharged as swiftly as it is safe to do so.
2. This delivery plan sets out our programme to further enhance health and social care services. Working so the people of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that:
   - is integrated;
   - focuses on prevention, anticipation and supported self-management;
   - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
   - focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and
   - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.
3. To realise these aims, we will continue to evolve our health and care services to meet new patterns of care, demand, and opportunities from new treatments and technologies. Since 2007 we have ensured that NHS funding has not only been protected but has increase to record high levels, supporting NHS frontline staffing to substantially increase. There have also been significant improvements in treatment times, reductions in mortality rates, and reductions in healthcare associated infections. As a consequence of these improvements, delivered by committed health and care staff across the country, patient satisfaction has also increased to record highs.
4. To meet the changing needs of our nation, investment, while necessary, must be matched with reform to drive further improvements in our services. Our services will increasingly face demands from more people with long-term conditions needing support from health and social care. These challenges were recognised in the Audit Scotland report[2], NHS in Scotland 2016, and underline the importance of bringing together the different programmes of work to improve health and social care services.

1 http://www.gov.scot/Topics/Health/Policy/2020-Vision.
2 http://www.audit-scotland.gov.uk/report/nhs-in-scotland-2016.

5. This plan is not an exhaustive list of all the actions being taken to improve our health and our health and social care system. While it concentrates on health services, our aspirations will only be delivered through a wider focus on the support provided by a range of services. It acknowledges that change must take place at pace and in collaboration with partners across and outside of the public sector, and that partnership working is essential for the planning that will deliver the actions described here.

How Will We Deliver Our Plan?

6. This plan will help our health and social care system evolve, building on the excellence of NHS Scotland, recognising the critical role that services beyond the health sector must play and is ultimately fit for the challenges facing us. What that will look like for individuals is described in more detail in **Appendix 1**. We must prioritise the actions which will have the greatest impact on delivery. We will focus on three areas, often referred to as the 'triple aim':
   - we will improve the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all ('**better care**');
   - we will improve everyone's health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management ('**better health**'); and
   - we will increase the value from, and financial sustainability of, care by making the most effective use of the resources available to us and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention ('**better value**').

Better care

7. We need to ensure that everyone receives the right help at the right time, not just now, but in the years to come as our society continues to change. That requires a change in our approach to medicine and in how and where the services that support our health are delivered. First, we need to move away from services 'doing things' to people to working with them on all aspects of their care and support. People should be regularly involved in, and responsible for, their own health and wellbeing.

8. Ultimately, individuals and where appropriate, their families – should be at the centre of decisions that affect them. They should be given more freedom, choice, dignity and control over their care. Care planning should anticipate individuals' health and care needs – both by helping those with chronic and other complex conditions to manage their needs more proactively, and by focusing on a prevention and early intervention approach to supporting health throughout people's lives. This is not always a question of 'more' medicine, but making sure that support fits with, and is informed by, individual needs. Success should be measured by better outcomes for individuals, not simply on whether processes and systems have been followed. As set out in the Healthcare Quality Strategy for Scotland[3], it is an approach to health rooted in the principles of care that is person-centred, safe and effective.

9. We need services that have the capacity, focus and workforce to continue to address the increasing pressures of a changing society. Our approach to primary and community care on the one hand, and acute and hospital services on the other, should support the critical health challenges our society faces, not least with respect to an ageing population. For our Community Health Service, that will mean everyone should be able to see a wider range of professionals more quickly, working in teams. For acute and hospital services, it will mean thinking differently about how some health and care services are delivered if we are to ensure people receive high-quality, timely and sustainable support for their needs throughout their lives.

Better health

10. To improve the health of Scotland, we need a fundamental move away from a 'fix and treat' approach to our health and care to one based on anticipation, prevention and self-management. The key causes of preventable ill health should be tackled at an early stage. There must be a more comprehensive, cross-sector approach to create a culture in which healthy behaviours are the norm, starting from the earliest years and persisting throughout our lives. The approach must acknowledge the equal importance of physical and mental health as well as the need to address the underlying conditions that affect health.

11. This can only be done by health and other key public sector services (such as social care and education) working together systematically. All services must be sensitive to individual health and care needs, with a clear focus on early intervention. Moreover, it will not just be what services can provide, but what individuals themselves want and what those around them – not least families and carers – can provide with support. Services need to be designed around how best to support individuals, families and their communities and promote and maintain health and healthy living.

3 http://www.gov.scot/Resource/Doc/311667/0098354.pdf.

Better value

12. Better value means more than just living within our means; it means improving outcomes by delivering value from all our resources. It is not just about increasing the efficiency of what we currently do, but doing the right things in different ways. This will demand an integrated approach to the components of the delivery plan so that the whole approach and its constituent parts are understood and joined up.

13. Critical to this will be shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment.

14. Taking full account of the current pressures on primary and community services, we need to redesign those services around communities and ensure that they have the right capacity, resources and workforce. At the same time, people should look to improved and sustainable services from hospitals.

15. We need to free up capacity in hospitals and acute care, allowing for specialist diagnostic and elective centres to provide better-quality services to people and potentially changes to be made to the location of some services. Services should be organised and delivered at the level where they can provide the best, most effective service for individuals. Regional – and in some case, national – centres of expertise and planning should develop for some acute services to improve patient care. The governance structures of all our NHS Boards should support these changes and maximise 'Once for Scotland' efficiencies for the kind of functions all health services need to deliver. That doesn't mean structural change to NHS Boards responsible for the delivery of services to our patients but it does mean that they must work more collaboratively and across boundaries.

16. Evolving our services must also be rooted in a widespread culture of improvement. Sustainable improvements in care, health and value will only be achieved by a strong and continued focus on innovation, improvement and accountability across the whole health and social care workforce.

17. Our health and care system has achieved a great deal in the last ten years using improvement methods which are data rich, engaging of leaders and frontline staff, and outcome driven. The Scottish Patient Safety Programme[4] is a good example of what this approach can deliver. While work in safety, efficiency and person-centred care has been planned and led centrally, the improvement has been local. The NHS Scotland workforce is crucial to this, and teams released to test and measure have already produced globally recognised improvements for Scotland's patients, families and carers.

4 http://www.gov.scot/Resource/Doc/311667/0098354.pdf.

18. We will build on the extensive investment in improvement skills and capacity across the health service to continue testing and measuring changes to improve care, supported by the dedicated expertise of Healthcare Improvement Scotland.

19. In meeting the triple aim, our ambition is not about a single strand of work or necessarily about commissioning a new series of projects. Indeed, much of the work is already underway. It is about making sure the different components of change work together to achieve the interlinked aims of better care, better health and better value at pace. Across those different aims, our actions are being driven by four major programmes of activity:
    - health and social care integration;
    - the National Clinical Strategy[5];
    - public health improvement; and
    - NHS Board reform.

20. Taken together, these changes in health and social care will bring long-term sustainability of our services and the continuing improvement of the nation's health and wellbeing. They are underpinned by a series of cross-cutting, thematic programmes of activity, which are also set out below.

Health and social care integration

21. Optimising and joining up balanced health and care services, whether provided by NHS Scotland, local government or the third and independent sectors, is critical to realising our ambitions. Integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes. The people most affected by these developments, and for whom the greatest improvements can be achieved, are older people, people who have multiple, often complex care needs, and people at the end of their lives. Too often, older people, in particular, are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – and help for their carers – could better serve their needs.

5 http://www.gov.scot/Resource/0049/00494144.pdf.

22. For better integrated care to become a reality, the new Health and Social Care Partnerships must plan and deliver well-coordinated care that is timely and appropriate to people's needs. We are integrating health and social care in Scotland to ensure people get the right care, at the right time and in the right place, and are supported to live well and as independently as possible. An important aspect of this will be ensuring that people's care needs are better anticipated, so that fewer people are inappropriately admitted to hospital or long-term care. Consequently, we are focusing actions around three key areas: **reducing inappropriate use of hospital services**; **shifting resources to primary and community care**; and **supporting capacity of community care**.

Health and social care integration: actions

Reducing inappropriate use of hospital services

In **2017**, we will:

- Ensure Health and Social Care Partnerships – with NHS Boards, local authorities and other care providers – make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings. This will be a key lever in shifting the focus of care across health and social care services.
- Agree with partners how to deliver an ambition of raising the performance of the whole of Scotland on delayed discharges from hospitals to the performance of the top quartile of local areas. This will be done as a step to achieving our wider commitments of eliminating delayed discharges, reducing unscheduled hospital care and shifting resources into primary and community care.
- By **2018**, we aim to: Reduce unscheduled bed-days in hospital care by up to 10 percent (ie. by as many as 400,000 bed-days) by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital. A range of actions will be taken to achieve this, including improving links between secondary, primary and community care under integration, supported by further work to understand better and take action on the extent to which emergency admissions are currently inappropriate and avoidable. As a result, people should only stay in hospital for as long as necessary and get more appropriate care in a more homely setting. It will reduce growth in the use of hospital resources, support balance across NHS Board budgets and give clear impetus to the wider goal of the majority of the health budget being spent in the community by **2021** (as set out below). The annual reports produced by Health and Social Care Partnerships and regular monitoring data will enable progress to be tracked.

Health and social care integration: actions – continued

- By **2021**, we aim 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 receive one – these summaries bring together important information to support those with complex care needs or long-term conditions, such as future care plans and end of life preferences. More people will have the opportunity to develop their own personalised care and support plan. The availability of care options will be improved by doubling the palliative and end of life provision in the community, which will result in fewer people dying in a hospital setting.

Shifting resources to the community

- By **2021**, we will: Ensure Health and Social Care Partnerships increase spending on primary care services, so that spending on primary care increases to 11 percent of the frontline NHS Scotland budget. Again, the annual reports produced by Health and Social Care Partnerships and regular monitoring data will be used to assess progress.

Supporting the capacity of community care

- In **2017**, we will: Continue to take forward a programme of work to deliver change in the adult social care sector, together with COSLA and other partners. This has begun with work to reform the National Care Home Contract, social care workforce issues and new models of care and support in home care. Reform of the National Care Home Contract will maintain the continuity, stability and sustainability of residential care provision while embedding greater local flexibility, maximising efficiency, improving quality, enhancing personalisation and promoting innovation. This national, consensus-based approach to improving social care will reinforce the ability of Health and Social Care Partnerships to match care and health support for individuals more quickly and more appropriately.

National Clinical Strategy

23. The National Clinical Strategy sets out a framework for developing health services across Scotland for the next 10-20 years. It envisages a range of reforms so that health care across the country can become a more coherent, comprehensive and sustainable high-quality service – one that is fit to tackle the challenges we face. At its heart is a fundamental change in the respective work of acute and hospital services and primary and community care, and a change in the way that medicine is approached. As a result, the Strategy aims to:
    - strengthen primary and community care;
    - improve secondary and acute care; and
    - focus on realistic medicine.

Primary and community care

24. Community and hospital-based care needs to be integrated and rebalanced to ensure that local health services are more responsive and supportive to the needs of individuals, not least those with chronic conditions who would be better supported in primary and community care. That requires reforming the latter to deliver a stronger, better resourced and more flexible service for people. We are also working to address the current workload pressures and recruitment challenges facing many GP practices and cannot simply result in a crude redistribution of pressures between different parts of the health service. To do this, we must:

    - support individuals, families and carers to understand fully and manage their health and wellbeing, with a sharper focus on prevention, rehabilitation and independence;
    - expand the multi-disciplinary community care team with extended roles for a range of professionals and a clearer leadership role for GPs;
    - develop and roll out new models of care that are person- and relationship-centred and not focused on conditions alone;
    - enable those waiting for routine check-up or test results to be seen closer to home by a team of community health care professionals, in line with the work of the Modern Outpatient Programme[6] in hospitals (as detailed later);
    - ensure the problems of multiple longer-term conditions are addressed by social rather than medical responses, where that support is more appropriate; and
    - reduce the risk of admission to hospital through evidence-based interventions, particularly for older people and those with longer-term conditions.

    We will achieve this by **building up capacity in primary and community care** and **supporting development of new models of care**.

6 http://www.gov.scot/Publications/2016/12/2376.

Primary and community care: actions

Building up capacity in primary and community care

- In **2017**, we will: Continue the investment in recruitment and expansion of the primary care workforce which began in 2016, and which will mean that, by **2022**, there will be more GPs, every GP practice will have access to a pharmacist with advanced clinical skills and 1,000 new paramedics will be in post. This will reinforce the workforce and the capacity of primary and community care to support our services for the future and will be done in line with our National Health and Social Care Workforce Plan (as discussed later).

By **2018**, we aim to:

- Have increased health visitor numbers with a continued focus on early intervention for children through addressing needs identified through the Universal Health Visiting Pathway[7], which started in 2016. As a result of this, every family will be offered a minimum of 11 home visits including three child health reviews by **2020**, ensuring that children and their families are given the support they need for a healthier start in life.
- Have commenced Scotland's first graduate entry programme for medicine. This will focus on increasing the supply of doctors to rural areas and general practices more generally.
- By **2020**, we aim to: Have implemented the recommendations of the Improving Practice Sustainability Short Life Working Group, the GP Premises Short Life Working Group and the GP Cluster Advisory Group. These actions will support more sustainable GP practices over the long term and build stronger links to Health and Social Care Partnerships, ensuring that the changes in primary care are both effective and sustainable.

By **2021**, we aim to:

- Have strengthened the multi-disciplinary workforce across health services. We will agree a refreshed role for district nurses by **2017**, train an additional 500 advanced nurse practitioners by **2021** and create an additional 1,000 training places for nurses and midwives by **2021**. This will build on four successive increases in student nursing and midwifery intakes to meet additional demand, especially in primary and community settings.
- Have increased the number of undergraduates studying medicine by 250 as a result of the 50 additional places in Scotland's medical schools introduced in **2016**.
- Have increased spending on primary care and GP services by £500 million by the end of the current parliament so that it represents 11 percent of the frontline budget. This is a fundamental change in how health resources are directed and will enable the critical shift in balance to primary and community care.

7 http://www.gov.scot/Resource/0048/00487884.pdf.

Primary and community care: actions – continued

Supporting new models of care

In **2017**, we will:

- Negotiate a new landmark General Medical Services contract, as a foundation for developing multi-disciplinary teams and a clearer leadership role for GPs.
- Test and evaluate the new models of primary care in every NHS Board, which will be funded by £23 million, and disseminate good practice with support from the Scottish School of Primary Care. These new models of care will include developing new, effective approaches to out-of-hours services and mental health support, and are essential for moving to a more person- and relationship-centred approach to individual care across the whole of Scotland.
- Taken forward the recommendations from the Review of Maternity and Neonatal Services[8] and progress actions across all aspects of maternity and neonatal care.
- Launch Scotland's Oral Health Plan, following consultation, as part of a comprehensive approach to modernise dentistry and improve the oral health of the population through a prevention and early intervention approach.

By **2018**, we will:

- Have rolled out the Family Nurse Partnership programme nationally to provide targeted support for all eligible first-time teenage mothers. This will give intensive support to mothers and their children and give their health and wellbeing a strong start.

Secondary and acute care

25. People should only be in hospital when they cannot be treated in the community and should not stay in hospital any longer than necessary for their care. This will mean reducing inappropriate referral, attendance and admission to hospital, better signposting to ensure the right treatment in a timely fashion, and reducing unnecessary delay in individuals leaving hospital. Addressing admission to, and discharge from, hospitals will be the responsibility of Health and Social Care Partnerships; but all partners will need to work together to reduce the levels of delayed discharges, ensure services are in place to facilitate early discharge and avoid preventable admissions in the first place.

26. At the same time, within hospitals, more needs to be done to ensure better outcomes for people, while making a more effective use of resources. There is increasing evidence that better outcomes are achieved for people when complex operations are undertaken by specialist teams and some services are planned and delivered on a population basis. This might mean some services currently delivered at a local level would produce better outcomes for people if delivered on a wider basis. This kind of service change needs to be accompanied by investment in new, dedicated facilities to ensure that the capacity for high-quality, sustainable services can be delivered at the appropriate level.

8 http://www.gov.scot/Topics/People/Young-People/child-maternal-health/neonatal-maternity-review.

27. To achieve this we will take intensive and coordinated action in several key areas of secondary and acute care: **reducing unscheduled care**; **improving scheduled care**; and **improving outpatients**.

Secondary and acute care: actions

Reducing unscheduled care

In **2017**, we will:

- Complete the roll out of the Unscheduled Care Six Essential Actions[9] across the whole of acute care. Through improving the time-of-day of discharge, increasing weekend emergency discharges and a more effective use of electronic information in hospitals, we will enhance a patient's journey at each stage through the hospital system and back into the community without delay.
- Undertake a survey on admission and referral avoidance opportunities. This will give a strong evidence base to target modelling for how to reduce unscheduled care through integrated primary and secondary care services.

Improving scheduled care

In **2017**, we will:

- Put in place new arrangements for the regional planning of services. The National Clinical Strategy sets out an initial analysis of which clinical services might best be planned and delivered nationally and regionally, based on evidence supporting best outcomes for the populations those services will serve. This is a critical first step towards strengthening population-based planning arrangements for hospital services, working across Scotland. NHS boards will work together through three regional groups. In **2018**, the appropriate national and regional groups will set out how services will evolve over the next 15 to 20 years, in line with the National Clinical Strategy.
- Reduce cancellations and private care spend in scheduled care by rolling out the Patient Flow Programme from the current pilots across all NHS Boards. The Programme builds on the success of previous programmes – such as Day Surgery, Enhanced Recovery for Orthopaedics and Fracture Redesign – by increasing national and local capacity to use operations management techniques to improve care for patients. Four pilot boards are implementing improvement projects covering emergency and elective theatre operations, elective surgery planning and emergency medical patient flow. As this is expanded, it will introduce more responsive and efficient secondary care and reduce wastage and the unnecessary use of resources.

9 http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/UnscheduledCare/6-Essential-Actions-To-Improving-Unscheduled-Care.

