MORAY INTEGRATION JOINT BOARD

THURSDAY 26 APRIL 2018, 9.30AM – 12 NOON

INKWELL MAIN, ELGIN YOUTH CAFÉ

NOTICE IS HEREBY GIVEN that a Meeting of the **MORAY INTEGRATION JOINT BOARD** is to be held at **Inkwell Main, Elgin Youth Café** on **Thursday 26 April 2018** at **9.30am** to consider the business noted below.

Councillor Frank Brown
Chair, Moray Integration Joint Board

19 April 2018

AGENDA

1. Welcome and Apologies

2. Declaration of Member's Interests

3. Under paragraph 6.2 of the Moray Integration Joint Board Standing Orders, the public and media representatives will be excluded from the meeting for Items 16 and 17 of business on the grounds that the reports contain information which the Chair wishes to be considered in private.

4. Minute of the Meeting of the Integration Joint Board (IJB) dated 29 March 2018

5. Action Log of the IJB dated 29 March 2018

6. Chief Officers Update – Report by the Chief Officer

ITEMS FOR APPROVAL

7. Evaluation Report – Varis Court Augmented Care Unit and the Forres Neighbourhood Care Team – Report by Mr R Paterson, Senior Project Officer

8. Jubilee Cottages – Report by the Chief Officer

9. Equalities Mainstreaming Progress Report 2016-2018 – Report by the Chief Officer

ITEMS FOR NOTING

10. Minute of the Meeting of the IJB Audit and Risk Committee dated 14 December 2017

11. Revised Health and Social Care Integration Scheme for Moray – Report by the Legal Services Manager (Litigation and Licensing), Moray Council

12. Audit and Risk Committee Assurance Report – Report by the Chief Financial Officer

13. Clinical and Care Governance Committee Assurance Report – Report by the Chief Officer

14. Strategic Plan Review – Report by the Chief Officer

STANDING ITEMS

15. Items for the Attention of the Public – Discussion

Items which the Board will consider with the Press and Public excluded.

16. Funding of Shopmobility Moray – Report by the Head of Adult Services

17. Funding of Moray Handyperson Services – Report by the Head of Adult Services

MORAY INTEGRATION JOINT BOARD

MEMBERSHIP

Councillor Frank Brown (Chair)	Moray Council
Ms Christine Lester (Vice-Chair)	Non-Executive Board Member, NHS Grampian
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
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 Malcolm Metcalfe	Secondary Care Advisor, Moray Integration Joint Board
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 29 MARCH 2018

ALEXANDER GRAHAM BELL CENTRE, MORAY COLLEGE, ELGIN

PRESENT

VOTING MEMBERS

Ms Christine Lester (Chair)	Non-Exec Board Member, NHS Grampian
Councillor Frank Brown (Vice-Chair)	Moray Council
Councillor Claire Feaver	Moray Council
Ms Elidh Brown substitute for Mr Villani	tsiMoray
Councillor Louise Laing substitute for Councillor Morrison	Moray Council
Mr Jonathan Passmore substitute for Professor Croft	Non-Exec Board Member, NHS Grampian

NON-VOTING MEMBERS

Ms Tracey Abdy	Chief Financial Officer
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 Pam Gowans	Chief Officer, Moray Integration Joint Board
Mrs Linda Harper	Lead Nurse, 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
Mrs Val Thatcher	PPF Representative

IN ATTENDANCE

Ms Maggie Bruce	Senior Audit Manager, Audit Scotland
Councillor Tim Eagle	Moray Council
Mrs Margaret Forrest	Legal Services Manager (Litigation and Licensing), Moray Council
Mr Paul Johnson	Moray Alcohol and Drugs Partnership Lead Officer, Moray Council
Councillor Ray McLean	Moray Council
Mr Sandy Thomson	Lead Pharmacist, Health and Social Care Moray

APOLOGIES

Professor Amanda Croft	Executive Board Member, NHS Grampian
Councillor Shona Morrison	Moray Council
Dr Ann Hodges	Registered Medical Practitioner, Non Primary Medical Services
Mr Fabio Villani	tsiMoray
Dr Lewis Walker	Registered Medical Practitioner, Primary Medical Services

1.	**WELCOME and TRIBUTE**
	The Chair welcomed Mr Passmore to this his first meeting as substitute for Professor Croft. The Chair advised Dr Hodges was retiring and Dr Malcom Metcalfe would be replacing her as secondary care advisor from the next meeting. The Board joined the Chair in paying tribute to Dr Hodges for her contribution since the Board was formed.
2.	**DECLARATION OF MEMBERS' INTERESTS**
	Mr Augustus declared he had a personal interest in item 12 – Eligibility Criteria for Unpaid Adult Carers (The Carers (Scotland) Act 2016). There were no other declarations of Members' interests in respect of any item on the agenda.
3.	**MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD DATED 25 JANUARY 2018.**
	The minute of the meeting of the Moray Integration Joint Board dated 25 January 2018 was submitted and approved.
4.	**ACTION LOG DATED 25 JANUARY 2018**
	The Action Log of the Moray Integration Joint Board dated 25 January 2018 was discussed and it was noted all actions other than the following had been completed: i) item 1 – Action Log Dated 14 December 2017 – the Chief Officer advised that changes to the Public Sector Climate Change Duties Reports Submission had still to be completed; ii) item 3 – Annual Report of the Chief Social Work Officer 2016-17 – the Chief Social Work Officer advised a draft report has been issued and a final report will be submitted to the Board once it is available;

	iii) item 4 – Provision of Major Adaptations – to be submitted to Communities Committee at its meeting on 1 May 2018; and iv) item 7 – Her Majesty's Prison and Young Offenders Institute Grampian Health Centre – the Chief Social Work Officer advised prison numbers for Moray residents were low with 11 in Grampian Prison and 45 in Inverness Prison.
5.	**ORDER OF BUSINESS**
	The meeting agreed to vary the order of business as set down on the agenda and take item 10 – Minute of the Meeting of the Integration Joint Board Clinical and Care Governance Committee dated 3 November 2017 as the next item of business as the Chair was of the opinion it was more appropriate to review it at this juncture.
6.	**MINUTE OF THE MEETING OF THE INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE DATED 3 NOVEMBER 2017**
	The Minute of the Meeting of the Integration Joint Board Clinical and Care Governance Committee dated 3 November 2017 was submitted and noted.
7.	**CHIEF OFFICER'S REPORT TO THE MORAY INTEGRATION JOINT BOARD DATED 29 MARCH 2018**
	A report by the Chief Officer provided the Board with an update on key priorities as follows: • New Initiatives – Jubilee Cottages, Elgin, and Varis Court Augmented Care Unit, Forres, are being evaluated over the coming weeks. Progress with the development of a plan for Health and Social Care in Forres will be reported to the April meeting of the Board in the context of the Varis Court report. • Woodview – it was noted that 6 of the units at Woodview, Lhanbryde, are currently occupied. • Keith Health Centre – investigations are ongoing into land for the location of a new health centre. The Project Plan for the health centre will be submitted to the Board during 2018.
8.	**REVENUE BUDGET 2018/19**
	A report by the Chief Financial Officer informed the Board of the position in relation to the revenue budget for the 2018/19 financial year. Lengthy discussion took place on the challenges being faced due to the budget being £4.5m short. Dialogue covered the set aside budget, opportunities to change the provision of services or if there is opportunity to remove some services. It was noted that the settlement from Scottish Government to Moray Council and NHS Grampian had been challenging and had resulted in a less than favourable allocation to the Integration Joint Board. During discussion of the recommendations contained in the report the Chair stated she was of the opinion recommendation 2.1 iii) should be amended to include full support of the Board to allow objectives to be achieved.

	As no one was otherwise minded the Board agreed to the amendment of the recommendation. Thereafter, following further lengthy discussion the Board agreed to: i) approve the proposed savings detailed at paragraph 4.7 of the report; ii) accept the indicative unbalanced Revenue Budget for 2018/19 will be used as a working document to allow services to continue to be delivered, as detailed at appendix 1 of the report; iii) task the Senior Managers, together with the Chief Officer and Chief Financial Officer, with identifying further savings, continuing to pursue alternative methods of service delivery in driving the pace of change, whilst ensuring safe levels of care, to work closely with NHS Grampian and Moray Council with regard to the risk sharing arrangement that exists, and to give full support to the Board to allow it to achieve objectives; iv) a progress report being brought before the 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 of the report respectively to NHS Grampian and Moray Council to allow services to continue without disruption.
9.	**DELIVERING THE NEW 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND**
	A report by Sean Coady, Head of Service outlined 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; the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards; and the requirement for Primary Care Improvement Plans to be developed by 1 July 2018. Discussion took place on changes from the previous GMS to the current one. Dr Taylor advised new workload formulas had been introduced which take no account of rurality, age or sex; this could have consequences for Moray. He further stated there were concerns over some services being centralised as in the past this has led to poorer control. In reviewing the recommendations of the report the Chair stated she was of the opinion that 2.1 iv) should start 'considers and notes' and not 'considers and approves' and that 2.1 v) should be removed from the recommendations. She stated both amendments were required as the Memorandum of Understanding was a national document and would be signed at a national level. As no one was otherwise minded the Board agreed to the amendment of the recommendations.

	Thereafter the Board agreed to :- i) note the content of the report; ii) acknowledge the requirement for the Primary Care Improvement Plan; iii) be involved in the development of the plan prior to submission by 1 July 2018; and iv) note the Memorandum of Understanding (see appendix 1 of the report). Councillors Eagle and McLean, and Mrs Maclaren left the meeting at this juncture.
10.	**PRESCRIBING BUDGETS**
	A report by Pam Gowans, Chief Officer, informed the Board on the challenges in relation to prescribing budgets and, in particular, the elements of that over which the Board has limited control. The report also provided information for the Board in relation to actions being taken, or planned, to address the identified risks. Discussion took place on drugs use and what can be done to try and reduce costs. A campaign is being launched to educate the public to only order medicine when required and not to stockpile items. It was noted that some medication has little benefit however it can be difficult for patients to come to terms with this and can take time to help them understand why it is no longer required. The Lead Pharmacist offered to provide a presentation in Moray on drug costs, should the Board feel it would be of benefit. The Board agreed it would be useful to have a presentation of drug costs. Following further discussion the Board agreed to: i) note the proposed 2018/19 budget for primary care prescribing at £18,058K plus £370K for medicines use in community hospitals and community services; ii) 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.

11.	**PROPOSED CHANGE TO MEETING DATES 2018/2019**
	A report by the Chief Officer proposed a change to the schedule of meetings of the Clinical and Care Governance Committee for 2018/19. Following consideration the Board agreed to approve the revision to the schedule of meetings for the Clinical and Care Governance Committee.
12.	**ANNUAL PERFORMANCE REPORT 2017/18**
	A report by the Chief Officer informed the Board of the progress being made in the development of the Annual Performance Report 2017/18. Discussion took place on what is required in the annual performance report. Discussion took place on the need to help the public understand what is done and how Moray compares nationally. Thereafter the Board agreed to: 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.
13.	**ELIGIBILITY CRITERIA FOR UNPAID ADULT CARERS (THE CARERS (SCOTLAND) ACT 2016)**
	A report by Jane Mackie, Head of Adult Services, informed the Board of the results of the Moray Council public consultation on the draft eligibility criteria for support to unpaid adult carers. Following discussion and consideration of the content of the report the Board agreed to note: i) feedback from the public consultation; and ii) eligibility criteria for support to unpaid adult carers as set out in appendix 1 of the report.
14.	**DUTY OF CANDOUR CONSULTATION**
	A report by the Chief Officer advised the Moray Integration Joint Board (MIJB) on the new Duty of Candour provisions being implemented from 1 April 2018. Following discussion the Board agreed to note the new Duty of Candour arrangements being implemented from 1 April 2018.
15.	**THE MORAY 2015/18 ALCOHOL AND DRUGS PARTNERSHIP DELIVERY PLAN REVIEW**
	A report by Paul Johnson – Moray Alcohol and Drugs Partnership (MADP) Lead Officer informed the Board of the achievements and challenges identified in the review of the Moray 2015/2018 Alcohol and Drugs Partnership Delivery Plan.

	The MADP Lead Officer advised the third sector had help in community engagement. Clarification was sought on how the Board would be kept informed of progress and it was noted that this would be by way of a further report towards the end of 2018 and thereafter an annual report would be produced. Thereafter the Board agreed to: i) note the achievements and challenges identified in the Moray 2015/18 Delivery Plan Review; and ii) a report being submitted towards the end of 2018 and thereafter a report would be submitted annually to inform the Board of the progress in delivering the Moray 2018/21 Alcohol and Drugs Partnership Delivery Plan.
16.	**QUARTER 3 (OCTOBER – DECEMBER 2017) PERFORMANCE REPORT**
	A report by the Chief Officer presented the Board with a performance update at Quarter 3, 2017/18, including: • National core suite indicators and comparison to 32 national IJB's performance (appendix 1 of the report); • Local indicators linked to strategic priorities for Quarter 3 (Oct-Dec 18) (appendix 2 of the report); and • Highlight report on data presented in the National and Local indicators (appendix 3 of the report). The report also updated the Board on the request from the Ministerial Strategic Group for Integration Joint Boards to develop objectives to measure progress against 6 key indicators in 2018 (appendix 4 of the report). Following discussion the Board agreed to note the report submitted to the Ministerial Strategic Group against 6 key indicators in 2018 (appendix 4 of the report).
17.	**REVENUE BUDGET MONITORING QUARTER 3 FOR 2017/2018**
	A report by the Chief Financial Officer updated the Board on the Revenue Budget reporting position as at 31 December 2017 and a provisional forecast position for the year end. Following discussion the Board agreed to 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 of the report; and

	iv) updated budget position to reflect additional funding received through NHS Grampian, as detailed at paragraph 8.1.
18.	**ITEMS FOR THE ATTENTION OF THE PUBLIC – DISCUSSION**
	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) Budget information; ii) Medicines usage; and iii) Implementation of the Carers Act.
19.	**TRIBUTE**
	As this was Ms Lester's last meeting as Chair of the Board prior to Councillor Brown taking over, the Board joined Councillor Brown in thanking Ms Lester for all her effort while Chair.

MEETING OF MORAY INTEGRATION JOINT BOARD

THURSDAY 29 MARCH 2018

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Action Log Dated 25 January 2018	Item 1 – Action Log Dated 14 December 2017 – Changes to Public Sector Climate Change Duties Reports Submission still to be completed.	April 2018	Pam Gowans
		Item 3 – Annual Report of the Chief Social Work Officer 2016-17 – a draft report has been issued – final report to be submitted to the Board once available.	June 2018	Susan Maclaren
		Item 4 – Provision of Major Adaptations – not yet been presented to Moray Council's Communities Committee – submit to next Communities Committee meeting on 1 May 2018.	May 2018	Pam Gowans
2.	Chief Officer's Report to the Moray Integration Joint Board	Progress report required in respect of health and social care in Forres.	April 2018	Pam Gowans
		Project Plan for Keith Health Centre to be submitted during 2018.	June 2018	Pam Gowans
3.	Revenue Budget 2018/19	Senior Officers, together with the Chief Officer and Chief Financial Officer to identify further savings, to continue to pursue alternative methods of service delivery in driving the pace of change, whilst ensuring safe levels of care, to work closely with NHS Grampian and Moray Council with regard to the risk sharing arrangement that exists, and to give full support to the Board to allow it to achieve objectives.	ongoing	Senior Officers

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
	Revenue Budget 2018/19 (cont.)	Progress report to be submitted on the considerations and actions required in addressing the budget shortfall.	June 2018	Chief Financial Officer
4.	Prescribing Budgets	Arrange presentation in Moray on drug costs.	May 2018	David Pfleger/ Sandy Thomson
5.	Annual Performance Report 2017/18	Draft Annual Performance Report to be emailed prior to development session. Draft Annual Performance Report to be presented to June meeting.	April 2018 June 2018	Pam Gowans Pam Gowans
6.	The Moray 2015/18 Alcohol and Drugs Partnership Delivery Plan Review	Progress report to be submitted by the end of 2018. Annual Report to be submitted.	Nov 2018 Ongoing	Paul Johnson Paul Johnson
7.	Items for the Attention of the Public – Discussion	Budget information. Medicines usage. Implementation of the Carers Act.	April 2018	Fiona McPherson

CHIEF OFFICER'S REPORT TO THE MORAY INTEGRATION JOINT BOARD
26 APRIL 2018

Change in Integration Joint Board Chair

This meeting marks the change in Chair from Christine Lester, Non-Exec Board Member NHS Grampian to Frank Brown, Moray Council Councillor. Christine has been in the chair for the past 18 months, prior to which she was Vice-Chair and a member of the Transitional Leadership Group at the inception of Integration and the move toward Integration Joint Boards.

Woodview

Following the publication of a critical Care Inspectorate Report in relation to the unsuitability of an existing residential care facility in Forres (Maybank) for adults with autism, learning disabilities and challenging behaviour; the decision was taken in 2013 to commission the building of 8 bungalows, a communal area and staff office at Woodview, Urquhart Place, Lhanbryde. The underpinning premise of the project was that by supporting the Maybank service users to have their own tenancy and to support them to live in their own bungalows, would have a positive impact in terms of their quality of life. In turn, this would reduce the number of incidents of harm and challenging behaviour and would result on better staff retention and recruitment rates. Historically, Maybank had rarely had a full complement of staff which risked that the facility would have to close due unsafe staffing levels.

During the week of 14 August 2017, Maybank was decommissioned as a care home residence and the service users became tenants at the £2.5m new build development at Woodview.

Based on the above, the project had 2 main business objectives relating to the improvement of the quality of life of the tenants and the recruitment and retention of support workers. These objectives are:-

Objective 1: From September 2017 onwards, the staff retention rate at Urquhart Place will not drop below a monthly average of 80% of the whole time equivelant staff roll for this development; and

Objective 2: From September 2017 onwards, there will be a 50% reduction in the number of incidents at Woodview compared to the historical monthly average at Maybank.

The project has, to date, achieved the above objectives.

In relation to **Objective 1**, the following points should be noted:-

- With the exception of 1 member of staff going on maternity leave, there has been a 100% staff retention rate.

In the last 6 months the following achievements have been identified in relation to **objective 2**. The percentage change is in relation to the same period Oct 2016 to Mar 2017 at Maybank.

- A 71% reduction in PRN (as required additional) medication.
- A 72% reduction in number of incidents per month from 164 to 46
- The overall recorded incident severity is 25% less
- A 95% reduction in staff injuries from 75 to 4
- A 96% reduction in use of BSS (restraint techniques) From 384 to 16 and 100% reduction in use of supine.

While the 4 tenants have only recently moved to Woodview (August 2017), the initial evidence indicates that this project has surpassed its expectations as articulated by the SMART (*Specific / Measureable / Achievable / Relevant / Time-orientated*) business objectives. Two more tenants have moved into Woodview and to date they are both settled and presenting as being happy with their new accommodation. The impact on the individuals and their families cannot be underestimated.

Rob Outrum, Manager, Woodview rob.outram@moray.gov.uk

Signature: Date: 18 April 2018

Designation: Chief Officer Name: Pam Gowans

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 26 APRIL 2018**

SUBJECT: **EVALUATION REPORT-VARIS COURT AUGMENTED CARE UNITS AND THE FORRES NEIGHBOURHOOD CARE TEAM**

BY: **ROBIN PATERSON, SENIOR PROJECT OFFICER**

1. REASON FOR REPORT

1.1 To inform the Board of the progress to date in evaluating the Augmented Care Units (ACU's) and the Forres Neighbourhood Care Team (FNCT), located at Varis Court, Forres.

2. RECOMMENDATION

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

i) note the interim findings of the evaluation report in relation to the ACU test site and FNCT(Appendices 1 to 4);

ii) agree that the ACU test site evaluation and lease period be extended for a further 8 months to allow for a further exploration of the impact of this initiative on the health and social care system in the Forres locality area;

iii) note that this extension will also allow Dundee University to publish their findings in relation to an independent item of research focused on the application of the Buurtzorg principles in relation to the FNCT and the instrumental learning that this may reveal at both local and national levels; and

iv) agree that at the MIJB meeting on 29 November 2018, a further ACU evaluation report will be submitted along with the outline transformation reshaping care plan for the redesign of health & social care services in the Forres area.

