MORAY INTEGRATION JOINT BOARD THURSDAY 29

MARCH 2018, 9:30AM UNTIL 12 NOON

ALEXANDER GRAHAM BELL CENTRE, MORAY COLLEGE, ELGIN

NOTICE IS HEREBY GIVEN that a Meeting of the **MORAY INTEGRATION JOINT BOARD** is to be held at the **Alexander Graham Bell Centre, Moray College, Elgin** on **29 March 2018** at **9:30am** to consider the business noted below.

Christine Lester
Chair, Moray Integration Joint Board

23 March 2018

AGENDA

1. Welcome and Apologies
2. Declaration of Member's Interests
3. Minute of the Meeting of the Integration Joint Board (IJB) dated 25 January 2018
4. Action Log of the IJB dated 25 January 2018
5. Chief Officers Update – Report by the Chief Officer

ITEMS FOR APPROVAL

6. Revenue Budget 2018/19 – Report by the Chief Financial Offer
7. Delivering the New 2018 General Medical Services Contract in Scotland – Report by Sean Coady, Head of Service

8. Prescribing Budgets – Report by the Chief Officer

9. Proposed Change to Meeting Dates 2018/2019 – Report by the Chief Officer

ITEMS FOR NOTING

10. Minute of the Meeting of the IJB Clinical and Care Governance Committee dated 3 November 2017

11. Annual Performance Report 2017/2018 – Report by the Chief Officer

12. Eligibility Criteria for Unpaid Adult Carers (The Carers (Scotland) Act 2016) – Report by Jane Mackie, Head of Adult Services

13. Duty of Candour Consultation – Report by the Chief Officer

14. The Moray 2015/18 Alcohol and Drugs Partnership Delivery Plan Review – Report by Paul Johnson – MADP Lead Officer

STANDING ITEMS

15. Quarter 3 (October – December 2017) Performance Report – Report by the Chief Officer

16. Revenue Budget Monitoring Quarter 3 for 2017/2018 – Report by the Chief Financial Officer

17. Items for the Attention of the Public – Discussion

MORAY INTEGRATION JOINT BOARD

MEMBERSHIP

Ms Christine Lester (Chair)	Non-Executive Board Member, NHS Grampian
Councillor Frank Brown (Vice-Chair)	Moray Council
Dame Anne Begg	Non-Executive Board Member, NHS Grampian
Professor Amanda Croft	Executive Board Member, NHS Grampian
Councillor Claire Feaver	Moray Council
Councillor Shona Morrison	Moray Council

NON-VOTING MEMBERS

Tracey Abdy	Chief Financial Officer, Moray Integration Joint Board
Mr Ivan Augustus	Carer Representative
Mr Sean Coady	Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services, Health and Social Care Moray
Mr Tony Donaghey	UNISON, Moray Council
Ms Pamela Gowans	Chief Officer, Moray Integration Joint Board
Mrs Linda Harper	Lead Nurse, Moray Integration Joint Board
Dr Ann Hodges	Registered Medical Practitioner, Non Primary Medical Services, Moray Integration Joint Board
Mr Steven Lindsay	NHS Grampian Staff Partnership Representative
Ms Jane Mackie	Head of Adult Health and Social Care, Health and Social Care Moray
Mrs Susan Maclaren	Chief Social Work Officer, Moray Council
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services, Moray Integration Joint Board
Mrs Val Thatcher	Public Partnership Forum Representative
Mr Fabio Villani	tsiMORAY
Dr Lewis Walker	Registered Medical Practitioner, Primary Medical Services, Moray Integration Joint Board

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

THURSDAY 25 JANUARY 2018

INKWELL MAIN, ELGIN YOUTH CAFÉ

PRESENT

VOTING MEMBERS

Ms Christine Lester (Chair)	Non-Exec Board Member, NHS Grampian
Councillor Frank Brown (Vice-Chair)	Moray Council
Professor Amanda Croft	Executive Board Member, NHS Grampian
Councillor Claire Feaver	Moray Council
Councillor Shona Morrison	Moray Council

NON-VOTING MEMBERS

Ms Tracey Abdy	Chief Financial Officer
Mr Ivan Augustus	Carer Representative
Ms Pam Gowans	Chief Officer, Moray Integration Joint Board
Dr Ann Hodges	Registered Medical Practitioner, Non Primary Medical Services
Mr Steven Lindsay	NHS Grampian Staff Partnership Representative
Mrs Susan Maclaren	Chief Social Work Officer, Moray Council
Mrs Val Thatcher	PPF Representative
Dr Lewis Walker	Registered Medical Practitioner, Primary Medical Services

IN ATTENDANCE

Mrs Margaret Forrest	Legal Services Manager (Litigation and Licensing), Moray Council
Mr Robin Paterson	Senior Project Officer, Moray Council
Ms Lesley Attridge	Occupational Therapy and Intermediate Care Service Manager, Moray Council
Ms Frances Garrow	Organisational Development Manager, Moray Council
Ms Alex Pirie	Location Manager, Aberdeenshire Health and Social Care Partnership

APOLOGIES

Dame Anne Begg	Non-Exec Board Member, NHS Grampian
Mr Sean Coady	Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services, Health and Social Care Moray
Mr Tony Donaghey	UNISON, Moray Council
Mrs Linda Harper	Lead Nurse, Moray Integration Joint Board
Ms Jane Mackie	Head of Adult Health and Social Care, Health and Social Care Moray
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services
Mr Fabio Villani	tsiMoray

1.	**DECLARATION OF MEMBERS' INTERESTS**
	There were no declarations of Members' interests in respect of any item on the agenda.
2.	**MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD DATED 14 DECEMBER 2017**
	The minute of the meeting of the Moray Integration Joint Board dated 14 December 2017 was submitted and approved.
3.	**ACTION LOG DATED 14 DECEMBER 2017**
	The Action Log of the Moray Integration Joint Board (MIJB) dated 14 December 2017 was discussed and it was noted all actions other than the following had been completed: i) item 3 – Public Sector Climate Change Duties Reporting Submission 2016/17; the Chief Officer advised this was in hand and would be brought to the next Board meeting. ii) item 5 – the Chair stated she had been advised clients of Doocot View Learning Disability Respite Facility had not been advised of possible changes prior to the last MIJB, causing distress to those involved. She asked for an official apology to be issued on her behalf. The Chief Officer advised that she had sent out letters of apology to all those affected by the changes and gave assurance that social work teams were now working with those families directly to address specific needs. iii) item 13 – Implementation of the Carers (Scotland) Act 2016; to be submitted to the next Board meeting for noting following approval by the NHS and Council.
4.	**CHIEF OFFICER'S REPORT TO THE MORAY INTEGRATION JOINT BOARD**
	A report by the Chief Officer (CO) provided the Board with an update on key priorities as follows: • Jubliee Cottages – a learning review, as part of the evaluation and project management process, has been completed. • Moray Performance over the festive period – an overall positive performance for Moray Health and Social Care system during the festive period. Dr Gray's Hospital maintained its performance in relation to the 4 hour target placed on Accident and Emergency.

	• Queen's Nurse Award – Ally Lister, District Nurse Team Leader in Keith has received the award. In response to a query from the Chair the CO handed over to Amanda Croft, as Director of Nursing, who advised this award had been reintroduced in 2017 following a 20 year hiatus. She further advised Ally is the only person in Grampian to receive the award since the reintroduction. Dr A Hodges entered the meeting during discussion of this item.
5.	**DATA PROTECTION AND RECORDS MANAGEMENT**
	Under reference to paragraph 3 of the Minute of the special meeting of the Board dated 27 April 2017 a report by the Legal Services Manager (Litigation & Licensing), Moray Council, informed and advised the Board of its legal responsibilities and duties in respect of data protection and records management in order for it to consider and comply with those requirements. The Legal Services Manager (Litigation & Licensing) advised that the Information Commissioner's Office (ICO) registration fee will shortly be increasing from £35 to £55, however if registration is applied for prior to the increase the current fee will be applicable. The increased fee will only apply once renewal is requested. Discussion took place on who should be included in the list of those information will be shared with, as noted in the Appendix to the report and it was agreed the list be updated to include MPs and MSPs. The Legal Services Manager (Litigation & Licensing) advised the Board had discretion to amend what information was gathered and it was agreed this should be included in the application. The Legal Services Manager (Litigation & Licensing) further advised information on Transfers had been duplicated in the final page of the Appendix to the report and this would be rectified prior to the application being completed. Thereafter the Board agreed: i) to instruct the Chief Officer to complete the process with the ICO to formally register the Board as a Data Controller in line with the registration details attached at Appendix 1 of the report once the necessary changes have been made, upon payment of the appropriate fee and thereafter to maintain an annual registration; ii) that the Chief Officer be the nominated representative for the Board and the main point of contact for the ICO; iii) that the main point of contact for Subject Access Requests should be the Chief Officer; iv) to instruct the Chief Officer to signpost on the Board's website contact details for Subject Access Requests; and

	v) to note the intention to report to a future meeting of the Board on Subject Access Request Processes, the General Data Protection Regulations requirements and responsibilities and a Records Management Plan.
6.	**REVIEW OF FINANCIAL REGULATIONS**
	Under reference to paragraph 11 of the meeting dated 31 March 2016 a report by the Chief Financial Officer sought the approval of the Board to update the Financial Regulations. Following consideration the Board agreed: i) the proposed changes to the Integration Joint Board Financial Regulations as set out in Appendix 1 of the report; and ii) that the next review will be no later than March 2019.
7.	**UPDATED RESERVES POLICY**
	Under reference to paragraph 12 of the meeting dated 31 March 2016 a report by the Chief Financial Officer sought approval from the Board on its Reserves Policy. Following consideration the Board agreed: i) the Reserves Policy as detailed at Appendix 1 of the report; and ii) that the next review will be no later than March 2019.
8.	**CHIEF INTERNAL AUDITOR REAPPOINTMENT**
	Under reference to paragraph 7 of the meeting dated 31 March 2016 a report by the Chief Officer asked the Board to consider the reappointment of the Chief Internal Auditor, whose current term of appointment is due to expire as at 31 March 2018. Following consideration the Board agreed to re-appoint Atholl Scott, Internal Audit Manager, Moray Council, as the Chief Internal Auditor of the Board, for a further period of two years to 31 March 2020.
9.	**MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD AUDIT AND RISK COMMITTEE DATED 28 SEPTEMBER 2017**
	The minute of the meeting of the Moray Integration Joint Board Audit and Risk Committee dated 28 September 2017 was submitted and noted.
10.	**ANNUAL REPORT OF THE CHIEF SOCIAL WORK OFFICER 2016 – 17**
	A report by the Chief Social Work Officer (CSWO) informed the Board of the annual report of the CSWO on the statutory work undertaken on the Board's behalf, during the period 1 April 2016 to 31 March 2017 inclusive, that considered major policy and service initiatives across Social Work during the reporting period, summarised key issues in relation to governance and protection issues and advised the Board on measures taken to strengthen the workforce. The CSWO advised the Board that the Office of the Chief Social Work Advisor (CSWA) for Scotland receives CSWO reports from all of the 32 Scottish Local Authorities and issues an over-arching report which she will bring to a future meeting of the Board.

	The Chief Officer advised that the CSWA had visited Varis Court, the extra care facility in Forres and Woodview, the supported housing development in Lhanbryde. The CSWA had been very keen to see the housing initiatives supporting people to stay independent and well in Moray as these initiatives were fairly unique in Scottish terms. She was very impressed with the facilities and the staff approaches demonstrated on the day. Thereafter, following discussion the Board agreed to: i) note the contents of the report; and ii) task the CSWO with presenting the over-arching report provided by the CSWA to a future meeting of the Board.
11.	**PROGRESS REPORT ON MORAY JOINT CHILDREN'SSERVICES INSPECTION**
	A report by the Head of Integrated Children's Services informed the Board of the outcome of the recent progress review of joint children's services carried out by the Care Inspectorate. Discussion took place on the amount of additional work required following the inspection. It was stated that it would not be possible to sustain the level of commitment already shown; however, once change and improvement have been delivered workload will return to normal. Thereafter the Board agreed to note the content of the report.
12.	**DRAFT PERFORMANCE MANAGEMENT FRAMEWORK**
	A report by the Chief Officer updated the Board on the development and improvement of performance management arrangements, including a draft Performance Management Framework attached at Appendix 1 of the report. Following consideration the Board agreed to note the ongoing work being undertaken to further develop performance management arrangements locally. Ms A Pirie, Ms F Garrow and Ms L Attridge entered the meeting at this juncture.
13.	**PROVISION OF MAJOR ADAPTATIONS**
	A report by the Chief Officer informed the Board of the updated Policy and Protocol for Major Adaptations and to request authorisation of the papers. During discussion Ms Attridge advised that funding sat with the Board and therefore approval of the Policy and Protocol sat with the Board and it was not necessary to seek agreement from Moray Council Communities Committee. It was therefore agreed to amend recommendation 2.1 ii) of the report to refer the policy for noting and not for agreement. Thereafter the Board agreed to: i) authorise and approve the updated policy and guidelines for the provision of major adaptations in Council and private properties as attached at Appendix 1 of the report; ii) refer the policy to Moray Council's Communities Committee for noting; and iii) note the progress of the Adaptations Governance Group.

14.	**BUDGET UPDATE**
	Under reference to paragraph 14 of the Minute of the meeting dated 14 December 2017 a report by the Chief Financial Officer provided the Board with a further budget update in preparation for the 2018/19 financial year. Discussion took place on the current financial situation and it was stated that the funding from Partners will be advised on 28 February and a development session will be held to consider what is required to balance the budget. Thereafter the Board agreed to note the budget update in support of continued negotiation with Moray Council and NHS Grampian for the 2018/19 revenue budget.
15.	**DRAFT ORGANISATIONAL DEVELOPMENT AND WORKFORCE PLANS 2016-2019**
	A report by the Chief Officer invited the Board to approve the draft Organisational Development (OD) Plan 2016-2019 and note the work being undertaken in the development of the draft Workforce (WF) Plan 2016-2019 for Health and Social Care Moray. Ms Garrow advised the OD Plan was closely linked to the WF Plan and work was ongoing to gather evidence. The Chief Officer advised funding had been obtained to provide leadership development for Moray, Aberdeen City and Aberdeenshire senior teams in line with the current challenges ahead. Thereafter following further discussion the Board agreed to: i) approve the draft OD Plan 2016-2019; ii) note the OD Plan will be reviewed annually, with a report presented to the Board in Spring 2019; and iii) note the work being undertaken in the development of the draft WF Plan, with a draft to be presented to the Board meeting in March 2018. Ms F Garrow left the meeting at this juncture.
16.	**MEMBERSHIP OF THE INTEGRATION JOINT BOARD AND COMMITTEES**
	A report by the Chief Officer invited the Board to note the revised substitute membership of the Board made by Moray Council following a restructure. Under reference to paragraph 4.2 of the report Councillor Brown advised it had been the intention of the Council that Councillor Eagle and Councillor R McLean be substitutes for either Councillor Brown or Councillor Feaver as necessary. Thereafter the Board agreed to note the new substitute voting members appointed by Moray Council and that Councillor Eagle and Councillor R McLean would be available to substitute for either Councillor Brown or Councillor Feaver as necessary.

17.	**HER MAJESTYS PRISON AND YOUNG OFFENDERS INSTITUTE GRAMPIAN HEALTH CENTRE**
	A report by the Chief Officer updated the Board on the proposed recovery action plan for Her Majesty's Prison (HMP) and Young Offenders Institute (YOI) in Grampian. Ms Pirie thanked the Board for inviting her along and gave a brief overview of her role. She then advised the Board of progress made on the recovery action plan which was introduced following the inspection by HM Inspectorate of Prisons for Scotland that took place towards the end of 2015. Discussion took place on the role of the care staff and staffing levels within the unique environment within HMP and YOI Grampian Health Centre. The Chair stated it may be useful to seek clarification on numbers of Moray residents currently held at Inverness Prison. The Chief Social Work Officer (CSWO) undertook to seek the information and report back at a later date. Thereafter, following consideration of what data may be useful in terms of the strategic development of the Board, it agreed to: i) note the proposed Recovery Action Plan for the Prison Health Centre; ii) note the progress towards achieving key priority actions approved previously by the Aberdeenshire Integration Joint Board in October 2017; iii) note the wider national strategic developments in relation to health care delivery in Scottish Prisons; iv) agree to receive regular updates on progress with the action plan; and v) task the CSWO with seeking information on the number of Moray residents currently held at Inverness Prison and reporting the same to a future meeting of the Board.
18.	**ITEMS FOR THE ATTENTION OF THE PUBLIC**
	Under reference to paragraph 10 of the minute of the Moray Integration Joint Board dated 26 October 2017 the Board agreed that the following items be brought to the attention of the public: i) apology re lack of information provided to clients of Doocot View Learning Disability Respite Facility; ii) Ally Lister, District Nurse Team Leader, Keith awarded title of Queen's Nurse; iii) outcome of the joint inspection of services for children and young people; and iv) Dr Gray's accident and emergency department met the target waiting times with over 95% of patients being seen within the guideline times during the festive period. Ms A Pirrie and Mrs S Maclaren left the meeting at this juncture.

19.	**DRAFT FORRES PLAN**
	A report by the Head of Adult Services informed the Board of planning intentions for Forres, including Leanchoil Hospital. Discussion took place on the need for confidentiality. It was agreed that all reports to the Board and its Committees would be as open as possible but that there would be occasions when confidentiality would be required. Thereafter the Board agreed: i) the draft planning documents for further implementation as set out in the appendices to the report; and ii) progress would be reported back to the Board at intervals deemed appropriate. Professor Croft and Mr Lindsay left the meeting during discussion of this item.

MEETING OF MORAY INTEGRATION JOINT BOARD

THURSDAY 25 JANUARY 2018

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Action Log Dated 14 December 2017	Public Sector Climate Change Duties Reports Submission to be updated to reflect: i) that the Chief Officer is accountable to the IJB and not Moray Council and NHS Grampian; ii) reference to the Chief Financial Officer when detailing the management structure of Health and Social Care, Moray (page 6); and iii) the Chief Officer reviewing the submission carefully and amending any anomalies prior to reporting to the Scottish Government. Implementation of the Carers (Scotland) Act 2016, Scheme of Delegation, to be submitted for noting.	March 2018	Pam Gowans
2.	Data Protection and Records Management	Include information in registration that the Board has discretion to amend what information is gathered and update the appendix to the report to include MPs and MSPs in the agreed list of people who information can be shared with.	May 2018	Margaret Forrest

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
	Data Protection and Records Management (cont.)	Complete the process with the Information Commissioner's Officer to formally register the Board as a Data Controller and thereafter maintain an annual registration. Update the Board's website with contact details for Subject Access Requests. Report to a future meeting on Subject Access Request Processes, the General Data Protection Regulations requirements and responsibilities, and a Records Management Plan.	March 2018 March 2018 Nov 2018	Catherine Quinn Pam Gowans Pam Gowans
3.	Annual Report of the Chief Social Work Officer 2016-17	Report by the Chief Social Work Advisor for Scotland to be presented to a future meeting of the Board.	March 2018	Susan Maclaren
4.	Provision of Major Adaptations	Refer the Updated Policy and Protocol for Major Adaptations to Moray Council's Communities Committee for noting.	March 2018	Pam Gowans
5.	Draft Organisational Development and Workforce Plans 2016-2019	Review the Organisational Plan annually.	January 2019	Pam Gowans
6.	Membership of the Integration Joint Board and Committees	Councillor Eagle and Councillor R McLean to be noted as substitutes for either Councillor Brown or Councillor Feaver	January 2018	Clerk
7.	Her Majesty's Prison and Young Offenders Institute Grampian Health Centre	Verbal update to be provided on the number of Moray residents held in Inverness Prison	March 2018	Susan Maclaren
8.	Items for the Attention of the Public	Apology re lack of information provided to clients of Doocot View Learning Disability Respite Facility. Ally Lister, District Nurse Team Leader, Keith awarded title of Queen's Nurse.	February 2018	Pam Gowans

ITEM: 4
PAGE: 2

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
	Items for the Attention of the Public (cont.)	Outcome of the joint inspection of services for children and young people. Dr Gray's accident and emergency department met the target waiting times with over 95% of patients being seen within the guideline times during the festive period.	February 2018	Pam Gowans
9.	Draft Forres Plan	Report back on progress of the Plan.	June 2018	Jane Mackie

ITEM: 4
PAGE: 3

CHIEF OFFICER'S REPORT TO THE MORAY INTEGRATION JOINT BOARD
29 MARCH 2018

New Initiatives

The tests of change in relation to Jubilee Cottages and Varis Court Augmented Care Unit are currently being evaluated and initial insights are being gathered. Both of these projects have been up and running since summer 2017 and there will need to be consideration of the value added and difference made to the health and care system both in Elgin and in Forres. The IJB Strategic Planning and Commissioning Group will be reviewing the findings to date at the April 2018 meeting and a progress report will be presented to the April 2018 IJB. To date from a qualitative perspective the early findings for both are positive and the questions remains as to whether these are viable approaches for the future and as part of the overall redesign of services there is significant learning that needs to be considered or adopted across Moray.

Woodview

The new housing facility for people with specific complex needs at Woodview in Lhanbryde continues to progress well, now up and running since August 2018. There is data being collected that to date shows significant improvements in quality of life for the individuals assigned to the houses as well as improvements for the staff working with these individuals and their families. Evaluation is being progressed with the academic input established to support this. A report will be brought to the MIJB in due course to inform on the detail of this.

Keith Health Centre

Agreement was reached as NHS Grampian Asset Management on the 28th February 2018 to proceed to preparing an initial agreement in respect of the future provision of Keith Health Centre and to instruct NHS Grampian Property department to initiate formal discussions with Moray Council on options for land purchase. The Chief Officer has informed all relevant stakeholders of this progress and has attended the Keith Community Council meeting. A project plan will be put in place and resources to support the development of the initial agreement will need to be identified, the Chief Officer is in discussion with NHS Grampian in respect of this. It has been emphasised to all stakeholders and the media that at this point the timescale for a new facility is not known and it is unlikely to be in the immediate future, this however is a significant milestone. The future project plan will be presented to the MIJB during 2018.

Celebrating Excellence Day 2018

Nursing, Midwifery and Allied Health Professionals participated in this event on the 8th March 2018 in the Alexander Graham Bell Centre in Elgin. This day allowed for presentations and demonstration of some of the significant work taken forward by individuals and teams in striving for improvements in the way we work. The event was well attended by representatives from across Grampian. As well as providing a showcase for the excellent work being undertaken it also gave a platform for shared learning.

Community Conversations in Forres February 2018

Unfortunately due to the severe weather and disruption this evening event had to be cancelled. The Chief Officer, Project Manager and local Councillor did attend on the evening in case the communication networks had not reached everyone and there were two people for whom this had been the case but were understanding of the situation. A further event is being put in place.

Signature: Date: 21 March 2018

Designation: Chief Officer Name: Pam Gowans

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018**

SUBJECT: **REVENUE BUDGET 2018/19**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1 To inform the Moray Integration Joint Board (MIJB) of the position in relation to the revenue budget for the 2018/19 financial year.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board :

i) consider and approve the proposed savings detailed at paragraph 4.7;

ii) accept the indicative unbalanced Revenue Budget for 2018/19 as detailed at APPENDIX 1 will be used as a working document to allow services to continue to be delivered;

iii) task the Senior Managers, together with the Chief Officer and Chief Financial Officer to identify further savings, continue to pursue alternative methods of service delivery in driving the pace of change, whilst ensuring safe levels of care and to work closely with NHS Grampian and Moray Council with regard to the risk sharing arrangement that exists;

iv) agree to a progress report being brought before this Board on 29 June 2018 on the considerations and actions required in addressing the budget shortfall; and

v) approve Directions for issue at set out at APPENDICES 2 and 3 respectively to NHS Grampian and Moray Council to allow services to continue without disruption.

3. BACKGROUND

3.1 A challenging Scottish Government budget settlement for the 2017/18 financial year resulted in a less than favourable funding allocation to the MIJB from both NHS Grampian and Moray Council. At the special meeting of the MIJB on 30 March 2017, the Board accepted a working budget for 2017/18 to allow services to continue to be delivered whilst a recovery plan was developed (para 2 of the minute refers). At this point in time, the budget was displaying a gap in funding of £3.981m.

3.2 Following the closure of the 2016/17 annual accounts, an overspend position was realised on core services of £0.8m and an underspend on strategic funds of £3.5m due to slippage, resulting in a net favourable position of £2.7m. This one-off positive position, combined with further work on savings and budget pressure assessments supported a balanced budget position that was approved by this Board on 29 June 2017 (para 24 of the minute refers). The report at this time also highlighted the significance of using the £2.7m to balance the budget at the expense of creating a general reserve and that the financial outlook in future years would be concerning should additional funding not be received and further savings identified.

3.3 The MIJB has to consider its revenue budget in the context of a period of continuing real terms reductions in funding from central government to our funding partners. Audit Scotland has identified the move in Scottish Government funding for local authorities between 2010/11 and 2017/18 as an 8% reduction in real terms. Funding for NHS Boards continues to be challenging, although the NHS in Scotland is currently receiving relative protection compared with the rest of the public sector.

3.4 Further reductions in public sector funding were expected and in recognition of this the MIJB was presented with budget update reports on 14 December 2017 (para 15 of the Minute refers) and January 2018 (para 14 of the draft Minute refers), in relation to the challenges faced ahead of the 2018/19 financial year and the potential funding shortfall.

3.5 The 2017/18 financial settlement announced by the Cabinet Secretary for Finance and the Constitution included key statements in relation to the minimum settlement that integration joint boards should expect from their funding partners as follows:

- NHS contributions to Integration Joint Boards for delegated health functions will be maintained at least at 2016/17 cash levels;

- Local authorities will be able to adjust their allocations to Integration Joint Boards by up to their share of £80 million below the level of budget agreed in 2016/17.

The Moray Council allocation to the MIJB for the 2017/18 budget reflected the maximum permitted adjustment of £1.3M. Furthermore, the funding from both partners provided no allowance for pay award increases and other inflationary pressures. The 2018/19 settlement no longer stipulates conditions on the amount of funding allocated by the partners and alternatively, funding should be agreed through local negotiation.

3.6 The previous two financial years have resulted in additional social care funding for integration joint boards, routed through health boards. The 2018/19 settlement included £66m to be allocated through the local authority budget. The £66m was announced to support additional investment in social care in recognition of a range of pressures.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 BUDGET SETTELMENT

4.1.1 On 14 February 2018, Moray Council approved its revenue budget for the forthcoming financial year based on a one year settlement (para 10 of the draft Minute refers). This budget included savings totalling £6.5m for the 2018/19 financial year which included £1.759m as a reduction in funding to the MIJB. It should be noted that the approved budget reduction was reported as a net figure, that being £1.2m, reflecting the potential pressure arising from pay awards for local authority employees which Moray Council have agreed to fund. Additionally, the Scottish Government has made £66m available across Scotland to support investment in social care in recognition of a range of pressures being faced, including support for the implementation of the Carers (Scotland) Act 2016, maintaining the joint commitment to the Living Wage (to be extended to cover sleepovers) and an increase in the Free Personal and Nursing Care payments. As part of the settlement, Moray Council has included the Moray share of this funding to the MIJB which translates as £1.186m. It should be noted that an in-year adjustment is expected in consideration of the impact of the Carers (Scotland) Act 2016 on children's services that are out with the scope of the MIJB. This will not be material.

4.1.2 At a meeting of NHS Grampian's Budget Steering Group on 21 February 2018, a balanced 2018/19 revenue budget was proposed for approval prior to being presented to the NHS Grampian Board for approval on 5 April 2018. The NHS Grampian proposed budget represented an increase of 1.5% in baseline funding, that being higher than originally planned. This translates for the MIJB as a 1.5% uplift on the recurring budget. In addition, funding will be provided to meet the costs of the pay award above 1.0% for staff employed on Agenda for Change conditions i.e. not for medical staff or senior managers.

4.1.3 The Head of Financial Services, Moray Council and the Director of Finance, NHS Grampian have formally advised the MIJB Chief Officer of their contributions to the pooled budgets in-line with legislation.

4.2 MIJB FUNDING 2018/19

4.2.1 The MIJB has a responsibility under the Public Bodies (Joint Working) (Scotland) Act 2014 to set its revenue budget for the 2018/19 financial year by 31 March. The funding of the MIJB revenue budget in support of the delivery of the Strategic Plan is delegated from NHS Grampian and Moray Council. The funding allocated is summarised below:

	£'000
NHS Grampian	72,828
NHS Grampian Notional Budget for Set Aside Services	10,133
Scottish Government Funding for Social Care Pressures	1,186
Moray Council	37,330
Moray Council – Improvement Grants*	924
	122,401

* Improvement Grants includes £0.424m which requires to be ring-fenced as it relates to council tenants

4.3 HOSTED SERVICES

4.3.1 Within the scope of services delegated to the MIJB are Hosted Services. Budgets for hosted services are primarily based on an adjusted population based formula known as the National Resource Allocation Committee (NRAC) formula. Hosted Services are operated and managed on a Grampian wide basis. Hosting arrangements mean that one IJB within the Grampian Health Board area would host the service on behalf of all 3 IJB's. Strategic planning for the use of the hosted services is undertaken by the 3 IJB's for their respective populations.