Secondary and acute care: actions – continued

By **2021**, we will:

- Complete investment of £200 million in new elective treatment capacity and expanding the Golden Jubilee National Hospital. Overall, this investment will ensure that there is high-quality and adequate provision of elective care services to meet the needs of an ageing population.
- Complete investment of £100 million in cancer care to ensure: earlier detection with more rapid diagnosis and treatment; more and better care during and after treatment, taking account of what matters most to people with cancer; increased entry to clinical trials/research; and an evidence driven cancer intelligence system for clinicians and patients with access to near-to-real time information through care pathways. Addressing cancer in such a comprehensive way will target one of the critical health issues facing the population.

Improving outpatients

- By **2020**, we aim to: Have reduced unnecessary attendances and referrals to outpatient services through the recently-published Modern Outpatient Programme. The aim is to reduce the number of hospital-delivered outpatient appointments by 400,000, reversing the year-on-year increase of new appointments. It will draw on the existing Delivering Outpatient Integration Together (DOIT) Programme and other activities such as the Technology Enabled Care Programme to:
  - give GPs greater access to specialist advice to reduce the time people wait to get appropriate treatment;
  - use clinical decision support tools to reduce the amount of time people wait to get the right treatment;
  - reduce the number of attendances for people with multiple issues through a holistic approach to their support and care;
  - enable GPs to have more access to hospital-based tests so that people can be referred to the right clinician first time; and
  - facilitate more return or follow-up appointments in non-hospital settings through virtual consultation from their own home.

Realistic medicine

28. We need to change our long-term approach to the role of medicine and medical interventions in our health and wellbeing. A new clinical paradigm, based on a 'realistic medicine' approach and backed by clinical leadership, will support people through informed, shared decision-making that better reflects their preferences and what matters most to them. There needs to a greater focus on the discussions that medical practitioners have with people about their care, and what different types of medical intervention can entail. Relationships between individuals and practitioners should be based on helping people understand options about their care and choose treatment according to their preferences.

29. At the same time, we must get better value out of medicine and medical interventions and find ways to reduce any unnecessary cost. Waste and variation in clinical practice need to be addressed, and we should also support the reliable implementation of effective interventions that are not currently being made available to people.

30. Consequently, we need to take forward actions that will strengthen **relationships between professionals and individuals** as well as **reduce the unnecessary cost of medical action**.

Realistic medicine: actions

Strengthening relationships between professionals and individuals

In **2017**, we will:

- Refresh our Health Literacy Plan, Making It Easy[10], to support everyone in Scotland to have the confidence, knowledge, understanding and skills we need to live well with any health condition we have.
- Review the consent process for patients in Scotland with the General Medical Council and Academy of Medical Royal Colleges and make recommendations for implementation from **2018** onwards. This is a key element in transforming the relationship between individuals and medical professionals.

10 http://www.gov.scot/Topics/Health/Support-Social-Care/Health-Literacy.

Realistic medicine: actions – continued

By **2019**, we aim to:

- Commission a collaborative training programme for clinicians to help them to reduce unwarranted variation. This will support a workforce that can find more effective and valued ways of delivering medicine.
- Refresh the Professionalism and Excellence in Medicine Action Plan[11] and align high-impact actions to realistic medicine.

Reducing the unnecessary cost of medical action

By **2018**, we aim to:

- Incorporate the principles of realistic medicine as a core component of lifelong learning in medical education and mainstream the principles of realistic medicine into medical professionals' working lives at an early stage.

By **2019**, we aim to:

- Develop a Single National Formulary to further tackle health inequalities by reducing inappropriate variation in medicine use and cost and reduce the overall cost of medicine.

Public health improvement

31. Scotland's ability to respond to infectious diseases and other risks to health matches and, in some cases, exceeds that of much of the developed world. But in common with many developed societies, we face greater challenges to public health arising from lifestyle behaviours, wider social-cultural factors that prevent positive health choices being made and a modern environment that impacts on the health and wellbeing of individuals, families and communities. There are many social determinants which impact on health and wellbeing, including those that can affect us from our earliest years throughout our lives, such as Adverse Childhood Experiences. We need to increase public and service knowledge and awareness of where avoidable harm can be reduced, including a wider understanding of both physical and mental health and the right actions to promote and strengthen healthy lifestyles.

11 http://www.gov.scot/Publications/2014/01/8967.

32. This requires a concerted, sustained and comprehensive approach to improving population health through targeting particular health behaviours, acting to reduce avoidable harm and illnesses and taking a population- and lifetime-wide approach to prevention and early intervention treatment. We will:
    - create a clear set of **national public health priorities** for Scotland as a whole and streamline the currently cluttered **public health landscape**;
    - develop and build on our sustained approach to addressing the **key public health issues** of alcohol and tobacco misuse and diet and obesity;
    - drive forward a new approach to **mental health** that ensures support and treatment are mainstreamed across all parts of the health service – and beyond – and is not simply the responsibility of specialist services, working within the framework of a new 10-year mental health strategy to be published in early 2017; and
    - support a **More Active Scotland**[12].

Public health improvement: actions

Supporting national priorities

- In **2017**, we aim to: Set national public health priorities with SOLACE and COSLA, that will direct public health improvement across the whole of Scotland. This will establish the national consensus around public health direction that will inform local, regional and national action.
- By **2019**, we aim to: Support a new, single, national body to strengthen national leadership, visibility and critical mass to public health in Scotland. Such a body will have a powerful role in driving these national priorities and providing the evidence base to underpin immediate and future action.
- By **2020**, we aim to: Have set up local joint public health partnerships between local authorities, NHS Scotland and others to drive national public health priorities and adopt them to local contexts across the whole of Scotland. This will mainstream a joined-up approach to public health at a local level.

12 http://www.gov.scot/Resource/0044/00444577.pdf.

Public health improvement: actions – continued

Supporting key public health issues

In **2017**, we will:

- Continue delivery of the ambitious targets set out in our 2013 Strategy, Creating a Tobacco Free Generation[13], including reducing smoking rates to less than 5 percent by 2034. We will implement legislation to protect more children from secondhand smoke and reduce smoking in hospital grounds.
- Refresh the Alcohol Framework[14], building on the progress made so far across the key areas of: reducing the harms of consumption; supporting families and communities; encouraging positive attitudes and choices; and supporting effective treatment. A key part of the Framework is the introduction of a minimum unit price for alcohol and we will work towards its implementation at the earliest opportunity, subject to the current legal proceedings. This will combine into a highly ambitious approach to reducing alcohol harm in Scotland.
- Consult on a new strategy on diet and obesity. There are huge preventable costs to NHS Scotland and society associated with poor diet, as one of the critical health issues we are facing, and it requires a different approach to diet and obesity.
- Introduce the Active and Independent Living Improvement Programme which will support people of all ages and abilities to live well, be physically active, manage their own health conditions, remain in or return to employment, and live independently at home or in a homely setting.
- By **2021**, we will: Deliver the Maternal and Infant Nutrition Framework with a focus on improving early diet choices and driving improvements in the health of children from the earliest years. This will include: by **2017**, rolling out universal vitamins to all pregnant women; by **2019**, consolidating best practice and evidence on nutritional guidance for pregnancy up to when children are aged 3, and developing a competency framework to promote and support breastfeeding; and by **2020**, have integrated material into training packages for core education and continuing professional development.

13 http://www.gov.scot/resource/0041/00417331.pdf.
14 http://www.gov.scot/Publications/2009/03/04144703/14.

Public health improvement: actions – continued

Supporting mental health

- By **2018**, we will: Improve access to mental health support by rolling out computerised cognitive behavioural therapy services nationally.

By **2019**, we will:

- Have evaluated the most effective and sustainable models of supporting mental health in primary care, and roll these out nationally by **2020**.
- Have rolled out nationally targeted parenting programmes for parents of 3- and 4-year olds with conduct disorder.

By **2020**, we will:

- Have improved access to mental health services across Scotland, increased capacity and reduced waiting times by improving support for greater efficiency and effectiveness of services, including Child and Adolescent Mental Health Services and psychological therapies. This will be accompanied by a workforce development programme and direct investment to increase capacity of local services.
- Have delivered new programmes promoting better mental health among children and young people across the whole of Scotland.
- By **2021**, we will: Have invested £150 million to improve services supporting mental health through the actions set out in the 10-year strategy.

Supporting a More Active Scotland

- In **2017**, we will: Publish a new delivery plan to support the Active Scotland Outcomes Framework and the Vision for a More Active Scotland, with greater action to address inequalities in physical activity across Scotland and a refocusing of resources.
- By **2019**, we will: Have embedded the National Physical Activity Pathway in all appropriate clinical settings across the health care system, ensuring that:
  - hospitals routinely support patients and staff to be more physically active;
  - we build on our success in schools, creating a culture of being active within children and young people. This will include rolling out the Daily Mile, extending the number of school sports awards, strengthening the Active Schools network creating more quality opportunities and supporting more active travel to and from school;
  - all partners stay on track for delivering 200 Community Sports Hubs, providing local places for communities to be active designed by themselves around their own needs; and
  - we continue to build on the legacy of the 2014 Commonwealth Games using the European Championships in Glasgow in 2018 to encourage more Scots to be active.

NHS Board reform

33. As the NHS moves into this new and changing delivery environment, we need our health bodies and governance models to reflect those changes and support the delivery for the people of Scotland. Our reform focus will continue to be on providing quality care for people, a shift towards prevention and early intervention, and making best use of our resources, rather than on structures and bureaucracy. Governance arrangements will only adjust to support this shift if required – i.e. the 'form' of governance would follow the 'function' of service planning and delivery. Any such changes would have to meet two tests. Firstly, that the changes were better able to respond to the needs of local communities. Secondly, that the changes would have to ensure better collaboration between NHS boards and, additionally, improve how our NHS works with providers of other public services to secure better outcomes for people.

34. We will also build on the work that has already taken place through a 'Once for Scotland' approach to provide efficient and consistent delivery of functions and prioritise those non-patient facing services which make sense to be delivered on a national basis. The approach will consider the differing needs across Scotland, and will be, for example, 'island-proofed' as part of the Scottish Government's wider commitment on recognising the distinct nature of island communities. Our territorial and patient facing national boards such as the Ambulance Service and NHS 24 must be allowed to focus on delivery of the "triple aim" of better care, better health and better value.

NHS Board reform: actions

In **2017**, we will:

- Review the functions of existing national NHS Boards to explore the scope for more effective and consistent **delivery of national services** and the support provided to local health and social care system for service delivery at regional level. As part of this, clear guidance will be put in place to NHS Boards that their Local Delivery Plans for 2017/18 must show their contributions to driving the work of this delivery plan, not least their contributions in support of the regional planning of clinical services.
- Ensure that NHS Boards expand the **'Once for Scotland' approach** to support functions – potentially including human resources, financial administration, procurement, transport and others. A review will be completed in **2017**, and new national arrangements put in place from **2019**.
- Start a comprehensive programme to look at **leadership and talent management** development within NHS Scotland. This will ensure that current leaders are equipped to drive the changes required in health and social care, but it will also ensure sustainability of approach by identifying the next cohort of future leaders of NHS Scotland.

Cross-cutting actions

35. Improvements will be driven by the key components set out above, but they will need to be supported by a series of cross-cutting sets of actions. These are the key programmes of work which will inform all the change set out here:
    - our approach to improving the services for children and young people through Getting It Right For Every Child;
    - the National Health and Social Care Workforce Plan;
    - the review of health and social care targets.
    - a focus on research and development, innovation and digital health; and
    - a robust approach to engagement.

Getting It Right For Every Child

36. The principles of our Getting It Right For Every Child[15] approach to improving services for children and young people are simple: more effective and widespread prevention and early intervention; better cooperation amongst professionals and between them, the child or young person, and their family; and a holistic approach to addressing a child's wellbeing. In addition to actions included in the main components of work above, we will drive this agenda through: continued implementation of Children and Young People (Scotland) Act 2014[16], in particular, the Named Person and the Child's Plan; and developing a new Child and Adolescent Health and Wellbeing Strategy in **2017**. This will form the cornerstone for a comprehensive approach to ensuring that all the factors affecting a child's or young person's health are regularly identified and supported with the individual, their family and, where appropriate, services.

15 http://www.gov.scot/Topics/People/Young-People/gettingitright/what-is-girfec/foundations.
16 http://www.legislation.gov.uk/asp/2014/8/contents/enacted.

National Health and Social Care Workforce Plan

37. Reform that delivers improved outcomes for patients can only happen with a committed, supported workforce that has the right skills, flexibility and support. Everyone Matters: 2020 Workforce Vision[17] sets out the health and social care workforce policy for Scotland, and a vision and values. The National Health and Social Care Workforce Plan will take forward the commitment to a sustainable workforce by establishing the priorities for action, assess current resources, and detail the actions to close the gap between what we have and what we will need to deliver high-quality, integrated and transformed services to those who need them. To be published in Spring **2017**, the Plan will:

    - align workforce planning more effectively with the different components of the delivery plan so that capacity challenges are identified at an early stage; and
    - improve workforce planning practice to make clearer what should be planned at national, regional and local levels.

    A short discussion paper outlining these arrangements, produced in consultation with key stakeholders, is attached at **Appendix 2**.

Review of health and social care targets

38. Targets can be instrumental in driving improvements in performance, but we need to ensure that performance is focused on improving outcomes for individuals and communities. Chaired by Sir Harry Burns, a national review is being conducted into the present suite of targets and indicators for health and social care. The review will work with service users, staff, professional bodies, and providers to ensure targets and performance indicators lead to the best outcomes for people being cared for, whether in hospital, primary care, community care or social care services. The interim report is expected in the Spring and the final report later in **2017**.

Research and development, innovation and digital health

39. Research is central to all high-performing health systems, leading to better targeted and more personalised treatment and improved patient outcomes. Scotland has a solid track record as a health research nation and in winning competitively awarded research funds. Research and development (R&D) and innovation are core activities for our health and social care services in Scotland and development in health and social care will depend on the science and discovery that underpins it. Through NHS Research Scotland (NRS), there is already a firm foundation of collaborative R&D partnership working successfully across NHS Scotland, academia and life-science industries. We will continue to invest in NRS to support health-related R&D, building on its model to drive a renewed effort in health innovation, as well as in Scottish Health Innovations Ltd to encourage, develop and appropriately commercialise innovative ideas and new technologies arising from within the health services. By **2018**, we will also:

17 http://www.workforcevision.scot.nhs.uk.

- create governance structures to support a new, coherent and concerted effort on the promotion and exploitation of health-related innovation and new technologies for the benefit of the whole health service;
- develop regional innovation clusters to translate cutting-edge research and innovation into excellent individual health care; and
- support innovation and technology capacity-building at national, regional and local levels by facilitating, encouraging and empowering those who work in health and care to identify innovation challenges and develop partnerships to deliver solutions.

40. Digital technology is key to transforming health and social care services so that care can become more person-centred. Empowering people to more actively manage their own health means changing and investing in new technologies and services, by, for example enabling everyone in Scotland to have online access to a summary of their Electronic Patient Record. The time is right to develop a fresh, broad vision of how health and social care service processes in Scotland should be further transformed making better use of digital technology and data. There is an opportunity to bring together all IT, digital services, tele-health and tele-care, business and clinical intelligence, predictive analytics, digital innovation and data use interests in health and social care. This will be taken forward through:
    - a review led by international experts of our approach to digital health, use of data and intelligence, to be completed in **2017**, which will support the development of world-leading, digitally-enabled health and social care services; and
    - a new Digital Health and Social Care Strategy for Scotland, to be published in **2017**, that will support a digitally-active population, a digitally-enabled workforce, health and social care integration, whole-system intelligence and sustainable care delivery.

Engagement

41. Engagement with patients, service users, staff and their representatives, key stakeholders and volunteers is vital in delivering our plans. The public and all stakeholders must not only be aware of the broader context within which decisions about any service changes are taken over the coming years, but inform how those decisions are taken from a position of understanding both the challenges and opportunities facing us.

42. There has already been huge engagement in developing health and social care integration, realistic medicine and through the National Conversation on Creating a Healthier Scotland[18]. The latter alone reached over 9,000 people through 240 events and engagements and with over 360,000 inputs through digital and social channels. Building on this work, the Our Voice framework[19] has been developed in partnership with NHS Scotland, COSLA, the ALLIANCE and other third sector partners to support people to engage, with purpose, in improving health and social care. The framework builds on much of the good work already underway at individual and local level to hear the voices of patients, their families, carers and unpaid carers, and involve them in improvement. We will explore ways in which Our Voice can support engagement on the work of this delivery plan through use of methods such as the national citizens' panel and citizens' juries.

43. Key to this will also be building on existing engagement mechanisms to ensure that all those who will be critical in delivering this change are fully involved in planning how it will take place. Work will continue with delivery partners across the public sector on how to take forward the different existing components of the delivery plan's activity, and this will be accelerated in the context of ensuring that the links between different activities are identified and opportunities for joint working maximised.

44. At the same time, it will be essential that engagement with the NHS Scotland workforce around this agenda is robust and makes full use of the potential of the workforce to drive this change. Through developing the National Health and Social Care Workforce Plan and as part of wider professional engagement, we will work with relevant organisations and bodies to ensure that the workforce needs of the future are identified early and fully and the contributions of the workforce to these workstreams are properly supported. In recognition of the established partnership working model in NHS Scotland, we will develop this work further in collaboration with trade union and professional organisations.

18 https://healthier.scot/.

19 http://www.scottishhealthcouncil.org/patient__public_participation/our_voice/our_voice_framework.aspx#.WEk5e7lDTEo.

How Will Delivery Of Our Plan Be Funded?

45. Achieving long-term financial sustainability of our health and care system and making the best use of our total resources is critical to this delivery plan. We will need to deliver transformational change while managing increasing demand for services, inflationary pressures and the growing needs of an ageing population. This will require a short-, medium- and long-term focus on sustainability and value of services alongside reform.

46. Over the next five years, we will invest £70 billion of resources in our health and social care system. At the same time the impact of our demographics and inflation in pay and in prices means that we must increase our overall productivity. Health funding is expected to grow in resource terms by the end of this Parliament, with significant planned investment in areas such as primary care, mental health, social care, cancer and new elective capacity. Spending on primary care services is set to increase by £500 million so that it accounts for 11 percent of the frontline NHS Scotland budget by May 2021.