3. BACKGROUND

3.1 At the MIJB meeting held on 25 August 2016, Board members agreed to implement a 12 month test pilot of the 5 Augmented Care Unit's (ACU's) at Varis Court, Forres (para 7 of the minute refers).

3.2 At this meeting, it was also agreed that the ACU's and the supporting Forres Neighbourhood Care Team (FNCT) would be evaluated prior to any decision concerning the future continuation of this pilot or the mainstreaming of this test site across Moray.

3.3 As agreed at this meeting, the purpose of this report is to provide an evaluation of the ACU test site and FNCT following this 12 month test period which came to an end on 31 March 2018.

3.4 Board members will however note that this evaluation is presented as an interim report and it is proposed that a full evaluation report will now be submitted to the 29 November 2018 meeting of the MIJB.

3.5 Officers put forward this proposal based on 2 reasons. Firstly, with the 12 month evaluation period ending on 31 March 2018, it has not been possible to collate and analyse a full set of data in time for this Board Meeting. Secondly, Officers are of the opinion that the initial findings would benefit from further exploration and independent academic research.

3.6 The limitations of this interim evaluation report and the justification for further research are noted in paras 4.3 to 4.6 of this report.

3.7 Nevertheless, in the context of the redesign of Health & Social Care services in the Forres locality area, this interim report is considered as an important reference document that can help inform the output of the Forres Professional Project Management Group in terms of the development of an Outline Business Case.

3.8 Following the submission of a report presented to the MIJB Meeting on 25 January 2018 (paragraph 19 of the Minute refers), Board Members agreed that this business case outline would also be presented to the November MIJB Meeting. Both reports will now therefore be presented at the same meeting.

3.9 Board members will note that this report has 4 appendices. These are as follows:-

Appendix 1: Interim Evaluation SBAR Report (this outlines the background and key findings).
Appendix 2: Evaluation of the Operational Workload of the FNCT (this is the main data source referred to in the SBAR report).
Appendix 3: The FNCT Staff Survey (this summarises the findings of a team questionnaire).
Appendix 4: Leanchoil Hospital & ACU Varis Court Cost Comparison.

3.10 The following section of this report will summarise the key insights gained to date against the project test site evaluation outcomes.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 As stated in the report to the MIJB Meeting on 25 August 2016, it was proposed that the test pilot would be evaluated in relation to the following outcomes. These are:-

- An enhanced role for the Community Nursing Staff (both for FNCT and the District Nurse Teams);
- A more rewarding workplace for the ACU staff;
- Alternative treatment locations for medical staff to consider in the treatment of frail older people;
- Faster re-ablement and recovery;
- Improved social interaction and less social isolation;
- Improved Informal Carer Experience;
- Improved quality of life; *and*
- Best value.

4.2 As noted in the SBAR Report (**Appendix 1**), the following is a summary of the key insights in relation to each of these outcomes.

An enhanced role for the Community Nursing Staff (both for FNCT and the District Nurse Teams)

4.2.1 One key insight is that the FNCT have demonstrated that they are a flexible resource who are able to support patients and deliver care in a range of different settings; both within a home setting and within Varis Court.

A more rewarding workplace for the ACU (FNCT) staff

4.2.2 One key insight is that on balance the FNCT Staff Survey demonstrates (**Appendix 3**) more strengths than weaknesses in terms of professional satisfaction. For example, 71% of staff rated that they agreed that 'my work gives me a feeling of personal accomplishment'. Other strengths include autonomy in terms of decision making and the ability to help informal carers, family members and people accessing the service. The areas for development include the closer integration of the FNCT in relation to other health and social care teams in the Forres locality area and the easier accessing of resources and equipment for the team.

Alternative treatment locations for medical staff to consider in the treatment of frail older people

4.2.3 One key insight is that while the FNCT is able through the ACU's to provide care and support for many of the same type of referrals that would be received at Leanchoil Hospital, the re-ablement focus for the ACU development will mean that there is a gap in provision for the very frail and elderly who are 'non-ambulant'. The type of care and support is thought to be missing from the ACU/FNCT model.

Faster re-ablement and recovery

4.2.4 One key insight is that while the number of admissions to the ACU's is limited, the evidence indicates that the FNCT have managed to ensure that beds at the ACU have not become blocked by facilitating a return back home, or an alternative, when patients are medically well but also holistically ready to make this move. The team has helped reduce blockages in the system while supporting better patient outcomes to be achieved.

Improved social interaction and less social isolation

4.2.5 One key insight is that although limited, the evidence would suggest that Varis Court and the ACU's is in a good location to support a re-ablement approach and maintaining contact with the local community.

Improved Informal Carer Experience

4.2.6 The key insight is that although based on limited data, there is qualitative data that supports the view that the ACU and the FNCT help to provide a positive experience for informal carers.

Improved Quality of Life

4.2.7 The key insight is that with a significant number of frail and elderly people with a tenancy at Varis Court, there is evidence that the location of the ACU development and the FNCT within this building contributes to the quality of life for the people who live there.

Best Value

4.2.8 Based on the financial information available **(See Appendices 1 & 4)**, the average cost of a bed at the ACU development is estimated to be broadly comparable with a bed at Leanchoil Hospital. One interpretation of the financial data indicates that the average cost of a bed is 5.6% more expensive at the ACU development compared to Leanchoil Hospital. This is based on maximum bed capacity. Another estimate is that the cost of a bed at the ACU development is 10% less expensive compared to Leanchoil Hospital. This is based on actual bed occupancy.

4.2.9 In terms of the refurbishment, maintenance and repair costs, there is approximately a £4m future cost for Leanchoil Hospital compared to a nil cost for the ACU development. The reason why there is a nil cost for maintenance and repairs for the ACU's is that an allocation for these costs is included in the rent charge for these units. If the 5 ACU's are to be reverted to extra care flats in the future, there will then be a cost for re-carpeting the corridor area. This cost is still to be determined but would be estimated to be in the region of £5k.

4.2.10 In addition there will also be electricity costs to be paid for in relation to the ACU's. Health & Social Care Moray are still to be invoiced for electricity. This cost is therefore still to be determined.

4.3 In summary, the interim evaluation **(Appendix 1)** notes that while the report indicates that the ACU development is achieving positive outcomes for the people referred to this service, informal carers and the FNCT workforce there are a number of limitations in terms of the evaluation.

4.4 These limitations include the presently limited quantitative and qualitative data set used to inform a number of the above insights. This includes, for example, insights from informal carers and other Health and Social Care professionals who have a stake in this project. In addition, there is also an opportunity to more fully understand the economic impact of the ACU's and Varis Court development on the Forres Health & Social Care system. This weakness can however be addressed once a full 12 month data set is secured.

4.5 Further evaluation work also needs to be undertaken in relation to understanding the economic impact of the ACU development and the FNCT on the health and social care system in the Forres locality area. Officers consider that this is an area of research that should be undertaken as an independent item of academic research.

4.6 In addition, it is considered that the application of the Buurtzorg principles, in terms of providing an underpinning ethos for the FNCT, is not only of an interest to the MIJB but will also be of national interest at a time when integration authorities are engaged with redesigning their services with the intent of securing better outcomes. The continuation of the test site will also support this additional strand of research to be undertaken by Dundee University.

4.7 For these reasons, it is therefore recommended that the ACU test site is extended for a further 8 months to help facilitate the above research.

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 interim evaluation insights, as noted above, are consistent with the vision statement and with the 5 strategic priorities identified in the Strategic Commissioning Plan 2016-2019.

The intended outcome of the evaluation is aligned with the vision statement of Health & Social Care Moray: "To enable the people of Moray to lead independent, healthy and fulfilling lives in active and inclusive communities where everyone is valued, respected and supported to achieve their own goals."

(b) Policy and Legal
The evaluation report also reflects the aspirations as set out in the Older People's Commissioning Strategy for Moray (2014) and the 2020 Vision which aims to enable everyone to live longer, healthier lives at home or in a homely setting.

(c) Financial implications
Based on the costs profile for the current 12 month test site, the extension of the ACU/FNCT test site for a further 8 months from 1 April to 30 November 2018 is estimated to cost £327,160.

This cost will cover the leasing costs for the 5 ACU's and temporary secondment staffing costs.

It is however, anticipated that this will be a maximum cost and a revised staffing model -which is currently being developed- will aim to reduce the above cost. In reducing these costs, Officers are mindful that any future model of delivering health and social care in the Forres locality area needs to be financially sustainable and will work to achieve this goal.

Board members should also note that it is a requirement that 3 months' notice is also given to Hanover (Scotland) Housing Association Ltd if the 5 flats are no longer to be utilised as ACU's. It is estimated that this will cost an estimated £11,415 if the test site is terminated on 30 November 2018. In converting the ACU's back to extra care flats, there will also be a minimal cost involved in removing white goods etc from the units.

(d) Risk Implications and Mitigation
As the extension period of the proposed test site comes to an end, there is risk that FNCT staff will prematurely terminate their secondment and return to their substantive posts. There is therefore a risk that the evaluation period would be forced to be curtailed. The proposed mitigating action to address this risk is to give FNCT members a reassurance that their substantive posts are secure and will not be affected by the extension of this test site.

(e) Staffing Implications
As noted above, for the test site to be operational from 1 April to 30 November 2018, it will be necessary to extend the secondments for the existing FNCT team for a further 8 months.

The necessary arrangements to extend these secondments or to ensure an appropriate nurse team staff complement for the test site is in place, will be the responsibility of the NHS Grampian Human Resource function.

(f) Property
There are no property issues directly arising from this report for Health & Social Care Moray, Moray Adult Community Care Services or NHS Grampian. The 5 ACU's are part of the Varis Court Development and are part of a service contract between Hanover (Scotland) Housing Association Ltd and Moray Adult Community Care Services on behalf of Health & Social Care Moray.

If the MIJB agree to approve the test site for a further 8 months, it is proposed that use of the 5 ACU's can be extended as a variation of the existing contract with Hanover (Scotland) Housing Association Ltd. subject to the approval of the Integration Joint Board. The Hanover Area Service Manager has also offered to extend the use of the 5 ACU's for a further 8 months.

If the MIJB do not agree to extend this test site for a further 8 months, the 5 ACU's can be reverted to extra care units at a minimal cost.

(g) Equalities

There are no equality issues directly arising from extending this test site for a further 6 months.

(h) Consultations

This report has been circulated to
Lesley Attridge (Intermediate Care & OT Manager),
Roddy Huggan (Commissioning & Performance Manager),
Jane Mackie (Head of Adult Services),
Karen Innes (HR Manager, NHS Grampian),
Bob Sivewright (Finance Manager, NHS Grampian),
Deborah O'Shea (Snr Finance Officer),
Fiona Abbott (Acting Service Manager Community Hospitals. The Forres Core Professional Group (including GP's from the Varis and Culbin Practices),
Tracey Abdy (Chief Finance Manager),
Matt Offer (FNCT Lead), Legal Services Manager (Moray Council) and
Pam Gowans (Chief Officer).

One comment received from Fiona Harris, Practice Manager, Culbin & Varis Medical Practices disagrees with para 4.2.3 of this report and contends that:-

"The remit of Leanchoil is different to that of the Varis Court ACU & FNCT (Leanchoil provides step up/down beds for Dr Gray's Hospital (DGH) whereas Varis Court ACU & FNCT provides short-term acute beds/care to avoid hospital admission). It would not be appropriate for Varis Court ACU & FNCT to receive the referrals which currently go to Leanchoil, as these are predominantly step down from DGH and therefore currently result in much longer admissions which would block the beds in the ACU".

All others who were consulted are in agreement with the content of the report where it relates to their area of responsibility.

6. CONCLUSION

6.1 Board members are asked to note the interim findings from the Varis Court ACU and FNCT test site;

6.2 Board members are asked to support the extension of the ACU test site for a further 8 months from 1 April to 30 November 2018;

6.3 Board members will note that this extension will allow further time for the test site to be evaluated;

6.4 Board members will note that a full evaluation report will be submitted to the IJB Meeting along with the outline transformational reshaping care plan for the redesign of health & social care services for the Forres Locality Area on 18 November 2018.

Author of Report: Robin Paterson, Senior Project Officer
Background Papers: available from the author of this report

Ref:

Signature: _____ Date: 17 April 2018

Designation: Chief Officer Name: Pam Gowans

Subject: Interim Evaluation SBAR Report- Varis Court Augmented Care Units and the Forres Neighbourhood Care Team.

1.0 Situation

1.1 At the Integrated Joint Board Meeting held on 25 August 2016, it was agreed that a 12 month test pilot of the 5 Augmented Care Units (ACU's) at Varis Court and the supporting Forres Neighbourhood Care Team (FNCT) would be evaluated.

1.2 The objective for this evaluation is to explore if a new model of care relating to this development could provide a more sustainable way of delivering health and social care services in the Forres locality area.

1.3 Since this approval was given, the reason for embarking on this test site has become more acute since nurse staffing levels at Leanchoil Community Hospital can no longer be maintained at a safe level for 9 inpatients and, at the time of submitting this report, the number of beds at the hospital has been reduced to 4. The reduction in admissions reflects the nurse staffing resource that is currently available.

1.4 Consequently, in light of the increasing uncertainties in relation to the future viability of Leanchoil hospital, at the Integrated Joint Board Meeting held on 25 January 2018, it was agreed that the recently established Forres Locality Professional Core Group would be given the responsibility for developing an outline business case for a sustainable model for the delivery of health and social care services in the Forres locality area.

1.5 It is the expectation that this group will present this outline business case for consideration and approval by the Integrated Joint Board in November 2018.

1.6 The purpose of this report is therefore twofold. The original purpose for developing this SBAR report was to give an interim up-date on the insights that can be gained from the ACU test site to the Integrated Joint Board Meeting on 26th April 2018.

1.7 Following the establishment of the Forres Locality Professional Core Group, the additional reason for this report is to contribute to establishing an evidence base for the redesign health and social care services in the Forres locality area.

2.0 Background

2.1 The focus of this evaluation project is the 5 bed ACU development which is located within the 33 unit extra care housing development at Varis Court and the FNCT that supports these units.

2.2 Varis Court was originally commissioned by Health & Social Care Moray to provide affordable accommodation that meets the demand for sheltered and extra care housing for older people with complex care needs in the Forres area.

2.3 The relatively large number of units contained within this new build meant that 5 of these apartments could be leased to Health & Social Care Moray on a 12 month trial basis as a test site for the delivery of inpatient care in the Forres locality area.

2.4 As part of the rationale for developing this proposal, Health & Social Care colleagues considered that in contrast to a hospital ward setting the provision of 2 bedroomed apartments with kitchen facilities could facilitate in aiding re-ablement, recovery and reducing the risk of institutionalisation. The location of the units near the centre of Forres and being part of wider community development could also potentially be beneficial to the health and well-being of the people admitted to the ACU's and promoting social inclusion.

2.5 In terms of staffing, a 24 hour/7 day a week nursing team (later named as the Forres Neighbourhood Care Team -FNCT) was recruited to support the ACU's. The posts proposed to be recruited were 1wte x band 8a and 10.98 wte X band 5's at a cost of £487,000.

2.6 Following the agreement of the Integrated Joint Board (IJB), at the meeting on 25 August 2016, the purpose of this test site was to explore how the ACU development could support the personal outcomes of the people staying in these 5 units for reablement and recovery as well as a number service outcomes for Health & Social Care Moray.

2.7 In determining if the ACU development could be adopted and mainstreamed as part of future health and social care provision in the Forres locality area , the immediate and specific purpose is therefore to explore the impact and learning from this development in relation to the following outcomes:-

- An Enhanced role for the Community Nursing Staff (both for FNCT and the District Nurse Teams);
- A more rewarding workplace for the ACU staff;
- Alternative treatment locations for medical staff to consider in the treatment of frail older people;
- Faster re-ablement and recovery;
- Improved social interaction and less social isolation;
- Improved Informal Carer Experience; and
- Improved quality of life.

2.8 In addition, if a sustainable model for the future delivery of health and social care services is to be identified, it is important to explore if the ACU and the FNCT developments represent best value for money for Health & Social Care Moray. This is also a key element of the test site to be ascertained.

2.9 Finally, it should also be noted that a research proposal by Dr Brian Howieson, Faculty of Health Studies, The University of Dundee, is presently being developed to explore the application of the Buurtzorg principles in relation to the operation of the FNCT.

2.10 This piece of independent research will include a literature review as well as primary research with colleagues and other project stakeholders in the Forres Locality area. It is the intention that the paper will be ready to be presented to the IJB Meeting in November before being published as an academic paper.

3.0 Appraisal

3.1 The 12 month evaluation period for this test site runs from April 2017 to March 2018. The late start date following IJB approval reflects the time taken for the ACU to be established; including the recruitment of the FNCT.

3.2 The time taken for the project to become fully operational means that, subject to IJB approval, it is proposed that the 12 month test site period will be further extended. This extension will allow further data to be gathered from this test site.

3.3 Please also note the data included in the Operational Workload covers the period 01 April 2017 to 16 December 2017 inclusive.

3.4 Using both quantitative and qualitative data, 'Draft Evaluation of the Operational Workload of the Forres Neighbourhood Care Team' has been prepared by Shirley Feaks, Performance Officer, Health & Social Care Moray (**See Appendix 2**).

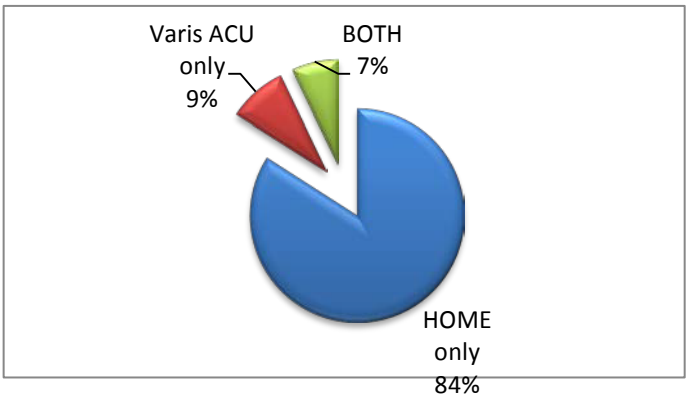
3.5 The data from this evaluation, has been used to consider the impact of the project in relation to each of the pre-agreed outcomes noted in para 2.7 of this report. Each of these outcomes and the related key insights gained will now be outlined in turn.

3.6 An Enhanced role for the Community Nursing Staff

3.6.1 Although the test site was originally conceived as being based on the premise that the FNCT would provide support solely within the confines of the ACU's, the following chart illustrates that the team have provided to date 95% of all their patient support in the home and 16% of support in either a combination of the ACU or in the home environment.

Receipt of Care:

Place of care	No OF REFERRALS
Home only	95
Varis only	10
Both	8
TOTAL	**113**



3.6.2 From August, a higher amount of support has been provided within the ACU's and during the month of November there was a total of 63 beds days for 8 patients **(see Appendix 2:p22).**

Key Insight

3.6.3 One key and clear insight that can be drawn from this data is that the FNCT have demonstrated that they are a flexible resource who are able to support patients and deliver care in a range of different settings; both within a home setting and within Varis Court.

3.6.4 This degree of flexibility to work in a range of different settings is an important point when considering the future role of the local District Nursing Team as part of the redesign of health and social care services for the Forres locality area.

3.7 A more rewarding workplace for the ACU staff

3.7.1 As previously noted, at the inception of this test site it was the intention that 11 WTE's Nurses would be recruited for this project.

3.7.2 A total of 8 WTE's were however filled for the FNCT leaving 3 posts vacant. However, it should be noted that the bank staff have been used on an ad hoc basis to cover planned leave for FNCT members. To-date, all members of the FNCT have been retained.

3.7.3 A staff questionnaire was also provided for all FNCT members to complete from 19 to 23 March 2018 **(See Appendix 3)**.

3.7.4 The questionnaire provide FNCT members the opportunity to rate their response to 7 questions. These questions related to the level of job satisfaction, the degree of autonomy experience in relation to decision making and the opportunity to use their skills and abilities to help others.