The 2018/19 budget for Moray's share of all Hosted services is £3.723m as detailed below.

	£'000
Hosted by Aberdeen City IJB	
Intermediate Care	357
Sexual Health Services	753
Hosted by Aberdeenshire IJB	
Marie Curie Nursing	122
Heart Failure Service	46
Continence Service	113
Diabetes MCN including Retinal Screening	162
Chronis Oedema Service	35
HMP Grampian	397
Police Forensics Examiners	107
Hosted by Moray IJB	
GMED Out of Hours	1529
Primary Care Contracts	102
TOTAL HOSTED SERVICES	**3,723**

4.4 LARGE HOSPITAL SERVICES (SET ASIDE)

4.4.1 Budgets for Large Hospital Services continue to be managed on a day to day basis by the NHS Grampian Acute Sector and Mental Health Service, however Moray IJB has an allocated set aside budget designed to represent the consumption of these services by the Moray population. The MIJB has responsibility for the strategic planning of these services in partnership with the Acute Sector and Mental Health Service. In November 2017, the Information Services Division (ISD) provided health boards with set aside activity for the 2016/17 financial year. The data displayed an increase in activity with the largest increases being in A&E attendance and General Medicine. When applying direct costs to convert this activity into a set aside budget this results in a decrease in the overall budget of £0.030m from £10.163m to £10.133m. The notional Set Aside budget is detailed below:

	£'000
General Medicine	6,666
Geriatric Medicine	29
Rehabilitation Medicine	79
Respiratory Medicine	260
Palliative Care	19
A & E Inpatient	85
A & E Outpatient	2,428
Learning Disabilities	6
Psychiatry of Old Age	152
General Psychiatry	409
Total Set Aside Budget	**10,133**

4.5 BUDGET PRESSURES

4.5.1 Budget pressures are a major consideration for the MIJB and are an intrinsic part of the budget setting process. The less than favourable funding allocation received from Moray Council and NHS Grampian for the 2017/18 financial year has inevitably had a substantial impact on the process for 2018/19. The table below outlines the anticipated pressures being faced by the MIJB in the forthcoming financial year.

	£'000
Primary Care Prescribing	1,270
External Purchasing	997
Pay Awards (NHS Grampian)	815
High Cost Complex Care Packages	735
Hosted Services (GMED)	203
Mental Health (Locums)	200
PAIAW	70
Primary Care Premises	50
Service Re-provision	50
Total Budget Pressures	**4,390**

4.6 EARMARKED COMMITTMENTS

4.6.1 There are a number of areas that will require funding in 2018/19 as a result of slippage in the prior year. These requirements have been discussed by the Senior Management Team who supports the proposal to earmark funding for the specific purposes as highlighted below.

	£'000
Child Health Commissioner	26
Mental Health	72
Total Earmarked Commitments	**98**

4.7 BUDGET SAVINGS

4.7.1 The Senior Management Team have continued to work with the Operational Management Team to identify additional savings whilst striving to drive the pace of change through service redesign. Undoubtedly, it has been challenging to make this identification in an environment where there is significant growth in our ageing population and increasing demands on services, compounded by the fact that a large proportion of health and social care budgets are restricted in nature and being limited by contractual obligation, contracts which are negotiated nationally and health services being free at the point of delivery.

4.7.2 The work carried out to further identify savings and efficiencies has produced the potential of £1.060m. Whilst efforts have determined this level of saving, the reality is that this is insufficient to meet the financial challenge being faced by the MIJB. The savings that have been identified have been summarised in the table below:

Service Area	**Description of Saving**	**£'000**
Community Hospitals	Process Change and Management	100
Community Nursing	Re-alignment of Responsibilities	125
Mental Health	Purchasing Budget Efficiency	52
Health Improvement	Re-alignment of Post	46
Care Provided In-House	Re-provision of Respite Services	86
External Commissioning	De-commissioning of Accommodated Respite & Service Review	391
Community Services - Dental	Relocation of Staff and Activity	110
Administration & Management	Increase Vacancy Target	50
Prescribing	Medicines Management	100
Total Proposed Savings		**1,060**

4.7.3 The savings plan set out above for approval is not anticipated to have an impact on clinical and care governance. Should any potential issue of this nature arise then the Senior Management Team will address this in the first instance. Should the necessity arise, then the matter will be reported to the Clinical & Care Governance Committee and the MIJB as appropriate.

4.8 BUDGET OVERVIEW

4.8.1 The MIJB indicative revenue budget for 2018/19 is £126.997m (including £10.133m Set Aside). The detail is provided at **APPENDIX 1** and a summary is provided below.

	£'000
BUDGET	
Total Core Budget	110,183
Budget Pressures (para 4.5.1)	4,390
Earmarked Commitments	98
New Burdens	1,186
Strategic Fund Commitments	2,067
Identified Savings for Approval (para 4.7)	(1060)
Set Aside Budget	10,133
INDICATIVE UNBALANCED REVENUE BUDGET [1]	**126,997**
Unidentified Savings	**(4,596)**
FUNDING	
NHS Grampian (inc Set Aside)	82,961
Moray Council (inc Improvement Grants)	38,254
Additional Social Care Funding routed through Moray Council	1,186
TOTAL FUNDING	**122,401**

[1] The unbalanced budget represents the forecast costs of running current services less identified savings. As acknowledged in the report recommendations the Board is required to operate within available funding and budget holders will be undertaking further work to identify savings options to present to the Board

4.9 FINANCIAL OUTLOOK AND REVIEW

4.9.1 After engagement by the Chief Officer and Chief Financial Officer into the budget setting conversations and processes that have taken place within Moray Council and NHS Grampian, a budget shortfall for the 2018/19 financial year of £4.596m remains a principle risk and focus. Whilst a savings plan has been presented for approval, the Senior Management Team continues to consider options to reduce the gap. Work will continue in the forthcoming period and throughout the year on the identification of further efficiencies, service redesign and a programme of transformation.

4.9.2 The increasing demands on health and social care services are well publicised together with the pressures being faced by demand exceeding the available resources. The difficulty exists in redesigning services efficiently and effectively, ensuring the population of Moray remains the focus whilst financial constraints are a major consideration. From the onset of integration the MIJB has been faced with the challenge of identifying savings annually in order to balance budgets.

4.9.3 Future year funding for the MIJB from the funding partners is uncertain. It is anticipated that local authority funding will decrease in cash terms until 2021/22. The MIJB is likely to experience future funding reductions from Moray Council at similar levels to 2018/19 and should plan on this basis. Health Boards are likely to retain a certain level of protection in comparison; however there is no anticipated budget increases expected.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

The approval of an adequate revenue budget for the MIJB is key to the delivery of health and social care services in Moray in accordance with the Strategic Plan.

(b) Policy and Legal

In accordance with the Public Bodies (Joint Working) (Scotland) Act 2014, MIJB is subject to the audit and accounts regulations and legislation of a body under Section 106 of the Local Government (Scotland) Act 1973 and is classified as a local government body for accounts purposes by the Office for National Statistics (ONS).

(c) Financial implications

The 2018/19 revenue budget requirement (excluding Set Aside) as detailed in **APPENDIX 1** is **£116.864m** which includes proposed savings plan of £1.060m.

The funding being made available by Moray Council and NHS Grampian totals **£112.268m** (excluding Set Aside). This leaves the MIJB with a budget shortfall at the start of the year of **£4.596m**.

The notional Set Aside budget for Moray's share of the Large Hospital Services has been set at £10.133m. This reflects a £0.030m reduction in the funding received since the inception of the MIJB and is based on the most recent activity analysis data. The full funding of this budget is provided by NHS Grampian

(d) Risk Implications and Mitigation

The indicative budget proposed for 2018/19 is subject to the following risks:

- Budget shortfall – Senior Managers, together with the Chief Officer and Chief Financial Officer will undertake work to identify further savings, continue to pursue alternative methods of service delivery in driving the pace of change, whilst ensuring safe levels of care and work closely with NHS Grampian and Moray Council with regard to the risk sharing arrangement that exists.

- GP Prescribing – can be extremely volatile with volume and price increases leading to substantial adverse variances. A separate report on GP Prescribing is being presented at this meeting.

- Service users with complex care needs attract high cost packages – the financial consequences of any future high cost referrals will need to be managed within the overall resource of the MIJB.

- Price inflation will add pressure to budgets. There has been a considerable rise in inflation over recent months. The budget pressures highlighted at para 4.5 outline the known pressures at the time of writing this budget, however it is necessary to note that budget pressures may exceed the allocation. This will be monitored closely and reported accordingly to the MIJB.

- There is a requirement to closely manage service vacancies to ensure service structures reflect the need of the service whilst generating a short term savings through vacancies.

(e) Staffing Implications

The current savings plan proposed for approval in para 4.7 does not contain implications for Moray Council and NHS Grampian staff. The impact on the staffing budget will be kept under review as further work is undertaken to identify options to address the budget shortfall.

There are no other direct staffing implications associated with the budget other than in relation to pay awards.

(f) Property

None arising directly from this report.

(g) Equalities

None arising directly from this report.

(h) Consultations

Consultations have taken place with the Senior Management Team, Service Managers of Health and Social Care Moray, the Head of Financial Services and Legal Services Manager (Litigation and Licensing) (both Moray Council) and the Deputy Director of Finance, NHS Grampian who are in agreement with this report with regard to their respective responsibilities.

6. CONCLUSION

6.1 Legislation requires the MIJB to set its revenue budget by 31 March each year. The existing budget shortfall is £4.596m. The Section 95 Officer as the Chief Financial Officer to the Board recommends the utilisation of the indicative budget attached in Appendix 1 as a working document and that a further updated plan is taken to the Board within 3 months, with the Section 95 officer of the Moray Council and NHS Grampian Director of Finance advised where there is a risk that financial balance will not be achieved.

Author of Report: Tracey Abdy, Chief Financial Officer
Background Papers: with Author
Ref:

Signature: _____ Date: 11 March 2018

Designation: Chief Financial Officer Name: Tracey Abdy

APPENDIX 1

ITEM: 6
PAGE: 12

MORAY INTEGRATION JOINT BOARD
INDICATIVE REVENUE BUDGET 2018/19

		Annual Net Budget £000's 2017-18
Community Hospitals		5,032
Community Nursing		3,315
Learning Disabilities		5,897
Mental Health		7,093
Addictions		361
Adult Protection & Health Improvement		197
Care Services provided in-house		14,028
Older people & PSD - Assessment & Care		16,186
Intermediate Care & OT		1,526
Care Services provided by External Contractors		11,038
Other Community Services		
Allied Health Professionals		3,308
Dental		1,986
Public Health		394
Pharmacy		254
Specialist Nurses		832
Admin & Management		1,622
Primary Care Prescribing		16,849
Primary Care Moray		14,949
Hosted Services		3,723
Out of Area Placements		669
Improvement Grants		
General Services		500
Housing Revenue Account (Ring-fenced)		424
Total Moray IJB Core		**110,183**
Identified Budget Pressures for 2018/19		4,390
Commitments from ICF & DD		2,067
Commitments from Earmarked Reserves		98
New Burdens		1,186
Savings Identified		(1,060)
Total Budget Requirement for 2018/19		**116,864**
Budget Available for Core Services		
NHS Grampian		72,828
Moray Council		38,254
SG funding for Social Care		1,186
Total Available Budget for 2018/19		**112,268**
Budget Shortfall to be Addressed		**(4,596)**
SET ASIDE BUDGET		**10,133**

MORAY INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

GRAMPIAN HEALTH BOARD is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan.

Services:	All services listed in Annex 1, Part 2 and Annex 4 of the Moray Health and Social Care Integration Scheme.
Functions:-	All functions listed in Annex 1, Part 1 of the Moray Health and Social Care Integration Scheme.
Associated Budget:-	£61 million, of which £4million relates to Moray's share for services to be hosted and £17 million relates to primary care prescribing. An additional £10 million is set aside for large hospital services. These figures are indicative at the moment and will be confirmed in a further direction to be issued in June 2018.

This direction is effective from 1 April 2018.

MORAY INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

MORAY COUNCIL is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan

Services:	All services listed in Annex 2, Part 2 of the Moray Health and Social Care Integration Scheme.
Functions:-	All functions listed in Annex 2, Part 1 of the Moray Health and Social Care Integration Scheme.
Associated Budget:-	£51 million, of which £0.5 million is ring fenced for Housing Revenue Account aids and adaptations.
	These figures are indicative at the moment and will be confirmed in a further direction to be issued in June 2018.

This direction is effective from 1 April 2018.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018**

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

BY: **SEAN COADY, HEAD OF SERVICE**

1. REASON FOR REPORT

1.1 To inform the Board and outline the content of the proposed new 2018 General Medical Services (GMS) Contract in Scotland; which can be found at http://www.gov.scot/Resource/0052/00527530.pdf

1.2 To outline the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards.

1.3 To outline the requirement for Primary Care Improvement Plans to be developed by 1 July 2018.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board:

i) considers and notes the content of this report;

ii) acknowledges the requirement for the Primary Care Improvement Plan;

iii) agrees to be involved in the development of the plan prior to submission by 1 July 2018;

iv) considers and approves the Memorandum of Understanding (SEE APPENDIX 1); and

v) authorises the Chief Officer to sign the Memorandum of Understanding on the Board's behalf and acknowledge the implementation requirements set out within this.

3. BACKGROUND

3.1 A strong and thriving general practice is critical to sustaining high quality universal healthcare. In November 2017, the Scottish Government published the draft 2018 General Medical Services Contract in Scotland. In January 2018, this contract was voted on and accepted by General Practitioners in Scotland.

3.2 The intention is that the new contract will bring a number of benefits for patients. In particular this will be achieved through:

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

3.3 The intended benefits of the new contract for the GP profession will be:

- Promoting and supporting the GP in the role as Expert Medical Generalist
- Phase 1 of the contract introduces a new workload formula with promised increased investment in health and social care services to support general practice as well as a review of pay and expenses. This review will give rise to further proposals for phase 2 of the new contract by 2020.
- Work towards a more manageable workload – additional Primary Care staff to work alongside and support GPs and practice staff to reduce GP workload and improve patient care and access by having the right health care professional available at the right time.
- Improving infrastructure and reducing risk: including management / ownership of premises, shared responsibility as data controller for information sharing, responsibilities for new staff.

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

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Memorandum of Understanding

The MoU recognises the statutory role of Integration Authorities in commissioning primary care services and service redesign. It also recognises the role of NHS Boards in service delivery, as employers and as partners in General Medical Service contracts. The MoU provides reassurance that partners are committed to working collaboratively and positively in the period to March 2021 and beyond to deliver real change in local health and care systems that will reduce workload and risk for GPs and ensure effective multi-disciplinary team working for the benefit of patients.

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

Development of Primary Care Improvement Plan:

- IJBs will set out a Primary Care Improvement Plan to identify how additional funds are deployed in line with the Contract Framework.
- The Plan will outline how these services will be introduced before the end of the transition period at March 2021, establishing an effective multi-disciplinary team model at Practice and Cluster level.
- These plans will be developed in collaboration with local GPs and others and should be agreed whilst taking advice from the Grampian GP Subcommittee (or representatives by agreement locally) as the formally agreed advisors on general medical service matters. Any specific contractual elements must be agreed with the Local Medical Committee of the BMA.
- Local and Regional Planning will recognise the statutory role of IJBs as commissioners. IJBs will give clear direction to the NHS Board on its function to secure these primary care services.
- In developing and implementing these plans, IJBs should consider population health needs and existing service delivery.
- Integration Joint Boards will be accountable for delivery and monitoring progress for the local Plan.
- Where more than one IJB is covering a NHS Board area, the IJBs must collaborate in relation to effective and efficient use of resources.

4.3 Existing work has shown the benefits of co-ordinated working within a wider multi-disciplinary team aligned to General Practice. The MoU outlines the priorities over a three year period (April 2018 – March 2021).

The priority new services and staff are:

- Vaccination services (staged for types of vaccinations but fully in place by April 2021).
- Pharmacotherapy services – made up, by 2021, of level one core (acute prescribing, repeats, discharge letters, medication compliance reviews); followed by level two additional advanced (medication review, resolving high risk medication problems); level three additional specialist (polypharmacy reviews, specialist clinics).
- Community treatment and care services (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring) with phlebotomy delivered as a priority in the first stage.
- Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care.
- Additional professionals for multi-disciplinary team working dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal, mental health services).
- Community Link Workers.
- New staff will be employed predominantly through the NHS Board and work in models and systems agreed between each HSCP and local GPs
- New staff should, where appropriate, be operationally aligned to GP practices or groups of practices (e.g. clusters).
- Where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.
- Existing practice staff continue to be employed by Practices.
- Practice Managers will contribute to the development of the wider Practice Teams and co-ordinated operational delivery of services.

4.4 Funding

The Scottish Government have committed to invest an additional £250m per year by 2021 to support the development of Multi Disciplinary Teams (MDTs) to ensure delivery of the promised changes. The funds will support the new practice funding formula, national support arrangements, premises support and the development of the multi-disciplinary team.

- The Scottish Draft Budget proposals for 2018/19 published in December 2017 confirmed a first phase of funding of £110m for 2018/19.

- A letter was circulated in November 2017 to Practices setting out the implications of the new proposed funding formula and allocating £23m to ensure a practice income guarantee across Scotland. Although no practice will see a reduction in funding, concerns have been raised that this formula does not reflect the challenges of providing a sustainable service to, or to recruitment and retention within, more rural settings. A small number of practices within Grampian will see a small increase to their funding while the majority will remain on current income levels. The main increase to funding has been focused on urban areas and concern has been expressed that these practices may benefit from this increase in terms of improved recruitment and retention.
- A proportion (to be confirmed) of the £110m for 2018/19 will be allocated using the NRAC formula to support the development of multi-disciplinary teams in line with the MoU. Primary Care Improvement Plans will set out how these funds will be used.

4.5 Workforce Implications

The new contract will support the development of new roles within multi-disciplinary teams working in and alongside GP Practices. The contract also plans the transition of the GP role into an Expert Medical Generalist. These changes will require local and national workforce planning and development. Recruitment and retention of appropriate staff will remain a challenge across many areas of Grampian. The extent and pace of change to deliver the changes to ways of working over the three years (2018-21) will be determined largely by workforce availability, training, competency and capability and the availability of resources through the Primary Care Fund.

4.6 Moray Progress

Moray General Practices worked collaboratively in 2016 to develop a GP Strategy (**APPENDIX 2**). The GP Strategy will be the foundation of the development of the Primary Care Improvement Plan. The intention is to scope current services to explore opportunities in regards to meeting the demands of the new arrangements. The Clinical Leads are seeking feedback from practices across Moray to understand the opportunities and challenges this may bring. Over the next few weeks information will be gathered and collated from each practice to inform the developing plan, and a workshop will be held on 10 May 2018 to support the future plan.

4.7 There are however significant risks attached to the new arrangements for remuneration which is now aligned to demography and deprivation and not rurality. It is strongly felt that this may adversely impact on the ability of practices to recruit and retain workforce and be attractive in the future.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

The Primary Care Improvement Plan will sit with the Board's Strategic Plan.

(b) Policy and Legal

The central purpose of the 2018 GMS contract is to provide better service to patients by providing stability and sustainability to General practice. In so doing it also provides an environment that supports the wider policy aim of delivering care and support close to home when possible.

The MoU requires the Board to give clear direction to NHS Boards in relation to primary medical services by including specific reference to both the available workforce and financial resources. Directions to date have only listed functions and financial resources and will need to be expanded as the plan is developed and implemented to include available workforce information in order to meet this obligation.

The MoU is to be reviewed and updated before 31 March 2021 and a future report will come to the Board about this.

(c) Financial implications

The implementation of the 2018 General Medical Services contract for Scotland will see £250million per annum by 2021 in support of General Practice.

(d) Risk Implications and Mitigation

The implementation of the new contract will only be possible with full engagement of all IJBs, NHS Board, GP Sub Committee and LMC. Achieving implementation of the Primary Care Improvement Plans will require a clear three year programme and funding profile. The new contract seeks to address GP primary care sustainability.

(e) Staffing Implications

The new contract will support the development of new roles within multi-disciplinary teams working in and alongside GP Practices. The contract also plans the transition of the GP role into an Expert Medical Generalist. These changes will require local and national workforce planning and development.

(f) Property

There are no property implications arising from the report.

(g) Equalities

There are no equality implications arising from the report.

(h) Consultations

National public consultations are being supported by the Alliance across Scotland.

6. CONCLUSION

6.1 The MoU requires to be signed off by each IJB in Grampian

6.2 IJB will support the development of the Primary Care Improvement Plan

Author of Report: Sean Coady
Background Papers:
Ref:

Signature: _____ Date : 20th March 2018

Designation: Head of Service Name: Sean Coady

Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards
GMS Contract Implementation in the context of Primary Care Service Redesign

Introduction and Context

The principles underpinning the approach to general practice in Scotland were set out in a document *General Practice: Contract and Context – Principles of the Scottish Approach* published by the Scottish General Practitioners Committee ("SGPC") of the British Medical Association (BMA) and the Scottish Government in October 2016, noting that the Scottish Government and the SGPC are the two negotiating parties on commercial general practitioner (GP) contractual matters in Scotland. This Memorandum of Understanding ("MOU") between **The Scottish Government**, **the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards** builds on these arrangements and represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. The MOU also recognises the role of NHS Boards in service delivery and as NHS staff employers and parties to General Medical Services ("GMS") contracts.

For the purposes of this MOU, we refer to Health and Social Care Partnerships (HSCPs) responsible for the planning and commissioning of primary care services.

As an Expert Medical Generalist (as defined in the Scottish GMS contract offer document for 2018 the "Scottish Blue Book"), the GP will focus on:

- undifferentiated presentations,
- complex care,
- local and whole system quality improvement, and
- local clinical leadership for the delivery of general medical services under GMS contracts.

Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses physiotherapists), health and social care community based services and with acute services where required. The EMG will be supported by a multi-disciplinary team (MDT); maximising the contribution of both clinical and non-clinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others.

Delivering improved levels of local care in the community will have a clear benefit for patients and must rely on effective collaboration between GPs, HSCPs, NHS Boards and other partners, both in and out of hours, valuing the respective contributions of those who deliver these services. This will require clear articulation of the respective roles and responsibilities of GPs and other members of the primary care team both generally and in respect of each of the services set out in a HSCP Primary Care Improvement Plan (see Sections F and G of this MOU).

The development of primary care service redesign in the context of delivery of the new GMS contract should accord with seven key principles:

Safe –Patient safety is the highest priority for service delivery regardless of the service design or delivery model.

Person-Centred - Partnerships between patients, their families and those commissioning and delivering healthcare services work to provide care which is appropriate and based on an assessment of individual needs and values and is outcome focussed, demonstrates continuity of care (in the context of both professionals and services), clear communication and shared decision-making. Having regard to the five principles underpinning the Health and Social Care Standards: dignity and respect, compassion, to be included, responsive care and support and wellbeing.

Equitable – fair and accessible to all.

Outcome focused – making the best decisions for safe and high quality patient care and wellbeing.

Effective - The most appropriate treatments, interventions, support and services will continue to be accessible, provided in the most appropriate place by the right person at the right time to everyone. Changes to service delivery should not result in any diminution of care or outcomes for patients.

Sustainable – delivers a viable long term model for general practice that is resilient in the context of the wider community care setting on a continuous basis; and promotes and supports the development of the skill mix within the practice setting.

Affordability and value for money – Making the best use of public funds; delivering the general practice model within the available resources; with appropriate quality assurance processes.

An important determinant of success will be how the planned changes are implemented, seek to influence and depend on wider services.

This change has already started with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract. The new approach introduced by the GMS Statement of Financial Entitlements for 2016-17, sees GP practices working together in local Clusters with their HSCP and NHS Boards to identify priorities and improve the quality of services and outcomes for people.

Further key enablers for change include:

(1) Premises: The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant transfer in the risk of owning premises away from individual GPs to the Scottish Government. Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan. Details on the criteria for lease transfer and for accessing interest free loans will be set out in the premises Code of Practice and summarised in the GMS contract offer document which sets out the terms of the proposed new Scottish GMS contract.

*(2) Information Sharing Arrangements***:** The Information Commissioner's Office (ICO) has issued a statement that whilst they had previously considered GPs to be sole data controllers of their patient records; they now accept that GPs and their contracting Health Boards have joint data controller processing responsibilities towards the GP patient record.
The new GMS contractual provisions in Scotland will reduce the risk to GPs of being data controllers by clarifying respective responsibilities within this joint controller arrangement. These contractual changes will support ICO's position that GPs are not the sole data controllers of the GP patient records but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GPs' responsibilities and GPs will not be exposed to liabilities relating to data outwith their meaningful control.
The new contractual provisions will lay the foundations for increased lawful, proactive and appropriate sharing of information amongst professionals working within the health and social care system for the purposes of patient care.

*(3) Workforce***:** The national health and social care workforce plan published on 28 June 2017 noted that Part 3 of the Plan, which would determine the Scottish Government's thinking on the primary care workforce, would be published in early 2018 following the conclusion of the Scottish GMS contract negotiations. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

A. Purpose and aim of the MOU

This MOU will cover an initial 3 year period 1 April 2018 to 31 March 2021 and is structured to set out the key aspects relevant to facilitating the statement of intent the document represents:

Section A – Purpose and aim
Section B - Parties and their responsibilities
Section C - Key stakeholders
Section D - Resources
Section E - Oversight
Section F – Primary Care Improvement Plans
Section G – Key Priorities

It provides the basis for the development by HSCPs, as part of their statutory Strategic Planning responsibilities, of clear HSCP Primary Care Improvement Plans, setting how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts. Plans will have a specific focus on the key priority areas listed at Section G of this MOU with the aim of transitioning their delivery by the wider MDT between 2018 and 2021.

Taken together with the Scottish GMS contract offer document, the National Code of Practice for GP premises, and the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018, this MOU underpins the new Scottish GMS contract; and enables the move towards a new model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

In addition, The *National Health and Social Care Workforce Plan: Part 3 Primary Care,* to be published following agreement on the new Scottish GMS contract, will set out the context and arrangements for increasing the Scottish GP and related primary care workforce and both the capacity and capability of the multi-disciplinary team.

This MOU will be reviewed and updated by the parties before 31 March 2021 through arrangements that will be agreed by March 2018.

B. Responsibilities (of parties to the MOU)

The respective responsibilities of the parties to this MOU are:

Integration Authority responsibilities (typically delivered through the Health and Social Care Partnership delivery organisations):

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.

- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.
- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that patient needs identified in care plans are met

Scottish General Practice Committee responsibilities:

- Negotiating, with the Scottish Government, the terms of the GMS contract in Scotland as the negotiating committee of the BMA in Scotland.
- Conducting the poll (and any future poll) of its members on the terms of the GMS contract in Scotland.
- Representing the national view of the GP profession.
- Explaining the new Scottish GMS contract to the profession (including communication with Local Medical Committees (LMC) and GP practices).
- Ensuring that GP practices are supported encouraged and enabled to deliver any obligations placed on them as part of the GMS contract; and, through LMCs and clusters, to contribute effectively to the development of the HSCP Primary Care Improvement Plan.

NHS Territorial Boards responsibilities:

- Contracting for the provision of primary medical services for their respective NHS Board areas
- Ensure that primary medical services meet the reasonable needs of their Board area as required under Section 2C of the NHS (Scotland) Act 1978.
- Delivering primary medical services as directed by HSCP as service commissioners.
- Arrangements for local delivery of the new Scottish GMS contract via HSCPs

- As employers, NHS Boards will be responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of the priority areas set out in Section G.

Scottish Government responsibilities:

- Setting the legislative framework underpinning the commissioning of primary medical services by HSCPs and delivery by NHS Boards.
- In collaboration with NHS Boards and with HSCPs, shaping the strategic direction and the development of commissioning guidance in respect of primary care that is in line with the aims and objectives set out in National Clinical Strategy and the Health and Social Care Delivery Plan.
- Providing financial resources in support of the new Scottish GMS contract and primary care transformation (including the transfer of services) in line with the Scottish Government spending review process.
- Making arrangements with stakeholders to meet the future GP workforce requirements both in terms of numbers and education and training.
- Agreeing the metrics and milestones against which progress will be measured; with regular progress reporting as part of the existing statutory arrangements for reporting performance against Strategic Plans.

C Key Stakeholders

HSCPs must collaborate with NHS Boards as partners in the development and delivery of their Strategic Plan (and the associated Primary Care Improvement Plan). Local and Regional Planning arrangements will need to recognise the statutory role of the HSCP as service commissioners; and the partnership role of NHS Boards as NHS employers and parties to the GMS contracts for the delivery of primary medical services in their Board area.

In addition to this, HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users. In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to):

- Patients, their families and carers
- Local communities
- SAS and NHS 24
- Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees)
- Primary care providers
- Primary care staff who are not healthcare professionals
- Third sector bodies carrying out activities related to the provision of primary care

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

Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services, mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

D. Resources

General Practice funding – through the GMS contract funding allocated to NHS Boards, general practice funding represents a significant element of the public investment in community and primary care. The published draft Primary Medical Services budget was £821 million in 2017-18 – funding the remuneration of 4,460 General Practitioners; the c.3000 practice staff they employ, both nursing and non-clinical, and the non-staff expenses of running practices. This investment enables over 23 million healthcare interactions every year. The Primary Medical Services investment funds the part of the system that is the first port of call for most people's healthcare needs most of the time. In addition to the direct care enabled by this investment, the clinical decisions GPs make – whether to treat; how to treat; whether to refer to further specialist treatment – have a much wider impact on the health and social care system. The "GP footprint" is estimated to be as much as four times the direct investment in Primary Medical Services. This investment through the contract is, therefore, critical to the sustainability of the whole health and care system.