47. A financial plan will support this delivery plan, creating the environment and incentives for change, and supporting transition. This will ensure stability to maintain the quality of care, health of the population and best value from resources through:
    - providing dedicated funding to invest in the levers of change;
    - putting in place arrangements to support sustainable financial balance across the whole of NHS Scotland;
    - creating short-term financial capacity to allow time to deliver change through efficiencies in current ways of working;
    - supporting clinicians to make best use of resources through investment in costing and value tools to support shared decision making on clinical and financial evidence;
    - driving an early intervention and prevention approach across services; and
    - developing an approach to infrastructure and digital that supports the shift from hospital to community and primary care and works across the public sector estate.

48. The components within the delivery plan will be financially and economically assessed at key stages in their development, from initial scoping through to implementation, to create a comprehensive assessment of affordability and sustainability.

How Will Delivery Be Tracked?

49. It is crucial that the delivery plan does not remain a simple statement of intent, but a continuing process of monitoring, challenge and review. Every component of the delivery plan will continue to be tested for its fit with our strategic aims and how it supports shifting the balance of care towards community settings, managing demand, reducing waste, harm and variation, and delivering value from our total resources. We will challenge the expected levels of investment and levels of efficiencies in local, regional and national plans to ensure delivery of the aims of the delivery plan.

50. As part of this, a robust, integrated performance framework for the different components of the delivery plan will be developed for early **2017**. Progress will be regularly reviewed to ensure that actions not only remain on track and anticipated outcomes can be fully realised, but that the delivery plan is updated with new measures as appropriate. It cannot remain a static document, but a way of continually assessing whether the measures and approach being taken are appropriate and sufficient to secure our Vision.

Appendix 1: What Will Be Different in a Transformed Health and Social Care System in Scotland?

What will be different for individuals
• People will be equal partners with their clinicians, working with them to arrive at decisions about their care that are right for them. They will be supported to reflect on and express their preferences, based on their own unique circumstances, expectations and values. This might mean less medical intervention, if simpler options would deliver the results that matter to them. • People will be supported to have the confidence, knowledge, understanding and skills to live well, on their own terms, with whatever conditions they have. They will have access to greater support from a range of services beyond health, with a view to increasing their resilience and reinforcing their whole wellbeing. • Health and social care professionals will work together to help older people and those with more complex needs receive the right support at the right time, and where possible, live well and independently by managing their conditions themselves. • Hospitals will focus on the medical support that acute care can and should provide, and stays in hospital will be shorter. Individuals will benefit from more care being delivered in the community, and where possible, at home. • Everyone will have online access to a summary of their Electronic Patient Record and digital technology will underpin and transform the delivery of services across the health and social care system. • Children, young people and their families will benefit from services across the public sector – including health, education, social care and other services – working together to support prevention and early intervention of any emerging health issues. • The diet and health of children from the earliest years will improve from coordinated and comprehensive nutritional support for children and families. • There will be a significant reduction in the harmful impact on health of alcohol, tobacco and obesity, and our approach to oral health will be founded on prevention. • People will have access to more and more effective services across the health system to support mental health, including the specialist services for children and young people. Mental health will be considered as important as physical health. • People will lead more active, and as a result, healthier lifestyles. • People will receive more sensitive, end of life support that will aim to support them in the setting that they wish. All those who need hospice, palliative or end of life care will receive it and benefit from individual care and support plans. Fewer people will die in hospitals.

What will be different for communities

- Most care will be provided locally through an expanded Community Health Service, avoiding the need to go into hospital.
- People will benefit from local practices and other community care with a wider range of available support. Practices will typically consist of complementary teams of professionals, bringing together clusters of health support and expertise. Communities will have access to quicker and joined-up treatment – this might be the GP, but supported by a team including highly-trained nurses, physiotherapists, pharmacists, mental health workers and social workers. GPs will take on a greater leadership role.
- Local practices will be able to provide more information and secure better advice for people locally without the need to attend hospitals to get specialist consultancy advice. That advice will be increasingly delivered locally.
- Families will receive more integrated and extended primary and community care for their children. There will be more home visits from health care professionals, including three child health reviews, and teenage mothers will receive more intensive and dedicated maternal support.

What will be different regionally

- Some clinical services will be planned and delivered on a regional basis so that specialist expertise can deliver better outcomes for individuals, services can be provided quicker and stays will be shorter. This will ensure that the services provided to people are high quality and the expertise remains as effective as possible.
- More centres will be provided to help NHS Scotland handle the growing demand for planned surgery, particularly from an ageing population. Such centres will allow medical professionals to become extremely skilled and have facilities to the highest standards. This will take pressure off other hospitals so there are fewer delays when urgent or emergency care is needed.

What will be different nationally

- There will be a national set of health priorities giving clear, consistent direction for how to improve public health across the whole of Scotland and a single national body to drive the priorities.
- Services and functions of the health service which can be delivered more efficiently at national level will be done on a 'Once for Scotland' basis.

Appendix 2: National Health and Social Care Workforce Plan: Outline Discussion Paper

Introduction

1. This document sets out the initial arrangements for the production, in early 2017, of a National Discussion Document on workforce planning in health and social care. A consultation exercise undertaken at this stage will report back and a final version of a National Health and Social Care Workforce Plan will be published in Spring 2017. There are three distinct stages:
   - **Outline Discussion Paper:** setting out initial arrangements prior to –
   - the **National Discussion Document:** to be published in early 2017, leading to –
   - the **National Health and Social Care Workforce Plan**, to be published by Spring 2017.

2. This is a complex area which will need time for all relevant stakeholders to have an opportunity for real engagement in order fully scope the landscape, issues and levers in order to 'get it right'. The production of the Workforce Plan by Spring 2017 should be seen as an **intermediate** step and part of a developing and iterative approach, not an end in itself. The Workforce Plan will be the first in an **annual series** aimed at improving workforce planning practice, as well as developing more effective and informed intelligence.

3. The Workforce Plan will present an opportunity to: a) refresh guidance for production of NHS Scotland workforce plans; and b) introduce workforce planning to which provides an overall picture for health and social care staff. The current position is different for NHS Scotland and Health and Social Care Partnerships, but the two will become increasingly interdependent in delivering care across Scotland, linking back to the recent Audit Scotland report recommendations. This outline discussion paper, the forthcoming National Discussion Document and the Workforce Plan, therefore, seek to achieve a balance in referring to working planning as it applies across NHS Scotland, and social work and social care interests.

4. Health and Social Care Partnerships are expected to develop integrated workforce plans to ensure people get the right support at the right time from staff who not only have the skills but are working in the most appropriate setting. The Workforce Plan should, therefore, look to support this agenda.

5. The need for the Workforce Plan derives from the national and international context within which workforce planning in health and social care needs to take place. The incremental approach reflects the timelines required to deliver a changed workforce and the effects of changing demand, demography and generational perspectives on work/life balance and careers. While the Workforce Plan and subsequent annual Plans will be practically focused and useable, they must also read across to and be able to adjust to strategic areas of health and social care reform.

6. This paper describes outline arrangements, processes around engagement, and some of the context for this work.

Aim of the Outline Discussion Paper

7. The aim of this paper is to set out the intended actions reflecting the Scottish Government's Programme for Government commitment on workforce planning and to assure organisations within health and social care – including NHS Boards and the full range of employers in the social service sector – of their full involvement in the work being undertaken to realise this commitment.

Objectives

8. We are working to develop national and regional workforce planning through a Workforce Plan which helps deliver the direction set out in a range of strategic developments – among them this delivery plan as well as the National Clinical Strategy – while also reflecting progress in key areas of health and social care such as integration and self-directed support. To do this, we must ensure that all key stakeholders are able to contribute to and help to shape the Workforce Plan, so that it addresses their interests and issues.

9. As we work towards a Workforce Plan in 2017, we want to ensure a clear view for those responsible for workforce planning within health and social care services, on:
   - roles and responsibilities with regards to workforce planning, and in the production of the Workforce Plan itself, as well as current arrangements already in place;
   - Ministers' intentions to ensure better coordination of national, regional and local workforce planning against a complex and shifting health and social care background; and
   - how more consistent and coordinated workforce planning can help deliver better services and outcomes for Scotland's people.

   The Workforce Plan will also provide an opportunity to consider integrated workforce planning arrangements, recognising differences in workforce planning practice between NHS Scotland, local authorities and other social service employers.

Context

10. The need for a Workforce Plan stems from the Programme for Scotland commitments in relation to health and social care, as well as from Audit Scotland recommendations on workforce planning in relation to its recent findings on the public sector workforce[20], health and social care integration[21] and on the NHS in 2016[22].

11. It is important that the Workforce Plan should apply in an integrated context, covering the social care services sector, comprising a wide range of support and services and employing 130,000 NHS Scotland staff and over 200,000 staff across the third, independent and public sectors[23]. There is a statutory duty on NHS Boards to undertake workforce planning and this will continue to apply. We, therefore, expect the Workforce Plan to be:
    - **a strategic document**, setting out the workforce vision for health and social care services, the priorities to be taken forward, the assessment of current resources to deliver the vision, and actions to close the gap between what we have and what we will need;
    - **apply at a national level**, linking, as appropriate, to regional and local levels; and
    - **active and useable**, making coherent workforce planning links between national and regional activity and offering frameworks for practical workforce planning in both the NHS Scotland and social services sectors.

12. The Workforce Plan will consider how workforce planning is influenced by the following developments in health and social care:
    - public service reform and integration of health and social care, allowing space for NHS Boards, local authorities and Health and Social Care Partnerships to plan for the workforce for the health and social care system that Scotland needs, now and in future;
    - Progr.5ng plans for elective centres;
    - recommendations on workforce planning from Audit Scotland[24];
    - the NHS Scotland Workforce 2020 Vision, Everyone Matters; and
    - approaches and methodologies in use which support development of services delivered by multi-disciplinary teams – for example, the Workforce Planning Guide by the Scottish Social Services Council, the NHS Scotland 6 Step Model, and local authority tools and guidance.

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20 http://www.audit-scotland.gov.uk/report/scotlands-public-sector-workforce.

21 http://www.audit-scotland.gov.uk/report/health-and-social-care-integration.

22 http://www.audit-scotland.gov.uk/uploads/docs/report/2016/nr_161027_nhs_overview.pdf.

23 http://data.sssc.uk.com/data-publications/22-workforce-data-report/128-scottish-social-service-sector-report-on-2015-workforce-data.

24 "The Scottish Government, in partnership with NHS Boards and integration authorities, should share good practice about health and social care integration, including effective governance arrangements, budget-setting and strategic and workforce planning". [Audit Scotland – NHS in Scotland 2016-17].

13. In relation to meeting the challenging health and social care needs required, the Workforce Plan will:

- set out a useable framework to improve current workforce planning practice;
- clarify how workforce planning should take place nationally, regionally and locally across health and social care;
- map and coordinate similarities and differences in workforce planning practice; and
- harmonise, reconcile and share approaches where appropriate, while preserving what works well.

Intended outcomes

14. The Workforce Plan will help to bring about:

- clearer understanding about respective roles and responsibilities on workforce planning;
- clearer understanding about the changes and improvements which need to be made and why;
- improved consistency, allowing for sharing of best workforce planning practice across Scotland;
- clearer evidence that robust workforce planning helps to deliver effective, efficient delivery of services and better patient/ service user/ client outcomes; and
- a longer-term view of the challenges in regard to capacity and capability of this workforce and the solutions we need to design now in response to these.

Process for developing the Workforce Plan

15. An important first step will be to define and articulate the scale of the challenge and the scope of the Workforce Plan. Though NHS Boards are required to follow a single methodology, workforce planning practice can vary significantly. There is also considerable diversity in workforce planning practice between NHS Boards and employers in the social services sector. However, there are indications that workforce challenges are common to both, including: an ageing workforce and the need to provide care for a larger proportion of the population; increasing activity and demand on services; difficulties in recruitment for some hard-to-fill posts; the need to design multi-professional approaches to service challenges; and the availability and suitability of training and career pathways. Starting to be clearer about what can/should be dealt with nationally, regionally and locally will help.

16. Some workforce planning issues will require more pressing action. For the short to medium term, the Workforce Plan will need to:
    - for NHS Scotland, align workforce planning objectives with strategic policies, enabling capacity challenges to be identified before they become an issue;
    - improve workforce planning practice and issue more useable guidance to assist employers. This will apply across health and social care and, for NHS Scotland, will be specific about how this can be done at national, regional and local levels, recognising the key interest of Health and Social Care Partnerships in this development; and
    - examine how collecting, reporting and triangulating workforce planning information might be undertaken more efficiently, so we ensure it embeds with strategic and financial planning issues and translates into planned rather than reactive action. This might also be explored in an integrated context, given the range of different tools and resources available.

17. For the longer term, the Workforce Plan will need to develop a series of actions, perhaps set within a framework of tools accessible by different employers, allowing them to use these to build sufficient numbers of appropriately trained and qualified staff. This will involve exploring how to develop better intelligence through workforce analysis – being clear how a range of demand factors impact on supply. We will want to describe this in more detail as we move to publish the National Discussion Document in early 2017.

Timescale

18. Designing a framework for workforce planning which can apply successfully to different sectors will take time. The arrangements for publishing the National Discussion Document and the Workforce Plan are:
    - in **December 2016**, issue this Outline Discussion Paper, seeking input in parallel from key stakeholders and consulting with COSLA and other key local government partners, NHS Management Steering Group, the Scottish Partnership Forum, the Human Resources Working Group on Integration and employer representative bodies such as Scottish Care and the Coalition of Care and Support Providers in Scotland. There will also be discussions with NHS Scotland and Health and Social Care Partnerships, professional bodies, representatives from the primary care sector and other professional stakeholders;
    - in **early 2017**, publish the National Discussion Document, aligning with other relevant publications/releases at that time; and
    - in **Spring 2017**, publish the National Health and Social Care Workforce Plan, which NHS Boards and employers in the social care sector can use to support development of their local plans, working with Health and Social Care Partnerships as appropriate.

Approach

19. The proposed new approach in the Workforce Plan will require roles and responsibilities in respect of workforce planning activity to be clarified and will involve:

    i. forging closer links between and among:

    - senior managers in NHS Boards, local government and the social services sector responsible for strategic planning;
    - planners in NHS Boards, local government and the social services sector involved with implementing robust, progressive workforce plans, and aligning them with those for financial and service planning;
    - service managers, in a unique position to know the strengths and weaknesses of services to patients, service users and clients provided locally;
    - groups of health and social care professionals, whose views on achieving an optimum workforce balance will help build a workforce which will meet the future needs of health and social care;
    - trade unions across health and social care, whose input is key to creating the right working conditions for those professionals; and

    ii. equipping NHS Boards, local government and the social care sector with the means to plan ahead effectively to ensure they have the right staff in the right place at the right time to provide safe, high-quality health and social care services for Scotland's people.

Next steps

20. We want as far as possible to use the **existing** infrastructure to work towards a Workforce Plan by:
    - using this Discussion Paper and the National Discussion Document to invite constructive input, views and comment; and
    - visiting NHS Boards, Health and Social Care Partnerships, COSLA, local authorities and other social services employers to seek views, intelligence and support; and consulting the full range of stakeholders across the health, social care sectors, independent sector, trade unions and professional/regulatory organisations, educational institutions and other interested parties.

21. Arrangements covering governance, data and risks are currently being put in place to underpin the development of the Workforce Plan. These will ensure priority issues faced by the health and social care sector are addressed in a fully inclusive way. Once agreed, these arrangements will be shared with relevant parties.

Challenges

22. Some of the workforce planning challenges specific to NHS Boards and social services sector are outlined below.

NHS Boards

23. Building a more effective workforce planning network with NHS managers, including HR Directors and workforce planners in NHS Boards, is urgently required.
    - **Nationally:** we will hold early discussions with HR Directors about the establishment of a national workforce planning group, to be taken forward in partnership between Scottish Government and the service, to ensure there is clarity of responsibility, governance and expectation. Dialogue to facilitate and establish this will involve membership from the wider medical and non-medical professions. This group will also need to consider how best to involve Health and Social Care Partnerships and social care representatives on practical workforce planning issues. The group will require a work programme that is solution-driven, and will need an active and dynamic agenda that prioritises workforce planning challenges, linked clearly to national priorities.
    - **Regionally:** regional workforce planning already takes place in the North, West and South East/Tayside – but it is variable in scope. A more inclusive approach is needed to allow solutions to be designed across individual NHS Board boundaries. The discussions above could also consider how work should be grouped at regional level, to evolve regional approaches to particular capacity challenges.

- **Locally:** we need to maintain links with individual NHS Boards, local authorities and Health and Social Care Partnerships to ensure they are aware of and able to respond to the challenges in the Workforce Plan.

Social care employers

24. The Workforce Plan will need to recognise and address the challenges faced by the social services sector in recruiting and retaining the staff needed to deliver social care services. It will need to be relevant in different contexts, and achieve a 'fit' between existing workforce plans within health and social care (including NHS Boards, Health and Social Care Partnerships and local authorities).

25. Opportunities for joint working on this topic should be explored to minimise duplication of effort. It may be possible in future, for example, to consider the scope of Health and Social Care Partnership and NHS Board workforce plans so that they apply in more focused ways to different parts of the workforce – for example, the workforce delivering community health and social care services, and the workforce which delivers acute sector services. There will be opportunities to look at these issues in the National Discussion Document in early 2017.

26. It may be appropriate for the social care services sector to consider: whether it might build national and regional approaches into its workforce planning; and how local flexibility can best operate (particularly in the context of local government). Discussion on this will require further engagement within the social care sector, specifically involving local government and its representative organisations. In the social services sector it is understood that most, if not all, organisations take decisions about workforce planning at senior level and collect data on current:
    - staff numbers and costs;
    - vacancies; and
    - training activity.

    Most organisations use this data for budget setting, day to day management and planning for short term needs. However relatively few use workforce planning tools – the most widely used being the Scottish Social Services Council Workforce Planning Guide[25].

25 http://learningzone.workforcesolutions.sssc.uk.com/course/view.php?id=25.