3.7.5 The questionnaire was completed by 7 of the 8 team members.

3.7.6 The following table ranks the 'highest' scoring questions.

Rank	Question	% 'Strongly' & 'Somewhat Agree' combined
1=	e- When a patient, carer or a family member has an issue, I can usually help support with resolving it.	100%
1=	d-I understand my role in the team.	100%
1=	g-How satisfied are you with your involvement in decisions that affect your work?	100%
4	a-I feel encouraged to come up with new and better ways of doing things.	86%
5	b-My work gives me a feeling of personal accomplishment	71%
6	h-Considering everything, how satisfied are you with your job?	57%

3.7.7 The following table ranks the 'lowest' scoring questions.

Rank	Question	% 'Strongly' & 'Somewhat Disagree' combined
1=	f-My job makes good use of my skills and abilities.	29%
1=	c-I have the tools and resources to do my job well.	29%

3.7.8 The questionnaire also offered the opportunity for FNCT members to comment on their experience of being a member of this test site. The comments provided, gave the opportunity to expand on the responses noted above.

3.7.9 For example, in response to the question 'what is different being a member of the FNCT compared to your previous nursing role', one responded said:

"Much less paperwork and audits. I feel as though I have time to get to know the patients and their families. I miss the ease of referral to MDT/Medics that was available in my last job. Encouraged in my new role to 'learn and develop' and to think more. Change of management structure makes me feel empowered to do the 'right thing' for patients and their families. I feel that I have the freedom to choose how I fulfil my role in the best interest of service users. This could be sitting with a dying patient or doing a jigsaw. Very much outwith the traditional 'medical model." FNCT member

For example, in response to the question "what do you think are the benefits to the people who you have supported which perhaps might not have been realised through an orthodox nursing approach?"

" People have benefited from 24 hour nursing care and being able to be supported in their own community. By developing therapeutic relationships and looking at the 'whole picture' – social, physical, spiritual, psychological, and emotional needs - have been able to inspire hope and confidence. Allowing people and their families to feel truly listened to and respected. Some people I have supported have benefited from being signposted to clinical nurse specialists in order to address their concerns. They have benefited from being signposted to services that may help them." FNCT Member.

3.7.10 The survey also recorded responses that are also possible future areas for development if the test site is to be extended.

"Closer ties with the DN's with shared knowledge and skills being utilised. More nursing based referrals rather than care. Regular in house training sessions. Named nurses with individual patients to oversee – access, OT, physio, referrals and discharges instigated from the first contact. Weekly meetings to discuss patients, workloads and support each other in keeping on track." FNCT Member.

In response to the opportunity to comment on "Do you have any other additional comments", it was commented;

"The ability to order own supplies/ equipment. Better communication with the MDT. More staff." FNCT Member.

Key Insights

3.7.11 In light of the national challenge to recruit nursing staff and in the context of the difficulties to recruit safe levels of nursing staff at Leanchoil Hospital, the success in recruiting for these temporary FNCT positions, albeit short of 3 WTE vacant posts, suggests that if a project is innovative in design then there is greater likelihood in filling nursing posts.

3.7.12 Anecdotally, this insight is substantiated by other innovative projects delivered by Health & Social Care Moray.

3.7.13 Since the difficulties experienced in recruiting sufficient numbers of nurses for Leanchoil Hospital has been a key driver for a more sustainable model of delivering health and social care services in the Forres locality area then this is an important point to be considered in any future redesign of services.

3.7.14 On balance the FNCT Staff Survey also demonstrates more strengths than weaknesses in terms of professional satisfaction. For example, 71% of staff rated that they agreed that 'my work gives me a feeling of personal accomplishment'. Other strengths include autonomy in terms of decision making and the ability to help informal carers, family members and people accessing the service. The areas for development include the closer integration of the FNCT in relation to other health and social care teams in the Forres locality area and the easier accessing of resources and equipment for the team.

3.8 Alternative treatment locations for medical staff to consider in the treatment of frail older people

3.8.1 The reason for the referral to the FNCT in relation to the ACU development, home based support or a combination of both is recorded in **Appendix 2 (page 19).**

3.8.2 For the ACU, the following table summarizes the reason for the referral.

4.6 The reasons for referral are as follows:

Reason for Referral	No	%
Palliative care	2	20.00%
Pain management	2	20.00%
UTI/ Respite	1	10.00%
Rehydration	1	10.00%
Fall/ back pain	1	10.00%
Push fluids	1	10.00%
UTI	1	10.00%
Respite	1	10.00%
Grand Total	**10**	**100.00%**

3.8.3 Once referred, the type of care provided in the ACU is noted below.

"4.10 The type of care provided to patients in the ACU was as follows:"

Type of care (more than one option can be applied)	No
Other	5
Venepuncture	4
Pain management	3
Catheritisation	2
Personal Care	2
Respite	2
reable	2
End of life	1
IV Fluids	1
Signposting	1
Total	23

3.8.4 In relation to the support provided in a home setting, the data shows a higher volume of referrals (95) **(Appendix 2:p1)** for the same period but in most cases a more straightforward treatment plan.

3.8.5 The qualitative data gathered also indicates that the support and treatment provided through the ACU's has prevented acute hospital admissions and as.

3.8.6 For example, the FNCT have noted in their records that:-

"Cognitive impairment came in with wife for respite for her. Without FNCT support wife would have not been able to cope due to her own medical condition and both could have been admitted to hospital."

"Off legs, dehydrated, pyrexial, not eating and drinking, nauseated, oral thrush, not tolerating medication. Antibiotics and anti-fungal cream changed with good effect, Required close nursing care, fluids, bloods and NEWS monitoring. Without FNCT support would have been admitted to hospital."

and

"Contacts x 7 days in Varis Court - all care & 46 visits. Patient was acutely unwell with UTI, constipation and dehydrated on admission to Flat 4. He was unable to care for himself at home and would certainly have required admission to hospital for rehydration and treatment of UTI. Patient lost alot of confidence as his illness coincided with 90th birthday and it concerned him that it was the 'beginning of the end.' Following discharge home FNCT continued to visit x2 daily and then reduced to x1 daily to check on him and help rebuild."

3.8.7 With the exception of the palliative cases, it is important to note that the above individuals have health conditions that would respond to a re-ablement and recovery approach.

3.8.8 Forres GP's, have however highlighted that there are admissions to Leanchoil Hospital that would not benefit from a re-ablement approach and would require a more intensive level of nursing care.

Key Insights

3.8.9 In many instances, the above data indicates that the FNCT is able through the ACU's to provide care and support for many of the same type of referrals that would be received at Leanchoil Hospital.

3.8.10 There is evidence to support the view that the use of the ACU's has prevented ongoing admissions to an acute setting.

3.8.11 The Forres GP's have noted that the re-ablement focus for the ACU development will mean that there is a gap in provision for the very frail and elderly who are 'non-ambulant'. The type of care and support is thought to be missing from the ACU/FNCT model.

3.8.12 An additional model of care that meets the needs for the very frail/elderly non-ambulant would therefore also need to be developed if Leanchoil Hospital was to be decommissioned.

3.8.13 Although not recorded in **Appendix 2**, the FNCT have also identified that treatment and support could be further enhanced with the provision of bottled oxygen on site at the ACU. The provision of an oxygen concentrator has now been agreed and will allow the ongoing treatment for patients requiring oxygen thus reducing the potential need for admission to an acute setting.

3.8.14 Through the Staff Survey, FNCT members also identified that having "to hand like previous jobs – iNR, bladder scanner" would be beneficial to this model.

3.8.15 The highest reason for all referrals into the FNCT was due to Falls (17 total, 15%), followed by Palliative care (13 total, 11.5%) and hospital discharge. (8 total, 7%) **(Appendix 2:p3)**

3.9 Faster re-ablement and recovery

3.9.1 Based on the data available the length of stay at the ACU's ranges from 1 day to 49 days and the average length of stay is 12.8 days.

3.9.2 When the palliative cases are excluded, the average length of stay is 19.3 days. The shortest stay was 4 days and the longest was 49 days. This is broadly in line with what would be considered an appropriate period of time for re-ablement.

Key Insights

3.9.3 While the number of admissions to the ACU's is limited, the above evidence indicates that the FNCT have managed to ensure that beds at the ACU have not become blocked by facilitating a return back home, or an alternative, when patients are medically well but also holistically ready to make this move. The team has helped reduced blockages in the system while supporting better patient outcomes to be achieved.

3.9.4 As the qualitative evidence throughout the report indicates, there is evidence that positive personal outcomes have been delivered for both people receiving support within the ACU and at home.

3.9.5 As noted in 3.8.11, it is noted that some people who are very frail/elderly will not benefit from a re-ablement approach.

3.10.1 In relation to the above outcome, there is also evidence that the location of the ACU's and Varis Court in close proximity to the town centre of Forres is an asset and supports reablement and recovery.

3.10.2 For example, the FNCT have noted:

"Inpatient in ACU 13/7 - 20/7. Her daughters and carers & other daughter who lives locally is struggling to cope. Patient admitted into ACU for one week…This is a new phase of her care as she have previously been reluctant to have carers to look after her at home, preferring her daughters to shower and look after her. She has had previous admissions to Dufftown for respite but much preferred being in Forres. She very much enjoyed going up the town in her wheelchair"

Key Insights

3.10.3 Although limited, the evidence would suggest that Varis Court and the ACU's is in a good location to support a re-ablement approach and maintaining contact with the local community.

3.11.1 There is limited data in relation to the informal care experience following an admission to the ACU. The following table indicates the categorisation of informal carers (Appendix 2;p19).

"The informal carer details are as follows:"

Informal Carer	No
carers	2
Daughter	1
Varis Court	1
Husband	1
Wife	1

3.11.2 The following comments, give an insight into the informal carers experience of engaging with the FNCT:-

"Difficult social circumstances…SW involved to ensure patient safety. Daughter struggling to cope with patient who lives with her. Recent chest infection and now UTI. Needing fluids encouraged and antibiotics. Without FNCT patient would have been admitted as daughter unable to cope (going through a divorce - husband being very difficult - living in annexe). Patient unwell with UTI increased anorexia, possible bowel ? Being investigated."

"Respite for her as unable to cope with own medical condition. Came in with husband who has dementia."

and

"Cognitive impairment came in with wife for respite for her. Without FNCT support wife would have not been able to cope due to her own medical condition and both could have been admitted to hospital."

Key Insights

3.11.3 Although based on limited data, there is evidence that the ACU and the FNCT help to provide a positive experience for informal carers.

3.12 Improved quality of life

3.12.1 As previously noted, the 5 ACU's are located in Varis Court which is run by Hanover Housing (Scotland) Ltd. The 28 other units at this location are occupied by people who have their own tenancy.

3.12.2 When Varis Court was commissioned by Health & Social Care Moray, there was a commitment by all parties to adopt a 'whole house' approach. This means that whenever possible, the different staff teams would always strive to work together to support the well-being, independence and quality of life of tenants.

3.12.3 While the impact of this project on this outcome will also be encompassed by the Buurtzorg Principles Evaluation undertaken by the University of Dundee, there is evidence of good working relationships being established with the mutual aim of supporting the quality of life of tenants at Varis Court. For example, the FNCT have recorded:-

"Resident Varis, moved to ACU. Palliative care was supported in ACU preventing hospital admission."

Key Insights

3.12.4 With a significant number of frail and elderly people with a tenancy at Varis Court, there is evidence that the location of the ACU development and the FNCT within this building contributes to the quality of life for the people who live there.

3.13 Consideration of Value for Money

3.13.1 A revenue cost comparison of the Leanchoil Hospital and the ACU's has been prepared by Bob Sievewirght, Finance Manager, Health & Social Care Moray (See Appendix 4).

3.13.2 The financial data can be presented in two ways based on a number of assumptions.

3.13.3 The first interpretation based on bed capacity and using the estimated staffing and other running costs for 2017/18, means that the average cost of a bed at Leanchoil Hospital is estimated to be £214/day. This compares to £226/day for a bed at the ACU development.

3.13.4 This cost comparison is based on the assumption that there are 8 beds at Leanchoil and 5 beds at the ACU development.

3.13.5 However, a second interpretation is that for 2016/17 taking into account actual bed occupancy, the cost of a bed day at Leanchoil was £250/day (based on Leanchoil bed day capacity). This would therefore be more expensive than the £226/day for a bed at the ACU development.

3.13.6 This cost comparison in based on the ACU running at full occupancy and the restricted capacity at Leanchoil Hospital.

3.13.7 In terms of the capital costs, it has previously been identified that the cost of refurbishment, to ensure that Leanchoil Hospital is fit for purpose, would be approximately £3m (based on a 2013 estimate). This estimate will be confirmed for the final evaluation report.

3.13.8 In addition, the backlog maintenance & repair cost for the hospital has been estimated to be in the region of £1m (based on a 2010 estimate). This estimate is subject to confirmation.

3.13.9 For the ACU development, there are no maintenance and repairs costs. A contribution to the capital costs are part of the lease arrangements with Hanover Housing (Scotland) Ltd.

3.13.10 It should be noted that from the 1 April 2018, the lease cost for the 5 ACU's will be reviewed by Hanover. Future costs could therefore be expected to be marginally more expensive.

3.13.11 In collating this interim report, it has not been possible to evaluate the financial impact of the FNCT supporting people in their own homes and on the wider health & social care system in the Forres area.

Key Insights

3.13.12 Based on the financial information available, the average cost of a bed at the ACU development is estimated to be broadly comparable with a bed at Leanchoil Hospital. As noted above, one interpretation of the data indicates that the average cost of a bed is 5.6% more expensive at the ACU development compared to Leanchoil Hospital and the other estimate is that the cost of a bed at the ACU development is 10% less expensive compared to Leanchoil Hospital. This is based on current staffing levels.

3.13.13 In terms of the refurbishment, maintenance and repair costs, there is approximately a £4m future cost for Leanchoil Hospital compared to a nil cost for the ACU development. As previously noted this capital cost is subject to confirmation.

3.13.14 In terms of the above capital costs, the absence of any financial risk for the ACU development is an important factor to be considered in relation to the development of a sustainable model for delivering health care services in the Forres locality area.

3.13.15 An exploration of the impact of the FCNT on delivering support in people's homes may also reveal additional financial benefits. Exploration of these additional potential benefits will be attempted to be ascertained as part of the final evaluation report.

3.14 Interim Appraisal Summary

3.14.1 Although in many instances the data available is limited, the interim evaluation report does indicate that the ACU development is achieving positive outcomes for the people referred to this service, informal carers and the FNCT workforce.

3.14.2 In light of these benefits and in the context of a broadly comparable average bed cost and all capital costs being covered by the lease payments to Hanover (Scotland) Housing Ltd, it is considered that the ACU development and the supporting FNCT does represent value for money and should be fully considered as part of the future plans for the redesign of health and social care services in the Forres locality area.

4.0 Recommendations

- **The Integration Joint Board and the Forres Locality Core Professional Group is asked to:-**
- **note the insights gained from this evaluation report;**
- **note that a further evaluation report will be generated based on the findings from a complete data set for this test site;**
- **note that further work needs to be undertaken to evaluate the financial impact of the ACU/FNCT on supporting people in their own homes and on the wider health & social care system in the Forres Area; *and***
- **note that Dundee University intend to evaluate the impact of the adoption of the Buurtzorg principles by the FNCT.**

Prepared by:- Robin Paterson, Snr Planning Officer, Shirley Feaks, Performance Officer

Bob Sivewright, Finance Manager and Matt Offer, Forres Neighbourhood Care Team Lead

Evaluation of Operational Workload of Forres Neighbourhood Care Team (FNCT) @ Varis Court - 01 April 2017 – 16 December 2017 inclusive

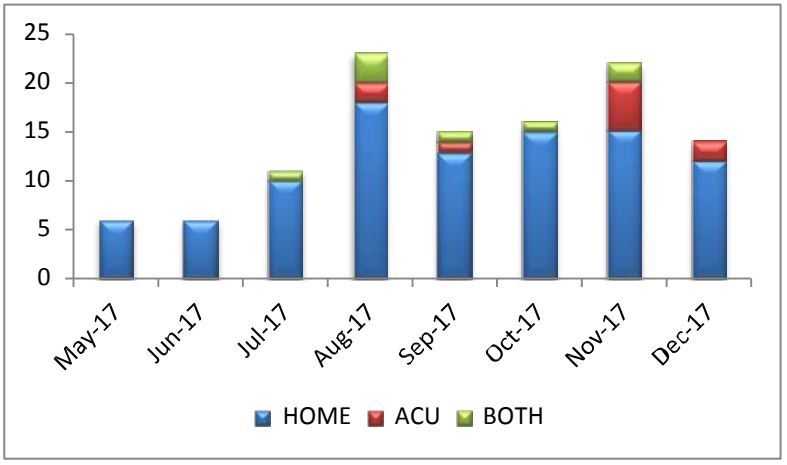
This is a report based on data gathered from 01 April 2017 to 16 December 2017. The FCNT was established as a test site for an initial period of one year.

The number of referrals made to the FCNT team per month is as follow for receipt of care to be provided at:

1. **Patients Home,**
2. **Augmented Care Units (ACU = total 5 flats),**
3. **Both (amalgamation of Patients home and ACU).**

Total number of referrals received by FCNT

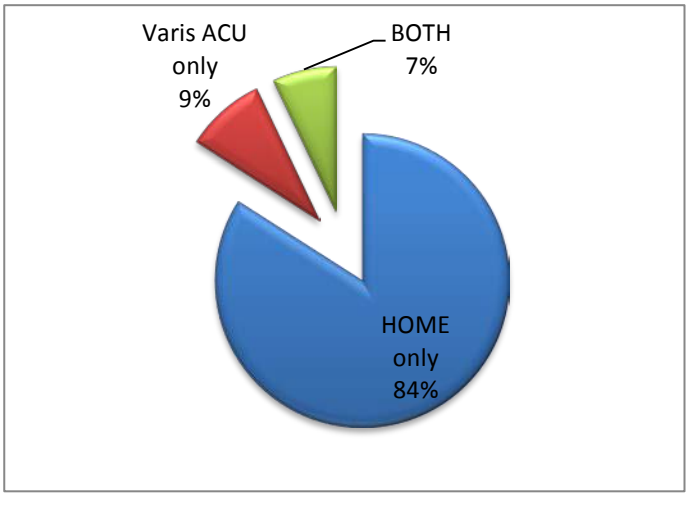
Month	HOME	ACU	BOTH	ALL
May-17	6	0	0	**6**
Jun-17	6	0	0	**6**
Jul-17	10	0	1	**11**
Aug-17	18	2	3	**23**
Sep-17	13	1	1	**15**
Oct-17	15	0	1	**16**
Nov-17	15	5	2	**22**
Dec-17	12	2	0	**14**
TOTAL	**95**	**10**	**8**	**113**



The total number of referrals received by the FNCT between 01 April 2017 – 16 December 2017 totalled **113 separate referrals**. Of these referrals, August seen the largest number of referrals, whereas May and June seen the least whilst the test site was being established. Of the 113 referrals **84% (95)** the FNCT provided a service in the service user's home.[1]

Receipt of Care:

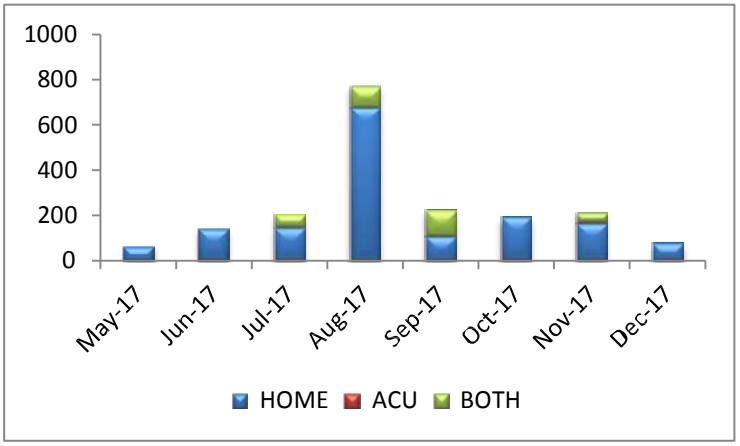
Place of care provided	No of Referrals received by FNCT
Home only	95
Varis only	10
Both	8
TOTAL	**113**



[1] It may be worth noting the ACU flats were fully occupied in the subsequent week after the 16 December but no record audit forms have been received to verify this.