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was invested through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the 3 financial years from 1 April 2018 to £250 million 2021-22.

<u>Process</u>

Specific levels of resource will be agreed as part of the Scottish Government's Spending Review and budget processes and allocated in line with the arrangements set out in this MOU.

Where appropriate these resources will be allocated to HSCPs through their NHS Board partners in line with the Scottish Government's National Resource Allocation formula (based on population need and taking account of geography and of life circumstances, including deprivation). Resources will be spent for the purposes set out in this Memorandum and in line with each HSCP Primary Care Improvement Plan to enable the transition to be managed and implemented effectively. The HSCP Plans must demonstrate how the funding will flow/be used to enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT. HSCPs will agree these Plans locally. These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. However, the arrangements for delivering the new GMS contract will be agreed with the Local Medical Committee. Integration Authorities will hold their officers to account for delivery of the milestones set out in the Plan, in line with their responsibility to ensure delivery of Strategic Plans, and through regular reporting to the Authority. Key partners and stakeholders should be fully engaged in the preparation, publication and review of the plans.

The resources and any associated outcomes and deliverables (aligned to the Scottish Government's National Performance Framework and the six Primary Care Outcomes) will be set out in an annual funding letter as part of the Scottish Government's budget setting process.

The extent and pace of change to deliver the changes to ways of working over the three years (2018-21) will be determined largely by workforce availability, training, competency and capability, the availability of resources through the Primary Care Fund, and will feature as a key element of the National Health and Social Care Workforce Plan: Part 3 Primary Care.

E. Oversight

New oversight arrangements for the implementation of the GMS contract in the context of wider primary care transformation in Scotland will be developed including:

A *National GMS Oversight Group* ("*the national oversight group*") with representatives from the Scottish Government, the SGPC, HSCPs and NHS Boards will be formed to oversee implementation by NHS Boards of the GMS contract in Scotland and the HSCP Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working.

National issue specific groups – A range of national issue specific groups with members drawn from a range of stakeholders, including NHS Boards, HSCPs and SGPC where appropriate will support and provide policy and professional advice to the national oversight group on a range of national policy areas relevant to the delivery of primary care transformation. These may include: GP Contract Implementation Group; GP premises; GP IT, e-Health; Data and Information; Remote and Rural; Nursing; GPN Group; Vaccination Transformation Programme; Patient Groups.

As well as the requirements on the HSCP to develop a Primary Care Improvement Plan as set out in Section D, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract as set out in the Scottish GMS contract offer document. These arrangements will include the priority areas set out in Section G of this MOU and must be agreed with the LMCs.

HSCPs should establish local arrangements to provide them with advice and professional views on the development and delivery of the Primary Care Improvement Plan. Arrangements will be determined locally and will take account of the requirement to engage stakeholders as set out above. The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee as set out above. HSCPs and NHS Boards will discuss and agree locally the arrangements for providing appropriate levels of support to enable this advice to be provided.

Within HSCPs, GP clusters have a critical role in improving the quality of care in general practice and influencing HSCPs both regarding how services work and service quality. Improving Together: a new quality framework for GP Clusters in Scotland[i] provides a framework for how that learning, developing and improving may be achieved. As GP Clusters mature, they will be expected to have a key role in proactively engaging with HSCPs, advising on the development of HSCP Primary Care Improvement Plans and working with their MDT and wider professional networks to ensure highly effective health and social care provision within and across the HSCP area and where relevant across HSCPs.

HSCPs will support and facilitate GP Clusters to ensure their involvement in quality improvement planning and quality improvement activity as part of whole system improvement. *Healthcare Improvement Scotland* will work in support of HSCPs where required to ensure that GP clusters have the support they need to engage effectively in quality improvement activity.

The *Local Intelligence Support Team* (LIST) already provides support to HSCPs and has been commissioned to provide support through HSCPs to GP clusters. This support involves on-site expert analytical advice to provide local decision-makers with meaningful and actionable intelligence, leading to improved outcomes for service users.

F. Primary Care Improvement Plan

The collaborative implementation of the new GMS contract in Scotland should be set in the context of the HSCP Primary Care Improvement Plan. Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. To support that aim HSCPs will collaborate on the planning, recruitment and deployment of staff.

Some services which are currently provided under general medical services contracts will be reconfigured in the future. Services or functions which are key priorities for the first 3 years from 2018 - 2021 are listed in Section G below. The expectation should be that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Additional investment is intended to provide additional MDT staff, which should, where appropriate, be aligned to GP practices to provide direct support to these practices under the oversight of GPs as senior clinicians. It will be important that GPs continue to work to their responsibility to ensure that their premises remain fit for purpose, services remain accessible to patients, that they are responsive to local needs and can maintain continuity of care; all of which will allow GPs to deliver an effective, integrated service as part of the MDT.
The HSCP Primary Care Improvement Plans will be considered alongside the NHS Board arrangements for the delivery of the GMS contract in Scotland in line with the requirements of the Scottish contract offer document.

The Plan should also consider how the new MDT model will align and work with community based and where relevant acute services, subject to wider stakeholder engagement to be determined by the HSCP in line with their statutory duty to consult.

<u>Key Requirements of the Primary Care Improvement Plan:</u>

- To be developed collaboratively with HSCPs, GPs, NHS Boards and the stakeholders detailed in Section C;
- To detail and plan the implementation of services and functions listed as key priorities under Section G, with reference to agreed milestones over a 3 year time period;
- To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas under Section G and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.
- To provide detail on available resources and spending plans (including workforce and infrastructure);
- To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.
- Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018

G. Key Priorities

Existing work to develop and test new models of care has shown benefits from the effective deployment of other professional staff working within a wider MDT aligned to general practice. The priority between 2018 and 2021 will be on the wider development of the services detailed below. Changes to services will only take place when it is safe to do so.

The service descriptions and delivery timescales given here are provided for the purposes of this MOU.

(1) The Vaccination Transformation Programme (VTP) was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations.

In the period to 2021, HSCPs will deliver phased service change based on a locally agreed plan as part of the HSCP Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting of work to other appropriate professionals and away from GPs. This has already happened in many parts of the NHS system across Scotland for Childhood Immunisations and Vaccinations. This change needs to be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up. As indicated above, there may be geographical and other limitations to the extent of any service redesign.

(2) Pharmacotherapy services – These services are in three tiers divided into core and additional activities, to be implemented in a phased approach.

By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the HSCP Primary Care Improvement Plan. This is to be followed by phases two (advanced) and three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role.

(3) Community Treatment and Care Services - These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan.

This change needs to be managed to ensure, by 2021 in collaboration with NHS Boards, a safe and sustainable service delivery model, based on appropriate local service design.

(4) Urgent care (advanced practitioners) - These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resource such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients, allowing GPs to better manage and free up their time.

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

(5) Additional Professional roles **-** Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT); this would be determined by local needs as part of the HSCP Primary Care Improvement Plan. For example, but not limited to:

- *Musculoskeletal focused physiotherapy services*
- *Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice*

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

(6) Community Links Worker (CLW) is a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plan HSCPs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.

Workforce As part of their role as EMGs, GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas under (1) to (6) of Section G in the MOU will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans.

Existing practice staff will continue to be employed directly by practices. Practice Managers, receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements.

Signatories

Signed on behalf of the Scottish General Practice Committee
Name: Date:
Signed on behalf of Integration Authorities (31 individual signatures)
Name: Date:
Signed on behalf of NHS Boards
Name: Date:
Signed on behalf of the Scottish Government
Name: Date:

i Improving together: a new quality framework for GP clusters in Scotland

20180329 GMS Contract - Appendix 2

Table of Contents

Strategic Context....2
Process....3
Strategic Themes....4
1. REDUCING INAPPROPRIATE HOSPITAL ADMISSIONS AND CARING FOR COMPLEX FRAIL ELDERLY AT HOME....4
2. DEALING WITH INCREASING PRACTICE DEMAND....5
3. DELIVERING QUALITY CARE TO COMPLEX PATIENTS....6
4. THE EXTENDED MULTI-DISCIPLINARY TEAM....7
5. RECRUITMENT AND RETENTION....8
KEY MAJOR EMERGING THEMES....9
ORGANISATIONAL DEVELOPMENT....10
The Three Tier Model....10
GP Quality Cluster....10
Conclusion....11
APPENDICES....12
Appendix 1....12
Appendix 2....14
Appendix 3....15

The Moray General Practice Strategic Plan 2016-2019

The Scottish Government (SG) anticipates that with the integration of health and social care General Practice will have a central role in the delivery of a new model that better meets the needs of patients, populations, practices and the wider health and social care system. Their stated aim is a measurable improvement in health and social care outcomes.

In recognising and understanding this expectation the 13 General Practices in Moray have worked together to develop a strategic plan for the next 3 years.

Strategic Context

On the 1st April 2016 the new arrangements for Health and Social care commenced with the Moray Integration Joint Board (MIJB) operating with a pooled budget from The Moray Council (TMC) and NHS Grampian (NHSG).

The budget for the MIJB for the year 2016/17 will be £107m for the provision of all services outlined in the national integration scheme and further described in the MIJB Strategic Plan for Health and Social Care services (appendix 3).

The SG expects integrated services to emphasise preventative care and reduce both the level of hospital admissions and the time that some patients spend in hospital. There is also an expectation that costs will be reduced through the reduction in variation in practice across both the Health and Social Care sectors.

In SG statements GP is repeatedly described as having a crucial role in the successful delivery of the anticipated outcomes of Health and Social care integration. This will be through involvement at locality and “natural community” level whilst influencing positively the strategic planning of Joint Boards.

The nationally negotiated GP Contract is currently being remodeled in recognition of the new Health and Social care arrangements facilitating GP involvement in the new developing structures. The central thrust of this process is for a Contract that is based much less on central prescription and much more on the professionalism of General Practitioners individually and in groups and which promotes the quality and safety agenda.

The encouragement of GP leadership and a ‘peer led, values based’ approach to quality supported by GP Clusters is a fundamental change along with the establishment of productive and respectful relationships between GP’s themselves and between GP’s and their local Health and Social Care partners.

It is anticipated that the new GP Contract will be implemented in April 2017.

The last 12 months has seen the publication of many papers outlining the challenges facing the NHS and how these might be addressed. Particularly relevant to this process have been the Chief Medical Officer’s Annual Report 2014-15 “Realistic Medicine” and A National Clinical Strategy for Scotland (Appendix 3).

Whilst underscoring the challenges faced, there is encouragement to follow a health model which is based on honesty, quality, safety, respect and holism and which encourages frank and open conversations with the public about the ability of the health system to meet health need and expectation.

Both of these reports together with the National Review of Primary Care Out-of-Hours Services (OOHS) (Appendix 3) describe varying models of health care delivery, dependent on local circumstances, availability and development of a wide range of health care professionals, joint working, the "right person at the right time and in the right place" and individual practitioners working at the top of their license.

Whilst there is much optimism around the various changes occurring in health and social care provision it is important to appreciate the considerable pressures currently facing GP. These are mainly around recruitment and retention of General Practitioners, challenging demographics and associated rising health need, the macro economic situation and Governmental spending choices which have seen the proportion of NHS spend on General Practice falling to its lowest level ever.

These and other challenges facing General Practice are outlined objectively in the recent The King's Fund: Understanding pressures in general practice – 2016 (Appendix 3).

Process

The vast majority of health care contacts and a considerable number of social care contacts occur in General Practice. It is estimated that in excess of 90% of all daily NHS contacts take place in General Practice for less than 10% of the total NHS budget. It is therefore crucial for the wider strategic planning of the MIJB to have a clear strategic vision for GP in Moray.

In the Spring of 2016 a process of engagement with Moray General Practices was begun and is fully described in appendix 1. These discussions were embedded within the context of the recently published Moray Strategic Plan 2016-19 (appendix 3) which had been through a public consultation process ensuring that this high level planning document was both fully ratified by and expressed the wishes of the Moray population regarding the principles of service delivery for health, social care and increased well being. It is important to note that the development of this GP Strategic Plan is the response of the Medical Health Professionals working in Moray's general practices regarding what needs to be in place to safely develop and implement high quality services over this time frame thereby delivering on both the Key National and Moray Strategic Outcomes. As such this document can be regarded as an embedded sub-plan for implementation within the already agreed high level strategic plan.

Whilst children's services are not explicitly mentioned it is also important to note that GP delivers care to all age groups from 'cradle to grave' in a seamless fashion and that work will continue with other children's care providers to ensure continued high quality service delivery to this group.

Strategic Themes

From the work outlined above some clear themes emerged and should form the basis of developing strategic planning and implementation for GP in Moray.

1. REDUCING INAPPROPRIATE HOSPITAL ADMISSIONS AND CARING FOR COMPLEX FRAIL ELDERLY AT HOME

There is a clear directive from SG around reducing inappropriate admissions to hospital and safely caring for complex frail elderly and vulnerable patients at home. In Moray we already have the lowest admission rates of any of the IJB's in the NHSG region which is a testament to how local GP's have been working to cut admissions by re-organising and re-modeling their own practices' service delivery without any hospital to practice resource transfer to enable this to happen. Whilst reducing admission rates further is possible this is unlikely to be accomplished without significant additional input from the MIJB. A new focus will need to be on upstream reduction of rates of clinical deterioration to try and prevent crisis intervention.

The top priority is the development of an **Acute Response Team** which would be available in and out of hours and should include access to immediate care provision, community nursing and social care assessment. In order to make a safe medical assessment there would need to be access to **Point of Care Testing and Diagnostics** together with timely access to an **Elderly Medicine Team** to ensure comprehensive geriatric assessment if required. The latter is likely to be delivered through a commissioning process that also includes Dr Grays Hospital service interface as well as community needs. This process could complement the development of a **Rapid Assessment Hospital Unit** as part of dealing with unscheduled care pathways.

Practice based enablers of these processes will be through the development of the **Multi-Disciplinary Team** and in particular practice attached **Emergency Care Practitioners and Advanced Nurse Practitioners**. (See section 4)

Key further supports to aid these developments are: the skilling up of **Community Nursing Teams** In and Out of Hours, **IT** development allowing 24 hour access to patient records by all parties, the more effective use of existing **Community Hospitals as Hubs** (where a significant amount of additional service delivery could occur), enhanced communication with **Hospital Consultants**, access to step up/down beds where there is no community hospital, enhanced **Marie Curie** palliative care services in and out of hours.

Given the change in focus of care delivery there will be a requirement to identify **Learning Needs** across teams to support changes (e.g. GP's in elderly medicine/dementia).

2. DEALING WITH INCREASING PRACTICE DEMAND

Over the past 5 years there has been an unprecedented rise in practice contact in particular from Tier 1 issues (see appendix 2 for definitions). This has at times led to overwhelm of services especially at the start of the working week. Practices have evolved a variety of ways of dealing with this demand with increased use of telephone triage and provision of minor illness appointments by trained nurses. Evaluation of this group of patient needs however suggests that a large proportion could be better dealt with by patient education in self-management, shifting the balance of contact to community and third sector resources and assets, better signposting of resources out with the practice and improved communication with out of hours' services and NHS 24.

Ideally the **Point of Initial Contact** needs to address tier 1 presentations and Practices should be supported in using their telephone and website services more effectively in signposting and linking with more appropriate contacts for specific advice. This could be enhanced by a **Moray Wide App/Hub Point** for continuously updated, unified and improved information delivery. Better linking and capacity building with local **Pharmacies/Dentists/Opticians** could lead to more effective patient re-directing (or pre-directing). As an example Practices and local Pharmacies could engage in joint training to ensure minor illness and ailments are dealt with in a similar way across the community.

Patient education via multiple means and approaches is required to develop a climate of **Self-Help and Self-Management**, tapping into community assets mapped out via Third Sector interfaces. A key area is the development of the **Link Worker** concept to deal more effectively with distress and social issues and preventing 'Medicalised Angst' with its attendant inappropriate prescribing. Whilst many practices would like an attached counsellor or psychologist the ensuing change is likely to prove more effective if connected to a **Redesign of Mental Health Services** (primary/secondary care and social services/third sector) within a rapid access **One-Stop Hub** model for self and professional referral and assessment.

Utilising the **Modernising Primary Care Agenda** to map community based assets and strengths can be linked to **tsiMORAY** identifying 3rd sector resources and in tandem encourage community supported self care approaches.

Moray Practices may link together in joint **Admin Training** in developing triage, negotiating and signposting skills though increasingly it may be more effective for all initial practice contacts to be handled by an identified clinician.

Public Health is currently seen to be distanced from effective engagement within practices and there is a clear need for public health messages (and personnel) to be more robustly delivered within the practice context. This will require joint planning, direction and utilisation of resources.

3. DELIVERING QUALITY CARE TO COMPLEX PATIENTS

Increasingly the '10 minute consultation' in general practice is proving inadequate in dealing with the varieties of complexity presenting on a daily basis. These are patients with multi-morbidity, frailty, cancer, palliative care, dementia, etc, (the **Tier 3** patients) who require significantly longer consultations with an approach increasingly focused on **'What Matters To You?'** This generates the kind of in-depth meaningful conversations which can have a profound effect on future patient management.

The key issue for practices is in developing the capacity to provide the necessary time for these extended consultations. With the increasing demand from tier 1 problems squeezing available appointment times it is clear that dealing more effectively with this tier (see above) is one of the keys to releasing capacity.

All practices have well developed **Practice Nurse Teams** which have significant current roles in dealing with chronic disease management and minor illness. With the recent changes in the GP contract it is anticipated that this will release capacity for dealing with more intermediate and Tier 2 care. This will require additional ongoing training as roles change, supporting increasing clinical autonomy in care delivery.

The multi-disciplinary team (**MDT** see below) has a significant role to play in supporting GP consultations with skilled team members working around planned care scenarios. **Advanced Nurse Practitioner and Physician Assistant** roles within the practice can aid patient preparation for these appointments so that GP time can focus on what really matters to each patient. For cancer and palliative care in particular there may need to be even closer working with the **Macmillan nurse** and their specialist teams with joint consultations. Increased in-house **Pharmacist Support** will help reduce unnecessary polypharmacy and highlight the medications that can cause problems and need to be stopped versus those with clear benefits for ongoing treatment. This will have the twin effect of harm reduction and identifying prescribing budget savings which can then be targeted in different ways for improved service delivery.

Out-with the practice an accessible community based **Elderly Medicine Team** will help with support for assessment of particularly complex frail, vulnerable elderly patients with multi-morbidity. Access to enhanced decision support via improved communication links with **Hospital Based Consultants/Specialists** will aid consultations focusing on **Realistic Medicine** and quality of life outcomes.

Identifying Learning Needs and accessing appropriate training both for GP's and MDT members around enhanced roles will be important.

4. THE EXTENDED MULTI-DISCIPLINARY TEAM

The Ritchie report on Out of Hours services (appendix 3) has highlighted the need to build **extended MDT's** that can cover the whole 24 hours of service provision 365 days of the year. A key focus is on ensuring the right professional sees the right person at the right time. These teams need to encompass not only health care professionals but also social care, third and independent sectors. Their development will lead to new ways of working both within and out of hours. There is scope both for developing practice attached staff models and also models for Localities and Natural Communities across Moray whose individuality and needs provision may differ. There is no 'one size fits all' solution.

General Practitioners across Moray agreed that there were 3 key stand outs for extended MDT members. The first being practice attached **Emergency Care and/or Advanced Nurse Practitioners**. These practitioners have key roles in dealing with day to day urgent clinical care, intermediate care, house calls and triage, much of which is at **Tier 2** level and which will release GP capacity to deal with Tier 3 complexities. Some Moray practices have already remodeled services along these lines in part fuelled by potential GP recruitment and retention issues.

Practice Based Clinical Pharmacists are increasingly seen as important team members. They can enhance safety and provide harm reduction through medicines optimisation and reconciliation (e.g. hospital discharges) and oversee a practice based pharmacy assistant and admin team to navigate the increasing volume and complex landscape of acute and repeat prescription requests. This is an important function especially when any significant flux in the overall **Moray Prescribing Budget** could create potential shortfalls having a negative impact on other systems.

The **Community Pharmacist** also has a major role in giving advice and treating minor illness and ailments. This has the potential of directly reducing practice Tier 1 demand. Providing up to date training that incorporates support for individual prescribing qualifications together with management of clinical conditions in an identical way to the practice will ensure these conditions are treated in a similar way across communities and enhance standards of care.

Community Nursing Teams have always provided a very valuable support to housebound patients and are increasingly involved in delivering care to the frail, vulnerable elderly. As one of the key disciplines with a long history of working in tandem with GP's the **District Nurse** role needs to be supported in developing new and relevant skill sets required for enhanced care at home. In some practices they already work closely in liaison with Emergency Care and Advanced Nurse Practitioners. Because of this close working with individual practices it would make sense for the day to day **operational management** of these teams to be under local practice guidance.

As well as the 3 key team players above, it is also clear that there are other potential MDT members who have a role in providing effective care. Many practices highlighted the need for practice attached mental health workers/counsellors/link workers. However this need is likely best met by a redesign of current mental health services in Moray. As mentioned earlier in this document, an easily accessible community based Elderly Medicine Team is vital. Increasingly, general practice is dealing with the initial diagnosis and treatment of Dementia and practice attached Support Workers who also provide a link to Old Age Psychiatry service will be needed to coordinate care as demographics change.

There are currently specialist nurse services for Diabetes, Respiratory and Cardiac Failure whose functions could be better utilised by practices. Rapid access physiotherapist assessment for MSK could help deal with the 1 in 3 presentations in everyday practice for these conditions. Co-location and enhanced team working with Social Care could be paramount to keeping patients safely in their home environment.

Given the Ritchie OOH report cited above it is important to reiterate that opportunities to provide enhanced MDT's should incorporate flexible working practices to deliver services across all time frames.

5. RECRUITMENT AND RETENTION

A shortage of GP's is affecting recruitment and retention across Scotland especially in more rural areas. The Scottish Government has acknowledged that this is a significant problem which may get worse before improving. They have instigated various measures to try and mitigate the shortfall though recognising that a key strategy of increasing medical student intake and apportioning more trainees to general practice may take 10 years to fully bear fruit given the time needed to train a highly skilled GP. In Moray, with an aging medical workforce, it is estimated that as many as 45% of GP's may retire within the next 5 years. It is on this backdrop that some practices who have already experienced the lack of numbers of suitably qualified replacement GP's have remodelled their service delivery using alternative means such as **Emergency Care Practitioners**.

There is clearly a need to promote Moray as an attractive place to come and work with a variety of professional and personal development opportunities within an area of outstanding natural beauty together with varied indoor and outdoor leisure pursuits. The **MIJB** can assist in recruitment by promoting an **internet advertising campaign** to highlight the advantages of working in a smaller, friendly environment with huge scope for involvement at all levels of service design and delivery.

There is a recognition that younger doctors are currently trending towards **portfolio careers** and work-life balance by increasingly working part time with a reduced inclination to become partners in practice. Certain sub-specialties such as A&E and Dermatology lend themselves well to portfolio careers which should be encouraged. With the potential further development of Dr Grays Hospital it may be possible to create attractive posts that work across the hospital/general practice interface.

Moray GP's fully endorse independent contractor status. However, given that many younger doctors currently opt for salaried positions rather than partnership there is scope for having a **Moray wide agreed Terms and Conditions** for these individuals to ensure a more level recruitment playing field and allow practices to work increasingly in a more collaborative fashion, both with each other and Dr Grays Hospital. As a key attractor, **Premises and Estates** used to deliver GP services need to be modern and well maintained with access to development funding.

The creation of a collegiate approach to **Community Learning** with accredited links with **Academia** (such as with **UHI**) can portray Moray as an attractive centre of excellence with strong connections to future developments in secondary care at Dr Grays affording much mutual

benefit. There is a strong tradition of **Training Practices in Moray** incorporating medical students, FY2, ST1 and ST3 doctors in training and an increased focus on retaining these young trainees could pay long term dividends.

There are a number of things that **Practice Managers** can do currently as a group to share ways of working that promotes good business sense and decision making. Recognised as the 'engine room' which organises the processes and practices for effective care delivery PM's have a key role in workforce planning and efficient business operation.

Lastly, it could also be worth further exploration of provision of supported child care and accommodation as part of an attractive resettlement package together with perhaps the appointment of a shared Moray wide locum(s).

It is also important to note that recruitment issues will also surface in **Practice Nursing and Community Nursing**. It is vital that significant coordinated work force planning occurs with relevant bodies both locally and nationally (e.g. Nurse Directors and NES) to address potential shortfalls. Educational and training needs can be simultaneously addressed through linking with **Community Learning** (as above).

KEY MAJOR EMERGING THEMES

During the process of developing a Moray GP Strategic Plan the following 5 key themes have emerged. Whilst the recommendations for each section above are important in their own right it is suggested that these overarching themes in particular become integral to the MIJB future commissioning and planning processes.

1. **Commissioning of a New Community Based Elderly Medicine Model that is responsive to primary care and across the hospital interface**

2. **Acute Response Team – priority development to keep patients safely at home who do not require hospital admission (with enhanced diagnostics/POCT)**

3. **Point of Initial Contact – increasingly needs to address Tier 1 presentations by signposting and redirecting to release capacity for Tier 2 and 3 care**

4. **Redesign of Mental Health Services into a one-stop access Hub Model (inclusive of primary care psychology, secondary care services, social services, third sector, link worker, etc)**

5. **Enhanced MDT with priorities around Pharmacy support (Practice and Community), developing Community Nursing, ECP, AHP and Physician Assistant roles (also incorporating wider Primary Care Developments in Optometry and Dentistry)**

ORGANISATIONAL DEVELOPMENT

For a GP strategic plan to be implemented in Moray there are some organisational imperatives to be recognised. These have been identified in the Moray GP strategic planning process and reflect much of the current national thinking around both the ongoing contractual and integration processes.

The Three Tier Model

The role of the General Practitioner as the **'Expert Generalist'** is now embedded in the thinking of the SG and the Scottish General Practice Committee(SGPC) of the BMA as the "new "GP contract is developed.

For there to be a change in emphasis in what GPs do, there needs to be a fundamental structural and operational change in how health and social care presentations are managed.

The" **3 Tier model"** which is key to this shift in management is further described in Appendix 2

It is anticipated that GP will increasingly be focusing on Tier 2/3 presentations and exactly how this might happen in Moray is described in the sections above.

Future MIJB strategic planning must reflect this changing dynamic and consider how Tier 1 presentations are managed which requires a multifaceted approach across the Health and Social care system.

Only by doing this will General Practice meet the increasing demands of complex multiple morbidity and undifferentiated care as envisioned by SG and SGPC.

GP Quality Cluster

The development of GP Quality Clusters is an integral and crucial element of the developing GP Contract for 2017.

With the removal of the process and task driven work associated with QOF there is a desire to implement a new structure that promotes **Quality Improvement** (QI) within General Practice (internal role) and which also helps to reorientate the NHS nationally and locally towards integrated new models of primary care (external role).

General Practitioners in Moray recognise the need to develop a **Moray Cluster** which enables the QI activity but also acts as a vehicle to promote the GP Strategy and provide a pool for 'commissioned' GP Leadership. The Moray Cluster would be a natural successor for the current Moray GP Group and act as a forum for GPs and PMs to discuss additional matters such as business continuity and recruitment and retention.

The Moray GP Cluster would impact at both locality and "natural community" level and upwards into the Strategic Planning Group of the MIJB through involvement of GPs and their staff in these groupings whilst progressing an agreed GP strategic plan.

For such a Cluster to impact positively on Health and Social Care development and QI it would need adequate resourcing (financial, administrative, IT, relevant health and social care data etc).Some of this resourcing is described in the developing GP contract but it would require additional support from the MIJB to deliver the desired outcomes.

Conclusion

The Moray GP Strategic Plan 2016-19 has been developed by the 13 General Practices operating in Moray. It takes into account the views of General Practitioners and Practice Managers for the delivery of sustainable quality clinical services whilst recognising the challenging macro economic situation, the increasing and unrelenting demand on the system, the new organizational structures and the key national drivers for change. It is firmly embedded within the Moray Strategic Plan and seeks to deliver these high level principles within a clear implementation strategy.

With support from the MIJB there is huge potential to drive **transformational change** leading to enhanced health outcomes for the population of Moray.

Authors

Dr Lewis Walker (Strategic Clinical Lead MIJB)

Dr Graham Taylor (Strategic Clinical Lead MIJB)

APPENDICES

Appendix 1

A questionnaire was sent to all Moray General Practices for completion by GPs and Practice Managers. The response to this was very encouraging with 100% of Moray General Practices returning the questionnaire with consistent and clearly emerging themes.

There was detailed response and discussion around the following areas:

1) Reducing hospital admissions and caring for more complex frail elderly at home.