27. There is acknowledgement within the social service sector[26] about the urgency of workforce planning issues in light of demographic effects (such as ageing workforce) which influence the ability to plan ahead, the reliance of forecasting on available budgets and the daily effects of service changes (with consequences in planning for workforce). There are strong interconnections between workforce planning and pay, recruitment and retention and a range of other factors. It is clear that this will require an integrated approach not only to planning for services but also to workforce planning. This will require a systematic approach informed by accurate, coordinated and relevant data, allowing available capacity to be deployed flexibly.

Health and Social Care Partnerships

28. Although Health and Social Care Partnerships are required to complete integrated workforce development plans, not all have yet been completed and there is some variance in their contents. The position of Health and Social Care Partnerships is relevant here too. Although Health and Social Care Partnerships are not employers themselves, they are tasked with managing joint budgets to provide integrated health and community care services in the most effective way possible. They will play a key role in shaping workforce demand and in supporting 'intelligent forecasting', which should be reflected in both NHS Scotland and social care services workforce planning.

Discussion

29. We plan to contact all NHS Boards, COSLA and Health and Social Care Partnerships as we engage on developing the National Discussion Document. While aims and expectations depend on effective communication, we are realistic about the audience we can achieve in the limited time available. All are important and will need good reason to invest in facilitated time.

26 "Recruitment and Retention in the Social Service Workforce in Scotland" – Shona Mulholland, Jo Fawcett and Sue Granville (Why Research).

30. We will aim to involve the following professional staff groupings, principally through their existing representative bodies but also, where possible, individually:
    - staff side representatives – including Scottish Partnership Forum, the Society for Personnel and Development Scotland, Unison, Unite, GMB, the Royal College of Nursing, the Royal College of Midwives, and the British Medical Association;
    - the HR Working Group on Integration;
    - COSLA;
    - NHS Boards and local government (through SOLACE);
    - Health and Social Care Partnerships;
    - HR and SP Directors;
    - Medical Directors;
    - Nursing Directors;
    - Chief Social Work Officers;
    - Finance Directors;
    - service managers;
    - workforce Planners in NHS Boards – regional and local – and in local authorities;
    - recruitment managers;
    - service planners, including for acute and elective services, as well as representatives from local cancer planning groups and other condition-specific groups (such as the National Advisory Committee on Stroke);
    - clinicians and health and social care professionals;
    - NHS Education in Scotland, Scottish Social Services Council and other regulatory and educational interests;
    - the Royal Colleges; and
    - social care employer representatives bodies – the Coalition of Care Providers in Scotland, Scottish Care and others.

31. We will communicate with the groups outlined above in various ways, including:
    - tapping into planned meetings of existing committees, boards and other gatherings as appropriate, rather than setting up new structures;
    - assessing whether 'roadshow'-type events – with regional/board variations taking account of local issues – may be useful;
    - holding specific small events or workshops – informal and flexible, with few attendees but lively discussion;
    - organising more formal meetings, with presentations followed by discussion; and
    - facilitated discussion, at events such as Strengthening the Links.

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To: Chief Officers – Integration Authorities

19 January 2017

Dear Colleagues

MEASURING PERFORMANCE UNDER INTEGRATION

The Ministerial Strategic Group for Health and Community Care (MSG) discussed how to measure progress under integration at its meetings on 16 November and 21 December.

At the meeting on 21 December MSG agreed that for 2017/18 we will track across Integration Authorities:

(1) unplanned admissions;
(2) occupied bed days for unscheduled care;
(3) A&E performance;
(4) delayed discharges;
(5) end of life care; and
(6) the balance of spend across institutional and community services.

You are each invited to set out your local objectives for each of the indicators for 2017/18 by the end of February. MSG has agreed that it will receive a quarterly overview on progress across the whole system and you are asked to produce your objectives on that basis. We are meeting with the Executive Group of Chief Officers on Friday and will discuss what national support you would want us to offer for this process. Our objective will be to adapt and use existing data collection methodologies where possible and to establish a clear process for the work.

When we met on 16 December we had indicated that as a minimum we would provide data for each partnership covering each of the indicators. The data would show the position for all partnerships to enable individual Integration Authorities to understand the shape and

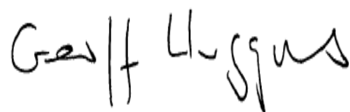
nature of their service relative to others. We are still working on the structure and format of that data. For now, we attach high level data covering a number of the areas (**Annex A**). Again we would intend to use the conversation on Friday to discuss the structure and format of the data with the intention of writing shortly after to all Chief Officers with the necessary material.

MSG noted that the approach for future years may change as a consequence of the Review into Targets and Indicators being undertaken by Sir Harry Burns and also as data sources for particular areas of service delivery improvement. It also noted that most key service delivery areas under integration have a direct impact on these higher level system indicators. In particular, it is important that we are able to understand both the contribution of social care and primary care services to these higher level system indicators, but also how they support important outcomes in respect of independent living and the protection and maintenance of health.

Local partnerships are already using a wide range of data to support their commissioning and delivery activity and will continue to operate under the duties in the 2014 Act in respect of public reporting. This process is not intended to duplicate or substitute for that process.

The Local Delivery Plan (LDP) Guidance for 2017/18 has been issued to NHS Chief Executives and sets the expectation that Boards and regional planning partnerships ensure that their objectives and plans are consistent with Integration Authority plans. Similarly, given the interaction with the hospital system you will need to ensure that your objectives and plans are consistent with NHS Board and regional plans for 2017/18.

Yours sincerely

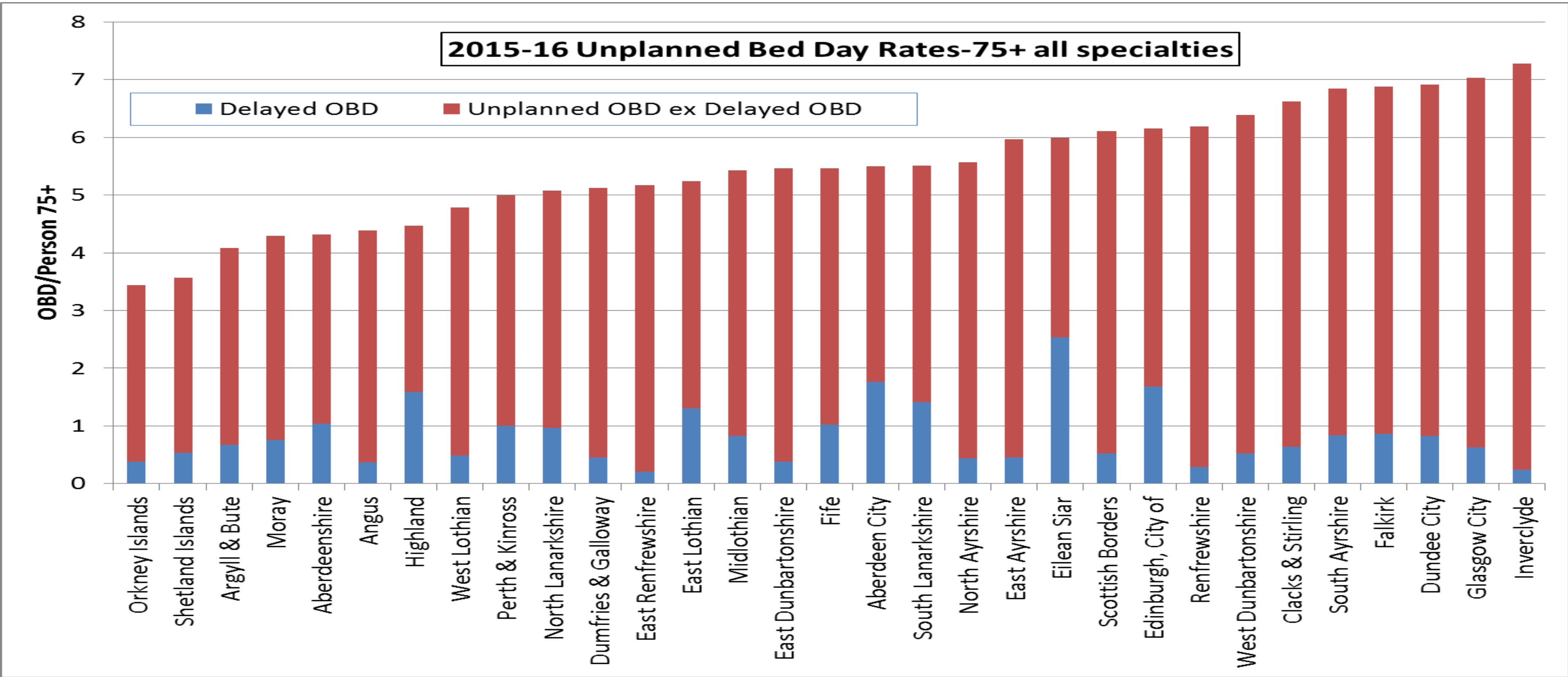


GEOFF HUGGINS
Scottish Government

PAULA McLEAY
COSLA

Annex A: example of data on key indicators

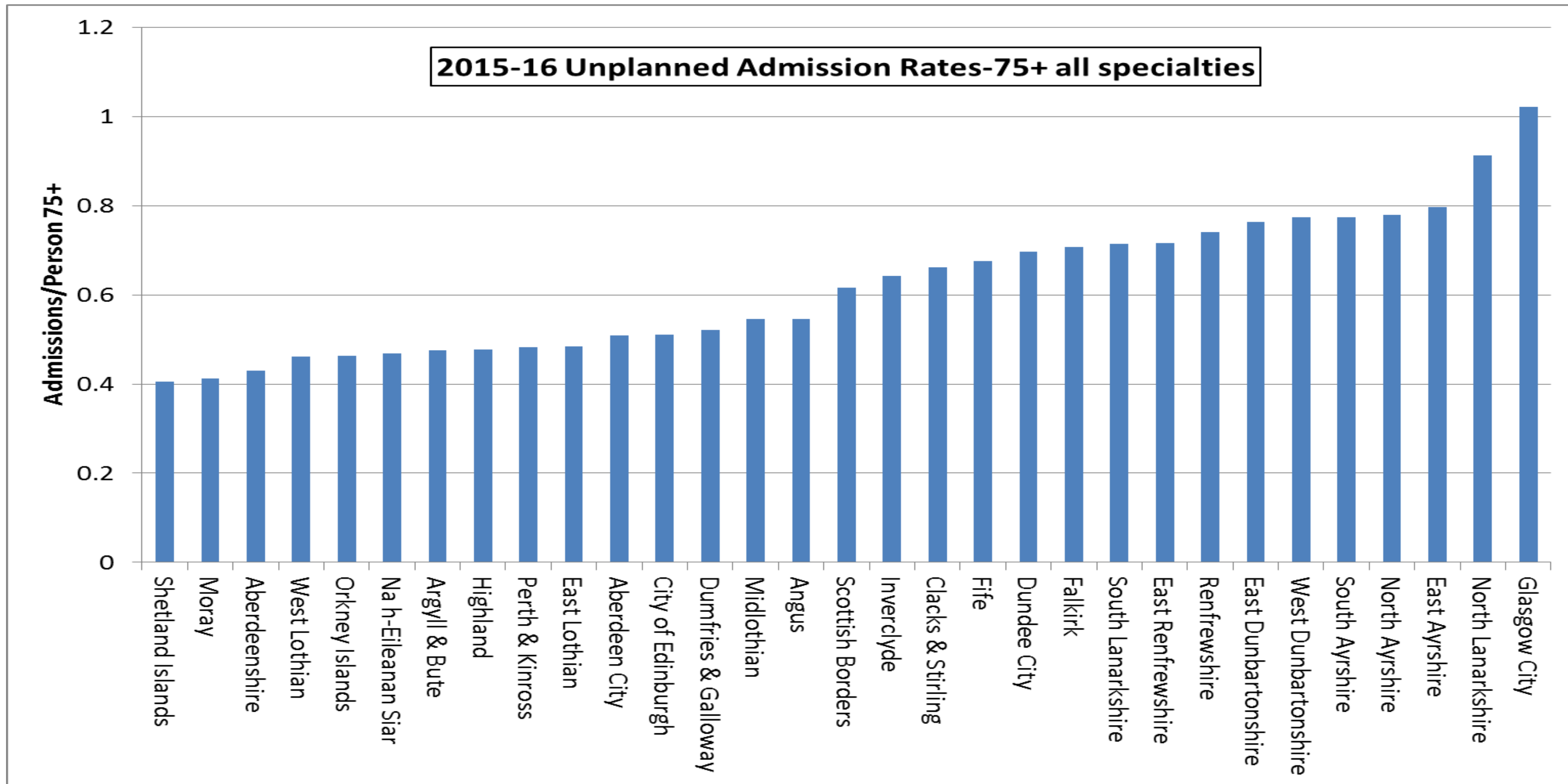
Unplanned Bed Days



Notes: This chart shows the unplanned bed days per capita for people aged 75+ for each partnership (in 2015/16). It is for unplanned bed days in all specialties and differentiates between the bed days used by delayed patients and other non-delayed bed days. A total of 2.5m bed days were used by people age 75+ of which 400k were by delayed patients, an average of 16% of the total bed days for this age group and varying across partnerships from 3.4% to 42%. There is a two-fold variation in the overall bed day rates across partnerships and a 12 fold variation in delayed bed

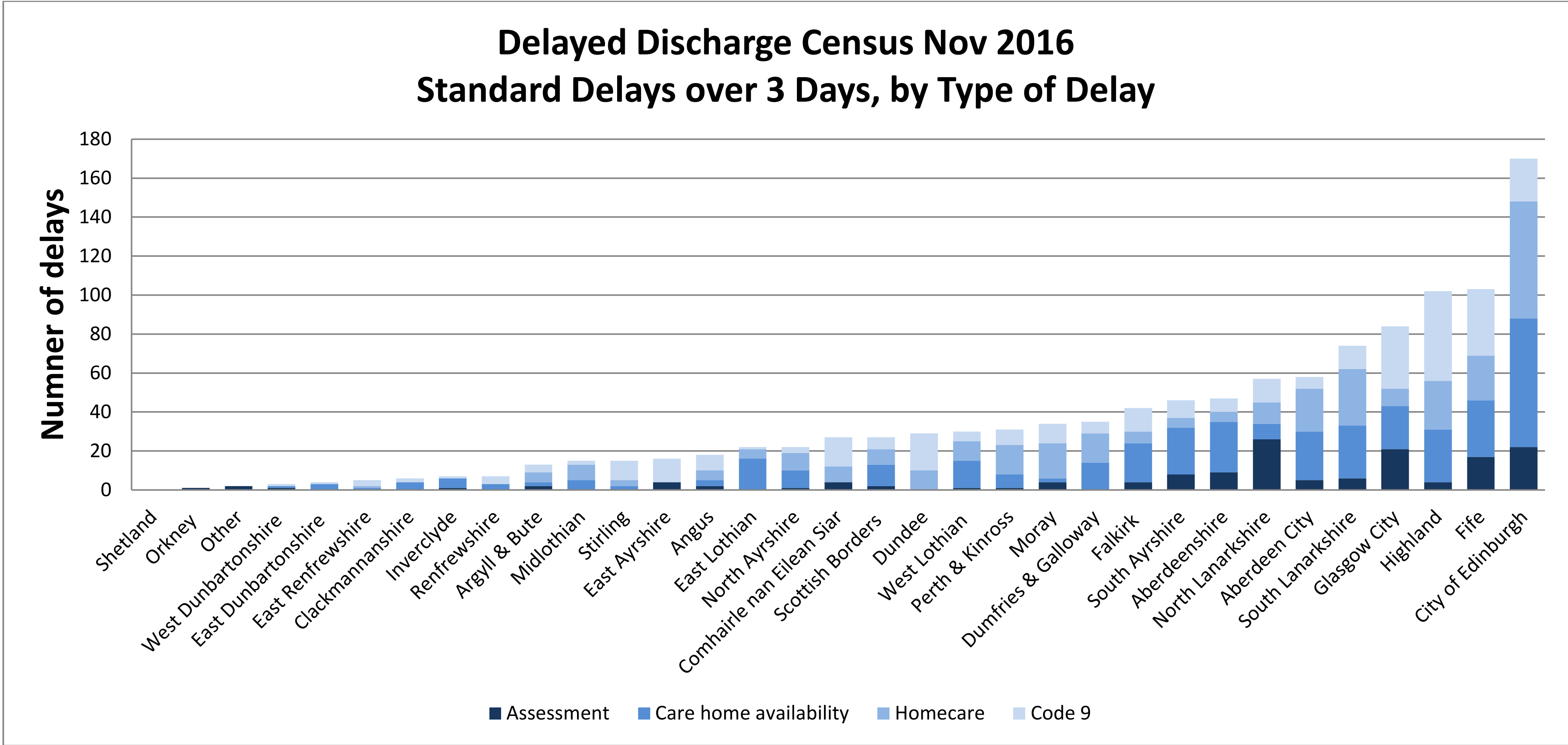
day rates. There is no association between delayed bed day rates and overall bed day rates. We can develop this analysis to include other age groups and to differentiate between specialties and type of delay.