Total number of contacts[2]

Month	HOME	ACU[i]	BOTH	ALL
May-17	63	0	0	**63**
Jun-17	141	0	0	**141**
Jul-17	146	0	56	**202**
Aug-17	679	0	93	**772**
Sep-17	106	2	114	**222**
Oct-17	190	0	1	**191**
Nov-17	166	3	45	**214**
Dec-17	73	1	0	**74**
TOTAL	**1564**	**6**	**309**	**1879**

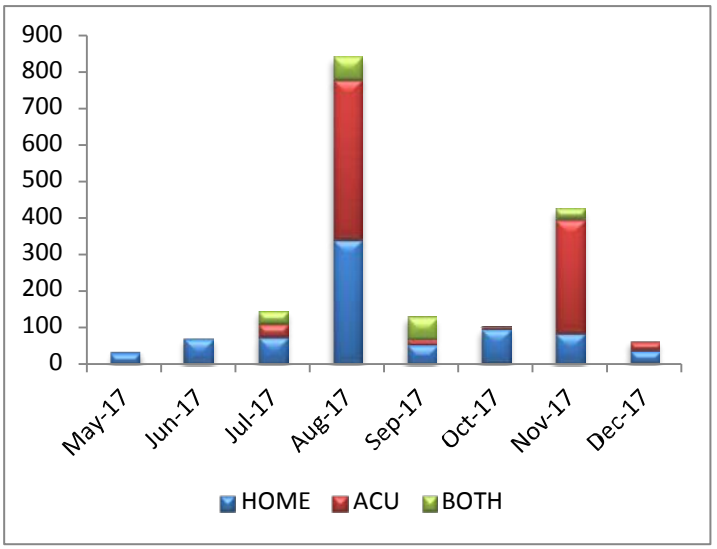


There is no reliable way of monitoring length of staff time per visit/contact with clients. As a estimate at 30 minutes per contact the total staff time could be 1879 contacts x 30 mins = 939.5 hours. Average of 8.3 hours of staff time per referral (of all referrals).

Estimated time per month in staff hours (ALL STAFF)

Month	HOME	ACU	BOTH	ALL
May-17	31.5	0	0	**31.5**
Jun-17	70.5	0	0	**70.5**
Jul-17	73	35	35	**143**
Aug-17	339.5	435	65.5	**840**
Sep-17	53	15	60	**128**
Oct-17	95	5	0.5	**100.5**
Nov-17	83.5	310	29.5	**423**
Dec-17	36.5	25	0	**61.5**
TOTAL	**782.5**	**825**	**190.5**	**1798**
Average per month (*7.5 months)	**104.3**	**110.0**	**25.4**	**239.7**

*Estimate a minimum of 5 hours per day per person



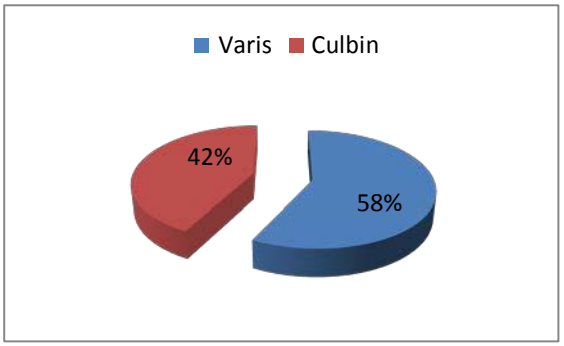
There is no reliable way to record the staff travelling time, however, as an indicator at 20 minutes travel time (10 mins each way) per contact at HOME only could be 1564 contacts x 20 mins = 3910 hours travelling over the reporting period (Average of possibly 521 hours per month (3910 / 7.5 months). Please note: not all contact time was visiting; some contacts were done over the telephone.

[2] The number of contacts are not recorded within admission to the ACU flats

The average age of people who received care increases with the intensity of care/nursing care required. The average at HOME is 80.7 years of age. Where care was provided at BOTH the average age is 83 years of age. Whereas the average age of those admitted into the ACU is 85.5 years of age.

The referrals of which where the patient was a patient of the GP Practice:

GP Practice	No
Varis	65
Culbin	48
Total	**113**



The highest reason for all referrals was due to Falls (**17 total, 15%**), followed by Palliative care (**13 total, 11.5%**) and hospital discharge. (**8 total, 7%).**

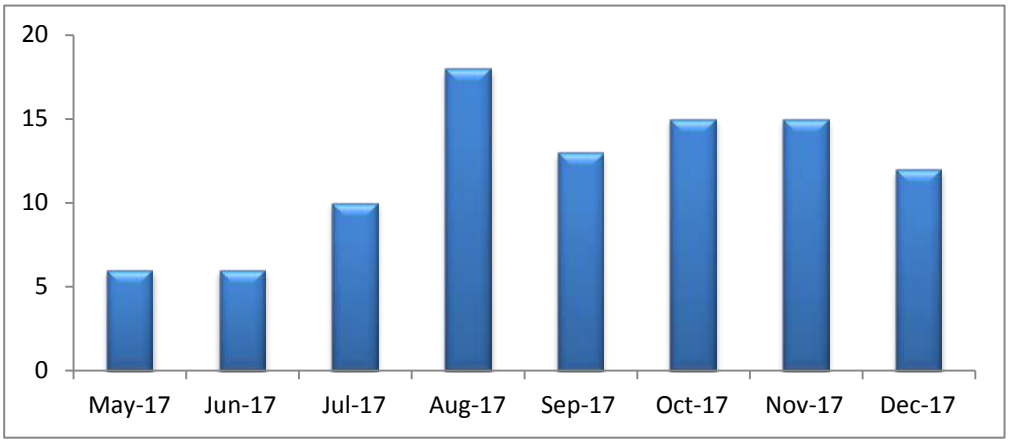
Referral Reason	% (top ten)	Number
Fall	15.04%	17
Palliative care	11.50%	13
hospital discharge	7.08%	8
Pain management	2.65%	3
UTI	2.65%	3
Generally unwell	2.65%	3
Pain management	1.77%	2
Catheter not draining	1.77%	2
Palliative	1.77%	2
Vomiting	1.77%	2
COPD	1.77%	2
Assessment	1.77%	2
Viral Pharyngitis	1.77%	2

The details of referrals have been analysed as per where the receipt of care has taken place on the following pages.

CARE RECEIVED AT PATIENTS HOME ONLY

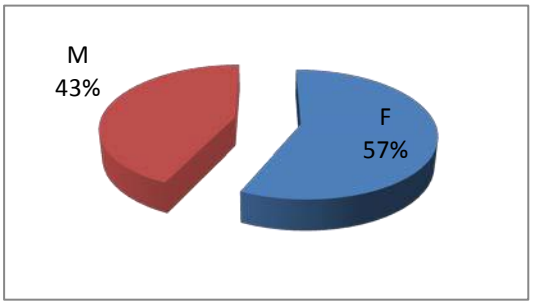
The number of referrals received by FNCT for receipt of care to be provided at HOME per month are as follows:

Month	No
May-17	6
Jun-17	6
Jul-17	10
Aug-17	18
Sep-17	13
Oct-17	15
Nov-17	15
Dec-17	12
Total	95



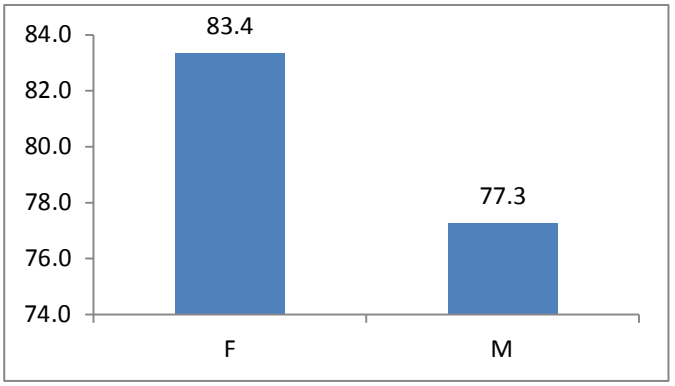
The gender of the referrals received by FNCT for receipt of care to be provided at HOME per month are as follows:

Gender	No
F	54
M	41
Total	95



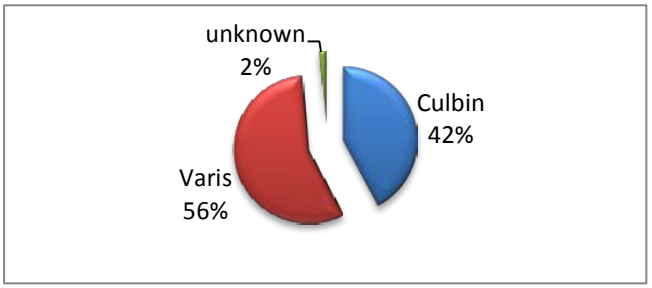
The average age of referrals received by FNCT for receipt of care to be provided at HOME per month are as follows. Please note the female average age is a lot higher than male:

Gender	Average Age
F	83.4
M	77.3
Total	80.0



The GP Practice numbers of the referrals received by FNCT for receipt of care to be provided at HOME per month are as follows:

GP Practice registered with	No
Culbin	41
Varis	53
Unknown	1



There are **42** (**44%)** of the 95 referrals received by FCNT which have an informal carer for receipt of care to be provided at HOME per month.

The informal carer details are as follows (37 total):

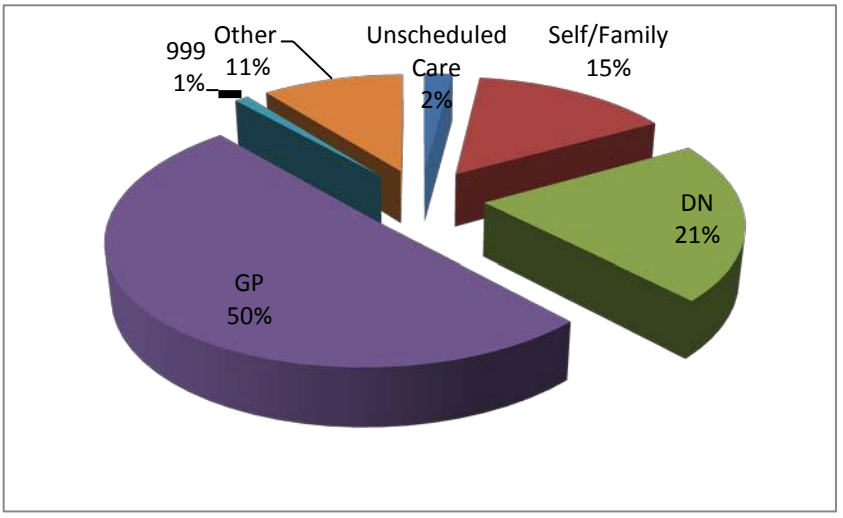
Informal Carer	No
Wife	9
Family	8
Daughter	7
Hanover	4
Cameron court	3
Husband	2
carers	2
unknown	1
Findhorn Foundation	1
Grand Total	**37**

The reasons for referral are as follows:

Reason for referral	No	%
Fall	15	15.79%
Palliative care	11	11.58%
hospital discharge	8	8.42%
Generally unwell	3	3.16%
Pain management	3	3.16%
UTI	2	2.11%
COPD	2	2.11%
Viral Pharyngitis	2	2.11%
Catheter not draining	2	2.11%
Palliative	2	2.11%
Assessment	2	2.11%
Not coping, support and meds (Abx)	1	1.05%
TIA/ Suspected stroke	1	1.05%
Vomiting	1	1.05%
Awaiting care to be sourced	1	1.05%
SC Fluids	1	1.05%
Calculation	1	1.05%
Dehydration	1	1.05%
Husband unwell	1	1.05%
Failing at home	1	1.05%
Leg pain	1	1.05%
Pancreatitis/ Abdominal discomfort	1	1.05%
Medication Management	1	1.05%
Anxiety/ low mood	1	1.05%
Mobility, Frailty, UTI?	1	1.05%
suspected UTI	1	1.05%
Monitor oral intake, BP, med management	1	1.05%
Diabetes and Urinary incontinence	1	1.05%
Nausea and vomiting	1	1.05%
Infection query	1	1.05%
Observations during chemo (daughter away)	1	1.05%
Enema administration	1	1.05%
Constipation & pain management	1	1.05%
Catheter care	1	1.05%
Recent fall, UTI?	1	1.05%
Advice on management of pulmonary fibrosis	1	1.05%
Symptom management out of hours	1	1.05%
not eating, drinking, mobilising	1	1.05%
Microlax enemas	1	1.05%

Referrer details are as follows:

Referrer	No
GP	48
DN	20
Self/Family	14
Other	10
Unscheduled Care	2
999	1



Referrer 'Other' details are as follows:

Referrer	No
Varis Staff	4
Carers	2
Oaks staff	2
Dr Grays	1
Friend	1

There were **91%** (86) of the patients were discharged from FCNT who remained in their home after receipt of FCNT care in their home. The other **8%** (9) were discharged to the following (none of these were residents within the Varis Court complex itself):

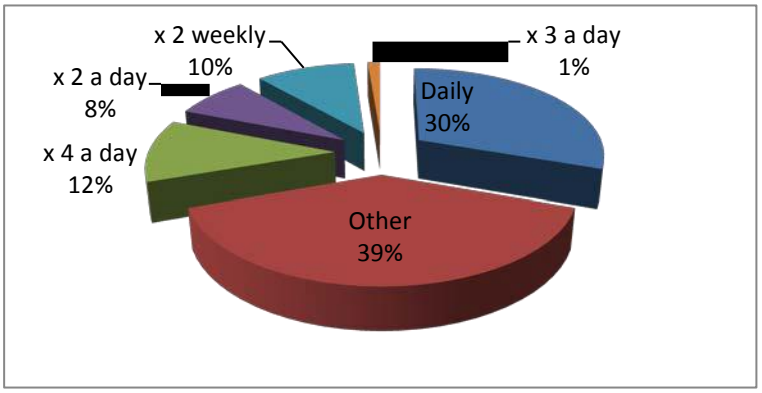
Discharge to other	No	
Hospital	5	The reasons for the referrals were: 1. Monitor oral intake, BP, Med management (LOS 2 days with FNCT x 4 pd) – admitted to hospital (no other details recorded) 2. Celluation (LOS 2 days with FNCT x 4 a day) - Matt initial assessment for monitoring of condition and oedema. Dressing to leg changed. Reviewed. Already under care of DNs 3. Nausea and Vomiting (LOS 3 days with FNCT Daily) - Patient had been nauseous. Obs and medication prompts and encouraged dietary intake. She was later admitted to hospital 4. Infection query, Change meds for observations. (LOS 4 days with FNCT Daily) Pyrexia of unknown cause. Change of Abx and paracetamol. Referred to GMED by carers, and taken to DGH due to requiring oxygen therapy. 5. TIA/ Suspected stroke. (LOS 51 days with FNCT Variable visits). Suspected stroke/TIA requiring care. Symptom management. Vomiting, Monitor BMs. 4 x daily until care started 4/9, then 2 x daily. Admitted to hospital on 21/9.

Discharge to other	No	
Deceased	2	The reasons for the referrals were: 1. Palliative care (LOS 5 days x 2 weekly) - Provided support at home with PC and symptom management. They had called GMED at 2200hrs to deal with agitation (before we were 24 hours) 2. Palliative care (LOS 45 days (other care) Support given re palliative care option of coming into the flats. One OOHS tel call re serous fluid leaking from legs. Legs creamed in the mornings for a short time.
Cathay	1	The reason for the referral was: 1. Palliative care - Admitted to Cathay (LOS 1 day with FNCT for end of life care) - Patient had been nauseous. Obs and medication prompts and encouraged dietary intake. She was later admitted to hospital

The number of days between referral and discharge **= 1050** in total, with an average of **11.05** days per referral (95). **8 of these referrals were residents within Varis Court.**

The frequency of care provided by the FNCT to patients in their own home was as follows:

Frequency of care	No
Daily	24
Other	31
x 4 a day	9
x 2 a day	6
x 2 weekly	8
x 3 a day	1



Care frequency (other) explained	No
One visit	23
Variable	4
1 visit daily for 3 days, then follow up visit on 23/6/17	1
not sure	1
reduced to daily 10/9	1
reduced to daily 21/7	1
x2 initially then x 1 AM	1
Total	**31**

The type of care provided to patients in their own home was as follows (Other was the highest **26%**, followed by Personal Care **15%** and Carer/Family liaison support **13%**:

Type of care (more than one option can be applied)	No
Other	**42**
Personal Care	**24**
Carer/family liaison support	**22**
Social Support	**17**
End of life	**12**
Pain management	**12**
Reable	**12**
Catheritisation	**8**
Signposting	**6**
IV Fluids	**4**
Venepuncture	**2**
Respite	**2**
IV Antibiotics	**1**
Total	**164**

The 'other' type explained:

Type of care (other)	No
Observations	14
Assessment	4
Wound management	2
Advice on self-management of pulmonary fibrosis	1
Reorientate to time (return day to night (currently mixed up)	1
Creaming of legs	1
Encourage fluids	1
symptom management	1
Enema	1
empty commode	1
Observations & Bowel management	1
Listening support	1
Reassurance after fall	1
Management of diabetes and incontinence	1
Replace dressing R leg	1
Meal prep & assistance	1
Meal Support & Med management	1
Medication review	1
MED PROMPT	1
meds, oral intake, BP	1
Meal prep	1

Type of care (other)	No
Obs and Medication support	1
Moving and handling	1
Constipation	1
Post fall check, obs	1
Grand Total	**42**

Of the patients receiving care in their own home, **26%** (25) were referred to another service.

Patients referred to 'OTHER' service:

Service (Other)	No
Marie Curie	4
OT	4
SW & OT	3
GMED	2
Dietician, OT, gmed 27/8/17	1
DN	1
Marie Curie & Macmillan	1
NESS	1
PSN contacted in Aberdeen	1
SW & Comm Alarm	1
Alternative therapy	1
Carers called NHS 24	1
Quarriers, OT, SW	1
OT, Physio, Continence	1
Access team	1
OT & smoking cessation (declined)	1
Grand Total	**25**

The outcomes of referred to other services:

Outcomes	No
unknown	17
Leaflets obtained for self-management of condition	1
Grab rails put in shower, advised to by Kelly sheets from Amazon. SW already involved re carers shower 2 x weekly	1
Urology nurse	1
GMED sorted out catheter	1
Advised to wear trainers and put the light on at night	1
Advice on commodes and appropriate equipment at home	1
Community Alarm installation	1

The total number of contacts were **1377**, which averages **18.9 contacts** per referral for those receiving FCNT care at home.