2) Dealing with increasing demand

3) Delivering quality care to complex patients

4) Recruitment and retention

5) Multi-disciplinary team

6) Other issues

Two evening meetings were arranged at the Alexander Graham Bell Centre in Elgin to which all GPs and Practice Managers were invited.

The first meeting addressed the question:

'What do we need to support the continuing and future provision of safe, effective, person centred and quality GP in Moray for the next 3-5 years?'

Consolidated information from the questionnaires had been fed back to all GP's/PM's prior to this first meeting and was used to inform and stimulate facilitated group based discussions.

The response to the questionnaire and the product of the first meeting identified clear and consistent themes which have been reflected in this strategic plan.

The second meeting addressed the question:

'How does Moray GP deliver an agreed strategic plan?'

This meeting addressed organisational and structural issues which would allow a GP strategic plan to be implemented whilst encouraging practices to work co-operatively and in a collegiate fashion whilst at the same time developing GP leadership and the quality and safety agenda.

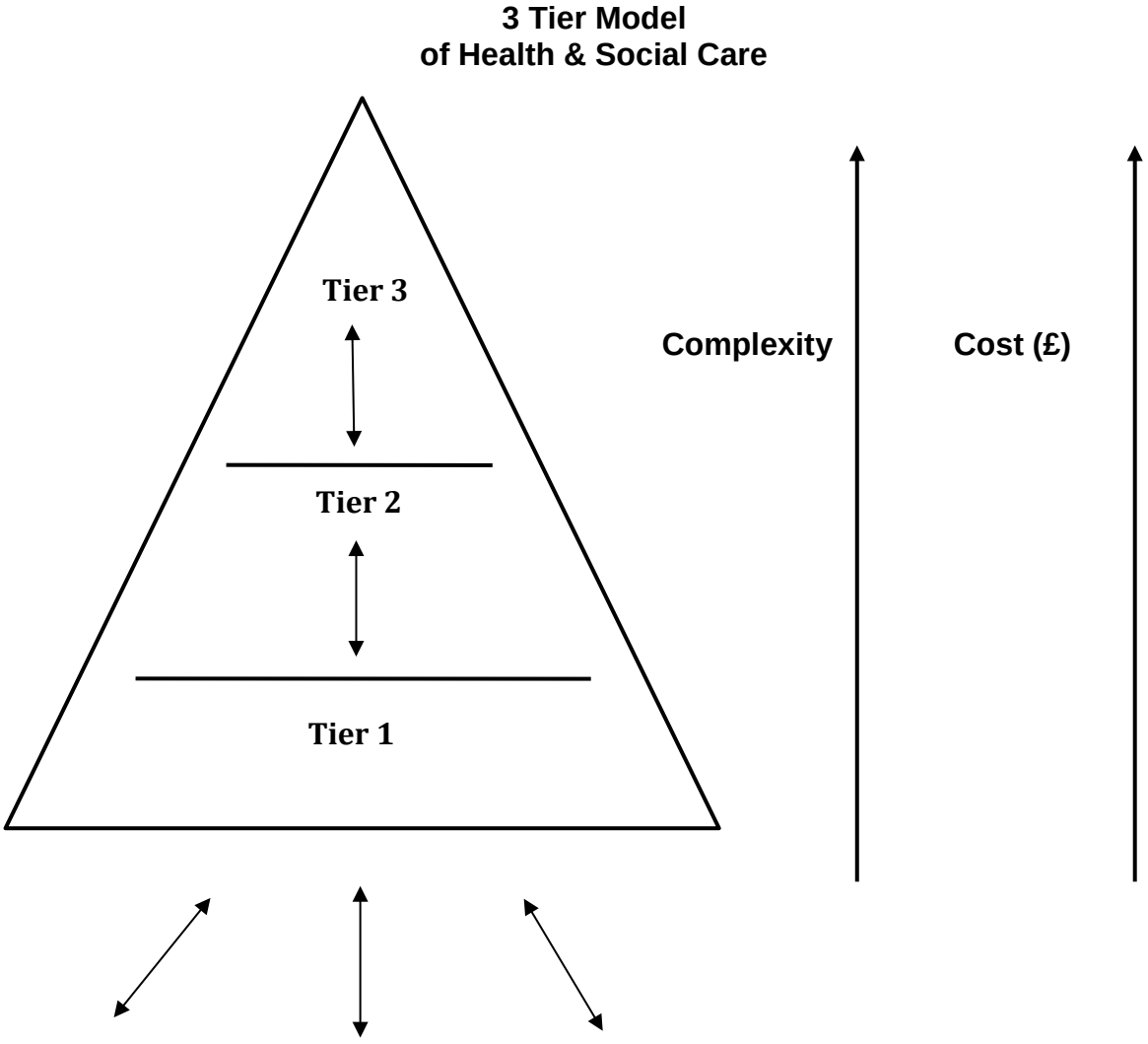
This was an open forum meeting and generated a great deal of discussion, debate and opinion about contractual drivers for change as well as those of integration.

The degree of engagement in this process has been very encouraging. As well as a 100% response rate to the initial questionnaire, all practices were represented at the first meeting (27 attendees) and twelve practices represented at the second meeting (22 attendees).

At the end of both meetings GPs and PMs stayed on to have informal discussions and make connections. **It is completely unprecedented to see this very significant level of engagement in Moray general practice, reflecting the enthusiasm and commitment generated by the opportunity to develop a high quality sustainable service delivery plan to meet patient needs over the next 3 years.**

.

Appendix 2



<u>Tier 1</u> – Highly dependent on promotion of self help, resilience and identification and utilisation of community based assets (both commissioned and non-commissioned). The aim is for low level social, physical and psychological distress to be managed more and more out with general practice or by non-GP members of primary care teams.

<u>Tier 2</u> – Will represent mainly stable physical and psychological conditions – stable and ongoing management of chronic disease, cancer and conditions of ageing.

<u>Tier 3</u> – Complex conditions requiring high level health and social care intervention – end of life care, complex co-morbidity, and significant physical and psychological distress.

Appendix 3

References

BMA Scotland: new GP contract 2016 – https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gp-contract-negotiations/contract-agreement-scotland

The Chief Medical Officer's Annual Report 2014-2015 – http://www.gov.scot/Publications/2016/01/3745

A National Clinical Strategy for Scotland - http://www.gov.scot/Publications/2016/02/8699

The King's Fund: Understanding pressures in general practice. May 2016 – http://www.kingsfund.org.uk/publications/pressures-in-general-practice

National Review of Primary Care Out-of-Hours Services, Professor Sir Lewis Ritchie, 2015 – http://www.gov.scot/Topics/Health/Services/nrpcooh

The Moray Strategic Plan 2016-19 - http://www.moray.gov.uk/moray_standard/page_100287.html

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018**

SUBJECT: **PRESCRIBING BUDGETS**

BY: **PAM GOWANS, CHIEF OFFICER**

1. REASON FOR REPORT

1.1 This report focuses on the challenges in relation to prescribing budgets and, in particular, the elements of that over which the limited control.

1.2 This report provides that information for the Moray Integration Joint Board (MIJB) in relation to actions being taken, or planned, to address the identified risks.

2. RECOMMENDATION

2.1 It is recommended that the MIJB:

i) notes the proposed 2018/19 budget for primary care prescribing at £18,058K plus £370K for medicines use in community hospitals and community services;

ii) agree to direct a robust approach in pursuing medicines efficiencies including:
- **a. maximising the use of generic medicines and removing patient choice for the branded product where not clinically indicated**
- **b. challenging the use of medicines of no, or limited, clinical benefit and stopping prescribing**

iii) acknowledge the level of financial risk associated with the underlying assumptions used to predict budget need and the influence of external factors to medicine use; and

iv) acknowledge the level of financial risk associated with the assumptions of achieving savings used in the budget assessment, particularly in relation to generic medicine costs and pregabalin pricing structures.

3. BACKGROUND

3.1 The prediction of future medicine use is extremely complex with multi-factorial drivers and a wide range of external influences over which there is limited control. Spend on this budget is generated by a large number of health interventions for patients which result in a prescription, often done under agreed clinical guidelines. Whilst the average cost of a prescription in NHS Grampian in 2016/17 was around £13.40, the volume of medicines used means the overall budget is significant.

3.2 Spend on prescription medicines is one of the largest single budget lines for Health and Social Care Moray. Predicted outturn for primary care prescribing for 2017/18 is £18m.

3.3 The issues of risk in relation to Primary Care Prescribing have been well understood for a number of years and as such work to mitigate and manage this is either already in place, or being planned within Health and Social Care Moray and NHS Grampian. The following sets out work already in place and actions being considered for 2018/19:

Activities already in place:

- A local enhanced service (LES) sets out enhancements to the GP contract in Moray that encourages practices to maximise use of generic medicines, review use of 'as required' medicines, and suggest switches to more cost efficient medicines. This LES was signed up to by all Moray practices except two. The LES is being further developed in 2018/19 with a more ambitious suite of activities to deliver increasingly cost efficient prescribing.
- Scriptswitch, a software package which suggests cost efficient changes to prescriptions at the point of prescription, continues to be used by all practices in Moray delivering savings of approximately £80K per annum.
- Health and Social Care Moray utilises government funding to contract 5 community pharmacies to deliver polypharmacy reviews in GP practices.
- Health and Social Care Moray employs a team of primary care pharmacy staff to support practices develop safe, effective and cost efficient prescribing processes. All managed sector practice based pharmacists are pharmacist independent prescribers and have their own clinic caseloads freeing up GP time.
- A number of Moray GP practices directly employ pharmacy staff, or purchase input from Health and Social Care Moray to support best practice and efficiency.
- A multidisciplinary Moray Prescribing Group, chaired by the Moray GP Prescribing Lead, meets bimonthly to support prescribing in Moray. A number of initiatives from this group or now being implemented across Grampian.

- A multidisciplinary NHS Grampian Primary Prescribing Group meets monthly to support prescribing in Grampian. Moray is represented on this group by the GP Prescribing Lead, Lead Pharmacist and Support Manager. This group has adopted a number of Moray initiatives for roll out across Grampian, and has developed some robust prescribing initiatives aimed at reducing prescribing spend.

Activities being considered:

- Investment in additional pharmacy staff across Moray to enable more targeted support to all practices. This initiative was delayed until there was confirmation government funding was recurring. Additional pharmacist time will be employed to ensure all practices have regular, sustainable pharmacist input. Technicians will be employed to work in all practices to deliver cost efficiency prescribing processes.
- A more robust approach to generic prescribing, targeting higher cost branded items for which a generic product is available.
- A more robust approach to review of prescriptions for medicines for which there is little or no clinical evidence, with the intention of stopping prescribing these items.
- The GP Prescribing LES is being further developed in 2018/19 with a more ambitious suite of activities to deliver increasingly cost efficient prescribing.
- Collaboration between the Moray Prescribing Group, the Moray GP Quality Lead, and practice Quality Leads to encourage high quality prescribing throughout Moray.
- Grampian wide publicity campaigns aimed at cost efficient prescribing and/or reducing 'waste' is being considered.
- Begin to identify the implications to Health and Social Care Moray of the 'pharmacotherapy service' outlined in the new GMS contract, and plan for its implementation in 2021.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Managing this budget is challenging as the 'control' sits with a large number of individual prescribers who have to meet the clinical needs of the local population in line with appropriate clinical and professional standards and guidelines. In addition, the widespread availability of information on social media results in significant pressure from patients to provide treatments not yet approved for use in Scotland, or with limited evidence to support them.

4.2 The prices paid for medicines used in Primary Care for branded medicines are set by manufacturers within a UK wide pricing arrangement. The cost of most generic (unbranded) medicines are set in Scotland by the NHS based on the best prices for which they can be purchased by community pharmacies.

4.3 Most of the management of the prescribing budget concentrates on promoting the most cost effective treatment options, identifying and responding to prescriber variation, reviewing patients' treatment regimens to ensure that prescribing is appropriate and cost effective, and minimising waste.

4.4 Key financial risks associated with the 2018/19 prescribing budget predictions are:

- Future prices for generic medicines remains difficult to predict. Recent cost rises have been related to changes to the EU rules governing the importation of active pharmaceutical ingredients and worsening drug shortages. It is predicted the impact within Grampian in 2017/18 will likely have an adverse cost of £2.3 - £3.0 million. This upward cost pressure may continue in 2018/19.
- It is difficult to predict the outcome of discussion between the Scottish Government and Community Pharmacy Scotland on the pricing of generic pregabalin. Note Scotland did not benefit to the same extent as England in 2017/18 from reduction in generic pregabalin prices. It may be prudent to take a cautious approach in predicting potential savings from falling generic pregabalin prices.
- Item volume could increase more than predicted.
- The introduction of new medicines/treatments has resource implications beyond medicine costs. While some medicines may replace existing treatments and be easier to manage, the overall effect of new medicine introduction invariably results in increased spend.
- Unmanaged movement of prescribing from secondary care to primary care without appropriate resource transfer.
- Reduced emphasis in the new GMS contract on medicines management activity focussed on cost effective use of medicines.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

As set out within Moray's Integration Scheme.

(b) Policy and Legal

The MIJB will issue new directions and identify resources for service delivery from 1 April 2018 (Para. 12.4.4 of the 2015 Integration Scheme). It will be the responsibility of the organisation receiving the direction to work with the Chief Officer and Chief Financial Officer to deliver services within the resources identified. The Moray Integration Scheme (para 12.8 of the 2015 Integration Scheme) makes provision for dealing with in year variations to budget and forecast overspend by reference to agreed corrective action and recovery plans. It also makes provision for dealing with year end actual overspend where such action and plans have been unsuccessful in balancing the relevant budget by reference to use of MIJB reserves and additional payments from Grampian Health Board/Moray Council.

(c) Financial implications

The financial implications are that there is a forecast overspend to the end of the 2017/18 financial year of £1.1m on primary care prescribing. Whilst the continuation, and introduction of new activities to manage the risks are being actively pursued to create efficiencies where possible, it has been prudent to assume a similar level of budget pressure as we look ahead to the 2018/19 financial year.

(d) Risk Implications and Mitigation

There is a risk of financial failure, that demand for medicines outstrips budget and the MIJB cannot deliver priorities, statutory work, and project an overspend. Risk will be mitigated by actions set out in this report to manage the budget, but the key financial risks are highlighted above.

(e) Staffing Implications

There are no workforce implications arising from this report.

(f) Property

There are no property issues arising from this report.

(g) Equalities

There are no equalities implications arising from this report.

(h) Consultations

Consultations have been undertaken with the following partnership members who are in agreement with the content of this report where it relates to their area of responsibility:

- Lead Pharmacist, Health and Social Care Moray
- Chief Financial Officer, MIJB
- Legal Services Manager (Licensing & Litigation), Moray Council
- Caroline Howie, Committee Services Officer, Moray Council

6. CONCLUSION

6.1 This report recommends the MIJB:

- **Notes the proposed 2018/19 budget for primary care prescribing at £18,058K plus £370K for medicines use in community hospitals and community services;**
- **Agree to direct a robust approach in pursuing medicines efficiencies including**
  - **maximising the use of generic medicines and removing patient choice for the branded product where not clinically indicated**
  - **challenging the use of medicines of no, or limited, clinical benefit and stopping prescribing**
- **Acknowledge the level of financial risk associated with the underlying assumptions used to predict budget need and the influence of external factors to medicine use; and**
- **Acknowledge the level of financial risk associated with the assumptions of achieving savings used in the budget assessment, particularly in relation to generic medicine costs and pregabalin pricing structures.**

Author of Report: Sandy Thomson, Lead Pharmacist, Health and Social Care Moray
Background Papers: With Author
Ref:

Signature: _ Date: 20 March 2018

Designation: Chief Officer Name: Pam Gowans

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018

SUBJECT: PROPOSED CHANGE TO MEETING DATES 2018/2019

BY: CHIEF OFFICER

1. REASON FOR REPORT

1.1 To propose a change to the schedule of meetings of the Clinical and Care Governance Committee for 2018/19.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board (MIJB) consider and approve a revision to the schedule of meetings for the Clinical and Care Governance Committee 2018/19.

3. BACKGROUND

3.1 A timetable of meetings for the MIJB was agreed at its meeting held on 31 August 2017 (para 9 of the Minute refers).

3.2 Current meetings scheduled for the Clinical and Care Governance Committee are considered to not be conducive to clinical availability and representation. The Clinical and Care Governance Committee, at its meeting on 2 February 2018 requested a revision to the proposed schedule of meetings for 2018/19 to ensure appropriate representation at each meeting (para 5 of the draft Minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The proposed change of scheduled dates is attached at **APPENDIX 1**.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019.

In terms of the Standing Orders approved by the Board at its meeting on 25 February 2016 (para 7 of the Minute refers), section 4.1, the date, time and frequency of meetings are to be set by the Board.

(b) Policy and Legal

None directly arising from this report.

(c) Financial implications

None directly arising from this report.

(d) Risk implications

None directly arising from this report.

(e) Staffing implications

None directly arising from this report.

(f) Property

None directly arising from this report.

(g) Equalities

None directly arising from this report.

(h) Consultations

Consultations have been undertaken with the following staff who are in agreement with the content of this report where it relates to their area of responsibility:

- Legal Services Manager (Licensing & Litigation), Moray Council
- Caroline Howie, Committee Services Officer, Moray Council
- Chief Financial Officer, MIJB

6. CONCLUSION

6.1 A revision to the schedule of meeting dates for the Clinical and Care Governance Committee would allow for enhanced clinical availability and appropriate representation at future meetings.

Author of Report:	Catherine Quinn, Executive Assistant
Background Papers:	Held with Author
Ref:	q:\ijb\mar 18

Signature: Date: 20 March 2018

Designation: Chief Officer Name: Pamela Gowans

INTEGRATION JOINT BOARD

MEETINGS TIMETABLE 2018/19

Remainder of Financial Year 2017/18

DATE	TIME	MEETING TYPE	Venue
25 January 2018	9:30am – 12 noon	Board Meeting	Inkwell Main, Elgin Youth Café
2 February 2018	9:30am – 12 noon	Clinical & Care Governance Committee	Spynie Dental Centre
22 February 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
29 March 2018	9:30am – 12 noon	Board Meeting	AGBC, Elgin
29 March 2018	1:00pm – 2:30pm	Audit & Risk Committee	AGBC, Elgin

Financial Year 2018/19

DATE	TIME	MEETING TYPE	Venue
26 April 2018	9:30am – 12 noon	Board Meeting	Inkwell Main, Elgin Youth Café
11 May 2018 31 May 2018	~~9:30am – 12 noon~~ 1.00 – 3.30pm	Clinical & Care Governance Committee	TBC
31 May 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
28 June 2018	9:30am – 12 noon	Board Meeting	TBC
28 June 2018	1:00pm – 2:30pm	Audit & Risk Committee	TBC
26 July 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
10 August 2018 30 August 2018	~~9:30am – 12 noon~~ 1.00 – 3.30pm	Clinical & Care Governance Committee	TBC
30 August 2018	9:30am – 12 noon	Board Meeting	TBC
27 September 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
27 September	1:00pm –	Audit & Risk	Inkwell Main, Elgin

DATE	TIME	MEETING TYPE	Venue
2018	2:30pm	Committee	Youth Café
9 November 2018 29 November 2018	~~9:30am – 12 noon~~ 1.00 – 3.30pm	Clinical & Care Governance Committee	TBC
29 November 2018	9:30am – 12 noon	Board Meeting	TBC
13 December 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
13 December 2018	1:00pm – 2:30pm	Audit & Risk Committee	Inkwell Main, Elgin Youth Café
31 January 2019	9:30am – 12 noon	Board Meeting	TBC
8 February 2019 28 February 2019	~~9:30am – 12 noon~~ 1.00 – 3.30pm	Clinical & Care Governance Committee	TBC
28 February 2019	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
28 March 2019	9:30am – 12 noon	Board Meeting	TBC
28 March 2019	1:00pm – 2:30pm	Audit & Risk Committee	TBC

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

FRIDAY 3 NOVEMBER 2017

ROOM 1, SPYNIE DENTAL CENTRE, ELGIN

PRESENT

VOTING MEMBERS

Professor Amanda Croft (Chair)	Executive Board Member, NHS Grampian
Councillor Shona Morrison (Vice Chair)	Moray Council

NON-VOTING MEMBERS

Ms Pam Gowans	Chief Officer, Moray Integration Joint Board
Dr Ann Hodges	Registered Medical Practitioner, Non Primary Medical Services
Mrs Val Thatcher	PPF Representative

IN ATTENDANCE

Mr Sean Coady	Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services, Health and Social Care Moray
Ms Jane Mackie	Head of Adult Health and Social Care, Health and Social Care Moray
Ms Debbie Barron	Clinical Quality Facilitator
Mr Angus Henderson	Dental Lead, Health and Social Care Moray
Mrs Caroline Howie	Committee Services Officer, as Clerk to the Committee

APOLOGIES

Mr Ivan Augustus	Carer Representative
Mrs Linda Harper	Lead Nurse, Moray Integration Joint Board
Mrs Susan Maclaren	Chief Social Work Officer, Moray Council
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services
Mrs Liz Tait	Professional Lead for Clinical Governance and Interim Head of Quality Governance and Risk Unit

1.	**ORDER OF BUSINESS**
	The Meeting agreed to vary the order of business as set down on the Agenda and take Item 9 "Public Dental Services" as the first item of business to allow Mr Henderson, who was presenting the report, to leave the meeting at the earliest opportunity.
2.	**PUBLIC DENTAL SERVICES**
	A report by the Dental Services Manager, Moray Public Dental Services, informed the Committee of a review of Clinical and Care Governance arrangements in Primary Care in respect of Public Dental Services. The relocation of Public Dental Services from Laich Dental Practice in Lossiemouth had been carried out successfully. Long term absences are impacting on the waiting list for Relative Analgesia (RA) sedation, known as gas and air by patients, this is being counteracted by providing sessions in RA sedation to enable other clinicians to carry this out and reduce waiting times. Mr Henderson advised he is due to leave the service at the end of the year and there was a risk to the service if recruitment to the post failed. Following discussion the Committee agreed to note the report. Mr Henderson left the meeting at this juncture.
3.	**DECLARATION OF MEMBER'S INTERESTS**
	There were no declarations of Member's interests in respect of any item on the agenda.
4.	**MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE DATED 4 AUGUST 2017**
	The minute of the meeting of the Moray Integration Joint Board Clinical and Care Governance Committee dated 4 August 2017 was submitted and approved.
5.	**ACTION LOG DATED 4 AUGUST 2017**
	The Action Log of the Moray Integration Joint Board Clinical and Care Governance Committee dated 4 August 2017 was discussed and the following points were noted: Under reference to item 3 of the log "Action Log Dated 5 May 2017"; the requested report on National Care Standards was not on the agenda. The Chief Officer advised the National Care Standards were now in place and an update would be provided at a future meeting. Under reference to item 3 of the log "Action Log Dated 5 May 2017"; the Committee agreed this item should be removed from the log as it was felt a report was not required as staffing issues are continually monitored. All other items were on schedule as per the Action Log.

6.	**CLINICAL AND CARE GOVERNANCE OPERATIONAL ARRANGEMENTS**
	A report by the Head of Adult Services and Social Care, and the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services provided an update to inform on actions that have taken place regarding operational clinical governance arrangements; specifically focusing on the level of reporting arrangements operationally in conjunction with other policies. During discussion it was noted there was no information on Mental Health within the report and Committee agreed this should be included; the Head of Adult Health and Social Care was tasked with ensuring this is reported to the next meeting. Following further discussion on the operational arrangements the Committee agreed to: i) note the basic structure of operational clinical governance arrangements will be retained; ii) note an Adverse Events Review Group will be established, as a subgroup of Senior Management Team meetings and convened by Heads of Service on a quarterly basis. The group will also incorporate the review of complaints, ombudsman reviews and the quality of reviews; iii) note the reporting arrangements will be improved to reflect more evidence based actions, using the NHS Grampian Clinical Governance Sector Reporting Framework template; iv) note the role of the Clinical Governance Support unit will continue to be essential as a central function in supporting clinical quality improvement and governance; v) note clinical quality indicators will be developed as part of the overall performance framework to enhance assurance; and vi) task the Head of Adult Health and Social Care with ensuring information on Mental Health is incorporated into the report for the next meeting.
7.	**CLINICAL AND CARE GOVERNANCE FRAMEWORK**
	A report by the Head of Adult Services and Social Care, and the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services presented Committee with an update of the Clinical and Care Governance Framework. The Chair raised concern that there was only 1 clinician in attendance and stated she would like information included in respect of the meeting Quorum. It was stated that agenda setting meetings would be held three weeks prior to Committee and information was to be added to the Framework in this respect. During further discussion clarification was sought on timescales for reporting to the Board. It was agreed that as minutes of the Clinical and Care Governance Committee are reported quarterly to the Board that an annual report to advise on Committee work should be presented to the Board with interim reports being issued as required for specific items.

	As no one was otherwise minded it was agreed to task the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services with updating the Framework in respect of the above. Thereafter the Committee agreed to: i) note the Clinical and Care Governance Framework attached as Appendix 1 of the report; ii) note the intention to review the Framework annually; and iii) task the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services with updating and issuing the Framework as discussed.
8.	**ADVERSE EVENTS AND COMPLAINTS REPORTING**
	Under reference to paragraph 8 of the minute of the meeting dated 4 August 2017 a report by the Head of Adult Services and Social Care, and the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services provided a quarterly complaints report. It was noted the number of adverse events in quarter 2 had fallen significantly since quarter 1, due to a reduction in adverse events within Learning Disabilities. Following discussion the Committee agreed to note the Quarter 2 (July – September 2017) Health and Social Care complaints and adverse events summary.
9.	**ESCALATION PROCESS**
	The Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services opened the discussion and sought clarification on how Committee envisaged the process of escalation of items functioning and how it can challenge itself. During discussion it was agreed there had been a gradual evolution of processes thus far, reports were clear and easier to read than when Committee first met and the current approach was felt to meet the needs of the Committee. It was further agreed that any items on the agenda that required to be brought to the attention of the Board would be agreed during discussion of the item. Following further discussion the Committee agreed items of significance would be reported to the Board as required.

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018

SUBJECT: ANNUAL PERFORMANCE REPORT 2017/18

BY: CHIEF OFFICER

1. REASON FOR REPORT

1.1 To inform the Moray Integration Joint Board (MIJB) of the progress being made in the development of the Annual Performance Report 2017/18.

2. RECOMMENDATION

2.1 It is recommended that the MIJB consider and:-

(i) note the approach taken to produce the 2016/17 Annual Performance Report;

(ii) provide comment and suggestion regarding preparation and content of the 2017/18 report; and

(iii) note a draft Annual Performance Report will be presented at the MIJB meeting on 26 April 2018.

3. BACKGROUND

3.1 Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 specifies that Integration Authorities must produce annual performance reports. Under the Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 (Scottish Statutory Instruments 2014, No. 326) and associated guidance, the performance report must cover a number of specific matters. These requirements are set out below and were included within the 2016/2017 report;

3.2 Demonstration of how Health and Social Care Moray (HSCM) has performed against the National Health and Wellbeing Outcomes, within the context of our Strategic Plan and Financial Statement. To support this, a set of Core Integration Indicators have been developed by the Scottish Government and the Board is expected to report upon performance using these and other locally specified indicators. The report is expected to include a comparison of performance in the last 5 years, or since establishment on 1 April 2016.

3.3 A summary of financial performance for the current reporting year, along with comparisons with the previous 5 years, or since assuming responsibility for delegated services on 1 April 2016. This should include the total spend by service and details of any underspend/overspends and the reasons for these.

3.4 An assessment of performance in relation to best value.

3.5 Description of the arrangements which have been put in place to involve and consult with localities and an assessment of how they have contributed to the provision of services.

3.6 Details of any inspections carried out by Healthcare Improvement Scotland and The Care Inspectorate relating to the functions delegated by Moray Council and Grampian Health Board.

3.7 The previous Annual Performance Report can be viewed at the following link: http://hscmoray.co.uk/uploads/1/0/8/1/108104703/annual_report_2016-17.pdf

3.8 The report did not cover all the work of HSCM, but focused on specific pieces of work which were able to demonstrate successful performance against a number of specific performance indicators. The performance indicators used were:

- HSCM Strategic Priorities
- National Outcomes for Integration
- National Core Indicators
- 6 National Outcomes for Integration

3.9 There was a large amount of performance data which was available to back up the report, however this was not all included within the public facing report and instead specific highlights were chosen which indicated particular areas of strong performance.

3.10 With 2016/2017 being the first year Integration Authorities were required to produce an Annual Performance Report, those published in July 2017 were the first of their kind. The Annual Performance Report Short Life Working Group (APR SLWG) has now had the opportunity to look at examples of what was produced by other Integration Authorities in order to consider whether there are any additional areas of focus that should be incorporated into the 2017/2018 report. The draft report will be reviewed by the Strategic Planning and Commissioning Group before a final draft being submitted to the MIJB for their comments and approval.