Unplanned admissions



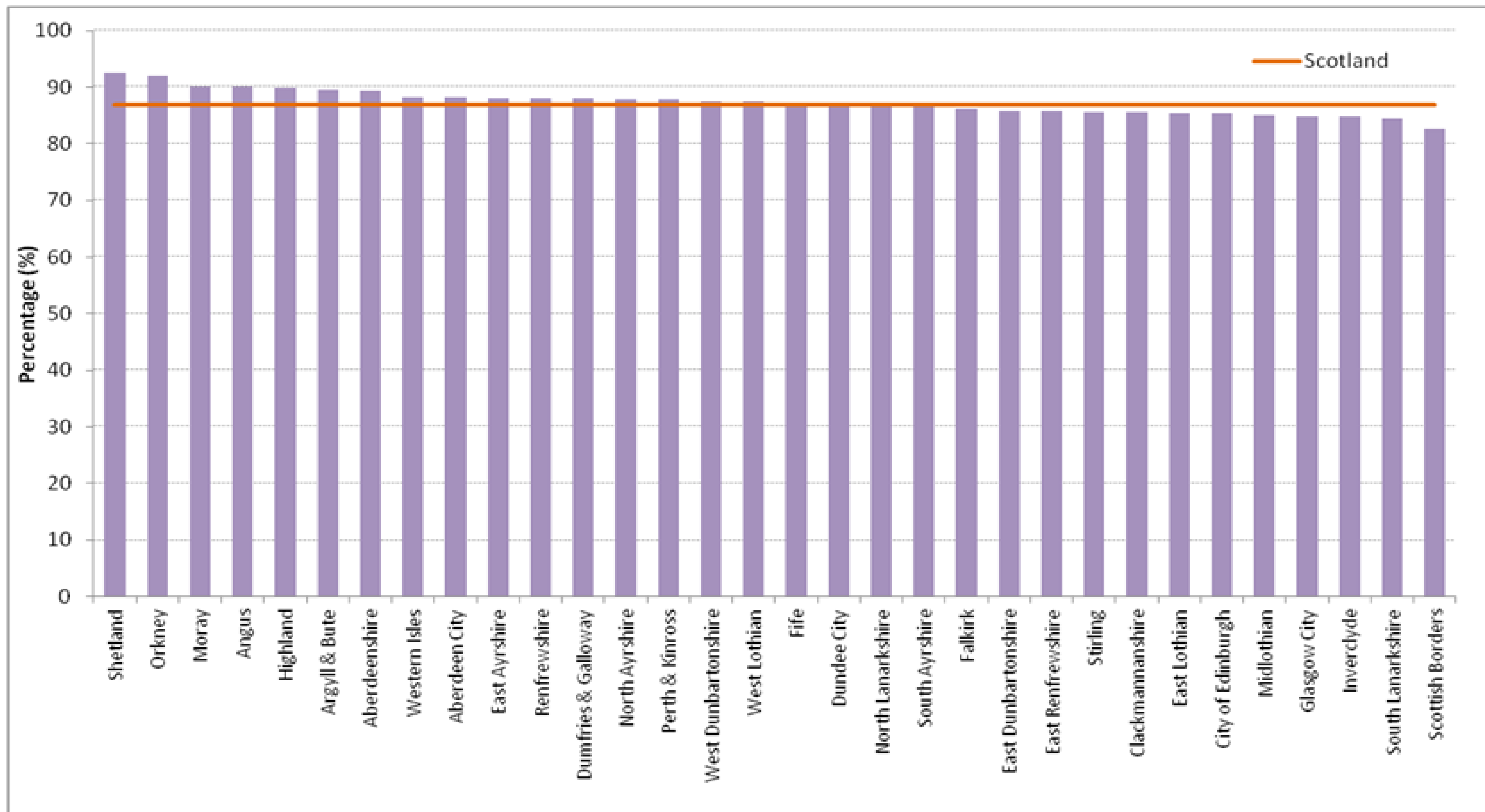
Notes: This chart shows the unplanned admissions per person aged 75+ in all specialties in 2015/16. We can see that the two fold variation seen in the bed days chart is evident here, although there is some slight re-ordering which is to be expected as bed day rates are a function of admission rates and length of stay. We can develop this analysis to consider different age groups and specialties.

Delayed Discharge Census: Standard Delays > 3 days by type of delay



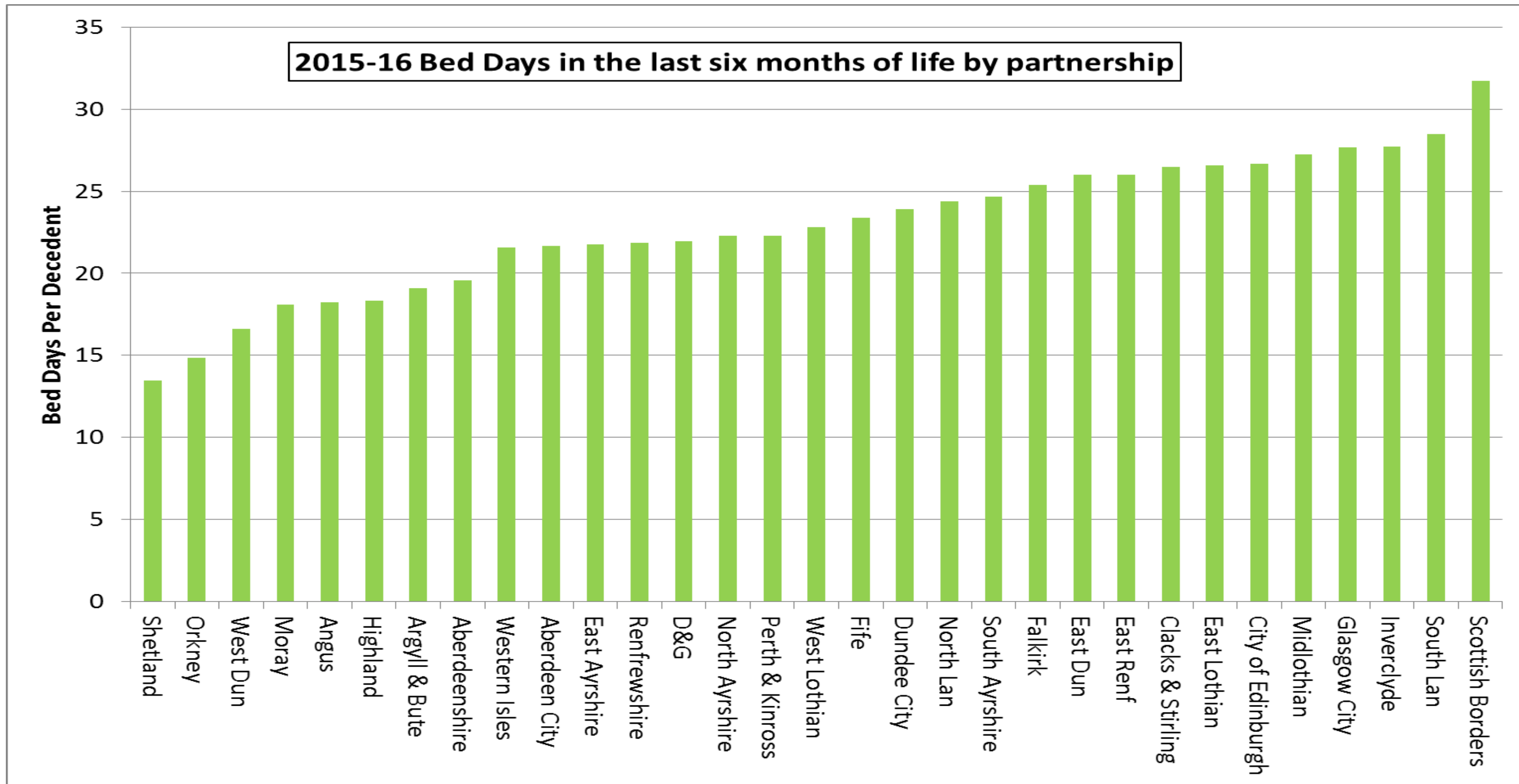
Notes: this chart shows the number of delays by type of across all partnerships. These figures exclude family reasons. There is considerable variation across partnerships. There are also differences in the main reason for delays. For example while care home and home care are key reasons for some partnerships, Code 9 categories appear to be the main reason for others

End of Life (a)



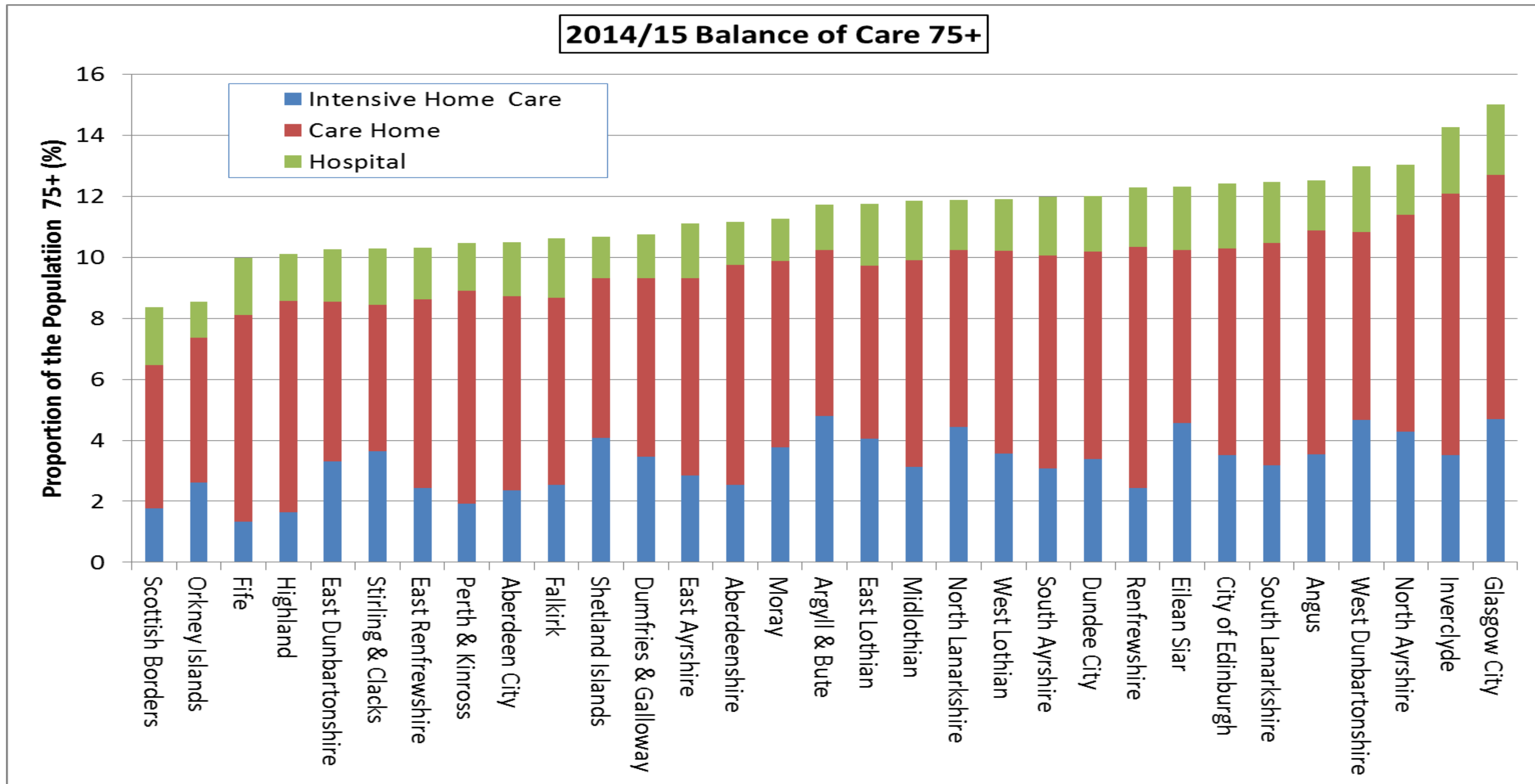
Notes: This chart shows the proportion of the last six months of life spent at home or in a community setting for people who died in 2015/16. There is a difference of 10% across partnerships. We can develop this analysis by considering different age groups and by differentiating between settings.

End of Life (b)



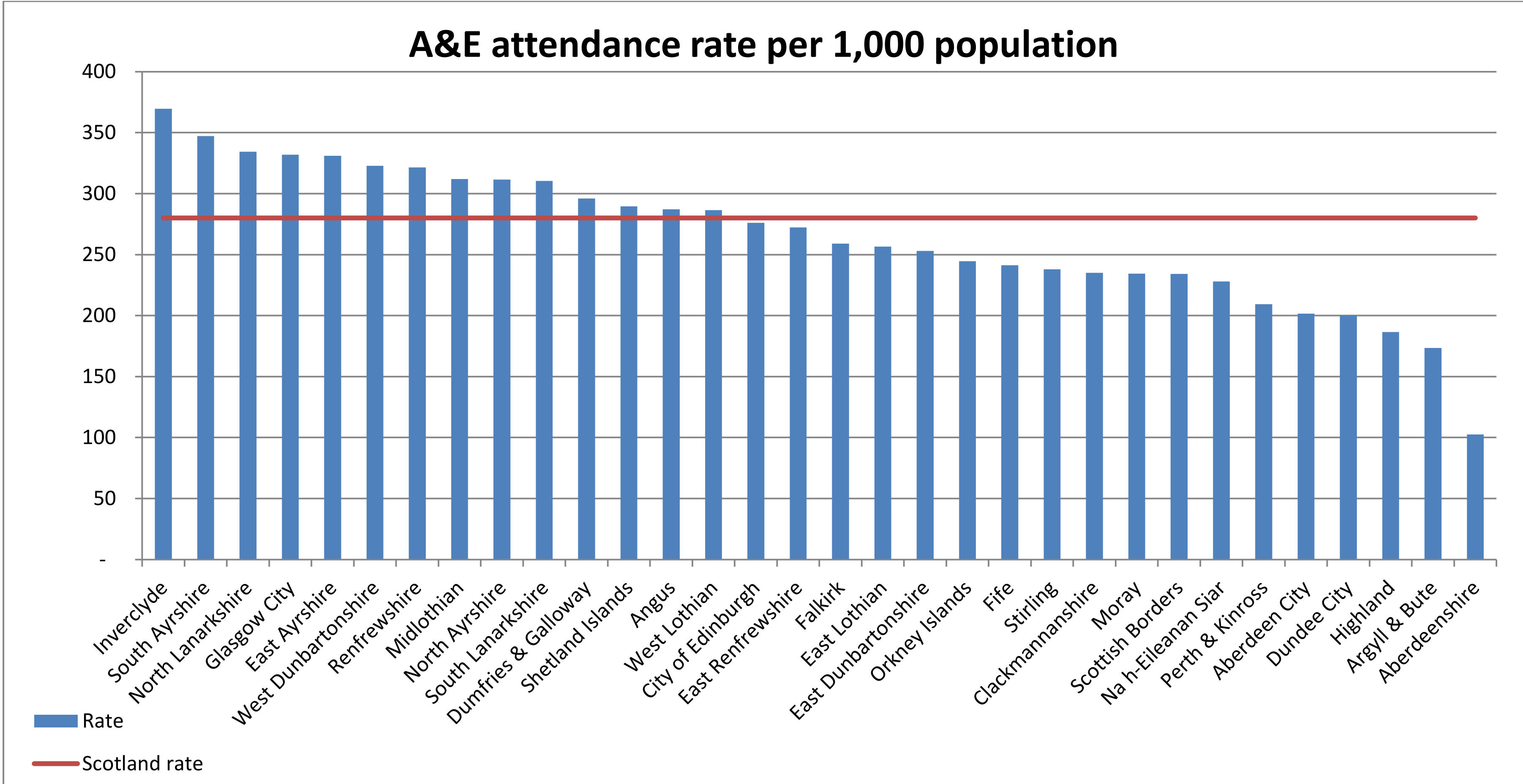
Notes: This chart shows the average unplanned bed days in the last six months of life for people who died in 2015/16. There is a two- fold variation across partnerships. If all Scottish partnerships could attain the same bed days per decedent as Shetland, half a million bed days could be saved-equivalent to the 10% commitment in the Delivery Plan.

Balance of Care



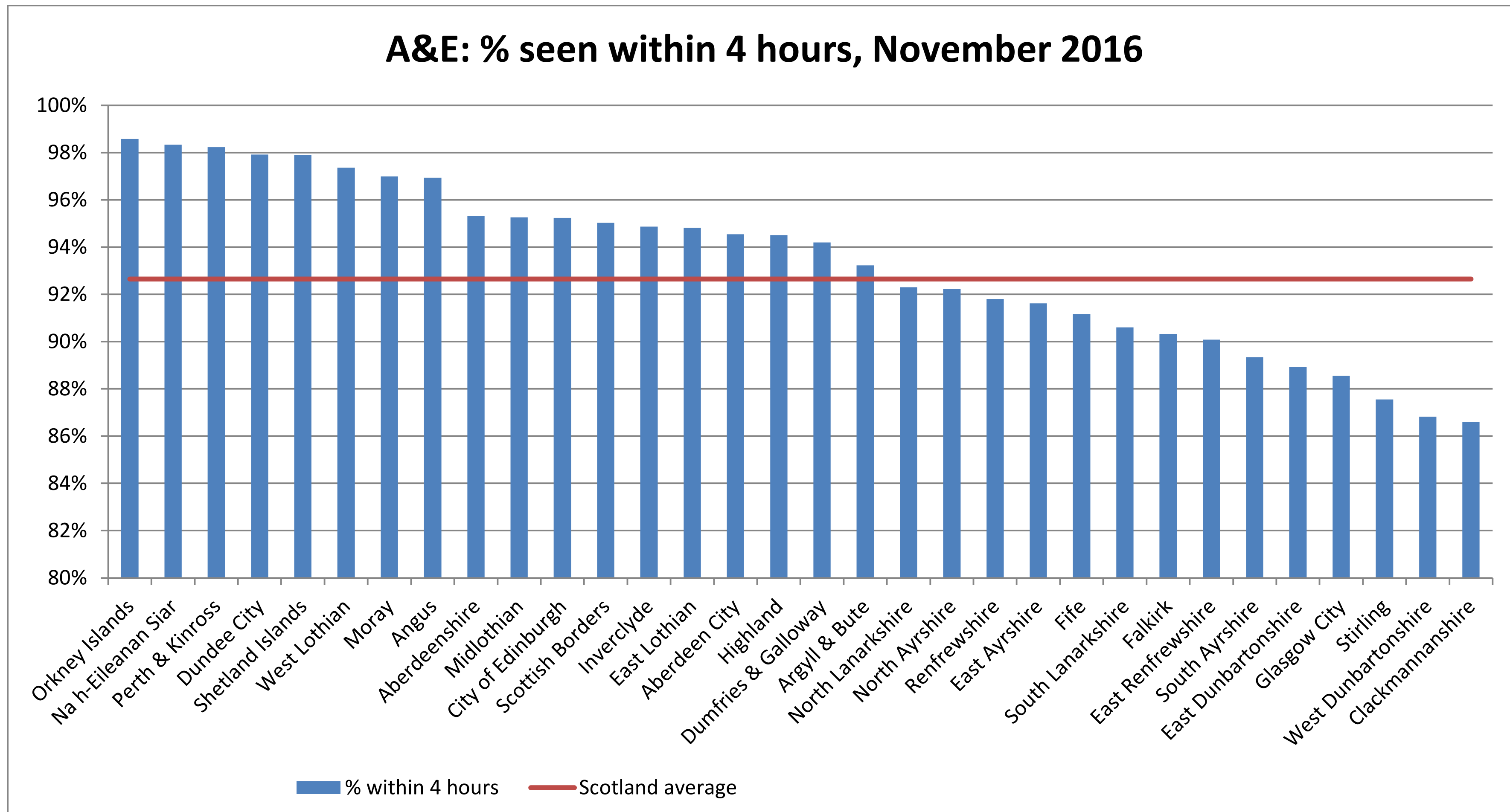
Notes: This chart looks at balance of care for people aged 75+ and shows the proportion of partnership populations aged 75+ who were either in hospital, in a care home or in receipt of 10+ hours home care in 2014/15. There is an almost two-fold variation (8% c/w 15%). Across Scotland, 8.5% of people aged 75+ were either a care home or hospital varying from 5.9% to 10.7% across partnerships. We can develop this analysis to include other age groups and to reflect the balance of care as a spectrum of settings; we can also look at spend across the spectrum.