My interpretation on whether the FCNT prevented admissions to hospital:

Description	No
Y	56
N/A	12
N	6
unknown	1
Total	**71**

N/A

Comment on FNCT prevent admission
COPD, Type II diabetes, contact visit to make known of FNCT, condition likely to deteriorate
Giving suppositories x 2 daily
Offered support to patient and family after discharge from hospital. Was sent home in a taxi so met patient and made sure ok and settled. FNCT phone number given. 2 x phone checks carried out
FNCT carried out one support visit before the patient was admitted to Cathay Nursing home palliative bed, as it was his request to have end of life care carried out in either a hospice or palliative bed in a nursing home
Provided support while husband unwell
Patient phoned as had tripped. Was feeling dizzy after the fall, none since. Had taken ibruphen. Obs taken. Advised to turn the light on or use a torch at night and to wear trainers. Worsening statement given. On contacting at 1700 patient feeling dizzy and in paint in house. GMED had called. Patient ignored
Assessment as father concerned that she has a UTI. Also concerned re falling and safety transferring her to commode. Assessment by Matt. Prescribed an antimetric, contacted access team re care package. OT contacted for pst for bariatric?
Initial assessment by Matt. 1.5 hrs further review in 3 days
Wife away for a few days. Patient concerned after having an episode of small bowel obstruction of whom to contact if emergency. FNCT number given for reassurance
Previously known to FNCT through support provided to wife (dementia), contacted team directly due to new concerns regarding wife's health, he also has required support due to decreased mobility caused by osteoarthritis.
Asked by GP to visit to offer support, is being supported by DN team.
FNCT introduced as requested. Varis court FNCT flats explained to patient and family

unknown

FCNT **Comment on FNCT prevent admission**
Nothing recorded in the comment box by FNCT staff

No

Admitted to hospital on 11/11
Matt initial assessment for monitoring of condition and oedema. Dressing to leg changed. Reviewed 20/10. Already under care of DNs
Referred due to loss of confidence after a recent fall. Struggling with side effects of chemotherapy, reduced mobility, pain management and meal preparation and PC. Admitted to Leanchoil due to deterioration in condition
Assessment, took bloods, increase mobility, heat pack cooled boiled peppermint tea. Epigastric pain on palpitation checked bowel sounds. Full assessment? Indigestion possible pancreatis. Was admitted to Dr Grays 2 days later due to blood results
Suspected stroke/TIA requiring care. Symptom management. Vomiting, Monitor BMs. 4 x daily until care started 4/9, then 2 x daily. Admitted to hospital on 21/9
Patient had been nauseous. Obs and medication prompts and encouraged dietary intake. She was later admitted to hospital

Comments on the discharge audits as to the reasoning behind prevention into hospital is as follows:

Comment on FNCT prevent admission
Mr A was struggling to cope with symptoms of nausea, anxiety and pain. With support from FNCT he was able to cope with the appropriate use of medication
Provided support at home with PC and symptom management. They had called GMED @ 2200hrs to deal with agitation (before we were 24 hours)
Asked to assess as wife had phoned the practice with concerns of dizziness, and her husband having a reduced urine output and generally feeling unwell. Assessed by Matt & medication changes made. Urine also dipped. Follow up visits for next 2 days, check BP & then further follow up visit weeks later to check. He quickly felt better.
Discharged from hospital home with symptoms of pain, constipation, urinary incontinence, had lost confidence when walking due to fall (#pubic raymae hosp admission reason). Socially there was some tension with husband due to situation that they found themselves in. FNCT provided support with PC, advice re bowels, urinary incontinence. Fall assessment in house - advised to purchase non slip socks. Ensure commode was stable. Patient was unable to talk to us re her situ which she was finding difficult. She was appreciative of the visits
Ensuring all was well following a fall. Check visits and applying gel to sore hip
Support provided at home during crisis period
Assessment by FNCT - information relayed to GP. Was in hospital 13/11
Catheter not draining, had to call GMED to change, picked up by DNs after weekend
Able to support the family to enable the patient to die at home. Family needing a lot of reassurance and patient symptom and PC given
Mr M was enabled by FNCT to have his enema administered at the appropriate time in the evening due to the 24 hour nature of the FNCT. He very much enjoyed our visits as he would chat away about the sad loss of his wife
Patient and his families wish was that he would die at home. FNCT were able to visit in the evenings to check all was well. A member of FCNT was with him at the time of death on 1/7/17 and was able to call OOHS Marie Curie to visit for verification of death
Patient had broken leg following a fall. On discharge she was unable to care for herself independently as she was in great pain. Was unable to weight bear on medical instruction so mobility was very difficult and she was unable to carry out some activities of daily living. She became tired and breathless on exertion though this improved over the course of the care period. Patient's son declined to provide PC. Son was not an early riser meaning patient could be left without a drink or breakfast until late on. Patient at initial assessment was very like the type of patient readmitted to hospital due to family being unable to cope. The support prevented this, enabling her to regain

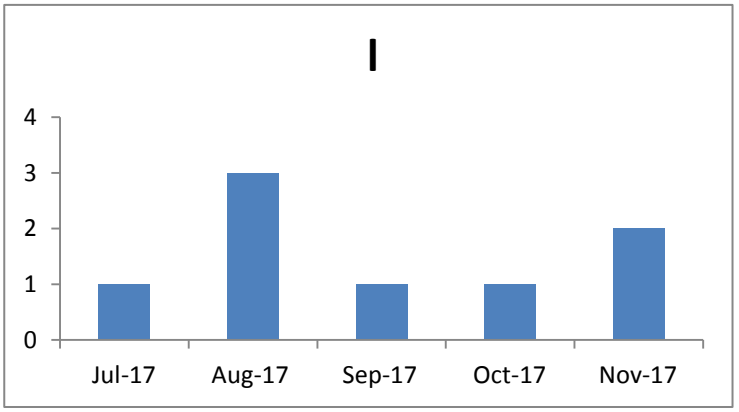
Comment on FNCT prevent admission
confidence and a degree of independence
FCNT able to support a family to have their loved one nursed in her own home which was her chosen place of death. The support given was valued
Failing at home. Required support for PC, catheter management, meal support. Care at home started on 1/12
Trial practical management of incontinence. 4 day visit of 11 pm & 6 am toileting. Little impact on bed flooding. Random BM tests for management of diabetes
Daughter is away working and for a short period she requested that we visit her daily for symptom check whilst on chemo.
Support given to Hanover staff following witnessed fall
Patient unwell in Hanover. Supported carers with visit requests when they were concerned about her. Also regular observations
Support given to Hanover staff following a fall. Obs taken
Had symptoms of palpitations, went to A&E rhythm strip taken by paramedics showed a run of SVT. GP asked to check and do obs
Catheter problems, involving visits for bladder??? Then recatherisation
Patient had several falls recently. She has not been eating, sleeping a lot. Constipation? FNCT to provide support, encourage dietary intake and encourage mobility. She has pain in left elbow and R lower ribs from previous falls
Struggling with issues of constipation and pain management
Wife needing support with PC. Whilst awaiting care to be sourced by access team, FCNT visiting 4 x daily. 34 days of 4 daily 30 mins visits. Patient's wife declined morning and evening visits due to times provided, further 30 mins visit provided until care sourced.
Asked to see patient by GP, carer had contacted GP asking if patient could be given some sedation to reduce anxiety. GP refused as increased falls risk. I spent 30 mins with patient who was suspicious as to why I was there. I asked how she was managing with PC, housework, food prep and her dog and she insisted that she had all the care she required, had 'no complaints' and compared to others she was very lucky. Daughter previously been sign posted to quarriers. Ref left open. Asked to visit again by GP 25/8 due to dehydration episodes of loose stools, sub cut fluids administered
End of life care. Wife called as catheter was bypassing.
Asked to visit by GP. Had an ambulance out for chest pain. Atrial flutter on ECG. Refused hospital admission. Home visit @ 1800hrs. Patient unlocked front door to allow staff access. Stated he felt alright but was very warm inside house. Encouraged to open lounge window. Observation home very unkept. Obs taken. Advised patient to contact FCNT if required. Contact details given. GP informed next morning.
Patient discharged from Dr Grays but x 4 daily care not going to be in place until Monday 30/10, son said he would manage. Son (has bi-polar) going to support her over the weekend but without additional support may feel unable to cope so would result in a failed discharge
Patient unwell. Confused and some sort of infection. Obs done and IV fluids given and monitoring
Review - Matt - change Abx as patient had taken all of his Abx over 24 hours. For supportive visits and medication management of oral Abx. Bed visits changed to x 4 visits.
Patient falling and having problems with hallucinations and pain management. Daughter not happy to leave her mum in the flats as was planned to have a 48 hour fall assessment. Assessment done at home. Changes made to medication by Matt
Patient generally unwell. Chest infection? Abx commenced. Obs checked
Asked to review as visits from staff struggling with her mobility and confusion. Urine tested. Observations obtained and advice given on medication management. MCV obtained and given to GP
Support given in palliative care phase of cardiac failure. Patient admitted to hospital 18/8 to manage distressing symptoms. Supported wife to enable her to sleep overnight (17/8) from 1130pm - 0630am. Marie Curie requesting overnight assistance and FNCT nurse response was quick due to distance.

Comment on FNCT prevent admission
Discharged from ACE unit following fall. Daughter providing all care, patient refusing referral to Access team. Help prevent a readmission. X 2 daily visits, AM & Lunch, meals, meds & PC. Push fluids, make sure wearing comm alarm, monitor BP
Support of end of life care OOHs
Asked by carers in Varis to assess as unresponsive. Patient found on the floor, Able to obey some simple commands and mobilise upon examination. Obs satisfactory
Has advanced lymphoma - not eating and drinking. Came in for symptom management - nausea, pain control, dizziness, dehydrations an falls. Given IV fluids reablement, medication review, nefedepine discontinued, would have been admitted to hospital if not seen by FNCT.
Patient discharged from Leanchoil and has care 4x daily. Carer unable to put to bed the previous night. Assessment and obs satisfactory. Helped carer on one occasion to walk her from the living room to her bedroom. Care organiser then had discussion with Matt
Redressing wound on right arm at the request of DNs
Observations, SC fluids, advice re pressure, care, equipment supplied, PC at times, medications supplied
Requested by DNs team to do a microlax enema and wound dressings x 1 for the weekend
Dehydrated and obs done, on assessment GMED contacted. Stayed at home. Follow up the next day. Continued visits with meal preparation - encouraging fluids and general observations, due to having problems with knees.
Assessment of catheter to see if patient and draining following a visit to unscheduled care
Check visits when daughter working away. Patient well known to FNCT and is palliative
Sent home after hospital discharge (stroke), requiring care. Symptom management. Vomiting, Monitor BMs. 4 x daily until care started 4/9, then 2 x daily. Care started 14/10
Obs checked and urinalysis. Visit carried out, also given advice on pressure areas and pressure sore prevention
Patient has lung cancer and became agitated following chest infection. Family were concerned as wouldn't take anti biotics. Full time carer for wife who has dementia. Family felt they weren't safe. Visits initially x2 daily then reduced to 1x daily. Infection now resolved on oral antibiotics
Support given re palliative care option of coming into the flats. One OOHS tel call re serous fluid leaking from legs. Legs creamed in the mornings for a short time.
Support for patient and family. They didn't want a hospital admission and needed to be supported at home and anti biotics administered to treat chest infection
Advice given on contacting OOHS if symptoms worsened overnight. Referred by GP asked to assess patients mobility, check observations, advice given on when to take PRN medication
Parkinson's patient referred by GP for generally unwell, observations and urinalysis to be checked. Advices re cramps if deterioration occurred and who to contact
IV antibiotics administered via PICC line when unscheduled care was closed on a bank holiday. After this FCNT took over the administration as this was done in his own home rather than the patient coming into unscheduled care
One visit to check observations in the evening after the health centre closed
referred by GP for home visit in the evening for symptom management due to ? Viral labrynthitits. Anti metric given and observations checked. Given an injection of cycligue?
Patient referred by GP due to recent episodes of confusion, unsteady on feet, increased falls, referred to continence service for incontinence pads. OT and Physio for home assessment

CARE RECEIVED AT PATIENTS HOME AND ADMISSION TO ACU (BOTH)

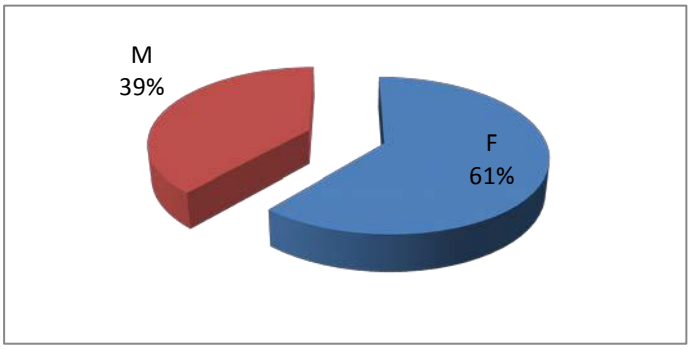
The number of referrals received by FNCT for receipt of care to be provided at BOTH per month are as follows:

Month	No
Jul-17	1
Aug-17	3
Sep-17	1
Oct-17	1
Nov-17	2
Grand Total	**8**



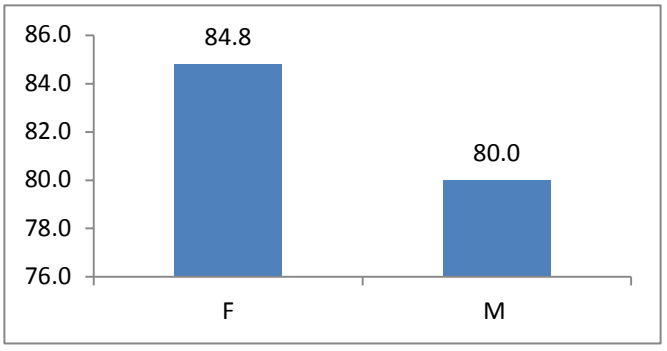
The gender of the referrals received by FNCT for receipt of care to be provided at BOTH per month are as follows:

Gender	No
F	5
M	3
Total	**8**



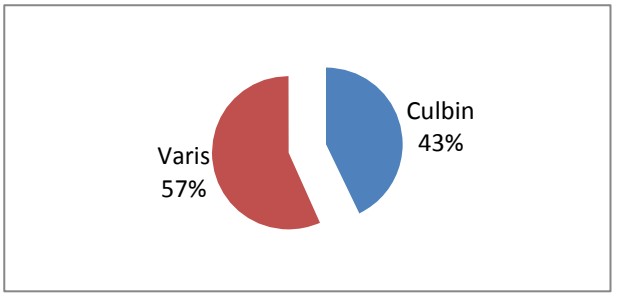
The average age of referrals received by FNCT for receipt of care to be provided at BOTH per month are as follows:

Gender	Average Age
F	**84.8**
M	**80.0**
Total	**83.0**



The GP Practice numbers of the referrals received by FNCT for receipt of care to be provided at BOTH per month are as follows:

GP Practice registered with	No
Culbin	3
Varis	5



There are 4 (**57%**) of the referral s received by FCNT which have an informal carer for receipt of care to be provided at BOTH per month.

The informal carer details are as follows:

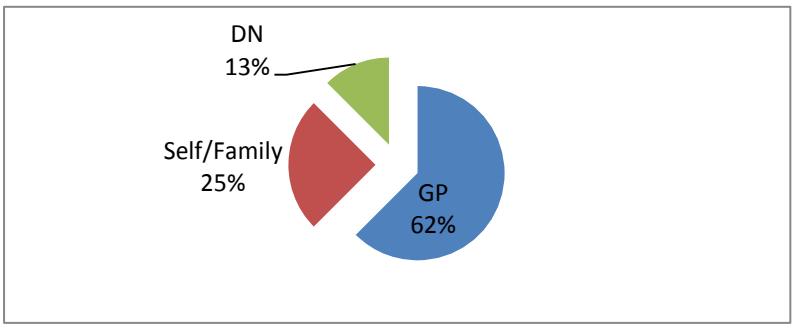
Informal Carer	No
Wife	2
Family	1
Daughter	1
Varies	1

The reasons for referral are as follows:

Reason for Referral	No	%
Fall	2	25.00%
Medication Management/ poor mobility	1	12.50%
Vomiting	1	12.50%
Frailty and reduced function	1	12.50%
Broken wrist, dislocated fingers	1	12.50%
Pain management & respite	1	12.50%
UTI, Chest infection, dehydration	1	12.50%
Grand Total	**8**	**100.00%**

Referrer details are as follows:

Referrer	No
GP	5
DN	1
Self/Family	2



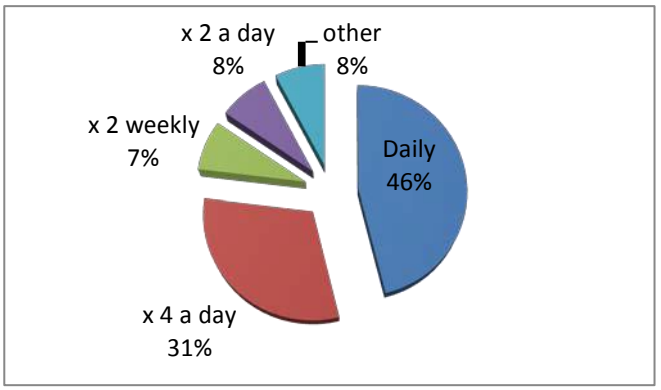
There were **100%** (8) of the patients were discharged from FCNT who remained in their home after receipt of FCNT care in their home/ACU.

The number of days between referral and discharge **= 114** in total, with an average **of 14.25** days per referral (8).

- **One referral was made by those who was a resident in Varis Court.**
- **38 bed days were utilised during the reporting period (8 referrals).**

The frequency of care provided by the FNCT to patients in their own home was as follows:

Care frequency (more than one option has been applied)	No
Daily	6
x 4 a day	4
x 2 weekly	1
x 2 a day	1
Other	1



Care frequency (other) explained	No
Daily phone call	1
Variable	1

The type of care provided to patients in their own home was as follows:

Type of care (more than one option can be applied)	No
Other	5
Personal Care	4
Re-able	3
Social Support	3
Carer/family liaison support	2
Signposting	2
Respite	2
Pain management	2
IV Fluids	1
Venepuncture	2
Catheritisation	1

Type of care (other)	No
Medication administration	1
Medication management	1
SC Fluids	1
symptom management	1
unsafe at home due to poor mobility	1

Of the patients receiving care in BOTH, 71% (6) were referred to another service.

Patients referred to 'OTHER' service:

Service OTHER	No
Access team	1
Dietician	1
OT, Marie Curie	1
Physio	1
SC & Pharmacy	1
SW	1

The outcomes of referred to other services:

Outcomes	No
unknown	3
OT assessment been completed and has appropriate equipment at home	1
Dossette box. Also sign posed to befriending service - refused	1
Elgin Parkinson's Group	1

The total number of contacts were **309**, which averages **24.4** contacts per referral for those receiving FCNT care at BOTH.