3.11 The 2017/2018 report is being prepared by the APR SLWG and it would welcome comments from the MIJB regarding the direction and content of the next report.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Health & Social Care Benchmarking Network has carried out a survey gathering experiences from Integration Authorities of preparing and publishing Annual Reports. They hope the findings from the survey will help to inform the preparation and content of future reports in order to facilitate improvements and identify ways in which the network could provide support. The survey has been considered by the APR SLWG and can be viewed at the following link: https://hscbn.files.wordpress.com/2018/01/apr-survey-report-final.pdf

4.2 Key findings from the survey, that have subsequently been considered by the APR SLWG are:-

- Timescale to produce the report – it was widely felt that 4 months after the end of the reporting period was too little time, when accounting for existing reporting requirements.
- Data availability was also a widespread issue, particularly due to the early deadline and a lack of reporting on locality level information.
- A lack of guidance and clarity on how to design and write the report was the other major issue; respondents felt that it was not made clear how the report could be made readable for the public whilst also useful for the IJB.
- Reporting landscape was viewed as a challenge – this was a challenge in terms of which data to use, the source of the data, did it conflict with other documents, for example, management accounts.
- Most respondents felt that their report found a balance between quantitative and qualitative data. The main form of qualitative data used was case studies to illustrate and exemplify the numerical data and 'tell the story' of the partnership. Others felt that they lacked the resources needed to gather such data.
- There was a wide variety of responses regarding Best Value. It seemed to be understood as a finance model.

4.3 The APR SLWG are working with Managers and their teams across Health and Social Care Moray (HSCM) to consider the assessment of performance for 2017/18 and the content of the Annual Performance Report. Key considerations by the group are:-

- There needs to be wider ownership and participation across HSCM in the production of the report.
- There needs to be an improved assessment in relation to Best Value, to evidence good governance, effective management of resources, and a focus on improvement, to deliver the best possible outcomes for the public.
- Case studies will be chosen carefully and evaluated to illustrate our learning points, not just the best of what we do.

3.11 The 2017/2018 report is being prepared by the APR SLWG and it would achievements and challenges.

- Report must be written for a wide target audience – the public, MIJB members, Elected Members etc.
- Data will be used to reflect the 'story' rather than simply reporting statistics.

4.4 The report is required to be published by 31 July 2018 and a draft Annual Performance Report will be presented to the MIJB meeting on 26 April 2018.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

As defined within the Moray Integration Scheme values and meeting the strategic aims contained within the MIJB Strategic Plan 2016-2019.

Annual performance reports will be of interest to Grampian Health Board and Moray Council in monitoring the success of the integrated arrangements that they have put in place and in considering whether or not there is a need to review the Integration Scheme.

(b) Policy and Legal

If during the reporting year there has been a review of the Integration Scheme then an annual report must also include a statement of the reasons for the review, whether a revised strategic plan was prepared and if so the changes to the strategic plan. This did not apply for the first performance report but would apply to the 2017/18 report.

Over and above the prescribed information, it is open to the Board to include any additional information within its annual report as it thinks fit.

(c) Financial implications

None directly associated with this report. .

(d) Risk Implications and Mitigation

None directly associated with this report.

(e) Staffing Implications

None directly associated with this report.

(f) Property

None directly associated with this report.

(g) Equalities

An Equality Impact Assessment is not required for the Annual Performance Report because its purpose is to underpin the strategic direction for the service and there will be no differential impact, as a result of the report, on people with protected characteristics.

(h) Consultations

Consultation on this report has taken place with the following staff who are in agreement with the content in relation to their area of responsibility:-

- Legal Services Manager (Litigation & Licensing)
- Caroline Howie, Committee Services Officer
- Chief Financial Officer, MIJB

6. CONCLUSION

6.1 This report recommends the MIJB consider, discuss and provide comment regarding the development of the Annual Performance Report 2017/18.

Author of Report: Catherine Quinn, Executive Assistant
Background Papers: With author
Ref: ijb\board meetings\Mar18

Signature: _____ Date: 20 March 2018

Designation: Chief Officer Name: Pam Gowans

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018

SUBJECT: ELIGIBILITY CRITERIA FOR UNPAID ADULT CARERS (THE CARERS (SCOTLAND) ACT 2016)

BY: JANE MACKIE, HEAD OF ADULT SERVICES

1. REASON FOR REPORT

1.1 To inform the Board of the results of the Moray Council public consultation on the draft eligibility criteria for support to unpaid adult carers.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board (MIJB) considers and notes the:

i) feedback from the public consultation

ii) eligibility criteria for support to unpaid adult carers, APPENDIX 1

3. BACKGROUND

3.1 The Carers (Scotland) Act 2016 will be implemented on 1 April 2018. It widens the definition of an unpaid carer to "any individual who provides or intends to provide care for another individual". The Act introduces new rights for unpaid carers and new duties for the local authority to provide support to carers.

3.2 In August 2017 the Scottish Government issued guidance on the local authority's duty to set local eligibility criteria for support to unpaid carers which must be consulted upon, agreed and published by 31 March 2018. This is a new arrangement for unpaid carers in Moray as criteria for adult carer support services is not presently applied. The general support currently delivered through Quarriers Carer Support Service (as part of the commissioned carer support contract) will continue to be universally available in addition to support for eligible carers.

3.3 On 22 November 2017 the Council approved a plan for public consultation on draft eligibility criteria for adult carer support (paragraph 12 of the Minute refers). The responsibility for delivering adult carer support in terms of the 2016 Act currently lies with the Moray Council. Following the current review of the Health and Social Care Integration Scheme, eligibility criteria will be the future responsibility of the Moray Integration Joint Board.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Public consultation took place for six weeks from 4 December 2017 to 19 January 2018. 500 hard copies of the consultation were made available, as well as electronic access online on the Moray Council website. Carers and members of the public were able to respond in writing, by telephone or on line survey, with support available if required for completion.

4.2 A range of methods for engagement and consultation with carers, their organisations, wider stakeholders and the general public was put in place. This included printed consultation packs issued to Quarriers carer centre, all libraries, Council Access Points, Moray Resource Centre, all community care teams. It was also issued to partner organisations, including Alzheimer Scotland, Crossroads, Cornerstone and Enable Scotland. Information and links were also sent to a range of local patient/service user groups. The Moray Integration Joint Board was included as consultees. Media releases and social media information were also included, as well as information in two partner organisation's newsletters.

4.3 Three face to face public information sessions were arranged in December – two public drop-in sessions and an information and discussion session at the Quarrier's Carers Café in Elgin. Partner carer organisations (Quarriers, Alzheimer Scotland, Crossroads, Cornerstone and Enable Scotland) were also offered face to face sessions for their carer groups.

4.4 A total of 10 responses were received. 7 of the 10 respondents indicated they were carers.

4.5 The majority of responses (7 out of 9) stated the right quality of life indicators had been identified.

4.6 8 out of 10 respondents stated the impact/risk factors which would be applied to determine eligibility were clear.

4.7 100% of responses (10) agreed with setting the proposed eligibility threshold to target carers with substantial or critical impact. Three comments highlighted the need for flexibility to allow for changing or increasing carer needs. This will be addressed in the information pack outlining the local eligibility criteria.

4.8 Respondents were asked whether the provision of a small budget gave eligible carers choice and control to meet their support needs. 9 out of 10 responses stated either "yes" or "somewhat".

4.9 There were 9 general comments or questions which will, where relevant, be addressed in the information pack.

4.10 In light of the public feedback, there were no changes made to the draft eligibility criteria. **APPENDIX 1** sets out the local eligibility criteria for support to unpaid adult carers approved by the Moray Council on 28 February 2018 (paragraph 4 of the draft Minute refers). Carers who meet the eligibility threshold for enhanced support will be offered a personal Self-directed Support (SDS) budget of £300 per annum. (This amount has been locally set and will be subject to review).

4.11 The approved eligibility criteria will be operational from 1 April 2018 for any adult carer receiving a new assessment/Adult Carer Support Plan.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future and Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016-2019

The importance of carers is acknowledged within Moray 2026: A Plan for the Future and Moray Corporate Plan 2015 – 2017: 'We will support communities and individual carers with the capacity to provide unpaid care.'

(b) Policy and Legal

The Carers (Scotland) Act 2016 legislates that all local authorities must consult on and publish eligibility criteria by the deadline outlined within this report. The Scottish Government has made it mandatory that local authorities delegate the function and responsibility for eligibility criteria to Integration Joint Boards. Following a review of the Health and Social Care Integration Scheme for Moray, and its approval by the Scottish Government, eligibility criteria will be the future responsibility of the Moray Integration Joint Board.

This work matches national health and wellbeing outcome 6 - "People who provide unpaid care are supported to look after their own health and wellbeing including reducing any negative impact of their caring role". It also contributes to the commitment in the Moray Integration Joint Board Strategic Plan to "provide support to carers so they can continue to care".

(c) Financial implications

The Moray Council report on 22 November 2017 (paragraph 12 of the Minute refers) outlined the financial implications of the Act to Moray Council and the Integration Joint Board, in terms of the provision of carer Self-directed Support and in terms of projected loss of income to the Moray Council in respect of accommodated and non-accommodated replacement care charges.

(d) Risk Implications

None arising directly from this report.

(e) Staffing Implications
None arising directly from this report.

(f) Property
None arising directly from this report.

(g) Equalities
An Equality Impact Assessment is not needed because the report concerns implementation of legislation. The Scottish Government carried out a full EPIA in relation to the Act.

(h) Consultations
The Head of Adult Services; the Chief Officer Health and Social Care Moray; the Chief Financial Officer Moray Integration Joint Board; the Commissioning and Performance Manager; the Public Involvement Officer; the Legal Services Manager (Litigation & Licensing) and the Executive Assistant were consulted regarding the content of this report and any comments considered.

6. CONCLUSION

6.1 The Board should note the new Eligibility Criteria for support to unpaid adult carers.

Author of Report: Pauline Knox, Senior Commissioning Officer
Background Papers:
Ref:

Signature: _____ Date: 20 March 2018

Designation: Chief Officer Name: Pam Gowans

Appendix 1

Eligibility Criteria for Support to Unpaid Adult Carers

	Can receive support through universal services and the local carer support service (Local authority has no duty to support)				Duty to provide support via Self Directed Support (in addition to support via local carer service and universal services)	
	CARING HAS NO IMPACT	**CARING HAS LOW IMPACT**	**CARING HAS MODERATE IMPACT**		**CARING HAS SUBSTANTIAL IMPACT**	**CARING HAS CRITICAL IMPACT**
Health & Wellbeing	Carer in good health Carer has good emotional wellbeing.	Carer's health beginning to be affected Caring role beginning to have an impact on emotional wellbeing	Carer's health at risk without intervention Some impact on carer's emotional wellbeing	**THRESHOLD**	Carer has health need that requires attention Significant impact on carer's emotional wellbeing	Carer's health is breaking/has broken down Carer's emotional wellbeing is breaking/has broken down
Relationships	Carer has a good relationship with the person they care for and is able to maintain relationships with other key people in their life.	Carer has some concerns about their relationship with the person they care for and/or their ability to maintain relationships with other key people in their life.	The carer has identified issues with their relationship with the person they care for that need to be addressed and/or they find it difficult to maintain relationships with other key people in their life		The carer's relationship with the person they care for is in danger of breaking down and/or they no longer are able to maintain relationships with other key people in their life	The carer's relationship with the person they care for has broken down and their caring role is no longer sustainable and/or they have lost touch with other key people in their life

Living Environment	Carer's living environment is suitable posing no risk to the physical health and safety of the carer and/or cared for person.	Carer's living environment is mostly suitable but could pose a risk to the health and safety of the carer and/or cared for person in the longer term.	Carer's living environment is unsuitable but poses no immediate risk to the health and safety of the carer and/or cared for person.		Carer's living environment is unsuitable and poses an immediate risk to the health and safety of the carer and/or cared for person.	Carer's living environment is unsuitable and there are immediate and critical risks to the health and safety of the carer and/or cared for person.
Employment & Training	Carer has no difficulty in managing caring and employment and/or education. Carer does not want to be in paid work or education	Carer has some difficulty managing caring and employment and there is a risk to sustaining employment and/or education in the long term. Carer is not in paid work or education but would like to be in the long term	Carer has difficulty managing caring and employment and there is a risk to sustaining employment and/or education in the medium term. Carer is not in paid work or education but would like to be in the medium term	**THRESHOLD**	Carer has significant difficulty managing caring and employment and there is a risk to sustaining employment and/or education in the short term. Carer is not in paid work or education but would like to be soon.	Carer has significant difficulty managing caring and employment and/or education and there is an imminent risk of giving up work or education. Carer is not in paid work or education but would like to be now.
Finance	Caring is not causing financial hardship e.g. carer can afford housing cost and utilities	Caring is causing a risk of financial hardship e.g. some difficulty meeting housing costs and utilities	Caring is causing some detrimental impact on finances e.g. difficulty meeting either housing costs OR utilities		Caring is having a significant impact on finances e.g. difficulty meeting housing costs AND utilities	Caring is causing severe financial hardship e.g. carer cannot afford household essentials and utilities, not meeting housing payments

Life Balance	Carer has regular opportunities to achieve the balance they want in their life. They have a broad choice of breaks and activities which promote physical, mental, emotional wellbeing	Carer has some opportunities to achieve the balance they want in their life. They have access to a choice of breaks and activities which promote physical, mental, emotional wellbeing	Due to their caring role, the carer has limited opportunities to achieve the balance they want in their life. They have access to a few breaks and activities which promote physical, mental, emotional wellbeing		Due to their caring role, the carer has few and irregular opportunities to achieve the balance they want in their life. They have little access to breaks and activities which promote physical, mental, emotional wellbeing	Due to their caring role, the carer has no opportunities to achieve the balance they want in their life. They have no access to breaks and activities which promote physical, mental, emotional wellbeing

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018

SUBJECT: DUTY OF CANDOUR CONSULTATION

BY: CHIEF OFFICER

1. REASON FOR REPORT

1.1 To advise the Moray Integration Joint Board (MIJB) on new Duty of Candour provisions being implemented from 1 April 2018.

2. RECOMMENDATION

2.1 **It is recommended that the MIJB consider and note the new Duty of Candour (DoC) arrangements being implemented from 1 April 2018.**

3. BACKGROUND

3.1 The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 received Royal Assent on 1 April 2016 and introduced a new organisational duty of candour on those providing health, care and social work services. The implementation date for the duty of candour to come into effect is 1 April 2018.

3.2 The overall purpose of the new duty is to ensure that listed responsible bodies, which include Moray Council and Grampian Health Board, are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act. This duty requires organisations to follow a DoC procedure which will include notifying the person affected, apologising and offering a meeting to give an account of what happened. The procedure will also require the organisation to review each incident and offer support to those affected (people who deliver and receive care). The details of this procedure will be set out in Regulations which will be published prior to 1st April 2018 along with guidance.

3.3 The following incident outcomes will trigger the DoC procedure:

- Death
- Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (severe harm)

Harm which is not severe but which results in:

- An increase in the person's treatment
- Changes to the structure of the person's body
- The shortening of life expectancy
- Impairment to the sensory, motor, physiologic or intellectual functions which has or is likely to last for a continuous period of at least 28 days
- The person experiencing pain or psychological harm which has or is likely to last for a continuous period of at least 28 days
- The person requiring treatment by a registered health professional in order to prevent death.

3.4 The DoC procedure involves taking actions to meet up with, and apologise to the patient / or those acting on their behalf, and provide support for them. The Act makes it clear that apologising in relation to the DoC cannot be taken by itself as an admission of negligence or a breach of statutory duty, but this will not prevent individuals affected from taking further action in relation to the incident. There will be a significant requirement to keep detailed records of the apology, each meeting and any actions taken at the meeting or as a result of the meeting.

3.5 To support organisations to meet these new requirements the Scottish Government, Healthcare Improvement Scotland (HIS), the Care Inspectorate (CI), Scottish Social Services Council (SSSC) and NHS Education for Scotland (NES) are working in partnership with a wide range of stakeholders to design and develop education and training resources and monitoring requirements to support organisations in meeting the new statutory duty of candour.

3.6 Moray Council and Grampian Health Board, as listed organisations covered by the The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 will be required to prepare and publish annual reports, which must contain the following information:-

- Details about the incidents that have occurred, and to which the DoC applied
- Information on the organisations compliance with the DoC procedure
- Information about policies and procedures for identifying and reporting incidents and support available to staff and persons affected by incidents
- Information relating to whether there have been changes to these policies resulting from incidents that have occurred.

4.0 KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 As CI and HIS already have existing systems for regulated health and social care services, the intention is to align existing processes and systems as far as possible to minimise paperwork whilst still ensuring that the organisational duty is being applied through a culture of openness and learning. Specific guidance including how organisations are to operate the DoC has not yet been published but is likely to include more details about:-

- The notification to be given by the responsible person;
- The apology to be provided by the responsible person to the relevant person;
- The actions to be taken by the responsible person to offer and arrange a meeting with the relevant person, including asking the relevant person whether the relevant person wishes to receive an account of the incident or information about further steps taken;
- The actions which must be taken at, and following, such a meeting;
- An account of the incident, information about further steps taken and any other information to be provided by the responsible person;
- The form and manner in which information must be provided;
- The circumstances in which the responsible person is to make available, or provide information about, support of persons affected by the incident;
- The keeping of information by the responsible person; and
- Steps to be taken by the responsible person.

4.2 A dedicated webpage available at the following link (http://www.gov.scot/Topics/Health/Policy/Duty-of-Candour) has been produced by the Scottish Government. This includes more information on regulations and guidance, examples of DoC and Frequently Asked Questions.

4.3 Health Care Inspectorate and SSSC are also lead agencies and they are communicating to Local Authorities and NHS Boards. A large multi-agency workshop was held on 21 February 2018 in Aberdeen. A subsequent workshop will be held in Moray on 28 March 2018.

5.0 SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

As defined within the Moray Integration Scheme values and meeting the strategic aims contained within the MIJB Strategic Plan 2016-2019.

(b) Policy and Legal

Being open and honest with people about harm caused as a result of healthcare is a key part of existing policy and processes. Indeed it is already a professional duty of all healthcare professionals. However the responsible body will be responsible for providing training and support to those carrying out the DoC procedure. Whilst the IJB is not itself a listed body, given its operational oversight role for integrated health and social care services it needs to assure itself as to the arrangements put in place within both Moray Council and NHS Grampian for Health and Social Care Moray staff.

(c) Financial implications

None directly associated with this report. .

(d) Risk Implications and Mitigation

None directly associated with this report.

(e) Staffing Implications

None directly associated with this report.

(f) Property

None directly associated with this report.

(g) Equalities

An Equality Impact Assessment (EIA) is not needed because the report concerns implementation of legislation.

(h) Consultations

Consultation on this report has taken place with the following staff who are in agreement with the content in relation to their area of responsibility:-

- Legal Services Manager (Litigation & Licensing), Moray Council
- Caroline Howie, Committee Services Officer, Moray Council
- Chief Financial Officer, MIJB

6.0 CONCLUSION

6.1 The details of this procedure will be set out in Regulations which will be published prior to 1 April 2018. Staff briefings and the cascading of information to staff will continue to take place over the next few months.

Author of Report: Catherine Quinn, Executive Assistant
Background Papers: With author
Ref: ijb\board\mar18

Signature: _____ Date: 20 March 2018

Designation: Chief Officer Name: Pam Gowans

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018

SUBJECT: THE MORAY 2015/18 ALCOHOL AND DRUGS PARTNERSHIP DELIVERY PLAN REVIEW

BY: PAUL JOHNSON – MADP LEAD OFFICER

1. REASON FOR REPORT

1.1 To inform the Moray Integrated Joint Board of the achievements and challenges identified in the review of the Moray 2015/2018 Alcohol and Drugs Partnership Delivery Plan.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board:

i) note the achievements and challenges identified in the Moray 2015/18 Delivery Plan Review; and

ii) is kept informed of the progress in delivering the Moray 2018/21 Alcohol and Drugs Partnership Delivery Plan.

3. BACKGROUND

3.1 The Moray Alcohol and Drug Partnership (MADP) provides the framework locally for its members to come together and co-ordinate work to reduce the impact of problematic alcohol and drug use on individuals, families and communities. One of the aims is 'to develop, implement and review on an ongoing basis, a comprehensive and evidence based MADP Delivery Plan, for tackling alcohol and drug problems at a local level.'

3.2 Alcohol and Drug Partnerships are required by the Scottish Government to produce three year Delivery Plans showing how the partnership will contribute to meeting both national and local priorities.

3.3 The feedback from the Scottish Government on the Moray 2015/18 Delivery plan was positive; stating that The Moray ADP Delivery Plan illustrates that "the ADP is in good place to build on work and further improve local drug and alcohol services" In addition, the Scottish Government have made references to the "good practice" in Moray, following submissions of the annual reports and examples of practice, to the Scottish Government.

3.4 The Delivery Plan Review, (**APPENDIX 1**) provides a Red, Amber Green ('R.A.G.') analysis applied to indicate status in terms of general progress in addressing the areas of work. This will support the production of the new 2018/21 Delivery Plan, identifying areas for continuation, enhancement, improvement, new areas of work, and areas which may no longer be required.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 In summary, the key achievements are:

a) The service redesign was completed with a new contract awarded to Quarriers. They continue to meet all of their objectives and contract requirements. A decision was taken by the MADP (13/11/2017) to invoke the two year extension of their contract.

b) Contracts are subject to performance management processes, in conjunction with commissioning colleagues.

c) Carers and family members are supported both through Arrows and the Quarriers Carer's services.

d) Moray has easy access to treatment; meeting the national target (100% compliance) of nobody having to wait longer than three weeks for treatment. In addition, Moray has a local target of 72 hours, with a 100% compliance rate.

e) Moray is able to offer a wide range of treatment ranging from clinical intervention (including Opioid Replacement Therapy) through to focussed SMART Recovery groups, 1 – 1, needle exchange, support to families, and peer support; linking in with a range of other services across Moray as part of promoting recovery.

f) The MADP has positive links with Police Scotland and other partners which encompass Community Safer; Criminal Justice and Community Justice.

g) Naloxone (which reverses the effects of opiate overdose, allowing time for medical assistance to arrive) is now more widely available. Individuals, peers, staff, and family members have been trained (and continue to be so) in its use. The Scottish Ambulance Service provides advice about treatment services to every non-fatal overdose.

h) The MADP links into MARACs to support victims of domestic abuse.

i) The MADP links in the Moray Licensing Forum to support the Moray Licensing Broad in carrying out their duties.

j) Moray services have developed a good relationship with HMP Inverness and Grampian, to ensure that those being released can be linked into support services directly upon release.

k) Workforce Development is now firmly embedded in Moray, with courses being provided and a Frontline Forum running quarterly.

4.2 Challenges

a) Taking forward the revised performance framework, utilising the new Scottish Government Drug and Alcohol Information System (DAISy) which incorporates the Recovery Outcomes tool. DAISy is due to be implemented this year (2018). Moray is well prepared for the implementation, and has started to use the Recovery Outcomes tool which will provide information on how well a person is recovering across ten domains, which are:
   - Substance use (both alcohol and drugs)
   - Self-care and Nutrition
   - Relationships
   - Physical health and Wellbeing
   - Mental health and Wellbeing
   - Occupying Time and Fulfilling Goals
   - Housing and Independent Living
   - Offending
   - Money Matters
   - Children

b) Hospital admissions continue to be an area requiring consideration. Work is being developed with Health Improvement Grampian to examine areas of intervention within hospital settings, in conjunction with the lead Public Health Consultant; considering areas such as alcohol related cancers, and liver disorders and opportunities to reduce harms associated with alcohol use.

c) Work linked to services for young people and how this ties in with the GIRFEC system and Prevention is being planned with Children's Services; tying in with the Children's Services Plan 2017/2020.

d) Further work is being planned and taken forward to deliver Alcohol Brief Interventions and MEOC (Making Every Opportunity Count) interventions in a range of settings, in conjunction with Health Improvement colleagues.

4.3 The Moray Alcohol and Drugs Partnership will produce a 2018/21 Delivery Plan, taking account of both the revised Scottish Government Alcohol and Drug Strategies, (which will be available in the summer of 2018) and Moray priorities.

4.4 The 2018/21 Delivery Plan will cross populate with the Moray LOIP and the MIJB Strategic Plan, alongside Moray strategic plans, such as, but not limited to, the Moray Children's Services Plan, Community Justice Strategy, Safer Community Strategy.

4.5 The Moray LOIP has defined four priority areas, of which priority 4 is "Changing our relationship with alcohol." The LOIP outcome being that "People are healthier and experience fewer harms as a result of alcohol use"; with the milstone being that "there is a reduction in alcohol related harm and there is an iprovement in community wellbeing".

4.6 The LOIP recognises that the Moray Integrated Joint Board through the Moray Alcohol and Drug Partnership will be the stragtegic lead partner for delivering the priority area and this will be incorporated into the revised Delivery Plan.

4.7 The Delivery Plan will be subject to performance reporting, linking in with the reporting frameworks for other Strategic plans such as, (but not limited to) the LOIP.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

The 2018/21 Delivery Plan will cross populate and support the strategic objectives within the Moray LOIP and the MIJB Strategic Plan.

In producing the MADP Delivery Plan, the MADP will make strategic recommendations, as appropriate, to the MIJB arising out of proposals within the new Delivery Plan.

(b) Policy and Legal

Alcohol and Drug partnerships are required to produce and submit a three year Delivery Plan to Scottish Government.

The new three year strategy, 2018/21 will reflect the priority areas outlined in both the revised drug and alcohol strategies, and Moray strategies. Guidance from the Scottish Government is pending which will outline the specific requirements. This guidance is still pending as it is tied up with the production of the revised Drug and Alcohol strategies.

The draft Delivery Plan will be subject to consualtion and consideration by the MADP, Health and Social staff and the third sector, including linking in with the Service User groups and the Health and Wellbeing Forum.

The Delivery Plan will be presented to the MIJB, via the Moray Alcohol and Drugs Partnership for final ratification.

(c) Financial implications

There are no financial implications directly arising from this report.

(d) Risk Implications and Mitigation

The commitment from all agencies within the Moray Alcohol and Drug Partnership must be acknowledged in delivering the range of services involved in supporting people with needs relating to alcohol or drugs use.

The new Delivery Plan will take account of the changing needs of the population in Moray, with an increased focus on reducing alcohol and drug related harms. There will be a clear performance management framework linked to the new strategy which will enable and risks to delivering the plan, to be properly managed.

(e) Staffing Implications

Workforce Development is a key improvement area set out in the Moray Delivery Plan and this will be a key area in the revised 2018/21 Delivery Plan.

There are no other staffing implications.

(f) Property

No implications.

(g) Equalities

The Delivery Pan works incorporates the Quality Principles which directly promotes equality of access to services and the involvement of those using services in decisions about their treatment and care, and their involvement in the design of services. Targets to improve these areas will be set out in the new 2018/21 Delivery Plan.

(h) Consultations

The MADP links in with the Service User groups and drop in sessions in order to seek views and gain feedback on the quality of services and areas for develoment. In addition, the MADP links in with TSi in engaging with a wide range of Community Groups; with the MADP attending events, both consulting with, and supporting such groups.

6. CONCLUSION

6.1 The Delivery Plan Review has provided an opportunity for the MADP to reflect on practice and to use the process to plan for 2018/21, ensuring that there is effective and efficient use of resources, and services meet the needs of the Moray population and communities.

Author of Report: Paul Johnson, MADP Team
Background Papers: Delivery Plan Review: Summary of Achievements and Challenges 2015 – 2018. Moray Delivery Plan Summary - Achievements and Challenges

Ref:

Signature: _____ Date: _21 March 2018_

Designation: _Head of Adult Services___ Name: _Jane Mackie

MORAY ADP DELIVERY PLAN:

SUMMARY OF ACHIEVEMENTS & CHALLENGES

2015 -2018

APPENDIX 1
ITEM 14

Document: Version 1.
Produced: 28/07/17.
Reviewed & Revised: 23/03/2018
Paul Johnson: MADP Lead Officer

BACKGROUND

All Alcohol and Drug Partnerships had to produce a three year Delivery Plan for the period 2015 – 2018.

This document summarises:

- Achievements
- Challenges – where work is still required

DELIVERY PLAN ACTIONS:

MORAY 2023: THE FIVE PRIORITY AREAS				
A growing, diverse, and sustainable economy. It covers business, employment, infrastructure, public services, and the third sector developing sustainable communities.	Healthier Citizens. To reduce incidence of obesity, reduce the number of smokers, reduce alcohol dependency, and improve mental health and wellbeing.	Ambitious and confident young people. To improve the life chances of children by supporting them and their families at the earliest possible stages and as required thereafter giving all children in Moray the best possible opportunities to achieve their potential.	Adults living healthier, sustainable independent lives safeguarded from harm a. Reshaping the support available for older people to ensure their needs are met to sustain active lives in the community; and, b. Reduce the number of households in fuel poverty.	Safer communities. We need to do more to protect those most vulnerable and at risk and be proactive to ensure that communities feel safer in the years ahead.

ACHIEVEMENTS.