A&E (a) : **A&E attendance rate per 1,000 population by Partnership 2015/16**



Notes: this shows the attendance rate at A&E per 1000 population by Partnership. There is considerable variation between Partnerships –370 per 1000 population in Inverclyde while 102 attendees per 1000 population in Aberdeenshire (Scotland – 280 per 1000). The difference is likely to reflect a range of issues including demographic factors, proximity of population to A&E facility as well as other healthcare provision .

A&E % seen within 4 hours



Notes: This chart shows performance on the 4 hour wait target by partnership. There is a difference of 11% between the highest performing area and the lowest performing area. The Scotland average is 93%. We can also provide A&E data on conversion rate- eg the proportion of A&E attendances which result in admission to hospital

ITEM No …11……….

REPORT TO: HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 FEBRUARY 2017

REPORT ON: DUNDEE MACMILLAN IMPROVING THE CANCER JOURNEY PROJECT

REPORT BY: CHIEF OFFICER

REPORT NO: DIJB3-2017

1.0 PURPOSE OF REPORT

To provide an update on the progress of the Dundee Macmillan Improving the Cancer Journey project (ICJ) and outline next steps.

2.0 RECOMMENDATIONS

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

2.1 Notes the progress made and key milestones for the project in 2017.

3.0 FINANCIAL IMPLICATIONS

None. The Dundee ICJ is funded by a grant of up to £1 million from Macmillan Cancer Support until June 2019.

4.0 MAIN TEXT

4.1 Background

4.1.1 Macmillan Cancer Support made contact with Dundee City Council in 2014 to discuss the possible development of a Macmillan Local Authorities Partnership with Dundee City Council. A co-ordinating group was then established and a formal application submitted to Macmillan in autumn of 2015. A formal grant agreement was signed between both parties in January 2016. The Senior Macmillan Partnership Manager, responsible for the management of the project, was appointed at the end of June 2016. Dundee Health and Social Care Partnership took lead responsibility in April 2016 with the project and budget now hosted with the Partnership.

4.1.2 Macmillan has targeted £6 million to test out the value of collaboration with local government. The charity has made this commitment because, despite their continuing support to the NHS in delivering the aspirations of all National Cancer Strategies across UK, it has come to recognise the significance of local authorities in terms of strategic influence and leadership, partnerships, commissioning and delivery of services that help people affected by cancer and their families and communities. The funding will be directed towards six to nine sites across UK. Dundee is the first site in Scotland (excluding the pilot ICJ project in Glasgow).

4.1.3 The approach by Macmillan has been informed by research they commissioned to understand the social care needs of people with cancer (*Hidden at Home: Macmillan Cancer Support, March 2015*). The research revealed the social care needs of people with cancer are far more widespread than they had expected and, in many cases, levels of support are falling woefully short.

4.2 The local context

4.2.1 In 2014, 5,800 people were estimated to be living with or beyond cancer in Dundee. This is expected to rise to 8,400 by 2030. Dundee is a city with higher than average incidence of all main cancers (except prostate) compared with the rest of the UK and life expectancy for people affected by cancer (PABC) (both male and female) is significantly worse than national average (as are deaths overall). A full package of baseline statistics about cancer in Dundee has been prepared by ISD to inform the development of the model. This is available on request.

4.3 Ambition and aims

4.3.1 We want everyone affected by cancer to be able to live as well and as independently as possible. The overall aim of the project is to provide clear, seamless and accessible pathways of care and support for PABC, based on a robust holistic assessment of individual need and what matters to them. This is underpinned by a number of objectives:

- To develop an integrated holistic needs assessment and post treatment care-planning framework and to promote early, targeted, planned intervention and support
- To develop re-enablement and rehabilitation packages to ensure health and wellbeing continues beyond acute care
- To promote self-directed support and encourage self-management
- To involve local communities in developing community led solutions
- To work across organisational boundaries with partners in Dundee to ensure the best possible outcomes for PABC.

4.4 Governance arrangements

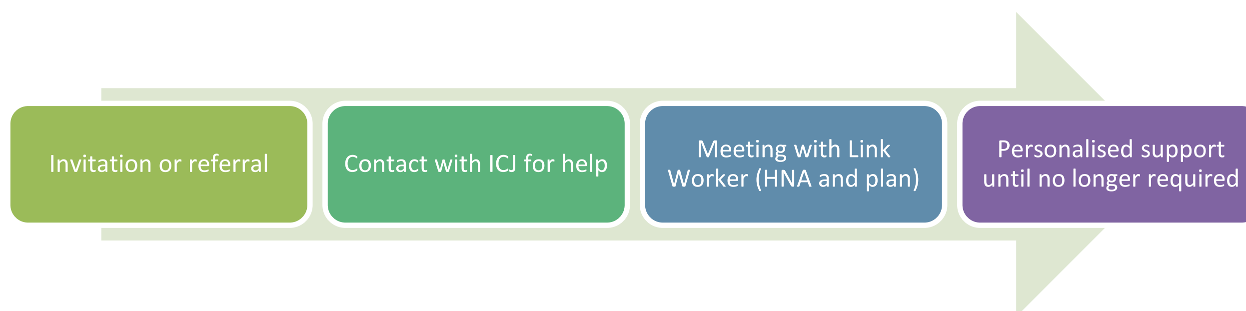
4.4.1 The project is overseen by a Project Board, chaired by the Chief Executive of Dundee City Council, David Martin, and comprised of senior representatives from other statutory partners, clinicians, Macmillan and the voluntary sector. The IJB is represented on the Project Board by the Chief Officer of the Health and Social Care Partnership. This group is accountable for the direction, development and delivery of the programme, ensuring that that the desired outcomes and benefits are achieved. The Board meets quarterly.

4.4.2 The Board is supported by a Project Team, chaired by the Senior Macmillan Partnership Manager, which meets every six weeks. Again, the membership of the group is drawn from across the Dundee ICJ partner organisations. The Team's focus is on the planning and day to day delivery of the programme, ensuring that activity is coherent, completed to time and the required quality, and with the associated risks and issues being effectively managed.

4.4.3 We are in the process of setting up a group of PABC to form a Cancer Voices Panel. This group will be involved in all aspects of the project and its decision-making and provide advice to the Project Board and Project Team.

4.5 Model

4.5.1 We have taken the principles and learning from the Glasgow ICJ to develop a very similar model for Dundee. Our service is also a 'hub and spoke' model with the client at the centre of the hub, allowing links to be made with partner organisations. The Holistic Needs Assessment (HNA) is the bedrock of the model. This covers physical issues, such as pain and fatigue, but also asks about emotional, social and financial needs such as housing, family and employment issues. The HNA will be offered in a community setting, for example, a local library. We are in the process of recruiting for two Link Workers who will meet the PABC, conduct the HNA and work with the individuals to set a plan of action. They will also co-ordinate referrals on behalf of the individual and follow up on their progress at agreed intervals.



4.5.2 We are implementing the model in three phases as outlined below:

Phase	Timing	Referral routes/activity
One	May to September 2017	• Invitation at point of diagnosis through letter from ISD • Concentrated engagement activity in Coldside and Lochee (two localities with the highest incidence of cancer) • Referrals from two Clinical Nurse Specialist (CNS) teams, Move More, Macmillan@Libraries project and Council Advice Services • Development of carers' pathway
Two	October 2017 to June 2018	• City wide access • Expansion of CNS referral • GP, Community Nursing, Community Officers and self referrals • Volunteering model developed • Employer and employee support
Three	July 2018 to June 2019	• Opt-out model • Decision about future of project, including whether to extend to other long-term health conditions

4.6 Progress to date

4.6.1 Between July and December 2016, the project was firmly in the scoping and development phase. This included setting up the governance arrangements outlined in 4.4 and the formation of two sub-groups of the Project Team, one to look after information and data and one responsible for communications and engagement. A detailed project plan and budget was prepared in collaboration with partners and project management documentation and processes put in place, including risk management and reporting.

4.6.2 In addition to project set up, and developing a high-level model, the two other priorities for this phase were the review and assessment of all data available to profile the cancer population in Dundee and their needs and relationship building. The review and assessment of data culminated in the production of the information pack mentioned in paragraph 4.2 above along with initial mapping of the services and support currently provided for PABC. We also agreed to act as the control group for the Glasgow ICJ, which will provide a further baseline for the project. Napier University will be conducting this work in February/March.

4.6.3 Relationship management activity is underpinned by a comprehensive participation and engagement plan and the emerging communications plan. The team have met with a wide range of stakeholders in Dundee, including Maggie's, Tayside Cancer Support, the Carer's Centre, Dundee Voluntary Action, Prostate Cancer UK, NHS Tayside staff at Ninewells and Roxburghe House. All have given strong support for the Dundee ICJ and are keen to be involved as it progresses. A small engagement event for PABC took place on 5 December, and the feedback

from the discussions chimed with the findings of Macmillan's Hidden at Home report: the group talked of poor communication; the lack of information on or signposting to where to get help and feelings of abandonment and isolation after treatment. All attendees at the event will continue to be involved with the Dundee ICJ, either as part of the Cancer Voice Panel or in some other way.

4.7 Key milestones for 2017

4.7.1 The three key milestones for the Dundee ICJ in 2017 are: the start Phase One in May; the public launch in September and the beginning of Phase Two in October. Our focus ahead of May is the recruitment of the Link Workers, detailed development of the first referral routes and establishing the required IT systems (the project will be hosted on Mosaic). We will also be involved in the development of the national evaluation framework for all ICJ projects.

5.0 POLICY IMPLICATIONS

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

6.0 CONSULTATIONS

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

7.0 BACKGROUND PAPERS

None

David W Lynch
Chief Officer

DATE: 2 February 2017

ITEM No …12……..

REPORT TO:	**HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 FEBRUARY 2017**
REPORT ON:	**CLINCIAL, CARE AND PROFESSIONAL GOVERNANCE**
REPORT BY:	**CHIEF OFFICER**
REPORT NO:	**DIJB8-2017**

1.0 PURPOSE OF REPORT

To inform the Dundee Health and Social Care Integration Joint Board of the implementation of Getting It Right for Everyone – A Clinical, Care and Professional Governance Framework within Dundee Health and Social Care Partnership.

2.0 RECOMMENDATIONS

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

2.1 Note the progress made to date;

2.2 Instruct the Chief Officer to provide exception reporting to every Performance & Audit Committee and six-monthly reports to the IJB beginning in November 2017.

3.0 FINANCIAL IMPLICATIONS

There are no financial implications arising from this report.

4.0 MAIN TEXT

4.1 Background

4.1.1 There is a requirement for partnerships to have a Clinical, Care and Professional Governance framework which will assure both the IJB and their parent bodies of the quality and safety for the services delivered by their staff. The clinical, care and professional governance arrangements for all services within the scope of the three Health and Social Partnerships within Tayside were described in the document Getting It Right for Everyone – A Clinical, Care and Professional Governance Framework (the Framework) (attached as appendix 1). This Framework was adopted by the Dundee Health and Social Care Partnership Integration Board on 24 March 2015. The arrangements for clinical, care governance and professional governance described in this paper are designed to assure Tayside's three Integration Joint Boards (IJBs), NHS Tayside and the area's three Local Authorities of the quality and safety of service delivered by its staff, and the difference services are making to the lives and outcomes of the people of Tayside who need them.

4.1.2 The framework identifies six key domains which were chosen to reflect the core elements of business in each Integrated Authority:

- Information Governance
- Professional Regulation and Workforce Development
- Patient/Service User/Carer and Staff Safety
- Patient/Service User/Carer and Staff Experience
- Quality and Effectiveness of Care
- Promotion of Equality and Social Justice

4.2 Embedding the Framework within the Partnership

4.2.1 To further develop the understanding of the Framework and its application, two development sessions were held with Managers to discuss the Framework, agree application and map out current resources. These sessions identified both the strengths in each parent organisations and the gaps in the application of the Framework. Following on from these sessions key area for further development were identified and included:

- A mapping of current arrangements against the six key domains.
- Further development of the Dundee CHP Performance Clinical Forum to incorporate all relevant services at an operational level.
- A review of Health and Safety monitoring arrangements to develop an integrated approach.
- A joint complaints process for the receipt, recording and analysis of complaints.
- A staff development programme which will take forward the roll out of the Framework and embed the principles within the day to day service delivery.
- The use of local systems to support single recording and reporting arrangement. This includes the use of Dundee City Council's Covalent system to record actions and the use of NHS Tayside Datix system to record risks and incidents.

4.2.3 It is anticipated that as the partnership governance arrangements continue to develop, other systems will be explored to take an integrated approach to recording and analysis of governance data and information.

4.3 Governance and Accountability Arrangements

4.3.1 The Framework (Appendix 1 – page 13) articulates the accountability arrangements for Clinical, Care and Professional governance.

4.3.2 The Chief Executives of the three Councils and NHS Tayside hold ultimate accountability for the delivery of clinical and care governance. In developing the Framework, a proposed reporting and accountability structure was developed. This introduced levels of reporting arrangements:

R1 – Tayside Joint Forum - This forum takes overall responsibility for the monitoring of Clinical, Care and Professional governance across Tayside. It is a professional reference group, bringing together senior professional leaders across Tayside. It should provide oversight and advice in respect of clinical, care and professional governance. The membership includes Chief Social Work Officers, Medical Director, Nurse Director, Director of Public Health, Pharmacy Director, Director of Allied Health, Associate Medical Director (Primary Care and Independent Contractors) and the Chair of the Area Clinical Forum.

R2 – Local Partnership Clinical Forum – This forum will sit at a Partnership level and will be made up of a range of professionals and managers, who are responsible for the implementation of the Framework and who hold accountability to the membership of R1 for outcomes. The membership of this forum will reflect the professionals represented in R1.

R3 – Professional/Clinical Advisory forums or equivalent - These groups are either Tayside wide forums such as the Tayside Mental Health Clinical, Care and Professional Governance Group or thematic groups such as the Diabetes Managed Clinical Network. There is further work to be done to clarify communication routes between the forum and the R2 groups.

R4 – Operational Groups - While this level of governance is not defined within the Framework, there is a recognition that at a Partnership operational level and in some cases by service or theme, there are currently groups within the Partnership which hold a Clinical, Care and Professional governance role. This includes the Adult Support and Protection Committee which considers and reports on risk, performance and practice; the staff side/trade union/management meetings; the CHP quality forums and health and safety groups. These groups will be built into the local articulation of the Framework and reporting arrangements between the local R4 groups and the Dundee R2 forum are being established.

4.4 Dundee Health and Social Care Clinical, Care and Professional Governance Forum (R2)

4.4.1 The Dundee Health and Social Care Clinical, Care and Professional Governance Forum was established as an interim Forum in the shadow year of the partnership. Since the full

commencement of the Act the membership and reporting arrangements were further reviewed and the Forum has commenced a series of meetings. It is chaired by David Shaw, Clinical Director.

4.4.2 The Forum will consider the following issues where they apply to matters of clinical, care and professional governance:

- Identified risks
- Health and Safety
- Analysis of Datix reports
- Local Adverse Events Reviews (LAERS)/Significant Clinical Event Analysis (SCEA)/Significant Incident Reports
- Reports as defined by the six domains (see 4.1.2)
- Minutes of R1/R3/R4 groups as required.

4.4.3 In addition, the Forum has agreed that services will be asked to provide a report detailing any risk and issues of governance. These reports will be timetabled in over the next financial year.

4.5 Performance Reporting

4.5.1 At this early stage, the Dundee Health and Social Care Clinical, Care and Professional Governance Forum is unable to provide a fully comprehensive report to the IJB as they are still gathering and agreeing the baseline data and reporting arrangements. This work will form the basis of a routine report to the Performance & Audit Committee and a fully comprehensive report to the IJB every six months. It is our recommendation that the first six-monthly report be tabled at the IJB in November 2017 (reporting period April 2017 – October 2017).

4.5.2 R1, as defined through the Framework, will report to the Clinical and Care Governance Forum. Through this forum, NHS Tayside will provide assurance to the IJB. In addition, matters of Clinical, Care & Professional Governance will be reported by the Chief Social Work Officer through her annual report.

5.0 POLICY IMPLICATIONS

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

6.0 CONSULTATIONS

The Chief Finance Officer, Clinical Director, Professional Advisers to the IJB and the Clerk were consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 8 February 2017

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Integrated Health and Social Care Partnerships

Getting it Right for Everyone - A Clinical, Care and Professional Governance Framework

"Governance is a system through which Organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in care will flourish." ***Scally and Donaldson, 1998.***

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1 Introduction

The main purpose of the integration of health, social work and social care services in Scotland is to improve the wellbeing of people who use such services, in particular those whose needs are complex and who require services and supports from health and social care at the same time. The Integration Schemes drawn up for each of Tayside's three Integration Authorities are intended to achieve improved outcomes for the people of Tayside, in line with the National Health and Wellbeing Outcomes (attached at Appendix 1) that are prescribed by Scottish Ministers in Regulations under Section 5(1) of the Public Bodies (Joint Working)(Scotland) Act 2014.