The number of ACU bed nights totalled **36.**

My interpretation on whether the FCNT prevented admissions to hospital:

Description	No
Y	8

Yes

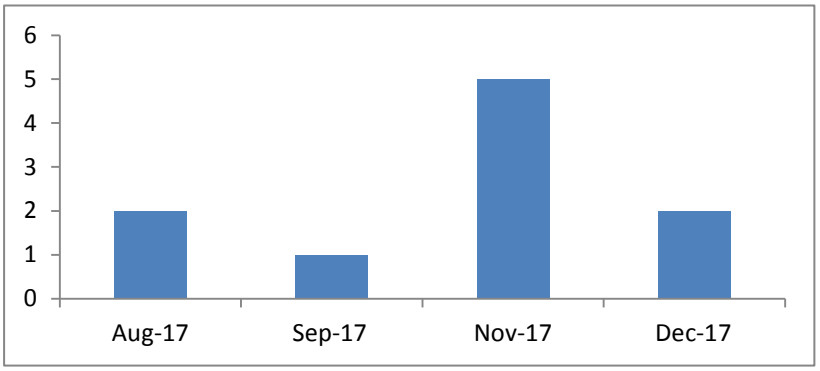
Comment on FNCT prevent admission
Inpatient in ACU 13/7 - 20/7. Her daughters and carers & other daughter who lives locally is struggling to cope. Patient admitted into ACU for one week. Showered x 2 weekly until care can be started by access team. Care also requested at tea time. This is a new phase of her care as she have previously been reluctant to have carers to look after her at home, preferring her daughters to shower and look after her. She has had previous admissions to Dufftown for respite but much preferred being in Forres. She very much enjoyed going up the town in her wheelchair
Inpatient in ACU 10/8 - 18/8
Admitted to flats x 3 days plus 4 visits. Full on care high falls risk. Unsafe to be left at home while wife away. Ambulance called in the morning while at home as had a fall. Unable to get out of chair independently
Contacts x 7 days in varis court - all care & 46 visits. Patient was acutely unwell with UTI, constipation and dehydrated on admission to Flat 4. He was unable to care for himself at home and would certainly have required admission to hospital for rehydration and treatment of UTI. Patient lost a lot of confidence as his illness coincided with 90th birthday and it concerned him that it was the 'beginning of the end.' Following discharge home FNCT continued to visit x2 daily and then reduced to x1 daily to check on him and help rebuild

Comment on FNCT prevent admission
3 night's inpatient. Assistance with PC and dressing changes have prevented hospital admission. Prevented GP call outs as bloods obtained and reviewed by team also
Off legs, dehydrated, pyrexia, not eating and drinking, nauseated, oral thrush, not tolerating medication. Antibiotics and anti-fungal cream changed with good effect, Required close nursing care, fluids, bloods and NEWS monitoring. Without FNCT support would have been admitted to hospital.
Uncontrolled vomiting @ home despite anti metrics to BM, for monitor +/- IV/SIC for comfort. Patient not eating or drinking at moment
In flats 24/11 - 1/12. Supported at home with medication management from 1/12 - 15/12 when care at home started

CARE RECEIVED AT ACU ONLY

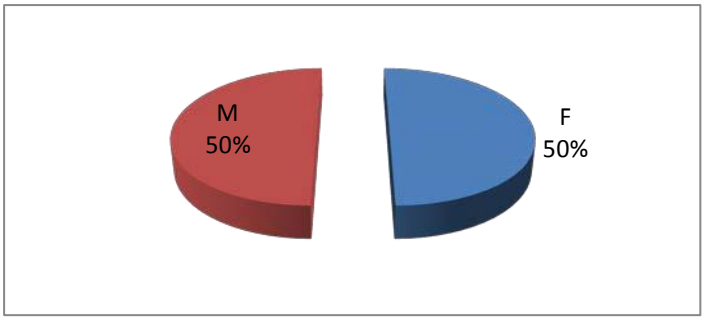
The number of referrals received by FNCT for receipt of care to be provided at ACU per month are as follows:

Month	No
Aug-17	2
Sep-17	1
Nov-17	5
Dec-17	2
Grand Total	**10**



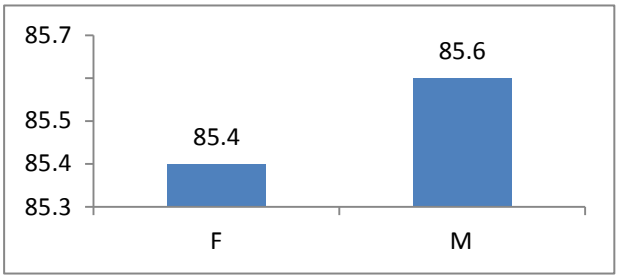
The gender of the referrals received by FNCT for receipt of care to be provided at ACU per month are as follows:

Gender	No
F	5
M	5
Total	**10**



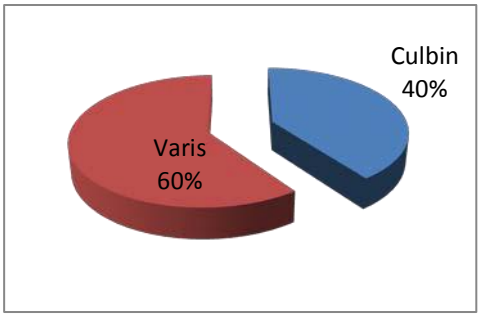
The average age of referrals received by FNCT for receipt of care to be provided at ACU per month are as follows:

Gender	Average
F	**85.4**
M	**85.6**
Total	**85.5**



The GP Practice numbers of the referrals received by FNCT for receipt of care to be provided at ACU per month are as follows:

GP Practice registered with	No
Culbin	4
Varis	6



There are 6 (**60%)** of the 10 referral s received by FCNT which have an informal carer for receipt of care to be provided at ACU per month.

The informal carer details are as follows:

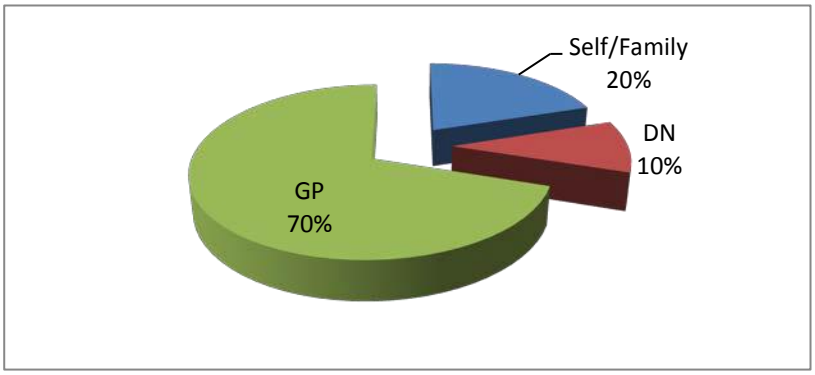
Informal Carer	No
carers	2
Daughter	1
Varis Court	1
Husband	1
Wife	1

The reasons for referral are as follows:

Reason for Referral	No	%
Palliative care	2	20.00%
Pain management	2	20.00%
UTI/ Respite	1	10.00%
Rehydration	1	10.00%
Fall/ back pain	1	10.00%
Push fluids	1	10.00%
UTI	1	10.00%
Respite	1	10.00%
Grand Total	**10**	**100.00%**

Referrer details are as follows:

Referrer	No
Self/Family	2
DN	1
GP	7



There were **63%** (7) of the patients were discharged from FCNT ACU to home. The other **37%** (3) were discharged to the following (none of these were residents within the Varis Court complex itself):

Discharge to other	No	
Hospital	1	The reasons for the referrals were: 1. Pain management, mobilisation (LOS 9 days with FNCT x 4 pd) – Admitted to flats x 3 days 5/12 - 8/12. died in hospital
Deceased	2	The reasons for the referrals were: 1. Palliative care (LOS 2 days with FNCT x 4 pd) – 2. End of life care brought into flats for 2 nights. Palliative 3. Palliative care (LOS 2 days with FNCT x 4 pd) – ACU 18/8 - 5/9. 5 contacts out with ACU. Resident Varis, moved to ACU. Palliative care was supported in ACU preventing hospital admission

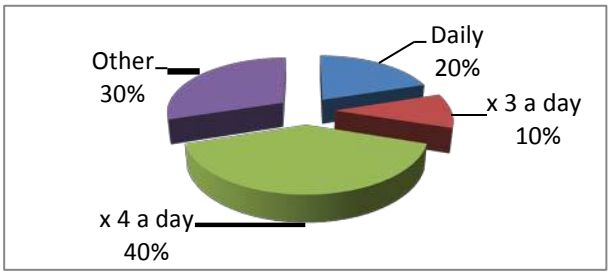
The number of days between referral and discharge **= 146** in total, with an average of **14.6** days per referral (10).

The number of bed days in the ACU during the reporting period was **129 bed days**.

1 of these referrals were residents within Varis Court.

The frequency of care provided by the FNCT to patients in the ACU was as follows:

Care frequency	No
Daily	2
x 3 a day	1
x 4 a day	4
Other	3



Care frequency (other) explained	No
Variable	3

The type of care provided to patients in the ACU was as follows:

Type of care (more than one option can be applied)	No
Other	5
Venepuncture	4
Pain management	3
Catheritisation	2
Personal Care	2
Respite	2
Re-able	2
End of life	1
IV Fluids	1
Signposting	1
Total	23

Type of care (other)	No
Management of meds and bowels	1
Mobilisation	1
Push fluids	1
Observations	1
Rehydration	1

Of the patients receiving care in the ACU, **13%** (1) was referred to another service.

Patients referred to 'OTHER' service:

Service (Other)	No
Quarriers	1

The outcomes of referred to other services:

Outcomes	No
unknown	1

The total number of bed days was **128,** which is an average of **12.8 bed days per person** within ACU.

My interpretation on whether the FCNT prevented admissions to hospital:

Description	No
Y	9
N	1
Total	**10**

No

Comment on FNCT prevent admission
Admitted to flats x 3 days 5/12 - 8/12. died in hospital

Yes

Comments on the discharge audits as to the reasoning behind prevention into hospital is as follows:

Comment on FNCT prevent admission
Significant decline noted over previous weeks, dehydration? In for assessment to push fluids
4 NIGHTS IN Varis for rehydration, bloods taken, wounds x 4 redressed
End of life care brought into flats for 2 nights. Palliative
Difficult social circumstances.. SW involved to ensure patient safety. Daughter struggling to cope with patient who lives with her. Recent chest infection and now UTI. Needing fluids encouraged and

Comment on FNCT prevent admission
antibiotics. Without FNCT patient would have been admitted as daughter unable to cope (going through a divorce - husband being very difficult - living in annexe). Patient unwell with UTI increased anorexia, possible bowel ? being investigated.
Cognitive impairment, came in with wife for respite for her. Without FNCT support wife would have not been able to cope due to her own medical condition and both could have been admitted to hospital
In flats 5/11 - 24/11. Respite for her as unable to cope with own medical condition. Came in with husband who has dementia.
Assessment of pain following falls. Assessed mobile. Pain assessment. Advised QDS paracetamol and to contact GP if no improvement. Had another fall on 23/9/17 (contacted by Varis carer) observations checked and assessment
Inpatient 28/8 - 16/10. reviewed at home 17/10. Assessment and management by FNCT and Matt liaising with geriatrician re complex co-morbidities prevented admission to hospital
ACU 18/8 - 5/9. 5 contacts outwith ACU. Resident Varis, moved to ACU. Palliative care was supported in ACU preventing hospital admission

Calendar of number of clients within ACU by date

July	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total bed days
													1	1	1	1	1	1	1	1												7
August	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
											1	1	1	2	2	2	1	2	1	1	2	2	2	2	2	3	3	3	2	2	2	39
September	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
	2	2	2	2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		35
October	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1																17
November	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
				1	2	2	2	2	2	2	2	2	2	3	3	3	3	3	3	3	3	3	3	4	3	3	1	1	1	1		63
December	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16																
	1				1	1	1	2	1	1	1																					8
																																167

FNCT Staff Survey results

The staff questionnaire was completed by 7 of the 8 FNCT members during the week of 19-23 March 2018.

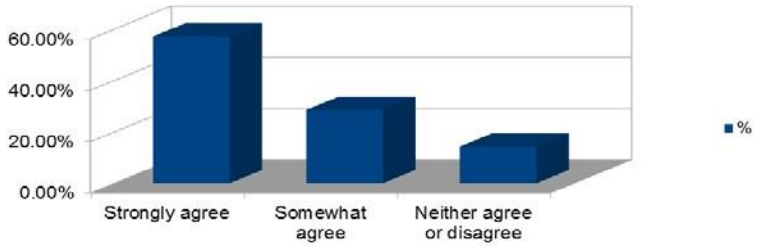
The results are as follows:

1. Employee Job Satisfaction

Staff were asked to tell us about their job and their experience as a FNCT member, the possible answers were – 'Strongly disagree', 'Somewhat disagree', 'Neither agree or disagree', 'Somewhat agree' or 'Strongly agree'.

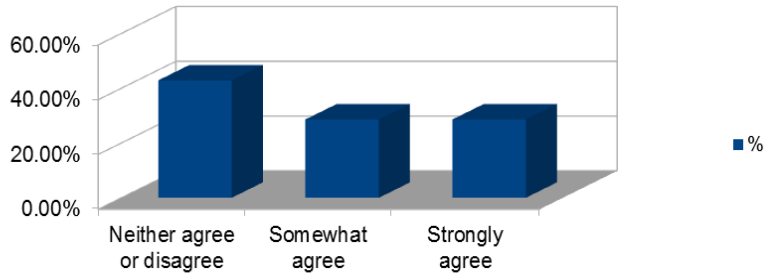
a) I feel encouraged to come up with new and better ways of doing things

Answer	No	%
Strongly agree	4	57.14%
Somewhat agree	2	28.57%
Neither agree or disagree	1	14.29%



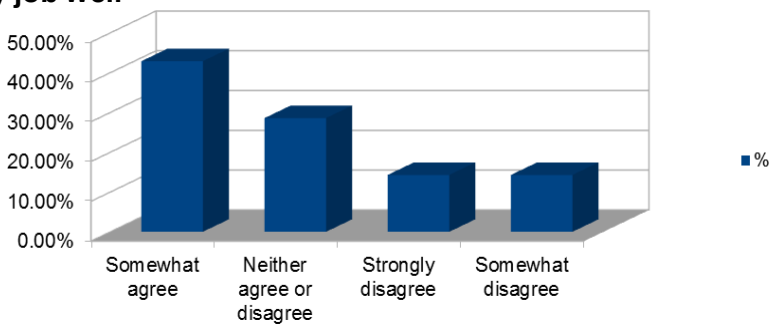
b) My work gives me a feeling of personal accomplishment

Answer	No	%
Neither agree or disagree	3	42.86%
Somewhat agree	2	28.57%
Strongly agree	2	28.57%



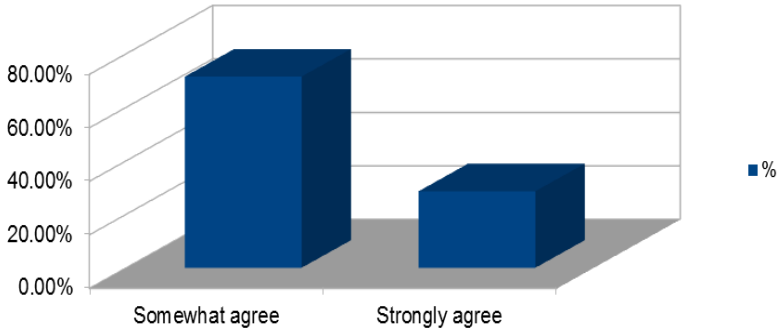
c) I have the tools and resources to do my job well

Answer	No	%
Somewhat agree	3	42.86%
Neither agree or disagree	2	28.57%
Strongly disagree	1	14.29%
Somewhat disagree	1	14.29%



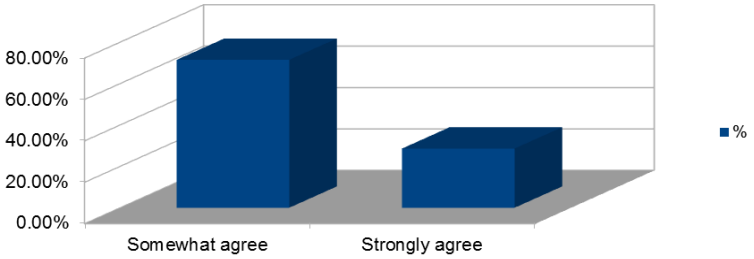
d) I understand my role in the teams

Answer	No	%
Somewhat agree	6	85.71%
Strongly agree	1	14.29%



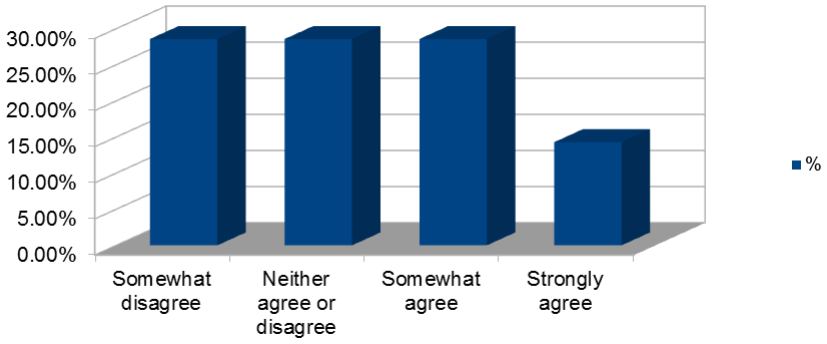
e) When a patient, carer or a family member has an issue, I can usually help support them with resolving it

Answer	No	%
Somewhat agree	5	71.43%
Strongly agree	2	28.57%



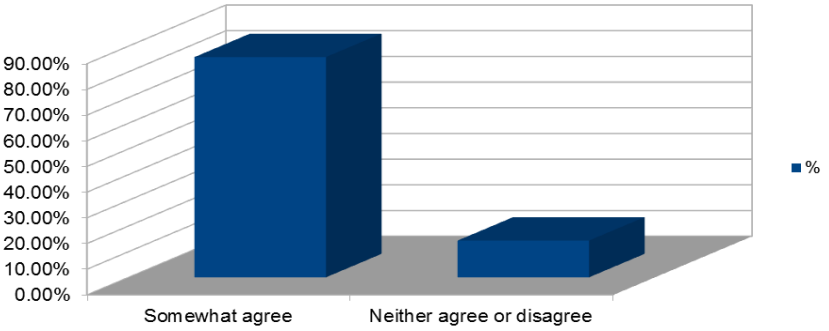
f) My job makes good use of my skills and abilities

Answer	No	%
Somewhat disagree	2	28.57%
Neither agree or disagree	2	28.57%
Somewhat agree	2	28.57%
Strongly agree	1	14.29%



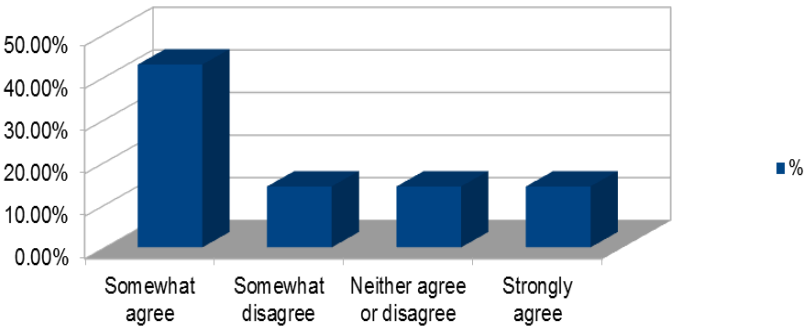
g) How satisfied are you with your involvement in decisions that affect your work?

Answer	No	%
Somewhat agree	6	85.71%
Neither agree or disagree	1	14.29%



h) Considering everything, how satisfied are you with your job?

Answer	No	%
Somewhat agree	3	42.86%
Somewhat disagree	1	14.29%
Neither agree or disagree	1	14.29%
Strongly agree	1	14.29%



There were 4 ANON replies and 3 named replies.

2. What is different about being a member of the FNCT compared to your previous nursing role?
Nursing in community. Being involved in patient assessments
Very different, I'm not entirely sure if I know what my role is. In many ways I love the flexibility to be able to respond quickly to situations. Eg referrals or a change in a patients condition. However, I do worry and I an very concerned that there are times that our lack of formal care plan is highlighted when different members of the team dont seem to know what we are doing for our patients
In my last post I was in management as well as hands on in the ward and daily encountered challenges. With FNCT I have found that I have done more caring than nursing. This side of nursing is all part of the Buurtzog model of care, but I feel some aspects people involved in primary care in Forres have not been sure of our role but are slowly starting to change and are referring more nursing patients.
Feel like the nursing being carried out in current positions with FCNT is very basic. Have had time to 'learn' from Matthew Offer in means of assessments/ chests, etc. lone working out of hours – no real safety net for self safety not having some equipment at hand like previous jobs – iNR, bladder scanner, general stock having to be sourced from other areas – which isn't always easy to get and some local teams (nursing) doesn't always appear to be on board with the project – wanting social parts to the patients covered by FNCT but not wanting nursing (ie medications, syringe drivers) to be done by us?
First post since qualifying so cannot compare
More interaction with patients; better understanding of each individual patient and his/her circumstances. Less stressful; more family friendly; more responsibility. I also feel more comfortable and encouraged to ask questions
Much less paperwork and audits. I feel as thought I have time to get to know the patients and their families. I miss the ease of referral to MDT/Medics that was available in my last job. Encouraged my new role to 'learn and develop' and to think more. Change of management structure makes me feel empowered to do the 'right thing' for patients and their families. I feel that I have the freedom to choose how I fulfil my role in the best interest of service users. This could be sitting with a dying patient or doing a jigsaw. Very much outwith the traditional 'medical model.'

3. What do you think are the benefits to the people who you have supported which perhaps might not have been realised through an orthodox nursing approach?
When patients in Varis Court get to know them well holistically and this helps us prepare for discharge. Seeing patients at home and spending long periods of time with them helps to better understand their needs
Our ability to respond to their changing needs. Our holistic approach and the fact we can spend time with them and really get to know them

With patients being looked after by the FCNT, I feel the benefits are that we offer a more personal holistic approach, without rushing us in the care in a hospital. Also, most patients prefer to stay in their own environment with familiar surroundings and continue to be looked after by the carers that they know, and with it being a small team can build a good relationship and trust
Enabling people to stay at home rather than admitted to hospital admitted to flat its like a home setting – partners can stay, visitors anytime etc
Enabling patients, empowering them to do as much for themselves as possible and enabling them to stay at home/in flats rather than being admitted to hospital
Some have been supported in the comfort of their own home with their family around which reduced any extra stress or anxiety they may have felt if they had been in a clinical hospital environment. Those that have been supported as in patients in the flats were able to recover and rehabilitate in an environment as close to their own home as possible. Also feel patients receive mores holistic and person centred care with FNCT in comparison to more orthodox nursing approaches
People have benefited from 24 hour nursing care and being able to be supported in their own community. By developing therapeutic relationships and looking at the 'whole picture' – social, physical, spiritual, psychological, and emotional needs - have been able to inspire hope and confidence. Allowing people and their families to feel truly listened to and respected. Some people I have supported have benefited from being signposted to clinical nurse specialists in order to address their concerns. They have benefited from being signposted to services that may help them.