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
We live longer, healthier lives	**HEALTH** People are healthier and experience fewer risks as a result of alcohol and drug use	There will be an improvement to the Physical and Mental wellbeing of those accessing Drug and Alcohol Services.	Continue to promote the safe use of Naloxone through training, advertisement at MADP Service locations and during one to one interventions. It will ensure that there is an accurate recording of naloxone related data on NEO module system. *Actions relating to this are*: • Service users encouraged to use Naxalone to reduce overdose and drug related deaths; as part of one interventions	Naloxone is widely promoted and is now available through both the Third and statutory sectors. The Scottish Ambulance Service is now able to distribute UNDO-OD cards for patients administered Naloxone for a non-fatal overdose. Staff across a range of services, individuals, peers, and family members have been trained in the administration of Naloxone. This is continuing. The availability of kits must be seen as being a high priority as part of reducing drug related harms and deaths. **RAG Status.** This section is **green**
			Continue to work with the Scottish Prison Service to facilitate the smooth transfer of clients from Prison Treatment Services to Community based Treatment Services. This will respond to the needs of the individual and take account of the associated through care arrangements. *Actions relating to this are:*	Operational systems are in place with both HMP Inverness and Grampian to engage with prisoners prior to and following release. Moray services provide "clinics" in the prisons to promote engagement and early (same day) engagement on release.

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			• The Moray alcohol and drugs recovery services will continue to link in with Criminal Justice services to ensure that all offenders returning to Moray are linked to services to ensure early engagement and therefore reduce the likelihood of relapse or overdose. • The MADP will link in with Criminal Justice policy and planning systems to ensure that district services continue to meet the needs of offenders and their families.	**RAG Status.** This section is **green**.
			Engage with national bodies that provide NPS specific training. It will take into account the recommendations of the NPS Expert Review Group and associated documents. *Actions relating to this are*: • NPS will be built into the Moray Workforce Development Programme The MADP will engage in the Grampian wide and national NPS discussions; sharing intelligence and good practice; and utilise this information to help develop education, prevention and support services.	Data shows that NPS use is at a very low level in Moray, although this is kept under review. The MADP has included NPS within workforce development sessions across a variety of staff groups e.g. UHI students, Residential Social Work Staff, Youth Work staff, and Housing. In addition, the MADP has produced NPS guidance (supported by NHS Grampian) and raised it as a specific topic in the Front Line Forum. Additional training in has been delivered by both SDF and Crewe (a national organisation) which included NPS. This is reported through the Workforce Development sub-group. **RAG Status.** This section is **green**.
			Link with local Service User Groups and Networks in a bid to continue to evaluate and respond to NPS use in Moray. *Actions relating to this are:* In addition to the above; ensure that NPS is part of the work stream for the Service user Engagement Officer; linking in with services as part of Service user engagement and service development.	See above. **RAG Status.** This section is **green**.
			Promote the early intervention and prevention agenda with regards to problematic drug and alcohol use through the Workforce Development Group. The workforce Development group will	STRADA ceased trading and some of their staff was transferred over to SDF. This caused considerable and delay in progressing

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			work with STRADA to develop the Moray a Workforce Strategy that will enable staff to provide advice on the safe use of alcohol and harm reduction messages with regards to problematic drug use. *Actions relating to this are:* The workforce development programme will be started in 2015. The development process will take twelve months with implementation and review and revisions being taken forward over the three years	the work. The Training Needs Analysis was undertaken by SDF and was presented to the MADP in May 2017. This was taken forward with training being provided by SDF, Crewe and internally. A report of the training provided by SDF, Crew and internally was presented to the MADP Workforce Development sub-group on the 7th February 2017. Discussions are currently underway with SDF and other providers to plan for 2018/19, utilising both free and commissioned training. **RAG Status.** This is **green.**
			Through the Grampian level NPS meeting, continue to explore the prevalence and use of NPS in the Moray area; allowing the MADP to gauge any changes in the prevalence of NPS use in the area and put in place the necessary measures to deal with this emerging trend. *Actions relating to this are:* • NPS will be built into the Moray Workforce Development Programme. • The MADP will engage in the Grampian wide and national NPS discussions; sharing intelligence and good practice; and utilise this information to help develop education, prevention and support services	Data shows that NPS use is at a very low level on Moray. The MADP has included NPS within workforce development sessions across a variety of staff groups e.g. UHI students, Residential Social Work Staff, Youth Work staff, and Housing. In addition, the MADP has produced NPS guidance (supported by NHS Grampian) and raised it as a specific topic in the Front Line Forum. Additional training has been provided by both SDF and Crewe which included NPS. **RAG Status.** This section is **green**.
We have tackled the significant inequalities in Scottish Society	**RECOVERY** Individuals are improving their health, well-being and life chances by recovering from problematic drug and alcohol use	There will be an increase in the percentage of those accessing Moray Drug and Alcohol Services who report making progress at 3 month, 6 months, and 12 months. (Outcomes Star)	Facilitate the development of a Peer Led Recovery Community in the Moray area, enabling individuals to recover from problematic drug and alcohol use in a way that builds their recovery, social and cultural capital. *Actions relating to this are:* • Implementing the service re-designs following the increased investment and	The recovery process has become embedded into the Moray service model, with the re-design and tendering for the direct access service. The model provide an integrated approach between the Third sector provider (Quarriers) who run the Direct Access service and MIDAS (Moray Integrated Drug and Alcohol Service); this being "the Moray Service".

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			tender process, resulting in a comprehensive Recovery orientated System of Care across Moray. • Peer led recovery is central to the service re-design and will be evaluated; taking account of the Quality Principles which is built into the quarterly performance management process.	Quarriers (Arrows) have continued to develop a Recovery focus, expanding opportunities for those in services. Both the Moray services areas have developed improved and positive links with the wider network of agencies; e.g., employment support, housing, mental health. Arrows have developed Peer led groups and these continue to be developed across Moray. Following consultation with service users on future models of service delivery; community outreach bases for Arrows were established in existing community buildings throughout Moray (Buckie, Forres and Keith) Feedback from service users highlighted the need for a more visible community facing presence, in the form of a building, in Moray to raise the profile of recovery and support. Such a community asset will create a safe and supported space from which people with lived experience could be empowered to establish links with the wider community. For confidentiality and ease of access, the current Arrows building is visible yet discreet in its presence in the community. Due to the nature of crisis support, harm reduction, and confidential engagement of the service, it has been identified that the current building is suitable to support triage and the initial intensive and structured support into treatment and recovery. A second base will better meet the needs of service users more established in their recovery and support a self-management recovery model. The Moray ADP has allocated additional non-recurrent funding for refurbishing the new building. This followed the formal commissioning processes. **RAG Status.** This section is **green**.
			Ensure that timely and accurate data is added to the Scottish Drug Misuse Database and the Drug and Alcohol Waiting Times Database, through	Moray is fully compliant with all of the data return and reporting requirements (SMR25s A and B) as evidenced by the waiting times returns from the

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			the Management and Performance Subgroup. *Actions relating to this are:* • Ensure that all services are aware of their responsibility to add accurate data on to ADMD and D&AWTD and encourage them to contact the SDMD and D&AWT Lead for Moray if inaccurate data is added in a timely manner. • Encourage all Services to complete the D&AWTD compliance sheet on a quarterly basis and return no later than the 12th of the following month at the end of a quarter. • SDMD and D&AWTD Lead for Moray will run monthly reports from the system to check service compliance. • SDMD and D&AWTD Lead for Moray will present quarterly reports outlining risks or challenges to the MADP Management and Performance Sub.	Scottish Government and contained with the MADP Quarterly reports. The actions (e.g. linking in with service providers – team meetings, contract reviews) to promote compliance are such that Moray is meeting the HEAT waiting time target (time between first appointment and treatment) and achieving 100% compliance, with all services completing the data returns, which is evidenced in the data returns data set from the Scottish Governments and NHS Grampian Quarterly report cards, which reports on compliance linked to data returns. **RAG Status.** This section is **green**
			Take cognisance of and put into place the recommendations as set out in the Delivering Recovery-Opioid Replacement Therapies (ORT) in Scotland-Independent Expert Review document. *Actions relating to this are:* • Moray provides Recovery Opioid Replacement Therapy in line with the National clinical Guidelines. • The Moray ORT programme is overseen by the Grampian Accountable Officer; who is the prescribing lead for Moray.	ORT is widely available across Moray with ORT forming part of comprehensive packages of support. Those requiring ORT are support by Specialist Addiction Consultant, GP's, CPN/Social work (Moray Integrated Drug and Alcohol Service), Arrows, and Peer support. **RAG status**: This section is **green**.
			Link in with and support the Mutual Aid Groups and packages that provide valuable support to those in Moray with problematic Drug and Alcohol use, through the use of the Front Line Forum. *Actions relating to this are:* • Implementing the service re-designs following the increased investment and tender process, resulting in a	The recovery process has become embedded into the Moray service model, with the re-design and tendering for the direct access service. The model provide an integrated approach between the Third sector provider Arrows (Quarriers) who run the Direct Access service and MIDAS (Moray Integrated Drug and Alcohol Service); this being "the Moray Service". Quarriers (Arrows) have continued to develop a Recovery focus, expanding opportunities for those

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			comprehensive Recovery orientated System of Care across Moray. • Peer led recovery is central to the service re-design and will be evaluated; taking account of the Quality Principles which is built into the quarterly performance management process. • Front line Forum dates will be set for each year.	in services. Both the Moray services areas have developed improved and positive links with the wider network of agencies; e.g. employment support, housing, mental health and community groups. Peer lead recovery groups are embedded into the service delivery model both within Arrows and in community settings. Front Line Forums are in place, covering a variety of topics, with differing agencies leading the discussions, and with dates set for the year. **RAG status**: This section is **green**.
We have improved life chances for children, young people and families at risk **Our children have the best start in life and are ready to succeed**	**FAMILIES** Children and family members of people misusing alcohol and drugs are safe, well supported and have improved life chances	There will be an increase in the number of family members of those with a substance misuse issue who are offered an intervention by 10% (Quarriers Data) There will be an increase in the number of Service Users and family members who are involved in the design, development and delivery of Service Users Care Plan (Care Plan Data)	Continue to work with local carer's support services and groups, as well as national bodies set up to assist family members who are affected by another's problematic drug or alcohol use, recognising that they require support and assistance in their own right. *Actions relating to this are:* • Support for Carers and family is built into the Service Re-design with contracts being performance managed. • Carers and family members will receive a service in their own right as part of the range of services in Moray.	Support for Carers and family members is built into the Service Re-design with contracts being performance managed. Carers and family members receive a service in their own right as part of the range of services in Moray. Quarriers have the carer's contract in Moray and people who are living with and supporting those with needs due to alcohol or drug use are explicitly supported. In addition, Quarriers provide support to young people who have parents involved in alcohol or drug use. **RAG status**: This section is **green**.
			Facilitate improved links with family members and carers to ensure that the Moray wide Alcohol and Drug service integrates the interventions of health, Social Work, and the Voluntary Sector Providers, efficiently for family members and carer's. *Actions relating to this are*: As above.	As above **RAG status**: This section is **green**.

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
We have strong resilient and supportive communities where people take responsibility for their own actions and how they affect others	**COMMUNITIY SAFETY** Communities and individuals live their lives safe from alcohol and drug related offending and anti-social behaviour	There will be a reduction in Alcohol and Drug related offending. Including Antisocial Behaviour, Serious, and Violent Crimes, Drug Dealing and Driving while under the influence of Alcohol. (Police Scotland Stats)	In conjunction with Police Scotland, work to reduce the number of offences that are committed under the influence of Alcohol or drugs, through early intervention work to educate people about safe levels of alcohol use. *Actions relating to this are:* • The MADP will provide advice, support, and expertise towards initiatives to remove reliance on alcohol and will commission services to assist those on a road to recovery thereby reducing propensity to offend. • The MADP will provide funding and support towards Op Avon and Safer Street activity	The service re-design was completed, bringing about an integrated service model in Moray; with the services continuing to build up positive links with the network of services in Moray. This has been enhanced by an increased focus on promoting early engagement and trying to reduce alcohol and drug related harms. A positive example of this is the work with HM Prisons; as part of pre-release planning. Operational systems are in place with both HMP Inverness and Grampian to engage with prisoners prior to and following release. Moray services provide “clinics” in the prisons to promote engagement and early (same day) engagement on release. Funding was provided to Op-Avon and Safer Streets; and these were evaluated. As a result of the evaluations, the OP-Avon approach has been reviewed; this is partly due to the decreasing levels of demand for the Op Avon style of activity and the needs to review the way young people are being supported. **RAG status**: This section is **green**.
			Support Police Scotland in the reduction of Illegal Substances available in the Moray area. *Actions relating to this are:* • The MADP will provide advice, support, and expertise towards initiatives to remove reliance on drugs/NPS and will commission services to assist those on a road to recovery thereby reducing propensity to offend.	The service re-design was completed, bringing about an integrated service model in Moray; with the services continuing to build up positive links with the network of services in Moray. This has been enhanced by an increased focus on promoting early engagement and trying to reduce alcohol and drug related harms. A positive example of this is the work with HM Prisons; as part of pre-release planning. Operational systems are in place with both HMP Inverness and Grampian to engage with prisoners prior to and following release. Moray services provide “clinics” in the prisons to promote engagement and early (same day) engagement on release.

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
				RAG status: This section is **green**.
			Continue to support and engage with the Domestic Abuse Partnership, the Community Safety Strategic Group, and the Public Protection Partnership in Moray to assist with the reduction of substance misuse related offending in the Moray area. *Actions relating to this are:* • The MADP will be represented on the Domestic Abuse Partnership and the Public Protection Partnership. • The MADP Lead will attend MARAC; contributing to support plans for victims of abuse. • Contribute my providing, advice, support, expertise, and resources to support reduction in offending initiatives. The service re-design will support offenders who need advice, guidance, and support for their alcohol/drug misuse as part of programmes to reduce the likelihood of re-offending.	The MADP has been a member of the Domestic Abuse Partnership. The MADP is represented on the Public Protection Partnership. The MADP Lead attends MARACs as part of the process to protect victims; contributing to the risk assessments and support plans as appropriate. The service re-design was completed, bringing about an integrated service model in Moray; with the services continuing to build up positive links with the network of services in Moray. This has been enhanced by an increased focus on promoting early engagement and trying to reduce alcohol and drug related harms. A positive example of this is the work with HM Prisons; as part of pre-release planning **RAG status**: This section is **green**.
			Engage with the Scottish Prison Service in HMP Porterfield (Inverness), HMP Grampian (Peterhead) and Criminal Justice to ensure that any prisoners with problematic alcohol and drug use are supported through their transition back into the community, in a bid to reduce alcohol and drug related reoffending in the Moray area. *Actions relating to this are:* • The Moray alcohol and drugs recovery services will continue to link in with Criminal Justice services to ensure that all offenders returning to Moray are linked to services to ensure early engagement and therefore reduce the likelihood of relapse or overdose. • The MADP will link in with Criminal Justice policy and planning systems to ensure that district services continue to meet the needs of offenders and their families.	The service re-design was completed, bringing about an integrated service model in Moray; with the services continuing to build up positive links with the network of services in Moray. This has been enhanced by an increased focus on promoting early engagement and trying to reduce alcohol and drug related harms. A positive example of this is the work with HM Prisons; as part of pre-release planning. The MADP link in with the Community Safety Partnership, the Public Protection partnership and the Community Justice Partnership as part of joint planning and integrated working; evidenced through minutes of meetings and attendance records. **RAG status**: This section is **green**.

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others	**LOCAL ENVIRONMENT** People live in positive, healthy-promoting local environments where alcohol and drugs are less readily available	Moray Streets are safe and free from Drug and Alcohol related harm (Needle Stick data, Needle Exchange Data) Support and inform the Local Licencing Board in formulating their Licensing Policy Statement Service Users will have increased, recovery and social capital (Service User feedback)	Continue to contribute to the Local Licensing Board with regards to over provision in the Moray area. The MADP will assist in writing the Statement of Policy for the Licensing (Scotland) Act 2005, which will be renewed in 2016 and every three years thereafter. *Actions relating to this are:* • The MADP will continue to work with the Local Licensing Board to support the reduction of risks and encouraging responsible behaviour; this includes promoting the Best Bar None programme.	The MADP are part of the Licensing Forum; contributing to the development of policy, by presenting papers on alcohol related harms, training, and policy advice; linking into systems to support members of the Licensing Board. The best Bar None Scheme is established with one of the bars going through to the national finals. **RAG status**: This section is **green**.
			Continue to work with Police Scotland, and Trading Standards to combat illegal Drug Possession and Supply and the unsafe use of NPS in the Moray area. *Actions relating to this are:* • The MADP will support the sharing of intelligence relating to demand, prevalence, and product type as part of education, prevention, and support. • Contribute to Safer Communities Hub tasking meeting – multi-agency response to tackling anti-social and illegal activity in Moray	The Police are members of the MADP; with the MADP also being part of the Safer Communities planning systems where information is shared and acted upon; in accordance with protocols and standards. The MADP is a member of the tasking Hub meetings. **RAG status**: This section is **green**.
			Continue to actively advertise and promote the use of the Needle Exchanges that are available throughout Moray, it will also respond to the needs of the Moray area with regards to Needle Exchanges over the time span of this strategy. *Actions relating to this are:* • Needle exchange service will continue to be provided from both the Drug/Alcohol single Point of Contact Treatment provider and Pharmacists. • The Needle Exchange service provider within the single point of contact will be	The needle exchange scheme is established in Moray within community pharmacists. In addition; Arrows (the Single Point of Contact) provides a needle exchange service as part of their comprehensive range of services. Dried Blood Spot testing is established across the Moray services. **RAG status**: This section is **green**.

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			conduit into the wider ROSC services for those wishing to have additional support as part of their recovery journey. • The Moray Dried Blood Spot Testing programme will be provided within the Single Point of Contact and the MIDAS.	
			Support Police Scotland in the reduction of Illegal Substances available in the Moray area by sharing intelligence data which can be used to plan services and local initiatives.	The Police are members of the MADP; with the MADP also being part of the Safer Communities planning systems where information is shared and acted upon; in accordance with protocols and standards. The MADP is a member of the tasking Hub meetings. **RAG status**: This section is **green**.
			Facilitate the opportunity for service users to move through services at a pace that is correct for them whilst keeping their motivation at a high level. *Actions relating to this are:* • Implementing the service re-designs following the increased investment and tender process, resulting in a comprehensive Recovery orientated System of Care across Moray. • Peer led recovery is central to the service re-design and will be evaluated; taking account of the Quality Principles which is built into the quarterly performance management process.	See sections above relating the implementation of the service re-design. In addition, the work undertaken by the Recovery Re-design Lead has significantly improved the joint working across services and case management. A report dated 12th May 2017 showing how the post met its objectives, was presented to, and endorsed by the MADP. **RAG status**: This section is **green**.
			Encourage the building of a recovery community in the area which is visible to all member of society in a bid to remove the stigma that often accompanies those who have problematic drug or alcohol use. *Actions relating to this are:* • Implementing the service re-designs following the increased investment and tender process, resulting in a	See above. **RAG status**: This section is **green**.

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			comprehensive Recovery orientated System of Care across Moray. • Peer led recovery is central to the service re-design and will be evaluated; taking account of the Quality Principles which is built into the quarterly performance management process.	
			Encourage peer led recovery, which will give service users the opportunity build the necessary skills to become a fully integrated member of society. *Actions relating to this are:* • Implementing the service re-designs following the increased investment and tender process, resulting in a comprehensive Recovery orientated System of Care across Moray. • Peer led recovery is central to the service re-design and will be evaluated; taking account of the Quality Principles which is built into the quarterly performance management process.	See above. **RAG status**: This section is **green**.
Our public services are high quality, continually improving, efficient and responsive to local peoples need	**SERVICES** Alcohol and drugs prevention, treatment and support services are high quality, continually improving, efficient, evidence based and responsive; ensuring people move through treatment into sustained recovery,	No Service User will wait more than 3 weeks between Referral and First Treatment HEAT H11	Work with the Workforce Development group and STRADA to ensure that all of the MADP service workers are highly skilled and able to work in a person centred way that responds to the needs of each individual. *Actions relating to this are:* • The workforce development programme will be started in 2015. The development process will take twelve months with implementation and review and revisions being taken forward over the three years. • Ensure that there is an effective integrated pathway for service users which offers a person led flexible range of services that are accessible to all throughout the Moray area. • Implementing the service re-designs following the increased investment and tender process, resulting in a comprehensive Recovery orientated System	The progress on Workforce Development was delayed due to the closure of STRADA and the transfer of work over to SDF. The MADP undertook a comprehensive literature review and a Training Needs Analysis within Children's services. This was that added to by a Moray wide Training Needs analysis supported by the Scottish Drugs Forum; leading to a more considered and detailed Workforce Development Plan. The needs analysis was completed in 2017 and this was taken forward during 2017/18 with a comprehensive range of courses provided internally and by external providers. The Front Line Forum ran every quarter with sessions run by a variety of providers and with attendances between 25 – 50 for each session.

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			of Care across Moray. • Peer led recovery is central to the service re-design and will be evaluated; taking account of the Quality Principles which is built into the quarterly performance management process.	There has been good progress in 2017/18, with a comprehensive range of courses courses being provided and an increased focus on supporting staff. As stated above, the re-design has been completed and Peer led recovery is central to the model. **RAG status**: This workforce development section is **green.** The service re-design actions are **green**. The overall grade is **green.**

SOME ACHIEVEMENT BUT NEEDING FURTHER WORK

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
We live longer, healthier lives	**HEALTH** People are healthier and experience fewer risks as a result of alcohol and drug use	There will be an improvement to the Physical and Mental wellbeing of those accessing Drug and Alcohol Services. (Outcomes Star data) There will be an increased number of ABI's delivered in Moray	Identify the level of physical and mental wellbeing of those accessing Drug and Alcohol Services, and improve it through the use of the Outcomes Star. *Actions relating to this are:* • Implementation of the care management approach as part of the Recovery Orientated system of Care and the use of the outcomes star. • Encourage signposting to other agencies as part of the person recovery plan which will incorporate evidence based interventions.	The recovery process has become embedded into the Moray service model, with the re-design and tendering for the direct access service. The model provide an integrated approach between the Third sector provider (Quarriers) who run the Direct Access service and MIDAS (Moray Integrated Drug and Alcohol Service); this being "the Moray Service". Quariers (Arrows) have continued to develop a Recovery focus, expanding opportunities for those in services. Both the Moray service areas have developed improved and positive links with the wider network of agencies; e.g., employment support, housing, mental health and community groups. The use of the Outcome Star has improved for direct case work as part of the person's support plan and review. However, using the cumulative data by services as part of workforce or services development has needed an increased focus. This is now a priority area for improvement; linking it in to the move over to using the Recovery Outcomes (RO) tool and DAISy (Drug and Alcohol Information

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
				Systems). RO is being implemented in July 2017 and DAISy from October 2018. A comprehensive review of what and how data is collected is being undertaken as part of revising and refreshing the Delivery plan for 2018/21 and implementing DIASy. **RAG Status.** Implementing the Care management approaches: **green,** although the RO component is: **amber**, given that this is still in the early stages of being used. The position is positive. However, given the ongoing work being undertaken with implementing DAISy the overall RAG status is **amber**.
			Aim to reduce the number of people accessing hospital with an alcohol or drug related diagnosis, and the number of those who suffer an alcohol or drug related death. *Actions relating to this are:* • Implementing the service re-design following the increased investment and tender process; resulting in a comprehensive Recovery orientated System of Care across Moray	The service re-design was completed, bringing about an integrated service model in Moray; with the services continuing to build up positive links with the network of services in Moray. This has been enhanced by an increased focus on promoting early engagement and trying to reduce alcohol and drug related harms. A positive example of this is the work with HM Prisons; as part of pre-release planning. The number of hospital admissions has remained constant as has the number of deaths. The deaths relate in part to an ageing cohort, with protracted long term usage and reflects the national data sets, as well as deaths linked to alcohol use. Work has been started to obtain a clearer picture of the un-scheduled care pathways for those entering hospital and/or dying. This will contribute to trying to promote engagement especially for those not currently using the specific alcohol/drug services but where their use is part of their complex needs. **RAG Status.** Implementing the service re-design: **green,** although the Alcohol/Drug related deaths

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
				component is: **amber** This reflects the needs for a continued focus on promoting engagement and reducing harms.
			Promote recovery from problematic drug and alcohol use, as well as harm reduction messages using a whole population approach. This will further be complemented with early intervention and education on problematic drug and alcohol use, working with Schools in the area, by educating young people about safe alcohol use, illegal drug use and the use of New Psychoactive Substances. *Actions relating to this are:* • Implementing the service re-design following the increased investment and tender process; resulting in a comprehensive Recovery orientated System of Care across Moray • Put forward and the tender for improving education, prevention and support for young people and drug/alcohol misuse • Implement the contract following the young people's tender; which will include recommendations for a sustainable newly redesigned services for young people	The decision to put forward a young people's tender was changed. The MADP undertook a comprehensive literature review and a Training Needs Analysis within Children's services. This was that added to by a Moray wide Training Needs analysis supported by the Scottish Drugs Forum; leading to a more considered and detailed Workforce Development Plan. To date there has not been sufficient data to support a separate "specialist" alcohol and drugs service for young people. There is work required to capture the work being undertaken on how young people are supported within the GIRFEC model. This is recognised by both Children's services and the MADP Children and Young People's Sub-Group; where actions have been identified taking account of and working to the recommendations in the Moray Children's Services Plan 2017 – 2020. **RAG Status.** This area is **amber**, as it requires further work.
We live longer, healthier lives	**PREVALANC**E Fewer adults and children are drinking or using drugs data level or patterns that are damaging to themselves or others	Accurate, easy to understand heath promoting information regarding Alcohol and Drugs will be shared, and easily disseminated to the wider Moray Community.	Assist in formulating and promoting easy to understand, accurate heath promoting information with regards to problematic drug and alcohol use which will be shared with the wider Moray Community. *Actions relating to this are:* • Link in with Education, Health Promotion, and Service users to develop and promote health promotion information. • Link the health promotion material and messages to the workforce development programme. • Education and prevention will be part of the young people's service which will be subject	As above Health Improvement has continued to support healthy choices, drug/alcohol reduction, and healthy lifestyles which include sexual health. This section is **green**. As stated above; this is an area requiring further work. **RAG Status.** This area is **amber**, as it requires further work.

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			to quarterly performance management to assess the effectiveness of approached.	
			Emphasise a continued reduction in the percentages of young people with problematic drug or alcohol use by working with Integrated Children's Services to facilitate an increase in young people's life chances through links with the Early Years and Young People Sub group. *Actions relating to this are:* • Put forward and the tender for improving education, prevention and support for young people and drug/alcohol misuse • Implement the contract following the young people's tender; which will include recommendations for a sustainable newly redesigned services for young people • The MADP Young People's sub-group will work across both drug/alcohol and Children 's services; contributing to joint planning, service design and evaluations of effectiveness; making recommendations for revisions and promoting good practice. • Children's Services will be included within the MADP workforce development programme.	See details above relating to the tender and services. This area is **amber**, as it requires further work as referred to above in relation to GIRFEC. Children's services are included in the Workforce Development programme which is supported by the Scottish Drugs Forum and recently by Crewe. They are included in the development programme but the action before this was to work across the services for joint planning, service design, and evaluations of effectiveness. As the young people's tender did not go ahead, the action has not been completed. New targets have been set out in the Children's Services Plan 2017-2020. A Young People's best practice literature review was undertaken which formed part of the workforce development work. This was complimented by Training Needs Assessment and plan produced by the Scottish Drugs Forum; which included the delivery of training. This is reported through the Workforce Development sub-group. **RAG Status.** This area is **amber** as a plan is being developed to capture the needs of young people. Positive progress has been made on workforce development and courses have been delivered with further ones planned. The status is **amber**
			Facilitate the use of ABI's in non-mandatory settings to help identify people who are consuming alcohol at unsafe levels, and offer them the necessary advice and help to reduce their levels of alcohol consumption.	Moray has had lower than expected number of ABI's delivered in mandatory settings. However, the interest in delivering these in the non-mandatory settings has increased with Housing and other settings taking this up. Training

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			Actions relating to this are: • Planning, development and implementation of a local ABI delivery plan (including non-mandatory settings) • Continued planning, delivery, and evaluation of ABI training and professional development opportunities for multi-agency personnel.is continued planning in place? • Utilisation of the Outreach MIB and Healthpoint Services so to provide approved health information, advice, and support to service users/communities on safe alcohol consumption have you used outreach services? Your comments focus on other services such as housing?	has been provided to Housing staff and systems have been set up to deliver ABI's and record the numbers being delivered. This is being enhanced by a new round of training being delivered to increase the capacity in the non-mandatory settings. The development work is still at an early stage and data needs to be calculated to see if the training increase the number of ABI's being delivered. **RAG Status.** RAG status is **amber** as further work is required to assess the effectiveness of the training and to plan for additional training.
			Continue to monitor a person's recovery journey through the Outcome Star and the National Recovery Outcomes which are attached to the Drug and Alcohol Information System (DAISy).[1] *Actions relating to this are:* • Outcome Star is used by all services within the Moray Drug/alcohol recovery services. • Outcome Star is integral to the care management process and incorporated into The Moray Recovery Orientated System of Care and embedded into service contract which are subject to quarterly performance management reports. • Outcome Star reviews are completed at 3, 6, 9 and 12 month intervals with the reviews being used to support a person's individual recovery, operational and strategic planning. The use and reporting the Outcome Star data is built into performance management and contract compliance.	The use of the Outcome Star has improved for direct case work as part of the person's support plan and review. However, using the cumulative data by services as part of workforce or services development has needed an increased focus. This is now a priority area for improvement; linking it in to the move over to using the Recovery Outcomes tool and DAISy. The RO is being implemented in July 2017 and DAISy from October 2018. A comprehensive review of what and how and how data is collected is being undertaken as part of implementing DIASy. **RAG Status.** Implementing the Care management approach: **green**, although the DAISy component is: **amber.** The overall position is **amber** given the work that is required on the DAISy
			Through the Children and Young People subgroup, continue to link with the SHANARRI outcomes and the outcomes from the Early Year	The Children and Family Social Work and Support Workers have been funded by the MADP.