The national health and wellbeing outcomes apply across all integrated health and social care services, ensuring that Health Boards, Local Authorities and Integration Authorities are clear about their shared priorities by bringing together responsibility and accountability for their delivery. The national health and wellbeing outcomes also provide the mechanism by which the Scottish Ministers will bring together the performance management mechanisms for health and social care. The national health and wellbeing outcomes, together with the integration planning and delivery principles, are grounded in a human rights based and social justice approach.

It is clearly recognised that the establishment and continuous review of the arrangements for clinical, care and professional governance for all services which are' in scope' are essential to the delivery in Tayside of each Integration Authority's obligations and quality ambitions. The arrangements for clinical, care governance and professional governance described in this paper are designed to assure Tayside's three Integration Joint Boards (IJBs), NHS Tayside and the area's three Local Authorities of the quality and safety of service delivered by its staff, and the difference services are making to the lives and outcomes of the people of Tayside who need them.

There are a number of bodies responsible for clinical and care governance and professional governance in Tayside. This paper sets out the proposed framework for clinical, care and professional governance arrangements to be used by Tayside's three health and social care Integration Authorities in Angus, Dundee and Perth & Kinross. The framework proposed describes and shows schematically the relationship between all of the relevant bodies in Tayside and outlines the specific responsibilities they carry for governance.

The framework has been developed to ensure that there are explicit and effective lines of accountability from care settings to each authority's IJB, the NHS Tayside Board and the three local authority's Chief Executives and elected members. The proposed framework recognises that such accountability is essential to assure high standards of care and professionalism in the services provided by each Integration Authority and the Board of NHS Tayside with the aim of achieving the best possible outcomes for service users in line with the National Outcomes Framework.

This Governance Framework will evolve in the light of experience with joint working and the local requirements for governance and service development. Oversight of this process will be the remit of the Tayside Joint Professional Forum (R1 in Figure 2) in support of the strategic plans within each Integration Authority and the development needs identified through each of the three the Local Professional Fora (R2) and the Integrated Joint Boards for the Angus, Dundee and Perth & Kinross Partnerships.

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Within this governance framework, accountability is viewed as a complex phenomenon with three core elements:

- Each individual's professional accountability for the quality of his or her own work, in line with the requirements of the relevant professional regulatory bodies
- The accountability of individual professionals to the requirements of the organisations in which they work
- The accountability of senior members of staff for the organisation's performance, and more widely for its provision of services to the people it serves

The Tayside Clinical, Care and Professional Governance Framework operates in the context of a developing legislative framework and alongside a wide range of policy drivers. Partner organisations across Angus, Dundee and Perth & Kinross will work to deliver services that are responsive, integrated and coordinated to meet the needs of individuals and communities in line with the strategic intentions expressed in law and policy. Improved outcomes and effective services for service users and their carers require alignment of culture, values and language.

In supporting organisational, service and staff development, the framework assumes acceptance of a range of underpinning principles. These include greater levels of anticipatory care and prevention; engagement of patients, service users and carers in the design and delivery of care; and greater co-production with third sector organisations, communities and support networks around individuals, families and communities. All managers and professionals involved in strategic planning, service development and individual care planning are required to consider and include the broad range of social support and community assets available in each community to help maximise the independence of people who need services and the supports provided to those who care for them.

This framework exists to improve performance across all the Governance domains outlined in Section 4 and the alignment of performance management systems across both Health and Local Authority services, including those that are not currently integrated.

2 Definition of Clinical and Care Governance

Clinical and care governance is the system by which Health Boards and local authorities are accountable for ensuring the safety and quality of health and social care services, and for creating appropriate conditions within which the highest standards of service can be promoted and sustained. The following definition of clinical and care governance underpins the clinical and care governance and professional governance framework for Tayside outlined in this paper.

2.1 Annex C of the Public Bodies (Joint Working) (Scotland) Act 2014 Clinical and Care Governance Framework sets out in some detail the working definition to be applied to Integrated Health and Social Care Services in Scotland. This working definition is as follows.

a) Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation – built upon partnership and collaboration within teams and between health and social care professionals and managers.

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b) It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening – whilst at the same time empowering clinical and care staff to contribute to the improvement of quality – making sure that there is a strong voice of the people and communities who use services, and their carers.

c) Clinical and care governance should have a high profile, to ensure that quality of care is given the highest priority at every level within integrated services. Effective clinical and care governance will provide assurance to patients, service users, carers, clinical and care staff and managers, Directors alike that:

- *Quality of care, effectiveness and efficiency drive decision-making about the planning, provision, organisation and management of services;*
- *The planning and delivery of services take full account of the perspective of patients, service users and carers;*
- *Unacceptable clinical and care practice will be detected and addressed.*

d) Effective clinical and care governance is not the sum of all these activities; rather it is the means by which these activities are brought together into this structured framework and linked to the corporate agenda of Integration Authorities, NHS Boards and Local Authorities.

e) A key purpose of clinical and care governance is to support staff in continuously improving the quality and safety of care. However, it will also ensure that wherever possible poor performance is identified and addressed. All health and social care professionals will remain accountable for their individual clinical and care decisions.

f) Many clinical and care governance issues will relate to the organisation and management of services rather than to individual clinical decisions. All aspects of the work of Integration Authorities, Health Boards and Local Authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. Clinical and care governance is principally concerned with those activities which directly affect the care, treatment and support people receive whether delivered by individuals or teams.

2.2 The Process of Clinical and Care Governance

The Chief Officers in each of Tayside's three Integration Authorities, the Chief Executive Officer (CEO) for NHS Tayside and the CEOs for each of the three Local Authorities will have in place, management structures that ensure accountability and responsibility for professional, clinical and care governance in each Integration Authority. Annex C of the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Clinical and Care Governance Framework sets out a series of five process steps to support clinical and care governance as follows

a) Information on the safety and quality of care is received.
b) Information is scrutinised to identify areas for action.
c) Actions arising from scrutiny and review of information are documented.
d) The impact of actions is monitored, measured and reported
e) Information on impact is reported against agreed priorities.

These five steps form the basis of the proposed performance framework described in this paper for Tayside's three Integration Authorities and this information will be used to demonstrate achievement of the nine national Health and Well-being outcomes and the local outcomes expressed in each Local Authority's Single Outcome Agreement (SOA).

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2.3 The principles contained in this framework are designed to integrate with the Strategic 2020 Vision and the patient safety agenda. While there is no similarly overarching articulation of these, the principles for Local Authority services align closely with those articulated by the Christie Commission, in the Social Care (Self Directed Support) (Scotland) Act 2013 and the Community Empowerment Bill. Core outcome measures will be agreed in line with the principles and proposed framework to ensure consistency of approach between Local Authorities, Tayside NHS Board and the IJBs for the three Tayside Partnerships. Performance will be assessed against an agreed, prioritised common data set for each of the governance domains as described at Paragraph 4 of this paper.

3 Professional Governance

3.1 Professional governance is an accountability framework that empowers health and social care professionals at the front line to collaborate effectively in the delivery of integrated services. The framework for professional governance includes such core elements as codes of conduct, standards of practice, policies and procedures, resource utilisation and stewardship, evidence-based practice and research, use of technology, quality and performance improvement. The purpose of system-wide professional governance is to coordinate the activities of the health and social care workforce to achieve the health and well being outcomes for patients, service users and carers in integrated health and social care settings across Tayside.

3.2 The Professional Governance Framework provides assurance to the IJBs, Angus, Dundee, Perth & Kinross Councils and Tayside Health Board that effective processes for health and social care professional practice are in place and implemented to develop, support and monitor workforce compliance with agreed accountability and governance frameworks.

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4 Performance Assurance Framework

Clinical and care governance in Tayside is currently monitored through the NHS Tayside and each Council's existing performance management systems. Professional governance is achieved through the agreed accountable professional officers, namely the Medical Director, the Director of Nursing and Midwifery, the Chief Social Work Officer, the Director of Pharmacy and the Director of AHPs.

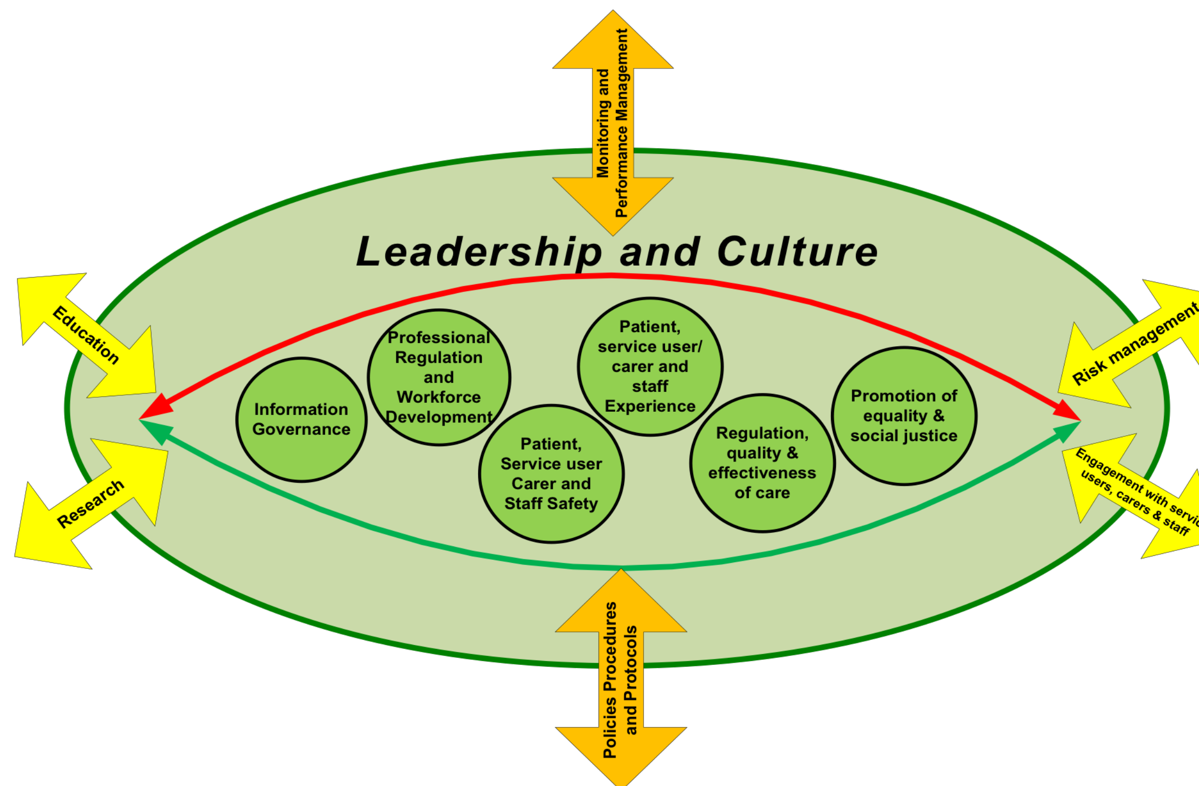

Figure 1 **Overview of Tayside Clinical and Care Governance and Professional Governance Framework**

The Chief Officer in each of Tayside's three Partnerships will have in place management structures that ensure accountability and responsibility for professional, clinical and care governance in each Integration Authority. Clinical and care governance and professional governance contribute to a higher level performance improvement framework that is well established as a self-evaluation framework within Tayside's three local authorities through the Performance Improvement Model (PIM). The PIM, which was developed by Scotland's Social Work inspection agency (SWIA, now the Care Inspectorate) for use with and by social work services across Scotland, recognises the important link between scrutiny and self-evaluation. The PIM provides a clear structure for self evaluation which focuses on performance across a number of key areas of activity, as detailed in Appendix 2.

The PIM, which is based on a three year cycle of scrutiny and self-evaluation, complements the principles of Best Value through a focus on getting the right results, having the right processes to deliver these and emphasising the role of leadership and high standards of corporate governance.

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A self-assessment tool for clinical and care governance and professional governance is being developed for use by Tayside's Integration Authorities that will include measures to facilitate a cycle of continuous improvement across all the domains included in Figure 1, consistent with the PIM and the performance review framework in NHS Tayside

The following domains have been chosen to reflect the core elements of business in each Integration Authority in which it is important to demonstrate appropriate and effective controls to achieve improvement in outcomes for patients, service users and carers across Tayside

- Information Governance 4.1
- Professional Regulation and Workforce Development 4.2
- Patient/Service user/Carer and Staff Safety 4.3
- Patient/Service user/Carer and Staff Experience 4.4
- Quality and effectiveness of care 4.5
- Promotion of Equality and Social Justice 4.6

4.1 Information Governance

This domain reflects the duties related to the protection of information, information sharing, records management, Information Technology management, data reporting and documentation standards, whose purpose is as follows

- Promotes a culture of openness in the sharing of information across health and social care professionals and agencies both in the design and development of shared information systems, and in the delivery of coordinated and integrated care for service users and their carers
- Simplifies and streamlines communication through shared systems and mechanisms, such as the use of a single point of contact (SPOC)
- Ensures compliance with data protection requirements and the principles of informed consent
- Ensures transparent, open, accessible and robust performance reporting
- Provides a framework to assess documentation standards, including documentation audits, using a sampling methodology
- Provides a framework for development of multi-professional electronic patient and service user records that include Integrated Care & Support Plans
- Understands and minimises unnecessary variation by the development of a shared minimum data set, the intelligent use of data, measurement and improvement science
- Ensures performance reporting is used to enable continuous improvement through the development of standard reports and system capability to meet both standard and ad hoc reporting requirements.
- Develops innovative solutions to support improved service delivery and service user experience, and make best use of resources, for example through the development of an integrated patient/service user tracking system to monitor individual progress along pathways of care

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4.2 Professional Regulation and Workforce Development

This domain reflects the need for our organisations to have assurance that we have a workforce fit for purpose and sustainable into the future. This is particularly important as we move towards new models of care where professionals will need to retain their accountability through professional leads in health and social care. There are also important provisions in existence that protect professional standards in education and research that would be essential for success in the future. This domain:

- Ensures organisational development and professional practice is evidence based and continuously improved, supported by a culture of learning and high performance, in line with regulatory and continuous professional development requirements and standards
- Ensures compliance with professional standards, codes of practice and performance requirements and alignment of activities with organisational objectives and service user outcomes
- Encourages and enables staff to work in multi-disciplinary and multi-professional teams and to use reflective practice to support the delivery of improved outcomes
- Promotes the development of staff in a range of generic skills, for example skills to take on a key worker role
- Promotes the development of specialist skills to deliver services in new ways, or in different settings, across professional groups and agencies
- Promotes learning from good practice, adverse incidents, complaints and risks.
- Creates an environment that supports the contribution of staff and their safety as well as supporting and enabling innovation.
- Ensures our staff act with honesty and integrity and comply with the duty of candour.
- Recognises the value of joint education as a vehicle for more promoting and supporting integrated working

4.3 Patient/Service User/Carer and Staff Safety

This domain reflects our duties to create a safe working environment for staff along with our duty of care to patients, service users and carers.

- Ensures services are as safe and effective as possible for the people who use services and the staff who provide them
- Ensures planned, strategic approaches to innovation and development through an organisational learning and improvement culture.
- Ensures accountability, management and mitigation of risk through joint risk registers and aligned strategic, operational and service level risk assessment and management processes.
- Anticipates and prevents harm through active use of learning from near misses and demonstrates robust systems for risk assessment and management; for example, in addressing medicines management issues, use of patient, service user and carer safety plans.
- Ensures compliance with Health and Safety requirements, Adult and Child protection arrangements, Violence Against Women and other Protecting People arrangements, and makes provision for Adults with Incapacity requirements
- Requires reporting of incidents, complaints, compliments and other forms of user feedback, and promotes learning from these

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- Develops a culture of openness, inter-agency coordination, communication and accountability, where learning from critical incidents and successes takes place informed by Significant Case Reviews, local adverse event reviews, Significant Adverse Event reviews, and is incorporated into training and education for staff

4.4 Patient/Service User/Carer and Staff Experience

This domain reflects the importance of involving service users and carers in the design and delivery of health and social care supports and services. It also reflects the importance of staff at the front line having the opportunity to shape services in line with specialist and best practice knowledge alongside their awareness of the needs of specific care groups and local communities. This domain:

- Provides a framework for staff and patient/service user/carer feedback, culture surveys and reported experience of service delivery
- Ensures planning, delivery and monitoring of services are informed by service user experience and that feedback is systematically sought and used to improve service quality, and user experience and outcomes
- Promotes patient, service user and carer involvement in identifying their individual outcomes; shaping individual care plans, services and organisational practices to achieve personalisation and person-centred approaches to care, in line with the requirements set out in the Social Care (Self-directed Support) (Scotland) Act 2013 .
- Promotes and develops mechanisms for the resolution of differences between professional opinion and user choice
- Promotes staff, service user and carer involvement in the planning and development of services
- Promotes the development of joint approaches to hearing and acting upon concerns before they become complaints – for example, through the delegation of authority to resolve issues as close as possible to the front line of services with the aim of improving the responsiveness of services and reducing the need for recourse to formal complaints processes
- Promotes the local development of joint approaches to managing complaints and a consistency of approach across Tayside

4.5 Quality and Effectiveness of Care

This domain reflects the drive towards evidence based practice to improve outcomes and achieve Best Value in the design, organisation and delivery of services. Good governance in this domain should deliver on the Christie Commission requirements and the 20:20 vision of person centred, high quality services for the people of Tayside. This domain:

- Establishes a system of governance that is designed to produce evidence of continuously improving outcomes for people who use, or may need services
- Promotes the development of integrated, locally developed pathways of care, within broad assurance principles for the whole of Tayside
- Delivers high quality, evidence-based care and prevention, informed by the development and monitoring of cross organisational measures and service specific outcomes

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- Demonstrates willingness to learn through further integration of formal review processes, such as Morbidity & Mortality reviews, Significant Case Reviews and external scrutiny reviews with bodies such as the Care Inspectorate and Health Improvement Scotland.
- Ensures active service evaluation though individual, team-based, service or partnership level, case and practice based audit programmes self-assessment and performance review processes
- Recognises the importance of engaging patients, service users and carers in the design and delivery of care to maximise effectiveness
- Reports to Board through Clinical Governance Committee and equivalent for Council Services

4.6 Promotion of Equality and Social Justice

The national health and wellbeing outcomes, together with the integration planning and delivery principles, are grounded in a human rights based and social justice approach. A human rights based approach is described as:

".. a way of empowering people to know and claim their rights. It increases the ability and accountability of individuals, organisations and the relevant professionals for respecting, protecting and fulfilling rights. This means giving people greater opportunities to participate in shaping the decisions that impact on their human rights.