4. What suggestions do you have for the improvement of FCNT?
More ANP so we have cover at the weekends and night. Allow Band 5 ANP training. Have Band 2/3 to assist
More regular staff meetings to improve communication. Have formal teaching. Better feedback from management (what's happening in the wider MDT). Some sort of basic care planning so we can prove we are providing our patients with the very best care. Also a clear set of aims and objectives when a patient is accepted so that staff, ex patients and relatives know the general plan. Where does the FNT fit in? Are the Gps happy with the service we provide? Are Dns happy with the service we provide?
Closer ties with the Dns with shared knowledge and skills being utilised. More nursing based referrals rather than care. Regular in house training sessions. Named nurses with individual patients to oversee – access, OT, physio, referrals and discharges instigated from the first contact. Weekly meetings to discuss patients, workloads and support eachother in keeping on track.
More time to learn. Stone and Pecos access. Extra support. Regular team meetings.
No comment
The ability to order own supplies/ equipment. Better communication with the MDT. More staff
Skill mix – About 50% of work could be done by Band 2/3 and think they should be introduced to the team as I feel some members of staff resent doing a lot of personal care but I think this is very beneficial to the service users. Stock – FNCT need to get their act together. We are constantly trying to 'source' stuff. Need to do a weekly stock check and order and stay on top of this. Monthly meetings – Not sure these are valued as they have stopped but these are good for 'team building' and ironing out problems. OT/Physio – Could it be that we have our own OT/Physio to work with us as part of our team? Like Debbie Taylor does for SW. Medical input – Sometimes the day shift it is difficult to know whether to contact yourself or Duty Dr. Would be good to know when you are not available. Community Nursing Team – would be good if both FNCT and DN team had a more collaborative relationship

5. Do you have any other additional comments you would like to make?
Work like to work more alongside DNs and Community Nurses
I think we have an excellent team and I whole heartedly believe in the concept of buurtzog. But I worry that the Band 5 nursing staff are still searching to identify what is expected of them and dont know have to drive the project forwards. It feels like we are drifting along a bit. I think that by this stage we should have a clearer idea of how the project should be evolving for the better. How can we expect the Gps to know what our role is when the team seems confused and are not in agreement about what our role is?

If the project is to continue to either have adaptions done to these premises, ie wider doors, our own space etc, or possibly move somewhere more suitable ie the premises beside cameron court
Integrate DN and FCNT?
Not a suitable post for a newly qualified nurse as the team is not established enough to support a NQN. The team is still learning the skills needed for the role. Not enough support re education and training/ learning new skills.
I can honestly say I love my job working in FNCT. I feel we are provided a much needed service for the community. We all work really well together as a team. I do think we would benefit from more regular team meetings, however, to help improve communication. I would appreciate more clinical training and education as well. Matt is a good teacher but it would be nice if he had more time available to share his knowledge and experience
Not sure that the flats really work – would be a lot better with a better buzzer system to give patients and their families confidence that someone is there to assure it. Think that patients are very lonely in the flats. Have felt overwhelmed at times by some of the requests I have had – feeling 'out of my depth'. Also I have found it difficult to feel competent in the 'new skills' I have learned. Have found some aspects of this job deeply rewarding – these are when I have got to know patients and their families well and we have been on a journey and I have felt I have been able to truly support them

Draft of Estimation of Direct Cost per Bed Capacity Comparison for 2017/18

Leanchoil			**ACU VARIS**	
Estimated End of Year	**Estimated End of Year**		**Item**	**Estimated End of Year**
	(1 April 2018)		**Cost to H&SCM**	**(1 April 2018)**
Staffing Nursing Team	489725		Staffing Nursing Team Developed through year	316505
(inclusive of all costs e.g. NI)			(inclusive of all costs e.g. NI)	
Additional Staffing (Auxiliary & cleaners)	13398		Additional Staffing (Auxiliary & cleaners)	
Utilities	72174		Utilities	(Electricity charges for 5 units to be confirmed)
Linen			Linen	
Rent Costs			Rent Costs	
(Inclusive of Maintenance)	0		(Inclusive of Maintenance)	36000
Staff Training			Staff Training	
Food			Food	134
Ground Maintenance			Ground Maintenance	
Travel	0		Travel	
Maintenance			Maintenance	
Rates	7754		Rates	16831
Miscellaneous	40702		Miscellaneous	42556
Total	**623753**		**Total**	**412026**
Leanchoil Est Daily cost per bed capacity 17/18 (8 beds)	**£214**		**ACU Est daily cost per bed capacity (beds)**	**£226**
2016/17 Actual Information				
Leanchoil Act daily cost per day capacity 16/17	**211**			
Leanchoil Act daily cost per bed day capacity occupied 16/17	**250**			

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 26 APRIL 2018

SUBJECT: JUBILEE COTTAGES

BY: CHIEF OFFICER

1. REASON FOR REPORT

1.1 To inform the Moray Integration Joint Board (MIJB) of progress to date and to seek approval to continue the use of Jubilee Cottages.

2. RECOMMENDATION

2.1 It is recommended that the MIJB considers and approves the ongoing use of the cottages for a further year for future review, based on the information supplied in the appendices.

3. BACKGROUND

3.1 The Jubilee Cottages were renovated to provide a high intensity rehabilitation and assessment service to people of Moray. The service aims to target elderly people who require rehabilitation or a robust holistic assessment to establish ongoing needs.

3.2 The cottages opened in May 2017 and 12 individuals have used the cottages for the purpose stated above.

3.3 Additional needs have also been met during their stay including complex social needs and rehousing needs as well as regaining a level of independence. Whilst this has necessitated a longer stay than initially planned, the consequence of this has been meeting and in effect, surpassing the outcomes for the individual.

3.4 The information provided in this report details the ongoing costs of the cottages for the MIJB to consider moving forward in retaining this resource for Moray. The original business case for the cottages anticipated that the turnaround annually based on optimum levels of use would be 30 clients. Based on average of staying there for 6-12 weeks for rehabilitation. It is noted that the actual usage is less than expected hence the requirement for further review of the use of the resource. **(SEE APPENDIX 1).**

3.5 The data demonstrates that the usage is below this optimum number but recognises that this is due to a number of factors:

- Risk adversity
- Education and training around utilising the resource
- Complexity of individuals leading to longer length of stay
- Delays with rehousing (hold up on new build completion, delays with welfare grant application approvals)

3.6 While these contributing factors have led to a reduced occupancy, the benefits of those that have used the resource has:

- Prevented admission to Long Term Care (LTC)
- Provided a broader and more inclusive service to other areas including Learning Disabilities and Mental Health, Housing Needs and Place of Safety, which was different from the original criteria
- Allowed Telecare to become part of ongoing support for service users
- Re-ablement carers to work directly with service users ensuring outcomes are met and appropriate packages are in place on returning home

3.7 The Jubilee Cottages are also identified as a main strategic resource to support further pilot projects due to commence in May 2018. The Out of Hours (OOHS) pilot project is going to look at the activity across Moray. The cottages could be an available resource to support this for the duration of this project which would include working closer with the Emergency Department and General Medical Ward at Dr Gray's Hospital.

3.8 In terms of financial realisation, **APPENDIX 2** evidences clearly that the cost, if the length of stay at the cottages had been in Dr Gray's Hospital with a transfer to a community hospital for the remainder, would be significantly higher.

3.9 The Service Level Agreement (SLA) continues in practice with Linkwood Medical Centre but on review with the practice there is no ongoing cost associated with this. They will provide medical attention when required, for anyone at the cottages that cannot get to their own registered GP during their stay at the cottages. Ongoing costs are detailed in **APPENDIX 3.**

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Shifting the balance of care has many advantages which are often realised fully beyond the short term. The ongoing use and continued investment of the cottages will allow time to address the current factors limiting the use and expanding on the benefits for facilitating discharge from hospital, promoting the use of technology in everyday life, and providing a crisis intervention resource for individuals in the community that do not require a hospital admission.

4.2 Further education and training of staff groups and the public will also be involved as part of this ongoing work.

4.3 The working group would also look to revisit the admission criteria based on the evaluation and the audit carried out (**APPENDIX 4**) to extend to other client groups.

4.4 Discussions have taken place with housing to look at how the model could offer more support where there are housing issues identified.

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

This policy is in line with MIJB's Strategic Plan. A key policy directive within the Strategic Plan 2016-2019 is to strive to maintain independence for individuals and the ability to live at home.

(b) Policy and Legal

The project will comply with all policy and legal requirements.

(c) Financial implications

The project will identify financial implications which will be reported as required.

(d) Risk Implications and Mitigation

This project does not introduce any further financial risks.

(e) Staffing Implications

There are no staffing implications arising from this report.

(f) Property

There are no property implications arising from this report.

(g) Equalities

An equality impact assessment has been completed for this project. The proposal assists in promoting equality of opportunity for elderly and disabled people.

(h) Consultations

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

- Chief Financial Officer, MIJB
- Legal Services Manager (Litigation & Licencing), Moray Council
- Caroline Howie, Committee Services Officer, Moray Council
- Head of Adult Services and Social Care
- Catherine Quinn, Support Manager
- Charles McKerron, Consultant Practitioner

6. CONCLUSION

6.1 MIJB are asked to support the continuation and further exploration of an adaptive model of Jubilee Cottages.

Author of Report: Lesley Attridge, Team Manager
Background Papers:
Ref:

Signature: _____ Date: 17 April 2018

Designation: Chief Officer Name: Pam Gowans

JUBILEE COTTAGES

Occupancy Notes

Of the 12 clients who have used the Cottages since 6th July 2017, the following has been noted:

1 Client 1 was a person with Learning Disability (LD) who was admitted due to vision problems and an inability to safely use the stairs at home. A new property was sought and, while this was underway, they were given support to gain in skill levels. Client was subsequently discharged to the new property after 83 days with a care package in place.

2 Client 2 was admitted from Dr Gray's Hospital (DGH) due to concerns when at home regarding being very fatigued when carrying out Activities of Daily Life (ADL) and not eating. Client was discharged home after 22 days with a twice-daily care package in place.

3 Client 3 was admitted from DGH as an Occupational Therapy (OT) referral following a stroke. After 32 days rehab, was discharged home with no requirement for a care package.

4 Client 4 was admitted from DGH as an OT referral. After intensive rehab, was discharged home to parent's address after a 13-day stay at Jubilee.

5 Client 5 was admitted for 5 days to Jubilee as a place of safety. Client was then discharged to emergency respite due to complex needs to then return home.

6 Client 6 was admitted from DGH as their confidence had dropped following a fall due to decreased mobility. Discharged home after 7 days rehab with no requirement for a care package.

7 Client 7 was admitted from hospital following a stroke. Client has braces on legs and uses a stick. Home has 2 flights of stairs so client is unable to manage this environment. Admitted to Jubilee to await rehousing. Delays with new-build housing meant client was a long-stay client, due for discharge mid-March; took ill and was admitted to DGH then transferred to ARI where they passed away. Total time in Jubilee to date of death was 227 days.

8 Client 8 was admitted following a breakdown in relationship with daughter with whom they had been staying. Subsequently discharged after 71 days to a new property with no requirement for a care package in place (although there does not appear to be a record of this on CareFirst as address still shows as Jubilee Cottages).

9 Client 9 had MH issues. After discharge from DGH, was admitted to Jubilee whilst waiting on a care package to become available in Cullen. As there is a serious shortage of carers in the Cullen area, client was in Jubilee for 116 days prior to being discharged with a care package of one med prompt daily.

10 Client 10 was admitted due to domestic issues. After assessment and re-enablement, was discharged home after 46 days with a once-daily care package in place.

11 Client 11 with LD who was admitted following a family breakdown after mother's death. Unable to return to the family home, it was anticipated the client would be able to be re-homed within the 6-week period. Underwent full OT assessments at Jubilee to further build skills. A delay in securing a tenancy meant client had a longer stay at Jubilee than originally anticipated. Finally discharged to a new tenancy after 153 days with independent skills far in excess of those originally expected.

12 Client 12 with slight mental health (MH) issues, admitted from DGH due to dilapidated condition of house which now has an Order from Environment Health on it. Currently waiting on word of a new tenancy and would expect to be discharged within 2-3 weeks. Current stay (up to and including 3rd April) amounts to 77 days (11 weeks).

Based on the average length of stay at Dr Gray's Hospital (DGH) and the presumption that a further stay at a community hospital would be the alternative for these clients the costs are projected as below.

Client	Total days at the Cottages	Average stay DGH (days)	Cost/£570/day DGH	Community Hospital transfer for remaining length of stay per client	Cost/£288/day Community Hospital
2	22	7	£3990	15	£4320
3	32	7	£3990	25	£5700
4	13	7	£3990	9	£2592
6	7	7	£3990	0	0
7	227	7	£3990	220	£50,160
9	116	7	£3990	107	£24,396
12	77	7	£3990	70	£15,960
			Total £27,300		**Total £103,128**

Total projected cost could have been = £130,428

Utility	**Total cost for all 6 cottages per annum**
Non Domestic Rates	6,240
Energy (estimated)	2,600
Other property costs	431
Telephones	1,723
TV Licences	882
Equipment & Furniture	101
Handyperson(existing resource)	7 visits completed £0.00
Total Costs 17/18	**11,977**
Original Estimated Costs	10,000
Other Non- recurring costs of refurbishment in 17/18	**6,044**

Jubilee Audit/Review March 2018

Part 1: Base analysis of spreadsheet provided by Jubilee Cottages Co-ordinator/Administrator correct to 8th March 2018.

For year 2017 to 08/03/18

All current or enquiry arising from hospital based referral

None have pre-assessment event noted

2018 Code	ID No.	Referrer	Referred From:	Accepted for Admission	Not Accepted	Reason	Admission	Residence No.	Status
1/18	J30979410	AP-SW	Muirton Ward Seafield (H)	Initially – N0 Reconsidered- Yes (PoS) (LA)			17/01/18 1st contact 12/12/17 Resp: 16/01/18	9	Still in residence – Awaiting tenancy Linn Court – designate Place of Safety.
2/18	J3078584	NHS-OT CR- 06/02/18	DGH	Yes			No		As of 12/02 no further information provided – referral lapsed.
3/18	J3104286	AP-SW CR-06/02/18	DGH	Yes			No		Service-user declined
4/18	NC details	AP-SW IR-CR-27/02/18	Turner Memorial (H)	Initially Yes	No	Wheelchair-user	No		Still under review

Summary Refusal: Lapsed

Declined

Access

Admission criteria: Place of safety (while awaiting new tenancy placement)

2016 Code	ID No.	Referrer	Referred From:	Accepted for admission	Not Accepted	Reason	Admission/ Discharge	Residence No.	Status / Additional Information
1/16		L (Att) CR- 28/03/2016	Initial C Referral		Yes	WC-user	No		Last known – at Seafield (H)
2017									
1/17		CCO IC- 29/03/17 CR-10/04/18	C	Yes		Min Reh Potential (stroke)	No		Last known – client admitted to Hospital
2/17	J3055498	CCO CR - 18/12/17	DGH	Yes			No		Admitted straight to Abbeyside residential care home.
3/17	J3089737	CCO	DGH (W4)	Yes			A-06/10/17 D-29/01/18 (116 days)	15	Awaiting tenancy in Cullen ILS going in daily while at Jubilee. Discharged with 7x15min Med Prompt.
4/17		CCO	Seafield (H)	Yes		Failed Admission			SU had no food – Seafield decided would continue with Rehab
5/17	J3101922	NHS-OT	DGH (W8)	Yes			A-26/07/17	5	SU still in residence – minimal rehab – leg braces in place can't access flat due to stairs. SU under 60yrs.
6/17	S2275147	NHS-OT	DGH (W6)	Yes			A-19/07/17 D-25/07/17 (7 days)	?	SU loss of confidence following a fall. No note of on-going SC or H Support.

7/17	J3068041	CCO	C	Yes (LA)			A-16/08/17 D-25/10/17 (71 days)	7	Initially referral was refused as S.U. not suitable. Reviewed referral accepted by LA. The service-user was discharged with no requirement for further care services.
8/17	J3002869	AP-SW	C	Yes			A-28/10/17	7	The Service-user is still at Jubilee Service-user had been resident at Moray Respite Flat but flat was required for another S.U. To remain at Jubilee until appropriate accommodation can be found. Continue with OT support to increase capacity in specified tasks.
9/17	J3049829	CCO + OT	C	Yes			A-20/10/17 D-04/12/17 (46 days)	13	Admitted for respite while informal carer was in hospital – during the period the S.U. at Jubilee his home was cleaned, new carpets purchased from the Welfare Fund. Discharged with no formal care package?

10/17	J3030556	CCO	C	Yes			-		Cottage available 20/07/17. CCO felt more appropriate to have support from Home Care. S.U. required reablement support to regain skills in personal care.
11/17	J3081106	L.A.	C	Yes			A-11/07/17 D-15/07/17 (5 days)	7	Referred to Jubilee as place of safety. Discharged to emergency Rehab. S.U. community referral with a pre-assessment.
12/17	J3049770	Access Review Team (SW)	C	Yes			A-07/09/17 D-28/11/17 (83 days)	9	Initial referral date: 26/07/17 but no cottage available. Discharged to home – on-going care? Pre-assessment available.
13/17	J3088515	CCO	DGH	Yes			A-03/07/17 D-24/07/17 (22 days)	13	Initial referral date 14/06/17 cottage not ready. S.U. fatigued; discharged with H.C. package 2xdaily.
14/17	J3101368	NHS-OT	DGH	Yes			A-09/06/17 D-10/07/17 (32 days)	9	Stroke rehab. Discharged with no further care.
15/17	S2175819	NHS-OT	DGH	Yes			A-10/05/17 D-22/05/17 (13 days)	13	S.U. to received intensive rehab. S.U. discharged to father's home. On-going formal care?

Summary Analysis

2016 - There was only one referral and was declined by the admission team as the S.U. was a wheelchair user (refusal bases access).

Summary Analysis - 2017

In total eleven service users where accepted for admission and accepted the referral, of those three were still in residence as of end date for spreadsheet (08/03/18). During the same period there were four failed admissions, where the service-user had been accepted.

Summary Analysis Refusal (i.e. S.U. not accepted for admission during specified period - 2017), please note this does not include service-users for whom after initial enquiry no further information was provided:

Criteria – refusal	**No. of Service-users**
Level of support required considered to high	3
Age – did not meet specified age criteria	1
Wheelchair user	5
Capacity – did not meet specified criteria (S.U. has to have capacity to accept referral)	2
S.U. declined	5
Client not Moray Authority	1

Additional Analysis -referral refused:

Referral arising from the: Community: 6 Hospital: 10 (include 2 from ARI) Out of Area: 1

Follow-up Analysis: Where the ID for the S.U. is known or can be gained from information provided (failed or rejected referral):

ID	Care status of client currently
J3055498	Admitted to The Grove Care Home 05/03/2018
J3030556	Service user was supported by ILS with P.C. for 1.25hrs per day 7/7 for several months thereafter care was reduced to 2 x 0.50hr visits per week (11/01/2018). S.U. also attends Day Care 1 x weekly
J3086237	Admitted to Spynie Care Home from Fleming hospital 10/11/2017.
J3081106	See below – Service user was admitted to Jubilee Cottages for five days to provide place of safety, discharged 15/07/17; admitted to emergency respite by Out of Hours (OOH) Social Work (SW) on 17/07/2017 no record of where he is now though address showing on CareFirst is the original address at time of admission.