[1] http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Drug-Alcohol-Information-System/

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
			Collaborative to ensure that young people who are affected by another's problematic drug or alcohol use have the best start in life. *Actions relating to this are:* • The MADP will continue to fund a Pregnancy and Early Years Social Worker and two Family Support Workers for a further three years. • The three posts will directly link in with and contribute to the Moray Early years Collaborative; work-streams 1, 2, and 3. The posts will provide quarterly performance management reports and be accountable to both Children's Services and the MADP.	The funding for the Support Workers ended in December 2017 and the Social Worker funding ends in June 2018. Children Services will undertake a review and identify how the learning from the posts can be embedded into mainstream practice. **RAG status**: This section is **amber** as the funding was provided and the services were set up. However as the review is still to be undertaken the section remains at **amber**.
			Review how adult drug and alcohol treatment services and children services work together to promote both the recovery from problematic drug and alcohol use and the welfare of children; this will take the Children Act (Scotland) into account. This review will assist in the further integration and coordination of drug and alcohol services for both adults and young people in Moray, bringing about best value for money. *Actions relating to this are:* • The MADP Children and Young People's sub-group will continue to be the policy and strategic link between the MADP and Children's services; contributing to the performance management of services (see above), workforce force development, policy and practice development. • The re-design for young people's services and services for families where there is drug/alcohol use and children will be overseen by the sub-group. • The MADP will support and provide match funding for the Quarriers Lloyds TSB service which supports families where there is drug/alcohol misuse; promoting recovery for the whole family.	The MADP Children and Young People's sub-group have continued to be the policy and strategic link between the MADP and Children's services; contributing to the performance management of services (see above), workforce force development, policy and practice development. Children's services are included in the Workforce Development. The decision to put forward a young people's tender was changed to carrying out a literature review exercise in order to inform good practice. The MADP undertook a comprehensive literature review and a Training Needs Analysis, as stated above. The MADP has provided match funding for Lloyds TSB. **RAG status:** The workforce development area is **green**. The work required in for young people's services is

NATIONAL OUTCOME	MADP OUTCOME	3 YEAR OUTCOMES	MADP ACTIONS The MADP will:	RAG STATUS
				still outstanding. Therefore, the RAG status is **amber**. The Lloyds TSB match funding status is **green**. Due to the amber areas, the overall RAG status is **amber**.
			Consult and link in with the Community Engagement Team and Community Safety Unit within the Moray Council to promote public reassurance on issues surrounding problematic Drug and Alcohol use. *Actions relating to this are* • In conjunction with Police Scotland, work to reduce the number of offences that are committed under the influence of Alcohol or drugs, through early intervention work to educate people about safe levels of alcohol use. Examples include supporting Operation Avon and Safer Streets campaigns and supporting education and prevention initiatives. • Link in with Local Management Groups and support staff local initiatives developed in conjunction with the LMG	Funding was provided to Op-Avon and Safer Streets; these were evaluated with reports published providing evidence of the outcomes, showing a reduction in offences and the number of young people supported. As a result of the evaluations, the OP-Avon and Safer Streets approach has been reviewed; with no further funding being allocated, this is partly due to the decreasing levels of demand for the Op Avon style of activity. Work has been undertaken through the Locality Management Teams, Early Engagement Teams, Health Improvement, and Tsi Moray to bring about community engagement; examples include setting up a participatory budget process with small grants being provided to community projects, community consultation and developments sessions taking place and improved links with LMG's through the Children and Young People's sub-group as part of gathering community intelligence and views about alcohol and drug use. **RAG status**: Although there has been productive area of work; given that this is highlighted as an action in the improvement planning process and further work is required in this area, this section is **amber**.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018**

SUBJECT: **QUARTER 3 (OCTOBER – DECEMBER 2017) PERFORMANCE REPORT**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To present the Moray Integration Joint Board (MIJB) with a performance update at Quarter 3, 2017/18, including:-

- National core suite indicators and comparison to 32 national IJB's performance **(APPENDIX 1)**;
- Local indicators linked to strategic priorities for Quarter 3 (Oct-Dec 18) **(APPENDIX 2);** and
- Highlight report on data presented in the National and Local indicators. **(APPENDIX 3)**.

1.2 To update the MIJB on the request from the Ministerial Strategic Group for IJB's to develop objectives to measure progress against 6 key indicators in 2018 **(APPENDIX 4)**.

2. RECOMMENDATION

2.1 It is recommended that the MIJB consider and:-

i) comment on performance and draft report template of national core suite indicators and comparisons to 32 national IJB's performance (APPENDIX 1);

ii) comment on performance and draft report template of local indicators linked to strategic priorities for Q3 (October – December 2017) (APPENDIX 2);

iii) comment on performance and draft report template of Highlight Report (APPENDIX 3); and

iv) note the report submitted to the Ministerial Strategic Group against 6 key indicators in 2018 (APPENDIX 4).

3. BACKGROUND

3.1 The purpose of this report is to ensure the MIJB fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in the Strategic Plan.

3.2 **APPENDIX 1** provides the published Core Suite of National Integration Indicators which details Moray performance against national indicators. Although the Core Suite is published quarterly, the majority of indicators are annual. This has just recently been updated to December 2017. Also included within this appendix is the current Moray performance in comparison across the 32 IJBs in Scotland.

3.3 **APPENDIX 2** details all the local indicators currently reported by NHS Grampian and Moray Council which relate to delegated functions. Local indicators are summarised to allow wider scrutiny by the MIJB across all publicly accountable indicators.

3.4 **APPENDIX 3** considers key highlights for further focus on currently reported items to the MIJB.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Indicators are assessed on their performance via a common performance monitoring Red, Amber, Green traffic light rating system (RAG).

RAG scoring based on the following criteria:	
GREEN	If Moray quarter has improved or stayed the same from previous, then GREEN
AMBER	If Moray quarter has worsened by 5% or less on previous quarter, then AMBER
RED	If Moray quarter has worsened by more than 5% of previous Moray quarter then RED

National core suite of indicators (APPENDIX 1)

4.2 The RAG status for National Indicators 1-10 are based on the variance in position when reported, rather than quarterly. These are outcome indicators based on survey feedback and are updated bi-annually.

4.3 Data for National Indicators 11 to 23 are derived from organisational/system data and are updated quarterly.

4.4 Data for indicators 10, 21, 22 and 23 are not yet available. The National Review of Targets and Indicators for health and social care in Scotland has recently been published and makes a number of recommendations regarding the development of targets and indicators at a national and local level. These recommendations will be considered as we review the indicators.

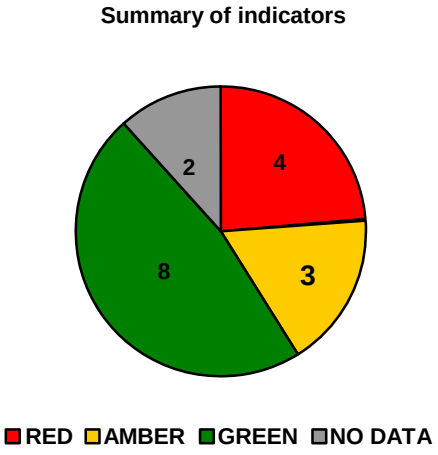
4.5 For the current reporting period, Moray performed better than the Scotland average for 13 of the 19 national indicators, with 6 performing worse than the Scotland average. Work will continue to further scope comparison data with 'peer' IJB areas.

Local indicators (APPENDIX 2)

4.6 As a consequence of a review of the Strategic Plan and performance management framework being undertaken in 2018, a review of local performance indicators will take place over the next few months. It is therefore anticipated that **APPENDIX 2** will be developed further and this will be presented to a future MIJB meeting later in 2018 for consideration and approval.

4.7 A Performance Management Group has been established to ensure the continued development around lead responsibility for each indicator/group of indicators, to refine targets and collate context around indicators. Work is also ongoing to add in additional local indicators particularly around social care.

4.8 Moray currently has 17 local indicators with 4 indicators showing their status as red and 3 amber. There are 8 indicators which are green and there are 2 that have no available data at this time but will be available for the next quarter. Refer to **APPENDIX 2** for the indicators and **APPENDIX 3** for analysis on the red indicators.



Highlight Report (APPENDIX 3)

4.9 This report highlights areas of health and social care delivery that are identified for improvement or for good performance.

4.10 Indicators which are currently a RED status (not meeting local targets and outwith tolerances) in **APPENDICES 1 and 2** are analysed by the Adult Services Performance Management Group who then identify which require attention and associated action.

Ministerial Strategic Group

4.11 A report was presented to the MIJB at its meeting on 23 February 2017, (Para 17 of the Minute refers), highlighting the request from the Ministerial Strategic Group (MSG) for IJB's to measure objectives demonstrating progress against 6 key indicators (unplanned admissions, occupied bed days for unscheduled care, A&E performance, delayed discharges, end of life care and the balance of spend across institutional and community services).

4.12 A workbook containing national data for the 6 core MSG indicators has been produced by the Health and Social Care Team at NHS Scotland Information Services Division (ISD) and a national data working group has been established (with Moray representation) to consider the format for reporting and agree the measures which will demonstrate progress against the 6 indicators. The Moray submission has been completed and has been included in **APPENDIX 4** for noting.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

Annual performance management reporting is a legislative requirement under section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014.

In addition to publishing an Annual Performance Report, the Moray Integration Scheme requires that the Moray IJB will "monitor the performance of the delivery of integrated services using the Strategic Plan on an ongoing basis" (para 5.2.2 of the Moray Integration Scheme refers).

(b) Policy and Legal

None directly associated with this report.

(c) Financial implications

None directly associated with this report..

(d) Risk Implications and Mitigation

MIJB Strategic Risk Register Risk 1: To monitor service performance against an agreed set of performance measures and to ensure appropriate information is presented to IJB to allow it to deliver this function.

(e) Staffing Implications

None directly associated with this report.

(f) Property

None directly associated with this report.

(g) Equalities

An Equality Impact Assessment is not required for the Performance Framework because its purpose is to underpin the strategic direction for the service and there will be no differential impact, as a result of the report, on people with protected characteristics.

(h) Consultations

Consultation on this report has taken place with the following staff who are in agreement with the content in relation to their area of responsibility:-

- Legal Services Manager (Litigation & Licensing)
- Caroline Howie, Committee Services Officer
- Chief Financial Officer, MIJB
- Service Managers

6. CONCLUSION

6.1 This report asks the MIJB to:-

(i) comment on performance and draft report template of national core suite indicators, local indicators and performance summarised in the highlight report; and

(ii) note the report to be submitted to the Ministerial Strategic Group against 6 key indicators in 2018.

Author of Report: Bruce Woodward, Senior Performance Officer
Background Papers: With author
Ref: ijb\board meetings\Mar18

Signature: _____ Date: 20 March 2018

Designation: Chief Officer Name: Pam Gowans

Appendix 1. Moray Core Suite of National Integration Indicators - Annual Performance

ISD's latest refresh of this data was December 2017, however please note that data is only updated to the end of the financial year available hence the newest data provided by ISD here is for 2016/17.

Data for the Core Suite of Integration Indicators, NI - 1 to NI - 23 are populated from national data sources and data is issued nationally. Indicators 1 to 10 are outcome indicators based on survey feedback and are updated bi-annually. Data for National Indicators 11 to 23 are derived from organisational/system data and are updated quarterly. Data for indicators 10, 21, 22 and 23 are not yet available.

	Indicator	Title	Previous score 2013/14	Current score 2015/16	Scotland 2015/16	RAG
Outcom	NI - 1	Percentage of adults able to look after their health very well or quite well	96%	96%	94%	G
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	81%	78%	84%	A
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	74%	72%	79%	A
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	71%	77%	75%	G
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	75%	78%	81%	G
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	85%	87%	87%	G
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	74%	86%	84%	G
	NI - 8	Total combined % carers who feel supported to continue in their caring role	44%	43%	41%	A
	NI - 9	Percentage of adults supported at home who agreed they felt safe	76%	81%	84%	G
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	

	Indicator	Title	Previous score	Current score	Scotland	RAG	
Data indicators	NI - 11	Premature mortality rate per 100,000 persons *(European age-standardised mortality rate per 100,000 for people aged under 75)*	399 2015	360 2016	440	G	
	NI - 12	Emergency admission rate (per 100,000 population)	8,673 2015/16	8,734 2016/17	12,294	A	*
	NI - 13	Emergency bed day rate (per 100,000 population)	94,533 2015/16	94,294 2016/17	125,634	G	*
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	76 2015/16	74 2016/17	99	G	
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	90% 2015/16	90% 2016/17	87%	G	
	NI - 16	Falls rate per 1,000 population aged 65+	17 2015/16	16 2016/17	22	G	*
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	78% 2015/16	78% 2016/17	83%	G	*
	NI - 18	Percentage of adults with intensive care needs receiving care at home	75% 2014/15	67% 2015/16	62%	R	
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	764 2015/16	1,095 2016/17	842	R	***
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22% 2015/16	21% 2016/17	25%	G	
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA		
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA		
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA		

*** *Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account for the definitional changes during the year 2016/17. The changes affected reporting of figures in some areas more than others therefore comparisons before and after July 2016 may not be possible at partnership level. It is estimated that, at Scotland level, the definitional changes account for a reduction of around 4% of bed days across previous months up to June 2016, and a decrease of approximately 1% in the 2016/17 bed day rate for people aged 75+.*

RAG scoring based on the following criteria

If Moray performance has improved or stayed the same then "Green"

If Moray performance has worsened by 5% or less then "Amber"

If Moray performance has worsened by more than 5% then "Red"

Moray Health and Social Care Partnership: Performance at a Glance Quarter 3 (October to December 2017)
Local Indicators

RAG scoring based on the following criteria		
Performance Against Previous Period	G	*If Moray quarter has improved or stayed the same from previous, then "Green"*
	A	*If Moray quarter has worsened by 5% or less of previous quarter, then "Amber"*
	R	*If Moray quarter has worsened by more than 5% of previous Moray quarter then "Red"*

ID.	Indicator Description	***Performance Current Quarter***	Target	Previous Quarter	Against Previous Quarter	Trend line	Trend Period	Current Quarter
L07	Rate of emergency occupied bed days for over 65s per 1000 population	***2495***	2360	2531	G		5 Quarters	Oct-Dec 17
L08	Emergency Admissions rate per 1000 population for over 65s	***182***	193	180	A		5 Quarters	Oct-Dec 17
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	***130***	125	128	A		5 Quarters	Oct-Dec 17
L10	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	***30***	-	31	G		5 Quarters	Oct-Dec 17
L11	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	***26***	35	27	G		5 Quarters	Oct-Dec 17
L12	A&E Attendance rates per 1000 population (All Ages)	***56.1***	19.3	59.9	G		5 Quarters	Oct-Dec 17
L13	A&E Percentage of people seen within 4 hours, within community hospitals	***100.0% (595)***	98%	100.0% (729)	G		5 Quarters	Oct-Dec 17
L14	Percentage of new dementia diagnoses who receive 1 year diagnostic support	***75.0%***	70%	90.7%	R		3 Financial Years	Apr-Sep 16
L15	Smoking cessation in 40% most deprived after 12 weeks	***44***	-	60	R		5 quarters	Apr-Jun 17
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	***100.0%***	90%	98.6%	G		5 Quarters	Jul-Sep 17
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	***100.0%***	90%	100.0%	G		5 Quarters	Jul-Sep 17
L18	Number of Alcohol Brief Interventions being delivered	***95***	257	65	G		5 Quarters	Oct-Dec 17

RAG scoring based on the following criteria		
Performance Against Previous Period	G	*If Moray quarter has improved or stayed the same from previous, then "Green"*
	A	*If Moray quarter has worsened by 5% or less of previous quarter, then "Amber"*
	R	*If Moray quarter has worsened by more than 5% of previous Moray quarter then "Red"*

ID.	Indicator Description	***Performance Current Quarter***	Target	Previous Quarter	Against Previous Quarter	Trend line	Trend Period	Current Quarter
L19A	Number of complaints received and % responded to within 20 working days - NHS	***10.0% (10)***	-	57.0% (14)	R		3 Quarters	Oct-Dec 17
L19B	Number of complaints received and % responded to within 20 working days - Council	No data available at the moment, this indicator should be available with the next update						
L20	NHS Sickness Absence % of Hours Lost	***4.6%***	4.0%	4.0%	A		5 Quarters	Oct-Dec 17
L21	Council Sickness Absence (% of Calendar Days Lost)	No data available at the moment, this indicator should be available with the next update						
L41	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	***61.5%***	90%	100.0%	R		3 Quarters	Oct-Dec 17

MIJB PERFORMANCE HIGHLIGHT REPORT

1. NATIONAL INDICATORS

There were no updates this quarter to any of the National Indicators (APPENDIX 1). Note that of the 23 national indicators used to measure progress towards the National Health and Wellbeing Outcomes, only 19 have data available for reporting.

The following indicators do not yet have reportable data:

10. Percentage of staff who say they would recommend their workplace as a good place to work

It has been agreed that NHS Scotland Staff Survey, and all Local Authorities will incorporate the question, and in future will spread to third and private sectors. The NHS data is not currently presented at partnership level and work needs to be undertaken to provide it in a meaningful way. For example, staff in hospitals will provide care for a range of geographic areas not one specific partnership.

Work has begun to explore if the survey question can also be extended to the majority of social care staff who work in the third and independent sectors. This will involve a number of providers of care and will be more complicated to collect. The mechanisms for collating and calculating this information is work in progress

21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home

The data would come from The General/Acute and Inpatient Day Case – Scottish Morbidity Record (SMR01), collecting episode level data on hospital inpatient and day case discharges from acute specialities from hospitals in Scotland. This contains fields on where people were admitted to hospital from and where they are discharged to. The information is not currently considered of usable quality, so data improvement work will be required by Information Services Division~~SD~~ (ISD) working with NHS Boards before this indicator can be used.

22. Percentage of people who are discharged from hospital within 72 hours of being ready

The development of this indicator by ISD is being led by the Delayed Discharge Task Force. It requires NHS Boards to set up new methods of recording and collecting the required information, and changes to administrative systems, which is not yet in place.

23. Expenditure on end of life care

The final definition for this indicator still needs to be worked out, and will need to ensure it complements the end of life activity indicator, and to ensure this is a meaningful indicator for Integration Authorities and the public.

2. LOCAL INDICATORS

The following Local Indicators are showing as Red (APPENDIX 2):

2.1 L14 Percentage of new dementia diagnoses who receive 1 year diagnostic support – Previously we could only report on a complete year for this indicator, however for the current reporting financial year 2016/17 we are able to get quarterly updates, therefore for the first 6 months, April to September 2016, although our position is less than the previous annual period, we are above target and would expect this indicator to return to green in the next quarter.

2.2 L15 Smoking cessation in 40% most deprived after 12 weeks – Despite a reduction from 60 quits to 44 in this indicator over the current reporting period April to June 2017, this is the second highest it has been in the last 5 quarters. There is variation across the quarters with the lowest number of quits recorded in the quarter ending December 2016 at 29 to the highest number in quarter ending March 2017 at 60 quits. The average number of quits over the last 5 quarters is 39. The current Grampian wide target is to exceed 792 twelve week quits amongst our 40% most deprived smokers, there is currently no target set for Moray.

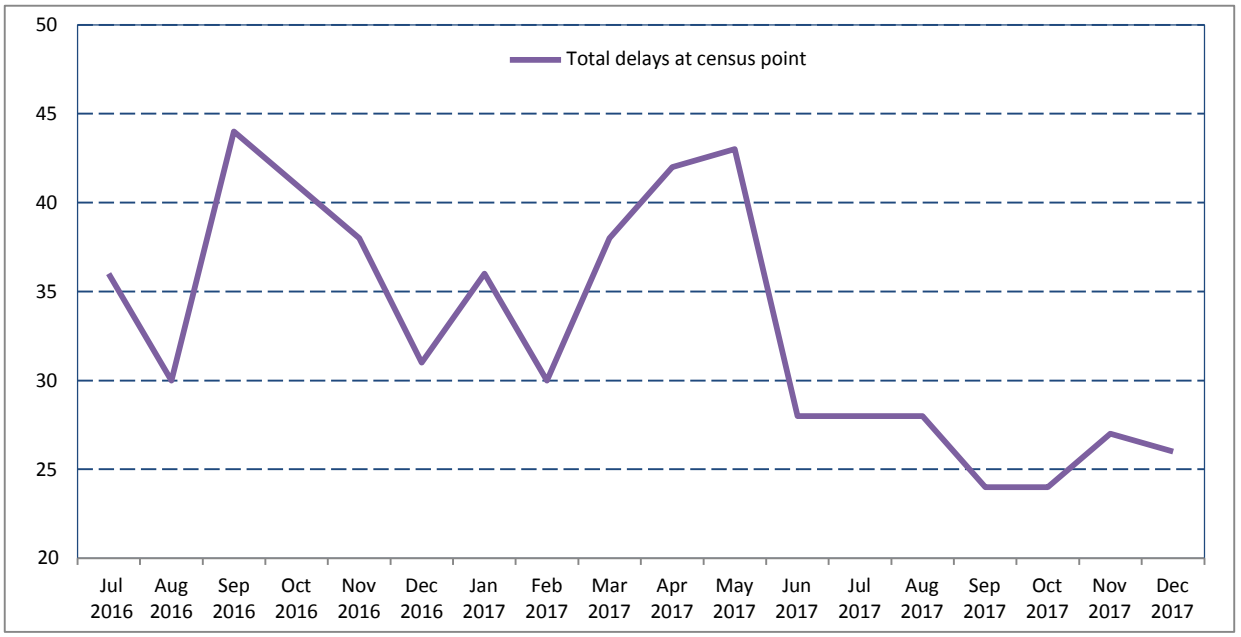
2.3 L19A Number of complaints received and % responded to within 20 working days – NHS – From April 2017 NHS Grampian changed the way complaints were reported, although this indicator was reported previously, from a data quality perspective we have only included trend data back to April 2017. Due to the small number of complaints received this can impact the percentages shown, to help understand this we have included the actual number in brackets. The average number of complaints received over the 9 months is around 4 per month, with on average 1 complaint responded to within 20 days per month. For the current quarter only 1 complaint was responded to within 20 days.

2.4 L41 Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral – This indicator comprises of Adult Services, Learning Disability, Primary Care and Psychotherapy. While 100% were seen by Secondary Care Psychology, Primary Care Psychology and Psychotherapy within 18 weeks, Learning Disability achieved 0%; this made the overall performance for Moray HSCP 61.5%. We are currently investigating how best to report Learning Disability separately as the service in Moray is not a joint service as it is for the rest of Grampian and therefor the data is not recorded similarly within Moray.

3. ADDITIONAL HIGHLIGHTS

3.1 Delayed Discharge

The number of people waiting to be discharged from hospital when they are ready (**Delayed Discharges**) has decreased significantly over the last two quarters.



Despite this improvement there are ongoing adjustments and improvements within the teams to further reduce the number.

Health & Social Care Moray	Unplanned admissions	Unplanned bed days	A&E attendances	Delayed discharge bed days	Last 6 months of life	Balance of Care
Baseline	Number of emergency admissions (Acute Specialties) Baseline 2015/16 7,685, 2016/17 7,827, 2017/18 (to Sep 17) 3,999	Number of unscheduled hospital bed days for Acute Specialties, excluding Geriatric Long Stay and Mental Health: Baseline 2015/16 63,680, 2016/17 66,153, 2017/18 (to Sep 17) 28,735. Number of Mental Health unscheduled hospital bed days Baseline 2015/16 10,348 2016/17 8,389 2017/18 (to Sept 17) 4,210	Number of A&E attendances Baseline 2015/16 22,428, 2016/17 22,876, 2017/18 (to Sep 17) 12,014.	Number of Delayed Discharge bed days (all delays standard and code 9's) Baseline 2015/16 9,135, 2016/17 12,883, 2017/18 (to Sep 17) 6,255. ▪ In 2015/16 26% of bed days occupied by delayed discharges were occupied by code 9's, this decreased to 25% in 2016/17 and increased again to 28% in 2017/18 (to Sep 17).	Percentage of last 6 months of life spent in the community Baseline 2015/16 90%, 2016/17 91%.	Balance of care – Percentage of population in community or institutional settings. Percentage of population aged 75+ in community setting (including care home) Baseline 2013/14 98.7%, 2014/15 98.5%, 2015/16 98.6%.
Objective	Moray's baseline data shows a continual increase in unplanned admissions. (57% of these from A&E). Projecting that 2017/18 will outturn at a 2.18% increase on the 2016/17 figure, the objective will be to achieve a reduction	Maintain number of unplanned bed days against the growth in 65+ population. Projecting that 2017/18 in acute specialities will outturn at a 13.1% decrease on the 2016/17 figure; i.e.	Moray's baseline data shows a continual increase in A%E attendances. Projecting that 2017/18 will outturn at an approximate 5% increase on	Moray's baseline data shows a decrease of 2.9% from 2016/17 to forecasted figures in 2017/18 The objective would be to reduce the number of bed days lost despite	Moray's baseline data shows an increase of 1% annually between 2013/14 – 2016/17. The objective would be to continue to achieve an increase on the 2016/17 figure to 92% by	Maintain current percentage of population in community setting against projected population growth.

	on the forecasted figure in the second half of 2018/19 (i.e. reduction in 7998 admissions), achieving an annual figure of 1% reduction by the end of 2018/19 (7918 admissions).	to 57,470, the objective would be to maintain a steadier rate of decline in 2018/19 to a level of **5**% below the 2017/18 figure i.e. an annual total of 54,597	2016/17 figures, i.e. to 24,028, the objective would be to achieve a reduction on the forecasted figure in the second half of 2017/18 (i.e. reduction in 24,028), achieving an annual figure of 1% reduction by the end of 2018/19 (23,788 attendances). Maintain average A&E % seen within 4 hours (97%) in 2015/16 during 2017/18 and 2018/19	projected growth of 65+ population by a stable rate of 2% on the 2017/18 rate – to an annual total of 12,260.	2018/19.	
How will it be achieved	Increasing availability and timeliness of care through strategic commissioning (eg creative use of SDS options). Strong focus on locality needs and solutions. Continued geriatric support to A&E.	6 Essential Actions Implementation of ACP and Community Hospital strategy Reshaping Care at Home Programme. Increasing availability and timeliness of care through	Improved working with GPs in localities – undertaking test of change models in the community to enhance primary care access and	Reshaping Care at Home Programme. Implementation of ACP and Community Hospital strategy Continued management and scrutiny of delayed	Implementation of Enabling Health and Wellbeing programme – Improving the experience of end of life care project. Implementation of ACP and	Reshaping Care at Home Programme. Implementation of Link Workers Pharmacy support to GP practices. Improved working with GPs in localities –

	Modernisation of Primary Care. Implementation of Link Workers. Pharmacy support to GP Practices. Reshaping Care at Home Programme. Falls Prevention pathway. Implementation of ACP and Community Hospital strategy SPARRA Out of Hours Redesign	strategic commissioning (e.g. creative use of SDS options). Strong focus on locality needs and solutions. Continued geriatric support to A&E. Modernisation of Primary Care. Implementation of Link Workers. Pharmacy support to GP Practices. Reshaping Care at Home Programme. Falls Prevention pathway SPARRA Out of Hours Redesign	minimise unnecessary admissions to A&E.	discharges. Implementation of Link Workers Pharmacy support to GP practices. Targeted support to carers. Delayed Discharge Action Planning	Community Hospital strategy Increasing availability and timeliness of care through strategic commissioning (particularly palliative and end of life care) Strong focus on locality needs and solutions. Modernisation of Primary Care. Targeted support to carers. Palliative Care Strategy Group.	undertaking test of change models in the community to enhance primary care access and minimise unnecessary admissions to A&E.
Progress (updated by ISD)	Number of emergency admissions (Acute Specialties) Baseline 2015/16 7,685, 2016/17 7,827, 2017/18 (to Sep 17) 3,999 2% increase in emergency admissions from 2015/16 to 2016/17	Number of unscheduled hospital bed days for Acute Specialties, excluding Geriatric Long Stay and Mental Health: Baseline 2015/16 63,680, 2016/17 66,153, 2017/18 (to Sep 17) 28,735. ▪ 4% increase in number of	▪ 2% increase in number of A&E attendances from 2015/16 to 2016/17 ▪ Percentage of attendances seen within 4 hours has remained constant at 97% in 2015/16, 96% in 2016/17 and 97% in 2017/18	▪ 29% increase in number of bed days occupied by delayed discharges 2015/16 to 2016/17. ▪ 25% increase in number of bed days occupied by Code 9 delayed discharges from 2015/16 to 2016/17.	▪ A higher percentage of individuals spend their last 6 months of life in a community setting, with 89% in 2013/14 and 2014/15, increasing to 90% in 2015/16 and 91% in 2016/17.	In 2015/16 83.8% aged 75+ were at Home (Unsupported), 9.4% at Home (Supported), 5.4% in a Care Home, 0.6% in a Community Hospital and 0.7% in a Large Hospital. This compares to 2013/14 where 81.7% were at Home

		unscheduled hospital bed days from 2015/16 to 2016/17. Number of Mental Health unscheduled hospital bed days Baseline 2015/16 10,348, 2016/17 8,389, 2017/18 (to Sep 17) 4,210 ▪ 23% reduction in number of unscheduled bed days from 2015/16 to 2016/17	(to Sep 17).			(Unsupported), 10.8% at Home (Supported), 6.1% in a Care Home, 0.6% in a Community Hospital and 0.7% in a Large Hospital.
Notes	We will review and plan savings that would be realised from a reduction of 1% (79 admissions) in 2018/19.	We will review and plan savings that would be realised from a reduction of 2873 bed days in 2018/19.	We will review and plan savings that would be realised from a reduction of 1% attendances.	Moray has achieved a reduction in DD bed days between April to September 2017. We will review and plan savings that would be realised from reducing another 250 bed days.	No data.	Most areas have a similarly high percentage for the overall number of those residents in a non-hospital setting. The variance tends to be between supported and unsupported and this will be given further analysis during 2018/19.