National Health and Wellbeing Outcomes Framework, Scottish Government

This domain reflects the responsibilities of Local Authorities and Health Boards under Human Rights Legislation, and within the National Health and Well Being Outcomes Framework, to have clear strategies in place to address inequalities that have an adverse effect on wellbeing, to promote social inclusion, equity of access to services and improved outcomes for people across Tayside. There are three linked national social policy frameworks: Achieving Our Potential, Equally Well and the Early Years Framework. These policy frameworks are complementary and are underpinned by principles of fairness and social justice. Together they reflect the joint aims of tackling poverty, addressing health inequalities and giving children the best start in life.

In Tayside there is a commitment on the part of all three Authorities articulated through each Authority's SOA and other policy documents, to address social inequalities and the impact that these have on other aspects of life in our communities, including health, employability and financial inclusion. NHS Tayside's Health Equity Strategy shares the same level of ambition by aiming to reduce health inequalities in Tayside within a generation. This domain:

- Demonstrates activities that support the improvement cycle to reduce inequalities in the delivery of services
- Ensures that impact assessments are undertaken to identify and minimise the impact of service developments on inequalities

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In line with the Scottish Government's commitment to the Scottish National Action Plan (SNAP) on Human Rights, this domain will adhere to the PANEL principles and the FAIR approach, advocated in the National Health and Wellbeing Outcomes Framework, to support the application of a human rights based approach in practice in Tayside.

PANEL Principles	
Participation	The right to participate in decisions
Accountability	Effective monitoring of Human Rights standards
Non discrimination and equality	All forms of discrimination are prohibited, prioritisation of those in greatest need
Empowerment	People understand and are able to claim their rights
Legality	Human Rights as legally enforceable entitlements

FAIR Approach	
Facts	Individual experiences
Analysis of rights at stake	What are the human rights or issues at stake?
Identification of shared responsibilities	What changes are necessary, who is responsible to help?
Review actions	Does review involve the individual affected?

5 Performance Management Framework

The national health and well-being outcomes provide a strategic framework for the planning and delivery of health and social care services. This suite of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as the difference that integrated health and social care services should make for the people who receive them.

Integration Authorities are required to publish an annual performance report, and each of Tayside's three IJBs will provide performance reports in accordance with the content prescribed in regulations, as well as providing additional performance information that reflects local priorities. The IJBs will adopt the performance measurement framework developed by the Scottish Government and will use this to inform local practice development and evidence improvement.

For each of the domains described above, an agreed number of outcome performance measures will be applied. These measures will align with those specified within the National Health and Well-being Outcomes Framework, as well as the PIM and NHS Tayside's performance improvement framework, and will be developed jointly over time to reflect the needs of, and outcomes from, services for the population of Tayside. This will be achieved through self assessment and agreed performance review processes.

6 Accountability for Clinical, Care and Professional Governance

NHS Tayside Board and the three Local Authorities have existing mechanisms to demonstrate accountability to the Scottish Government and the public. Joint boards will integrate new and existing methods of professional performance management and governance within each of the three

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Integration Authorities. These will include arrangements for the protection of people of all ages, as well as strategic planning and community planning across Tayside.

6.1 Accountabilities for Clinical, Care and Professional Governance

Chief Executives
The Chief Executive officers of the three Councils and Tayside NHS Board hold ultimate accountability for the delivery of clinical and care governance.

Chief Officers (CO)
The Chief Officer is the Accountable Officer for Health and Social Care Integration to the Joint Board. Each Integration Authority's CO will report to their respective IJB for strategic planning and to both their Council's Chief Executive, as well as the Chief Executive of NHS Tayside for the operational delivery of health and social care services. Joint performance review meetings, for ensuring improvement and operational delivery, involving both Chief Executives and the Chief Officer will take place on a regular basis and at minimum quarterly intervals. The CO will be a substantive member of the senior management teams of both their respective Councils and of NHS Tayside. A key element of the CO role will be to develop close working relationships with elected members of their respective Councils and Non Executive and Executive NHS Tayside Board members. In addition the CO will establish and maintain effective working relationships with a range of key stakeholders across NHS Tayside, the Council, the third and independent sectors, service users and carers, Scottish Government, trades unions and relevant professional organisations.

The Chief Social Work Officer (CSWO)
The CSWO, through delegated authority holds professional and operational accountability for delivery of safe and innovative social work and social care services within each of Tayside's three local authority areas. The CSWO will provide professional advice to the Council, and the IJB, in respect of the delivery of social work and social care services by Council staff and commissioned care providers in each of Tayside's three Integration Authorities

Professional Leads
Each Integration CO will have an appropriate senior team of 'direct reports' in order to fulfil their accountability for the Strategic Commissioning Plan that has been developed for each of Tayside's three Integration Authorities, and for the safe, efficient and effective delivery of services to the population of the local area served by each IJB.

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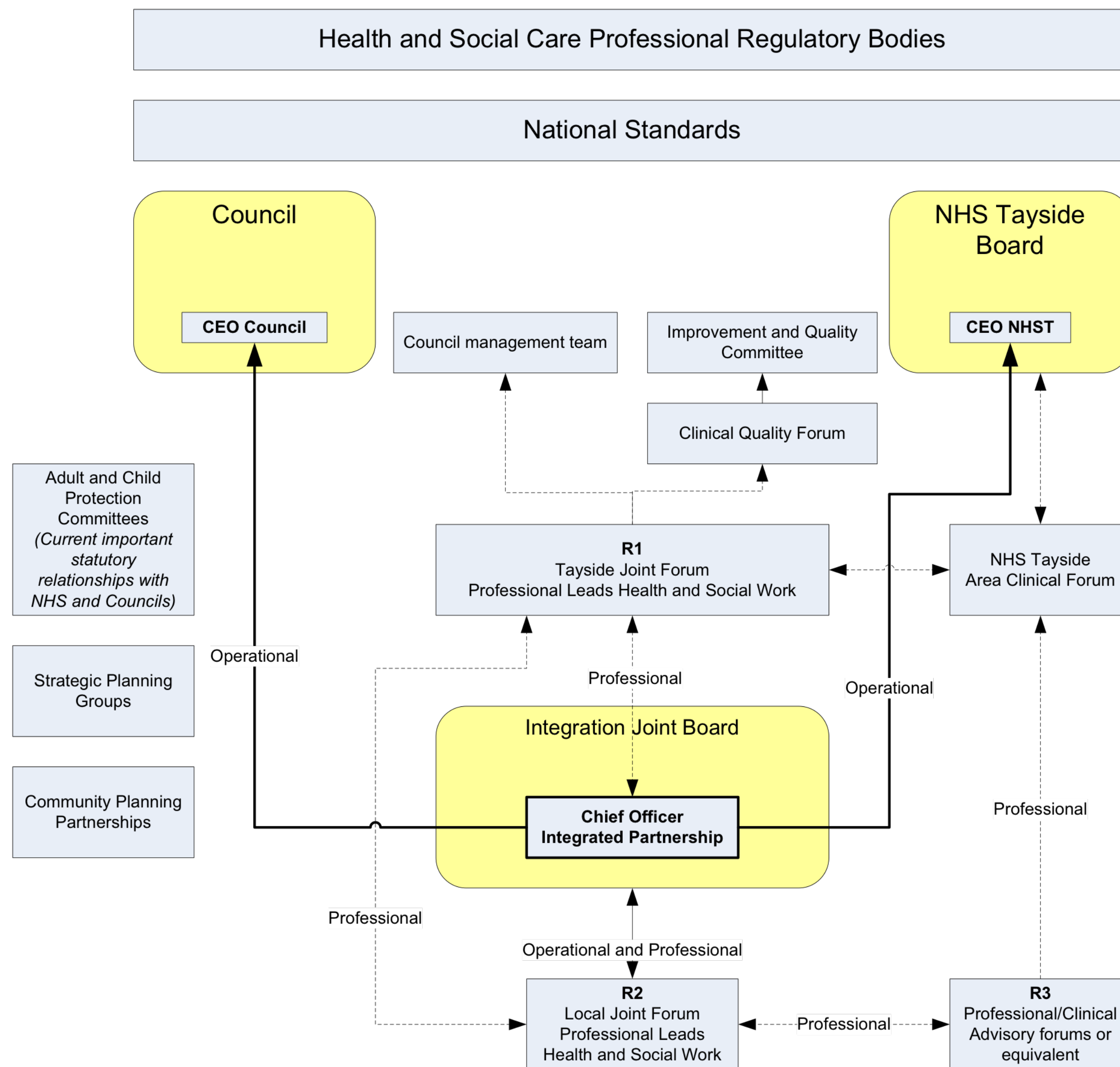

Figure 2 **Accountability for Clinical and Care Governance and Professional Governance**

7 Membership of the Tayside Clinical and Care Governance and Professional Governance Forum (R1)

Membership:	Roles and Responsibilities:
Chief Social Work Officer Angus Council Dundee Council Perth & Kinross Council	• The overall objective of the CSWO is to ensure the provision of effective, professional advice to local authorities, elected members and officers in the authorities' provision of social work services. The post should assist authorities in understanding the complexities of social work service delivery, including in relation to particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders and the key role social work plays in contributing to the achievement of national and local outcomes. • The CSWO also has a role to play in overall performance improvement and the identification and management of corporate risk insofar as they relate to social work services.
Medical Director NHS Tayside	• The role and responsibility for the NHS Tayside Medical Director is to lead the formation and implementation of clinical strategy, taking lead on clinical standards, providing clinical advice to the board, providing professional leadership, and being a bridge between medical staff and the board. • The Medical Director provides translation, assessing the mood and, crucially, creating alignment between the organisation and doctors. Outward-facing work with the PCT, strategic health authority and other external organisations. • Other key responsibilities include; clinical governance, acting as the Responsible Officer for revalidation, quality and safety, education, medical staffing planning, disciplinary issues concerning doctors.
Nursing & Midwifery Director NHS Tayside	• To provide leadership, assurance and professional accountability of all nursing & midwifery staff within the Health Board. • Reporting and providing professional leadership, escalating and managing strategic portfolios. • In addition, the incumbent will plan, organise and implement policies and procedures in cooperation with other departments and executives, and in accordance with standards of good Nursing and Midwifery practice.
Director of Public Health NHS Tayside	• The post holder is responsible for leading the delivery of the public health functions within NHS Tayside, Angus, Dundee and Perth and Kinross Councils.
Pharmacy Director NHS Tayside	• To provide strong and effective leadership for pharmacy through the period of radical change for the service both within NHS Tayside and nationally. • To be the responsible pharmaceutical officer to Tayside NHS Board & ensure senior pharmacy representation in all parts of the organisation • To encourage and facilitate new ways of delivering pharmaceutical care and to create and explore opportunities to develop roles, behaviours and ways of working to achieve consistent high standards of service for patients in all parts of the system reaching beyond NHST boundaries. • To develop the focus on pharmaceutical care in the community setting and lead the cultural changes required. • To assure the partnerships and the board of the overall strategic direction of the pharmacy services in Tayside
Director of Allied Health Professions (AHP) NHS Tayside	• To provide strong and effective leadership for Allied Health Professions through the period of radical change for the service both within NHS Tayside and nationally. • To be the responsible officer to Tayside NHS Board and ensure senior AHP representation in all parts of the organisation • To encourage and facilitate new ways of delivering care and to create and explore opportunities to develop roles, behaviours and ways of working to achieve consistent high standards of service for patients in all parts of the system reaching beyond NHST boundaries. • To develop the focus on Integrated AHP care in the community setting and lead the cultural changes required. • To assure the partnerships and the board of the overall strategic direction of the AHP services in Tayside

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Membership:	Roles and Responsibilities:
Associate Medical Director Primary Care & Independent Contractors NHS Tayside	• The Associate Medical Director (AMD) supports strategic objectives through oversight of high quality primary care services that are safe and efficient. • Specifically the AMD will be accountable for independent contractors within Tayside and their role in provision of services. • The AMD is responsible for the safety and capability of the independent contractor workforce, providing assurance to the Medical Director.
Chair Area Clinical Forum NHS Tayside	• The function of the Clinical Area Forum Chair is to review the business of Professional Advisory Committees to ensure a co-ordinated approach to clinical matters across professions and the organisation. • Other duties include providing a clinical perspective on National Policy, NHS Board plans and the strategy, engaging clinicians in service design and improvement, spreading best practice and encouraging multi-professional working

7.1 Terms of Reference

The Tayside Clinical and Care Governance and Professional Governance Forum is a professional reference group, bringing together senior professional leaders across Tayside. This group, chaired by one of its members, will oversee the delivery of integrated care and support along with change and innovation to ensure the delivery of safe and effective person-centred care within Tayside. This group will ensure that the responsibilities for Clinical and Care Governance and Professional Governance, which remain with NHS Tayside and the Council relate to the activity of the Board.

The group will provide oversight and advice and guidance to the Strategic Planning Groups, to each Integration Authority's CO and to the IJBs in respect of clinical and care and professional governance for the delivery of health and social care services across the localities identified in their strategic plans.

7.2 Roles and Responsibilities:

NHS Tayside Executive Medical, Nursing, Pharmacy and AHP Directors share accountability for Care Assurance, Clinical and Professional Governance across NHS Tayside services as a statutory duty delegated by the NHS Tayside Chief Executive. As part of their statutory duties, these officers or their designated deputes are required to attend the Joint Board to provide professional advice and assurance in respect of Clinical and Care Governance and Professional Governance in Tayside.

The Chief Social Work Officers, through delegated authority hold professional and operational accountability for the delivery of safe and innovative social work and social care services provided by the Council, as well as by external organisations from whom the Council has procured and commissioned services. An annual report on these matters will continue to be provided to the relevant committee of the Council and the Scottish Government. The Chief Social Work Officer will attend the Joint Board to provide professional advice and assurance in respect of Social Work staff and commissioned care providers.

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8 Membership of the Local Clinical and Care Governance and Professional Governance Forum (R2)

This group will be made up of a range of professionals and managers who are responsible for implementation and who hold accountability to the membership of R1 for outcomes. This will include a core membership to reflect the professions represented in R1

8.1 Terms of Reference:

To be agreed locally

9 Assurance Framework for Integrated Health and Social Care Partnerships in Tayside

Each Integration Authority is a board of governance, accountable for strategic planning and ensuring the operational delivery of those integrated services that are delegated to the Authority. The Health Board and Local Authority are ultimately accountable for the operational delivery of integrated services, with the Chief Executive Officer accountable for the delivery of those delegated functions and accountable for improvement responses to external inspections.

Clinical, care and professional governance arrangements for integrated services must fully align with the existing arrangements for governance within Tayside's Health Board and Local Authorities. These four public bodies must develop a consistent approach to assurance for quality and safety of care across all services, whether integrated or not. The integration scheme for each of Tayside's three integration authorities sets out the means by which each IJB will assure for the quality and safety of care in each integration authority. This framework underpins the commitments that are made in each of the three integration schemes.

Each of these domains will be underpinned by mechanisms to measure, quality, clinical and service effectiveness and sustainability. They will be compliant with statutory, legal and policy obligations strongly underpinned by human rights values and social justice. Service delivery will be evidenced based, underpinned by robust mechanisms to integrate professional education, research and development.

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10 References

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- *The Role of the Chief Social Work Officer (2010) Scottish Government http://www.scotland.gov.uk/Publications/2010/01/27154047/0*
- *The Scottish Government's 2020 Vision http://www.scotland.gov.uk/Topics/Health/Policy/2020-Vision*
- *University of California Davis Medical Centre Nursing Professional Governance Model http://www.ucdmc.ucdavis.edu/nurse/practicemodel/governance.html*

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Appendix 1 Health and Well-being Outcomes under Health and Social Care Integration

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

Outcome 1:	People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 2:	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Outcome 3.	People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 4.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 5.	Health and social care services contribute to reducing health inequalities.
Outcome 6.	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
Outcome 7.	People using health and social care services are safe from harm.
Outcome 8.	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Outcome 9.	Resources are used effectively and efficiently in the provision of health and social care services.

Appendix 2

What key outcomes have we achieved?	What impact have we had on people who use our services and other stakeholders?	How good is our delivery of key processes?	How good is our management?	How good is our leadership?	What is our capacity for improvement?
1. Key Outcomes	2. Impact on people who use our services	5. Delivery of key processes	6. Policy and service development, planning and performance management	9. Leadership and direction	10. Capacity for improvement
Outcomes for adults, carers, children and families Performance against national and local targets	Experience of individuals, children and their parents and carers who use our services	Access to services Day-to-day planning and resource allocation Assessment, care management and statutory supervision Risk management and accountability Personalised approaches Inclusion, equality and fairness in service delivery Joint and integrated delivery of services	Development of policy and procedures Operational and service planning Strategic planning including partnership planning Involvement of users, carers and other stakeholders Range and quality of services Quality assurance and continuous improvement	Vision, values and aims Leadership of people Leadership of change and improvement	Global judgement based on evidence of all key areas, in particular, outcomes, impacts and leadership direction
	3. Impact on employees		7. Management and support of employees		
	Motivation and satisfaction Employees' ownership of vision, policy and strategy		Recruitment and retention Employee deployment and teamwork Development of employees		
	4. Impact on the community		8. Resources and capacity building		
	Community perception, understanding and involvement Impact on other stakeholders Community capacity		Financial management Resource management Social work information systems Partnership arrangements Commissioning arrangements		

KEY
- 6 key questions
- 10 areas for evaluation
- Quality indicators

Figure 3 SWIA, 2009, 'Guide to Supported Self-Evaluation – Building Excellent Social Work Services',
Care Inspectorate, 2013, 'Joint Inspection of Adults' Services – Quality Indicator Framework',

Appendix 3

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