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 MARCH 2018

SUBJECT: REVENUE BUDGET MONITORING QUARTER 3 FOR 2017/2018

BY: CHIEF FINANCIAL OFFICER

1. REASON FOR REPORT

1.1 To update the Moray Integration Joint Board (MIJB) on the Revenue Budget reporting position as at 31 December 2017 and a provisional forecast position for the year end.

2. RECOMMENDATIONS

2.1 It is recommended that the MIJB consider and note the:

i) financial position of the Board at 31 December 2017 is showing an overspend of £1.601 million;

ii) provisional forecast position for 2017/18 of an overspend of £2.088 million on core services;

iii) revisions to staffing arrangements dealt with under delegated powers in accordance with the appropriate Council/NHS Grampian procedures for the period 1 October to 31 December 2017 as shown in Appendix 3; and

iv) updated budget position to reflect additional funding received through NHS Grampian, as detailed at paragraph 8.1.

3. BACKGROUND

3.1 The financial position for the MIJB services at 31 December 2017 is shown at **APPENDIX 1**. The figures reflect the position in that the MIJB core services are currently over spent by £1.601m. This is summarised in the table below.

	Annual Budget £m	Budget to date £m	Expenditure to date £m	Variance to date £m
MIJB Core Service	112.193	83.865	85.466	(1.601)
MIJB Strategic Funds	4.558	1.215	1.218	(0.003)
Total MIJB Expenditure	**116.751**	**85.080**	**86,684**	**(1.604)**

3.2 A list of services that are included in each budget heading are shown in **APPENDIX 2** for information.

3.3 The updated provisional forecast outturn to 31 March 2018 for the MIJB services is included in **APPENDIX 1**. The figures reflect the overall position, in that the MIJB core services are forecast to be over spent by £2.088m by the end of the financial year. This is summarised in the table below.

	Annual Budget £m	Provisional Outturn to 31 Mar 2018 £m	Anticipated Variance to 31 Mar 2018 £m	Variance against base budget %
MIJB Core Service	112.193	114.281	(2.088)	(2)
MIJB Strategic Funds	4.558	1.981	2.577	57
Total MIJB Expenditure	**116.751**	**116.338**	**0.489**	**0.4**

4. KEY MATTERS/SIGNIFICANT VARIANCES AS AT QUARTER 2

4.1 Community Hospitals & Community Admin

4.1.1 The underspends within community hospitals and community admin, remain over the four localities Elgin, Buckie, Forres, Keith/Speyside totalling £0.060m to 31 December.

4.1.2 Over spends continue to be realised for some of these services. The main overspend relates to community hospitals in Buckie £0.116m and Forres £0.010m, which is being reduced by under spends in admin £0.028m, medical staff £0.043m and Speyside £0.115m. An integrated staff team has been introduced in Speyside covering Stephen and Fleming hospitals under one Senior Nurse. Work continues in relation to skill mix and bank nursing untilisation in order to further address the impact of cumulative prior year efficiency targets which continues to present a challenge. Alongside this non-financial objectives, including meeting waiting times, patient safety and delayed discharge targets still require to be maintained.

4.1.3 This budget is forecasted to be £0.113m underspent by the end of the financial year, this is primarily due to underspends in Speyside hospitals and implementation of protocols and addressing staff utilisation with the aim of reducing bank costs.

4.2 Community Nursing

4.2.1 Community Nursing is showing an overspend of £0.024m as at 31 December but is now forecast to be £0.016m underspent by the end of the financial year, primarily due to the revised forecast for immunisations, which are not expected to be fully required during the year.

4.3 Learning Disabilities

4.3.1 The Learning Disability (LD) service is overspent by £0.076m. The overspend is primarily due to the purchase of care for people with complex needs £0.166m, including young people transferring from Integrated Children's services and people supported to leave hospital. This is being reduced by an underspend of £0.090m mainly relating to staffing vacancies within NHS Grampian.

4.3.2 This budget is forecasted to be £0.194m overspent by the end of the financial year, primarily due to the purchase of care for people with complex needs £0.313m. The was a release of the cost pressure £0.200m into the budget as agreed by MIJB on 29 June 2017 (paragraph 24 of the Minute refers). The forecast is based on the current level of clients and their activity and that the costs will remain at the current level. Work continues through the Learning Disabilties transformational change programme which is driven by previous service delivery models not being financially sustainable. Phase one of this programme was completed in October 2017. Phase two focuses on implementation, and quality assurance / benefits realisation from the new ways of working. This will enable the system to be confident that people are being supported in the best way to ensure they have the right kind of support to become as independent as possible. This also includes commissioning new and different services to work in different ways. Work on demographics suggests that the number of people with a learning disability will continue to increase, and these people will live longer with more complex needs, including health needs. The Scottish Government and Scottish Commission for Learning Disabilities have indicated they are keen to work with us to evaluate this system wide model as they see it as having significance nationally as a way of supporting people with learning disabilities.

4.3.3 The time line for the commissioning activity required as part of the transformational change has been developed and will cover from March 2018-2021. The Transformational Change Programme Board continues to scrutinise the progress of the systems change. Additionally, each individual support plan is scrutinised before expenditure is authorised by the Resouce Allocation meeting, which convenes weekly, chaired by the Service Manager.

4.4 Mental Health

4.4.1 Mental Health (MH) services are overspent by £0.213m. This includes medical staff including locum staff costs £0.143m, Allied Health Professional £0.044m and non pays £0.072, including the efficiency allocation. The overspends on these budgets are offset by underspends in other staff £0.027m, Mental Health Act £0.006m and assessment and care £0.013m.

4.4.2 This budget is forecasted to be £0.276m overspent by the end of the financial year, this is due to the usage of medical locum cover to the end of the financial year, as medical appointments have now been made and discontinuation of agency nursing staff. The Allied Health Professional establishment is under review. The overspending areas continue to be monitored by Senior managers and a plan is being drawn up to address the efficiency allocation.

4.5 Care Services Provided in-house

4.5.1 Care services provided in-house are overspent by £0.075m. There are numerous variances within this budget heading, the most significant is primarily due to the budget reduction approved as part of the savings element of the budget for 2017/18 of £0.125m, which has not yet been achieved. The Maybank service has now transferred to it's new location at Woodview, Urquhart Place in Lhanbryde and additional revenue costs for this new unit has created a non-recurring overspend of £0.046m, which has been agreed to be funded from capital in the next quarter. There are also overspends relating to income under recovering against the budget by £0.064m, Taigh Farrais £0.010m, Care at home £0.053m,and other minor overspends. This is being reduced by underspends in staffing including older people, learning disabilities and independent living services care at home of £0.108m which is due to the ongoing service redesign. There is an underspend of £0.017m for care at home staff transport and £0.028m for day services client transport, with overspend in Woodview £0.008m. Other minor underspend £0.015m.

4.5.2 An overspend of £0.048m is forecast at the end of the financial year, due to savings not achieved and the underspends in Care at home.

4.6 Older People and Physical Sensory Disability (Assessment & Care)

4.6.1 This budget is overspent by £0.240m. This relates to an over spend for the area teams relating to domiciliary care £0.367m, client transport costs £0.035m, income under recovering against budget £0.005m and property costs £0.005m. Income is also under recovering against budget for permanent care £0.041m, which is being reduced by an under spend of £0.213m in permanent care.

The variances within this overall budget heading reflect the shift in the balance of care to enable people to remain in their homes for longer.

4.6.2 This budget is forecasted to be £0.505m overspent by the end of the financial year, this is primarily due to the external purchasing of care continuing to increase due to growth and demand, the permanent care client income will continue to be below the level expected. This will be reduced by the underspends in permanent care which is assumed to remain at the current level due to the expectation that the number of clients and care package costs will not increase.

4.6.3 A change management process intended to identify efficiencies in working practices is underway with the consultation process for the change management plan should be progressed within the next 2 months following which the implementation of the changes. It would be anticipated that this will be imbedded in 2018 with a monitoring and review process throughout the following 6 months of implementation. In general terms variances within this overall budget heading reflect the shift in the balance of care.

4.7 Intermediate Care and Occupational Therapy (OT)

4.7.1 The budget is overspent by £0.094m. This relates to Aids & Adaptations £0.032m, the running costs of Jubilee Cottages £0.018m, Telecare £0.014m and the budget reduction of £0.030m for approved savings.

4.7.2 This budget is forecasted to be £0.118m overspent by the end of the financial year, this is due to the savings target of £0.030m which will not be achieved, due to an increase of referrals to the service resulting in a higher demand on the provision of equipment and adaptations to allow service users to remain at home and be independent. The current overspends in Aids & Adaptation, Telecare and the running costs of Jubilee Cottages will continue to the year end.

4.8 Care Services provided by External Contractors

4.8.1 This budget is overspent by £0.131m. This is primarily due to the budget being amended for the approved savings of £0.140m which have not yet been achieved and therefore it is contributing to the overspend. Other overspends include the purchasing of the replacement OT joint store stock system £0.030m, which is currently sitting as a commitment and once purchased will be funded from capital and other minor variances totalling £0.002m. This overspend is being reduced by client income above the budget £0.051m, an underspend in LD contracts due to voids not being charged £0.030m, MH care purchasing £0.030m and other minor variances totalling £0.026m.

4.8.2 This budget is forecasted to be £0.014m overspent by the end of the financial year, this is an improved position due to the MH contract that has been redesigned and will result in a contract reduction of £0.107m.

4.9 Other Community Services

4.9.1 This budget is overspent by £0.025m. This is due to overspends in allied health professionals £0.020m, pharmacy service £0.020m and specialist nurses £0.013m which is being reduced by an underspend in public health £0.028m.

4.9.2 This budget is forecasted to be £0.027m underspent by the end of the financial year, this is due to mainly one off overspends in pharmacy service £0.027m and specialist nurses £0.017m which are to be reviewed. This is partially offset by an increased forecast underspend in public health £0.060m which may reduce as objectives are addressed within Public Health, dental services £0.005m and allied health professionals £0.006m.

4.10 Administration & Management

4.10.1 This budget is showing no material variance as at 31 December. By the end of the year it is forecasted to be £0.155m underspent. This is an due to the vacancy factor target expected to exceed by £0.145m and underspends in business support £0.072m which is reduced by an overspend in management costs £0.051m to the year end.

4.11 Primary Care Prescribing

4.11.1 The primary care prescribing budget is reporting an over spend of £0.810m to 31 December. The volume increase in items to December has been close to expectations and the overspend relates mainly to continuing national factors including the impact of medicines on short supply where costs have increased, medicines coming off patent where agreed prices reductions have been lower than anticipated and tarriff reductions for 17/18 being delayed in implementation. Estimates for November and December are based on the latest actual expenditure information including October leading to the revised overspend position reported. Expenditure on items includes increased expenditure in advance of Christmas break and this is included in the estimate for December. To compensate for this the budget is phased with a greater than normal allocation in December which has contributed to the overall position as compared to November.

4.11.2 This budget is forecasted to be £1.135m overspent by the end of the financial year, this is due to the impact of national factors outlined in 4.11.1 above. The Pharmacy Medicines Directorate in NHS Grampian is working with local pharmacy teams to analyse the situation and to identify any further mitigating action that could be taken. The outcome of this is awaited but the impact of any possible action may be limited in 2017/18.

4.12 Hosted Services

4.12.1 This budget is overspent by £0.147m, which primarily relates to the GMED out of hours service, £0.109m, which is hosted by MIJB. Areview of the service provision is on going. There are also other minor overspends relating to Sexual Health services and the Police forensic examiner, which is being reduced by underspends in HMP Grampian.

4.12.2 This budget is forecasted to be £0.203m overspent by the end of the financial year, this is due to expected continuance of overspend particularly within GMED where a review is underway of the service and associated costs.

4.13 Improvement Grants

4.13.1 This budget is underspent by £0.203m, this is due to the Improvement grants and the timing of works as the budget is fully committed for 2017/18. It is anticipated that this budget will be £0.150m underspent by the end of the financial year.

5. STRATEGIC FUNDS

5.1 Strategic Funds (as agreed by this Board on 29 June 2017, paragraph 23 of the Minute refers) include:

- Identified budget pressures expected to affect 2017/18,
- Scottish Government funding allocated via the NHS arm of the budget for the MIJB, in relation to the Integrated Care Fund (ICF) and Delayed Discharge (DD) Funds,
- Commitments from Earmarked reserves,
- Provision for the recurring deficit, based on 2016/17 outturn and
- Savings identified by service managers.

5.2 By the end of the financial year, the Strategic Funds will reduce as the commitments and provisions materialise and the core budgets will increase correspondingly. The budget for 2017/18 is balanced by utilising the one off reserves from 2016/17 of £2.704m.

5.3 Other recurring strategic funds, relate to the additional monies for the ICF, DD and Scottish Government additional funding, which is expecting an under spend of £0.121m by the end of the financial year, due to slippage in projects during the year.

5.4 Other non recurring strategic funds, relate to additional funding received via NHS Grampian for the MIJB. Total non recurring funding received to date is £0.758m of which £0.314m is committed to the end of the financial year and an underspend of £0.444m is expected at the end of the financial year. Although this is an underspend in this financial year, it will mean that some of the funding will be required during 2018/19.

5.5 Earmarked reserves of £1.662m was expected at the start of the year, to date £0.136m has been allocated through other funding made available, leaving a budget of £1.526m at 31 December 2017. No further funding is forecasted to be required to the end of the financial year.

5.6 Budget pressures of £1.811m was expected to be required at the start of the year. To date £1.071m has been allocated, leaving a budget of £0.740m at 31 December 2017. It is anticipated that £0.250m is required to the end of the financial year.

5.7 Savings of £0.624m was identified at the start of the year and these have been allocated in full.

5.8 The strategic funds are forecast to be underspent by £2.582m by the end of the financial year, this will offset the core services forecasted overspend of £2.169m, leaving a non recurring forecast underspend of £0.413m. It is important to stress the need to hold reserves in order to create a balance to help cushion the uneven cash flows and create a contingency for unexpected events.

6. CHANGES TO STAFFING ARRANGEMENTS

6.1 At the meeting of the Board on 25 January 2018, the revised Financial Regulations were approved (paragraph 6 of the draft minute refers). All changes to staffing arrangements with financial implications for the Board's budget and effects on establishment of the Health and Social Care Moray workforce are to be advised to the Board.

6.2 Changes to staffing arrangements dealt with under delegated powers through apporiate Council/NHS Grampian procedures for the period 1 October to 31 December 2017 are detailed in **APPENDIX 3.**

7. PROGRESS IN IMPLEMENTING APPROVED SAVINGS

7.1 The revenue budget for 2017/18 was approved at the meeting of this Board on 29 June 2017(para 24 of the Minute refers). As part of the budget setting process, savings were identified of £0.624m. All of the savings have now been allocated. All savings have been incorporated into the forecast figures. Details of the progress of achieving the approved savings are included in **APPENDIX 4**.

8. UPDATED BUDGET POSITION

8.1 During the financial year, budget adjustments will arise relating in the main to the allocation of non-recurring funding that is received via NHS Grampian. In order to establish clarity of these budget allocations a summary reconciliation has been provided below.

	£m's
Approved Funding to Quarter 2	**116.462**
Forres Hospital running costs	0.048
Child commissioner	0.039
Primary Care	0.005
Hosted Services Adjustments	0.019
Six essential actions & winter pressures	0.138
Plasma	0.027
Other Minor Adjustments	0.009
Revised Funding to Quarter 3	**116.747**

9. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

This report is consistent with the objectives of the Moray 2026 and includes 2017/18 budget information for services included within the MIJB , which is key to the delivery of health and social care services in Moray in accordance with the Strategic Plan.

(b) Policy and Legal

It is the responsibility of the organisation receiving the direction to work with the Chief Officer and Chief Financial Officer to deliver services within the resources identified. The Moray Integration Scheme (para 12.8 of the 2015 Integration Scheme) makes provision for dealing with in year variations to budget and forecast overspend by reference to agreed corrective action and recovery plans. It also makes provision for dealing with year end actual overspend where such action and plans have been unsuccessful in balancing the relevant budget by reference to use of MIJB reserves and additional payments from Grampian Health Board/Moray Council.

(c) Financial implications

The financial details are set out in sections 3-8 of this report and in **APPENDIX 1**. For the period to 31 December 2017, an overspend is reported to the Board of £1.601m on core services. With the updated provisional forecast to the year end of £2.088m overspend.

The staffing changes detailed in **APPENDIX 3** have already been incorporated in the figures reported.

The movement in the 2017/18 budget as detailed in paragraph 8.1 have already been incorporated in the figures reported.

(d) Risk Implications and Mitigations

The most significant risk arising from this report is the control and management of expenditure to provide the Health and Social Care services required for the Moray Area, within budget.

There is also a risk that the disaggregated NHS Grampian budget figures will not have adequate remedial actions in time to prevent overspends. This in turn will increase the reliance on additional monies provided by Scottish Government for specific purposes being utilised to balance these budgets.

The current forecast overspend of £2.093m gives cause for concern going forward. The reserves of £2.704m have been required to help balance the budget for 2017/18, but this is a one off windfall. Further savings will be required to be identified in order for the MIJB to be able to sustain a stand still budget and cover the budget pressures from 2018/19 onwards.

(e) Staffing Implications

There are no direct implications in this report. **APPENDIX 3** summarises staffing decisions that have been implemented through delegated authority in the Health and Social Care Moray workforce.

(f) Property

There are no direct implications in this report.

(g) Equalities

There are no equality implications in this report

(h) Consultations

The Chief Officer,Chief Financial Officer, Legal Services Manager (licencing & litigation), the Senior Management Team and the Operational Management Team have been consulted and their comments have been incorporated in this report.

10. CONCLUSION

10.1 The MIJB Budget to 31 December 2017 has an over spend of £1.601m . Senior managers will continue to monitor the financial position closely and to develop agreed actions to rectify any shortfalls.

10.2 The provisional outturn position for 2017/18 for core services is £2.088m overspent, which is being offset by an underspend in recurring and non recurring strategic funds of £2.582m.

10.3 The finance position to 31 December 2017 includes the changes to staffing, as detailed in APPENDIX 3.

10.4 The financial position to 31 December 2017 reflects the updated budget position

Author of Report: D O'Shea Principal Accountant (MC) & B Sivewright Finance Manager (NHSG)
Background Papers: Papers held by respective Accountancy teams
Ref: DOS/LJC/

Signature: _____ Date: March 2018

Designation: Chief Financial Officer Name: Tracey Abdy

MORAY INTEGRATION JOINT BOARD

JOINT FINANCE REPORT APRIL 2017 - DECEMBER 2017

	Para Ref	Annual Net Budget £000's 2017-18	Budget (Net) To Date £000's	Actual &Comm To Date £000's	Variance £000's	Most recent Forecast £000's	Variance To Budget £000's	Forecast Variance %
Community Hospitals & Community Admin	**4.1**	5,356	4,030	3,970	60	5,243	113	2
Community Nursing	**4.2**	3,555	2,652	2,676	(24	3,539	16	0
Learning Disabilities	**4.3**	5,873	4,122	4,198	(76	6,067	(194)	(3)
Mental Health	**4.4**	7,149	5,334	5,547	(213	7,425	(276)	(4)
Addictions		946	725	741	(16	978	(32)	(3)
Adult Protection & Health Improvement		164	106	105	1	156	8	5
Care Services provided in-house	**4.5**	13,544	10,004	10,079	(75	13,592	(48)	(0)
Older People & PSD Services	**4.6**	16,096	11,933	12,173	(240	16,601	(505)	(3)
Intermediate Care & OT	**4.7**	1,429	1,061	1,155	(94	1,547	(118)	(8)
Care Services provided by External Contractors	**4.8**	10,956	8,407	8,538	(131)	10,970	(14)	(0)
Other Community Services	**4.9**	7,168	5,335	5,360	(25)	7,141	27	0
Admin & Management	**4.10**	2,470	1,932	1,932	0	2,310	160	6
Primary Care Prescribing	**4.11**	16,798	12,735	13,545	(810	17,933	(1,135)	(7)
Primary Care Services		15,229	11,372	11,386	(14	15,253	(24)	(0)
Hosted Services	**4.12**	3,811	2,873	3,020	(147	4,014	(203)	(5)
Out of Area		669	482	482	0	682	(13)	(2)
Improvement Grants	**4.13**	980	762	559	203	830	150	15
Total Moray IJB Core		112,193	83,865	85,466	(1,601)	114,281	(2,088)	(2)
Other Recurring Strategic Funds in the ledger	**5.3**	**1,506**	**1,096**	**1,099**	**(3)**	1,390	116	8
Other non-recurring Strategic Funds in the ledger	**5.4**	**758**	119	119	0	314	444	59
Total Moray IJB Including Other Strategic funds in the ledger		**114,457**	**85,080**	**86,684**	**(1,604)**	**115,985**	**(1,528)**	**(1)**
Other costs which may be incurred not in the ledger:								
Commitments from Earmarked reserves	**5.5**	1,526				**0**	**1,526**	
Identified budget pressure	**5.6**	740				**250**	**490**	
Recurring deficit		1,327				**1,327**	**0**	
MC reduction		(1,299)				**(1,300)**	**1**	
Savings identified	**5.7**	0				**0**	**0**	
Other costs which may be incurred not in the ledger:		**2,294**	**0**	**0**	**0**	**277**	**2,017**	**88**
Total Moray IJB (incl. other strategic funds) and other costs not in ledger	**5.8**	**116,751**	**85,080**	**86,684**	**(1,604)**	**116,262**	**489**	**0**

Description of MIJB Core Services

1. Community Hospitals related to the five community hospitals In Moray

2. Community Nursing related to Community Nursing services throughout Moray.

3. Learning Disabilities budget comprises of:-
   - Transitions,
   - Staff – social work and admin infrastructure,
   - External purchasing of care for residential & nursing care,
   - External purchasing of care for respite, day care and domiciliary care,
   - Medical, Nursing, Allied Health Professionals and other staff.

4. Mental Health budget comprises of:-
   - Staff social work and admin infrastructure,
   - External purchasing of care for residential & nursing care,
   - External purchasing of care for respite, day care and domiciliary care,
   - In patient accommodation in Buckie & Elgin.
   - Medical, Nursing, Allied Health Professionals and other staff.

5. Addictions budget comprises of:-
   - Staff – social work and admin infrastructure,
   - Medical and nursing staff
   - External purchasing of care for residential & nursing care,
   - External purchasing of care for respite, day care and domiciliary care,
   - Moray Alcohol & Drugs Partnership.

6. Adult Protection and Health Improvement

7. Care Services provided in-house Services budget comprises of:-
   - Employment Support services,
   - Care at Home service/ re-ablement,
   - Integrated Day services (including Moray Resource Centre),
   - Supported Housing/Respite and
   - Occupational Therapy Equipment Store.

8. Older People & Physical Sensory Disability (PSD) budget comprises of:-
   - Staff – social work infrastructure (including access team and area teams),
   - External purchasing of care for residential & nursing care,
   - External purchasing of care for respite, day care and domiciliary care and
   - Residential & Nursing Care home (permanent care),

9. Intermediate Care & Occupational Therapy budget includes:-
   - Staff – OT infrastructure
   - Occupational therapy equipment
   - Telecare/ Community Alarm equipment,
   - Blue Badge scheme

10. The Care Services provided by External Contractors Services budget includes:-
    - Commissioning and Performance team,
    - Carefirst team,
    - Social Work contracts (for all services)
    - Older People development,
    - Community Care finance,
    - Self Directed support,
    - Employability services and
    - Moray Training

11. Other Community Services budget comprises of:-
    - Community services for each locality (Allied Health Professionals (AHP's), Dental services, Public Health, Pharmacy and other specialist nursing roles).

12. Admin & Management budget comprises of :-
    - Admin & Management staff infrastructure
    - Business Support
    - Contribution to the Chief Officer costs
    - Target for staffing efficiencies from vacancies

13. Primary Care Prescribing includes cost of drugs prescribed in Moray.

14. Primary Care Services relate to General Practitioner GP services in Moray.

15. IJB Hosted, comprises of a range of services hosted by IJB's but provided on a Grampian wide basis. These include:-

    - GMED out of hours service.
    - Intermediate care of elderly & rehab.
    - Marie Curie Nursing Service – out of hours nursing service for end of life patients
    - Continence Service – provides advice on continence issues and runs continence clinics
    - Sexual Health service
    - Diabetes Development Funding – overseen by the diabetes Network. Also covers the retinal screening service
    - Chronic Oedema Service – provides specialist support to oedema patients
    - Heart Failure Service – provided specialist nursing support to patients suffering from heart failure.
    - HMP Grampian – provision of healthcare to HMP Grampian.

16. Out of Area Placements for a range of needs and conditions in accommodation out with Grampian

17. Improvement Grants manged by Council Housing Service, budget comprises of:-
    - Disabled adaptations
    - Private Sector Improvement grants
    - Grass cutting scheme

Other definitions:

Tier 1- Help to help you (information and advice), universal services to the whole community and an emphasis on prevention.

Tier 2- Help when you need it (immediate help in a crisis, re-ablement) and regaining independence.

Tier 3- Ongoing support for those in need through the delivery of 1 or more self-directed support options.

HEALTH & SOCIAL CARE MORAY

DELEGATED AUTHORITY REPORTS - PERIOD OCTOBER 2017 – DECEMBER 2017

Title of DAR	Summary of Proposal	Post(s)	Permanent/ Temporary	Duration (if Temporary)	Effective Dates	Funding
Administration Post	Create new P/T grade 5 post from vacant grade 4, delete grade 4 post	Grade 5 14.5hr Administration Officer to add to existing post holder 21.75 hrs	Perm	N/A		Funding available from deleting grade 4 post
Care at Home temporary contract extensions	Continuing temporary arrangement of Management & Support staff, due to service redesign	Various	Temp	31/03/18	Continuation	Funding from within service from held vacant posts, until CMP and service redesign implemented.
Extend Acting up role Advanced Practioner	Extend acting up for AP to 31.12.17	AP grade 10	Temp	31/12/17		Team Manager post reduced hours – funds acting up
Advanced Practioner reduction in hours	AP in West team to reduce hours form 28 – 20	AP grade 10	Perm	N/A	October 17	Budget reduction being held pending service redesign/CMP
Duty Occupational Therapy Post	Delete Duty OT post and create two part time OT posts	Delete 1.0 grade 9 OT and create 2.x 0.5 grade 9 OT post	Perm	N/A	Sept 17	Funding from deleting grade 9

SERVICE AREA	**SAVING PER IJB PAPER 29.6.17**	**DESCRIPTION PER BUDGET PAPER**	**RAG STATUS**	**SERVICE MANAGER UPDATE**
SECTION A – Savings to be achieved				
Community Nursing	£100,000	Staffing	🛑	A work force/load audit commences 4th December which, through analysis will provide a further update on this saving in relation to potential future achievement. It is unlikely that any level of savings will be received during 2017/18.
Addictions	£54,000	Staffing	✅	Saving achieved in full.
Care Provided In-House	£125,000	Efficiencies from Site Locations	🛑	Savings were initially offered up by better utilising sites and was caveated with the fact that implementation will take time. It is therefore, unlikely these savings will be achieved until 2018/19.
Older People (Intermediate Care & Occupational Therapy)	£30,000	Efficiency target set by service manager	🛑	Increased number of referrals to the service has placed a higher demand on the provision of equipment. It is therefore, unlikely these savings will be achieved.
External Commissioned Services	£140,000	Ongoing Efficiency review	🛑	Savings were initially offered relating to the review of contracts and implementation of the changes to contracts. Process delays will result in these saving not being achievable until 2018/19.
Primary Care Prescribing	£100,000	Local Enhanced Services(LES)	🛑	The saving was reliant on the LES being introduced and agreed by all GP practices. The practices have now signed up for the LES but roll out is still to be confirmed and it is therefore unlikely any saving will be achieved during 2017/18.
Older People (Assessment & Care)	£75,000	Staffing and care requirements	🛑	The saving will not be achievable during 2017/18. Review through change management processes will support the achievement of this saving during 2018/19.
Total Savings Per Budget Paper	£624,000			

ITEMS FOR THE ATTENTION OF THE PUBLIC

- DISCUSSION