Follow-up status of service-users (initially 22nd of March and reviewed 30th of March) who have been resident at Jubilee Cottages and been discharged; and current status of the three service-users that were listed as still resident at time of collecting statistics noted above (those are highlighted in pale blue for reference purposes), information is obtained from analysis of CareFirst record of each service-user:

No.	ID	Care status of client currently
1	J30979410	Has been offered a Sheltered Flat on 22/03/2018 (West Park Court) in Elgin and service user has viewed it. Has had a taster session at Older People's Day Service in Elgin 17/01/2018. S.U. has four daily visits by the ILT.
2	J3089737	Moved to his own tenancy in Cullen (no date given). He receives 0.25hrs care from Crossroads (Moray) Care 7/7 for medication prompts and welfare check. Service user has capacity but due to a combination of physical and mental health conditions he lacks insight into his health and care needs and medication compliance. OAP and CPN are involved.
3	J3101922 (under 65)	Died in hospital 09/03/2018; partner had been living at Cottage No. 9 with his partner; committed suicide three weeks after unexpected death of his partner (not Moray Adult Social Work Client).
4	S2275147	Home visit and discharge from Jubilee Cottages 19/07/2017. No further information. Moray Lifeline in Place.
5	J3068041	Moved to sheltered housing in Dufftown 25/10/2017 No record of any care provision. Moray Lifeline in Place.
6	J3002869 (under 65)	Allocated flat (08/02/2018) in Extra Care Housing in Elgin (Linkwood View) to provide 10.5 hr care p/w. Also 12hrs p/w from CSS to be reduced to 10hrs by June 2018 once able to attend gym independently. Also attends 3/7 Day Service. Moved to new tenancy on the 29th/03/2018
7	J3049829	Returned home to house he shares with his son 05/12/2017 Care at home being provided 0.5hrs per day 7/7
8	J3081106	OOH SW admitted service user to emergency respite from Jubilee Cottages (17/07/2017) unable to find out why or how long this was for and where he is now – address still showing as Rosebank, Keith (S.U. has issues with wife and son he lives with).

9	J3049770 (under 65)	Moved into a tenancy provided by Real Life Options (97 Alba Road, Buckie) Noted on 29/11/2017 S.U. has 60hrs p/w care and support which includes 2hr 10 min PC , meal prep - 14hr 5min meal observation - 17hrs, social activities – 10.50hrs , support with daily living skills - 7hrs, shopping - 3hrs,health appointments/meetings local – 0.25hrs, out of area appointments averaged - 1hr (including travel), travel to visit family - 5hrs .
10	J3088515	As of 03/05/2017 one day p/w Day Care at Chandlers Rise. As at 24/10/2017 received care at home for 5.50hrs p/w to support with medication prompts, personal care and, meal preparation on the days that the service-user does not receive meals-on-wheels.
11	J3101368	Service user was discharged home (11/07/2017) without needing any care as he had become independent in all aspects of daily living following a period of rehab at Jubilee Cottages.
12	S2175819 (under 65)	Discharged to her father's home from Jubilee Cottages 22/05/2017 to await her own tenancy. At 18/07/2017 Care First indicates she has her own tenancy close to where her father lives, and is also in receipt of ongoing support from drug and alcohol support worker.

Further Analysis

Service-user currently receiving limited or no formal care services	4
Service-user currently receiving 3.5hrs or less of care per week	2
Service-user currently receiving under 10 hours of care per week	2
Service-user currently receiving extensive package of care i.e. over 20 hours per week	2
Service-user deceased (service-user did not meet age criteria at time of admission)	1
Service-user's current status unknown	1
	Total (12)
Service-user still in residence at Jubilee Cottages	1
Service-user admitted for respite/place of safety/awaiting rehousing	8 (No.12)[1]

(No.12) 1 (discharged to father's home now in own tenancy)

- Number of service-users who were resident in Jubilee and were under 60 years old at time of residence: 4
- Of those admitted 17% would not meet the eligibility criteria for reablement as level of incapacity too high.
- Potential days of use: 820 x 5 cottages = 4,100 days if include 2016; Actual usage = 604 to 618 days. In real terms the active use of Jubilee cottages has been from January 2017 to March 2018 providing for a potential usage of: 455 x 5 cottages = 2,275 days; Actual percentage usage: 27%.

General Information

An inventory is available for each cottage and any breakages, or missing items can be charged to the service-user. All the bathrooms are wet rooms; each cottage has a TV. Usually there is a time lapse of a week from the referral being acknowledged and the referral being accepted by the allocation team and the service-user being informed; some have been achieved within two days but this is unusual; the service-user usually moves into their allocated cottage within a week to ten days.

Findings from on-site visit 29th of March 2018 combined with findings from the analysis of service-users of the project and occupancy rates:

Key: *Information recorded in italics is paraphrased from commentary provided by the OT Manager and the Project Administrator*; Information recorded in blue text contains Q.A. analysis of evidence to, for example, provide statistical information.

- Weekly meetings are held at Jubilee Cottages to discuss current and possible admissions, generally in attendance are: O.T. Team manager, Advanced O.T Practitioner, occasionally: Housing (Occupational Therapy) O.T, Team Manager (Access Team), Kay McInnes (Team Manager: Admissions, Discharges and Transfers), Jubilee Cottages Co-ordinator/administrator and various social workers may attend to present a case to the team.
- The final decision on admission lies with Kay McInnes (Team Manager Discharge Team) and Alex Morrison (Team Manager Access Team); input from Lesley Attridge (OT & Intermediate Care Service Manager).
- *The OT Manager commented that the initial intention for what Jubilee Cottages would actually do and what they have done in practice is quite different, there has been less need for occupational therapy input than originally thought when the project was set up.*
    - *The size and proportions of the properties are not suitable for rehabilitation where the service-user has more serious mobility problems or uses a wheelchair*, of the 17 service-users for whom the reasons for refusal of referral to Jubilee is known nearly 50% were on the grounds of issues with access. Refusal of service-user (17%) where dependency needs too high and/or did not have capacity to make informed choices.
- Occupancy has been poor since the project opened e.g. if the occupancy figures are taken for 2017 to March 2018 occupancy rates have been 27%; if admission criteria with regard to age (65+) had been rigidly enforced (4 of the twelve service-users were under 65 years) then the occupancy rate would have dropped to 6%.
    - *Initially O.T's had the responsibility for checking the properties and managing any damages, replacements, sourcing services (e.g. laundry services) as well as co-ordinating care and treatment planning for the service-users, this did pose issues in particular in relation to the time the OTs could devote to the checking and management of the properties; once the Coordinator/administrator in post the situation greatly improved with the additional advantage of far higher "buy-in" from individual Social Workers, due to the efficiency of the communication channels the Coordinator/administrator has put in place and manages.*
    - *People who are rehabilitated in hospital but need to build confidence and stamina can generally do so (and would be better to do so) at home with support from ILS team or resumption of mainstream Home Care, therefore Jubilee Cottages are not seen as the most effective option and hospitals*

and social workers in the community are reluctant to refer service-users for reablement even if there were not issues with access, capacity or level of need: Dr Gray's Hospital (DGH) and the community hospitals do not pressurise Jubilee to take patients as they are aware of the limiting eligibility criteria.

- *Jubilee has proved invaluable for people who have housing needs and/or social need (in some instances combined with alcohol dependencies, and have the desire to stop drinking) e.g. homelessness, unsuitable housing, emergency respite required due, for example, to family breakdown/loss; place of safety required i.e. of the twelve service-users who were admitted to Jubilee Cottages* 66% (8) had an established housing need and this was the key reason for their admission.
- *The project has been very successful for adults with learning disability (have capacity to give consent) who have never lived alone, enabling them to practice the daily living skills required for independent living in a safe assisted environment; and also provides the opportunity for professional assessment without the service-user's main guardian being present, which can be an inhibiting factor for assessors and/or the service-user.*
- *The O.T Manager (Paula Hart) feels that going forward there is scope to develop along the lines of focusing more on those with housing and social needs;* **and the evidence of the findings from the audit supports this**. *If this outcome was determined as the way forward for Jubilee Cottages then in order to optimise the service greater involvement with Housing Services would be essential; it is believed with appropriate support from housing services in place Jubilee Cottages would achieve full occupancy. Additionally an occupancy period of 12 weeks per service-user would be more appropriate in these circumstances;* to date the longest occupancy of one of the cottages by a service-user has been approximately 7.5 months.

- Of the twelve service-users who have occupied Jubilee Cottages 58% stayed longer than the 6 week maximum period which was set as a realistic rehabilitation period but which is not suitable for the delays associated with moving into a new tenancy. If the reablement period criteria of six weeks had been rigidly adhered to the occupancy rates would have dropped to (if those over six weeks were considered as staying for six weeks) 16%; further if the service-users who did not meet the age criteria were not admitted to Jubilee Cottages the occupancy rate would have fallen from 16% to 10%.
  - *The Coordinator/administrator commented that the service-users do not pay costs including utility bills for the duration of their stay; having the impact that service-users who had been in financial difficulties were given a respite period which enabled them to save or pay back some of the monies they owed*. It can be assumed that this would have a beneficial impact on the service-user's mental wellbeing as it would reduce stress and anxiety.
  - *Social Workers who refer and place clients within the service now take more responsibility for them whilst they are there; in the past there was a sense that the service-users once placed in Jubilee had much less engagement with their social worker; however since the administrator has developed a system whereby she sends out the minutes of weekly meetings to all involved including the service-user's social worker, and contacts the social worker prior to the next meeting for any updates relevant information is communicated to the team.*

- Only two of the service-users were supported by the ILS support workers while they were resident at Jubilee; most of the service-users were able to function independently or had input from other teams re: their social work support plan.
  - *There have been 2 admissions from ward 4 for people awaiting care and/or for suitable housing.*
  - *The cottages have been developed for single occupancy, and this has also raised a barrier to the use of the service by the group of service-users who meet the criteria and for whom the service was directed.* Of the seventeen service-users for whom there is a reason for refusal of the referral noted 29% was service-user rejection of the referral as they wished to stay at home having the support of their own informal carers i.e. family/partner etc. A situation had developed in one of the flats where a service-user's partner (Mr A[2]) who was only supposed to visit the service-user while she was living at Jubilee cottages gave up the tenancy of their home and slept beside his partner on a blow-up bed at Jubilee Cottages. The service-user unexpectedly died three weeks ago and as Mr A had no home to go to he was allowed to stay at Jubilee Cottages, although he was not known to Moray Social Care as a client, until alternative accommodation could be sourced

(2) Mr A is not the client's real name.

Recommendations:

That the eligibility criteria for entry to Jubilee cottages is reviewed as a priority if the service is to achieve full occupancy, best value and sustainability. The current eligibility criteria is targeted at those service-users sixty-five or over who require a period of reablement (six weeks) normally after a stay in acute hospital, or community hospital care. However it is this very group of service-users who are most likely to have mobility issues, it is not unreasonable to deduce that if a service-user from this group is able to manage physically at Jubilee Cottages then the best option for them would be to return to their own home where in many cases they will have support from informal carers: family, community and the Independent Living Service if a short period of intensive reablement is required for them to meet their outcomes.

The evidence supports that each case has to be considered on its own merits with regard to a review of the service-user's support plan and discharge plan, as **age is not a key factor** on needing one or more of social/mental health supports; combined with

- housing support;
- a respite period from their home environment;
- a period of time to regain their confidence before returning to their own home after a period of hospitalisation, potentially reducing the likelihood of unscheduled hospital readmission.

Equally it is clearly evidenced that in those cases a six week time period may not be appropriate; and therefore it is recommended that the criteria be reviewed to take account of this factor i.e. perhaps extending the period to 12 weeks, again this would be dependent on an assessment of the individual and what is appropriate to their assessed need.

The evidence clearly illuminates that there are two groups of service-users in particular for whom the project has had the best outcomes i.e.

(1) Those that are under-going transition from their previous accommodation (which may be the parental home) or a cared for service (this potentially could include a young person transitioning into adult services) to live in alternative accommodation, in the community, or some form of supported accommodation. This group of service-users have clearly benefited from a period of assistance and support with life skills and services to support their mental health and wellbeing; and
(2) Those service-users that also require social support including those with (mental wellbeing and/or addiction issues) and are currently homeless, and/or require a place of safety or emergency respite.

Authors: Jacq Goldthorp (Q.A. Auditor) and Alison Blair (03/02/2018).

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 26 APRIL 2018**

SUBJECT: **EQUALITIES MAINSTREAMING PROGRESS REPORT 2016-2018**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To seek approval of the Moray Integration Joint Board (MIJB) Equality Mainstreaming Progress Report 2016-2018.

1.2 To inform the MIJB of planned work in relation to equalities mainstreaming and outcomes during 2018/19.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board (MIJB) consider and:-

(i) note the Equalities Outcomes progress update (APPENDIX 1);

(ii) approve the MIJB Equality Mainstreaming Progress Report 2016-2018 (APPENDIX 2);

(iii) note the planned programme of work for 2018/19 in relation to equalities mainstreaming and outcomes;

(iv) note the Fairer Scotland Duty, which the Integration Joint Board will be subject to, came into force on 1 April 2018;

(v) agree the proposed extension of the remit of the Strategic Planning and Commissioning Executive Group; and

(vi) instruct the Chief Officer to submit for approval to the MIJB a revised set of equality outcomes, co-produced with people with protected characteristics, prior to 31 March 2019.

3. BACKGROUND

The Public Sector Equality Duty

3.1 The Public Sector Equality Duty, laid out in the Equality Act 2010 (the Act) came into force in Scotland in April 2011. This equality duty is often referred to as the "general duty" and it requires public authorities to have "due regard" to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act;
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not; and,
- Foster good relations between people who share a protected characteristic and those who do not.

3.2 The general duty covers the following protected characteristics: age; disability; sex; gender reassignment; pregnancy and maternity; sexual orientation; marriage and civil partnership; religion, belief or lack of religion/belief; and, race.

3.3 From April 2018 the Fairer Scotland Duty, under Part 1 of the Equality Act 2010, came into force across Scotland. The new duty places a legal responsibility on public bodies, including Integration Joint Boards to 'pay due regard' to how they can reduce inequalities of outcome caused by socio-economic disadvantage when making strategic decisions. Public bodies will also be required to publish a short written assessment showing how they have fulfilled the duty. Interim guidance to support the implementation of the new duty was published by the Scottish Government on 27 March 2018.

3.4 The Strategic Planning and Commissioning Executive Group (SPCEG) will give consideration to how the implementation of the Fairer Scotland Duty can be aligned within existing duty under the 2010 Act and existing commitments within the Strategic and Commissioning Plan to address health inequalities.

Equalities Outcomes

3.5 Integration Joint Boards were added to the list of public authorities subject to the requirements of the Act in 2015 and were required to publish Equality and Mainstreaming Outcomes plans by the end of April 2016.

3.6 The first MIJB Equality Outcomes and Mainstreaming Equalities Framework 2016/17 was published in April 2016. The Equality Outcomes contained within the framework were subject of consultation, including with people who have protected characteristics, and were aligned to directly contribute to the strategic priorities and shifts identified within the Strategic and Commissioning Plan.

3.7 There is a requirement to substantively review Equality and Mainstreaming Outcomes at least every four years; meaning the first substantive review in Moray must take place by 1 April 2020. A review of progress has taken place and the updated report is attached at **APPENDIX 1**.

Equality Mainstreaming Progress Report 2016-2018

3.8 The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (the Regulations) impose "specific duties" on Scottish public authorities to publish a set of Equality Outcomes and a report showing progress being made in mainstreaming equality at intervals of not more than two years. This means that as the MIJB assumed its equality duties as a public body from 1 April 2016 that the first mainstreaming equality update report must be published by 30 April 2018.

3.9 A progress report has now been produced for approval at **APPENDIX 2**. This provides an overview of progress made in achieving equality outcomes over the last two years. It also identified areas for improvement and priorities for the next year in relation to equalities mainstreaming. The report is compliant with the Act, supplementary regulations and guidance issued by the Equality and Human Rights Commission.

3.10 The Regulations specify that Equality Mainstreaming Progress Reports must be clearly identifiable and accessible to any member of the public who may have an interest in them. The Equality and Human Rights Commission recommends that reports are published on websites in a location that is easy to find and in a format that is compatible with accessibility features, such as screen reading facilities for people with sight impairments. It is therefore intended that, following approval, the report will be designed in compliance with accessibility standards, and uploaded onto the Health and Social Care Moray website. In addition, copies will be disseminated in appropriate formats to organisations and identifiable community groups who are known to have a specific interest in the rights of people with protected characteristics. An appropriate summary of the report will also be included within the Annual Performance Report 2017/18 to support wider dissemination of key information.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Equalities Mainstreaming and Outcomes Priorities for 2018/19

4.1 A key priority during 2018/19 will be to review the MIJB's existing equality outcomes to ensure they are fit for purpose, reflect the desired outcomes of affected communities. The SPCEG will give clear recommendations in relation to how equalities issues are supported, governed, monitored and driven forward by Health and Social Care Moray. This group will ensure any revised equality outcomes are co-produced with affected people, utilising and strengthening existing engagement mechanisms. It is recognised that this will require careful planning and significant expertise from across a range of stakeholders, including people who share protected characteristics.

4.2 In addition to the revision of equality outcomes and consideration of the Fairer Scotland Duty, the SPCEG will also consider:-

- An appropriate model of co-operation and mutual support with Moray Council and NHS Grampian in relation to the Public Sector Equality Duty, with a specific focus on employee information and procurement aspects of duties under the Act;
- Further development of an appropriate and proportionate model of impact assessment, including supporting governance structures and learning and workforce development considerations; and,
- Considering how commissioning activity, both internal and external, can better support the delivery of equality outcomes.

4.3 It is intended that a revised set of outcomes be available for submission to the IJB in early 2019.

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.

This report forms part of the governance arrangements of Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019.

(b) Policy and Legal

It is recognised that the MIJB is directly subject to the Public Sector Equality Duty and therefore continues to address equalities matters through integration arrangements to ensure compliance with the Equality Act 2010 (specific duties) (Scotland) Regulations 2012.

(c) Financial implications

None directly arising from this report.

(d) Risk implications

Failure to comply with the commitments of the Public Sector Equality Duty would result in services delegated to the MIJB not meeting the needs of people who share protected characteristics, leading to poorer outcomes and a widening inequality gap.

(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 Legal Services Manager (Licensing & Litigation), Moray Council, Chief Financial Officer, MIJB and Caroline Howie, Committee Services Officer, Moray Council who are in agreement with the content of this report where it relates to their area of responsibility:

6. CONCLUSION

6.1 This report provides a summary of progress for MIJB in the first two years operation, with a full review to be submitted to this committee by the end of 2019.

Author of Report:	Don Toonen, Equal Opportunities Officer & Catherine Quinn, Executive Assistant
Background Papers:	Held with author
Ref:	ijb\board meetings\Apr18

Signature: Date: 17 April 2018

Designation: Chief Officer Name: Pamela Gowans

Moray Integration Joint Board

Equality Outcomes
April 2016 – March 2020

What Moray Integration Joint Board (MIJB) wishes to achieve in the period April 2016 –March 2020 to progress equality both in the services it provides, and within the MIJB.

7th March 2016

This document is also available in large print and other formats and languages upon request. Please call either Sandra Gracie on 01343 567184 ext 67184 or Don Toonen on 01343 563321

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1. Foreword

The new Moray Integration Joint Board (MIJB) will commence on the 1st April 2016. It was created following the framework laid down in the Public Bodies (Joint Working) (Scotland) Act 2014 for the effective integration of adult health and social care services. The stated aims of the Act are to:

"...improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their own homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older."

The role of the MIJB is to direct a wide range of health and social care resources delegated by NHS Grampian and The Moray Council to achieve these aims.

The MIJB, managers, staff and partner agencies will work hard to deliver the highest quality of health and social care services for the people of Moray, working collaboratively through the Moray Community Planning Board as a statutory partner.

This is the Consultation Draft of our first Equality Outcomes Report covering the period 1st April 2016 to 31st March 2020. It is produced in compliance with the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 and the requirements of the Equality and Human Rights Commission for Scotland, the main regulatory body. The report sets out what we wish to achieve over the next four years in the areas of:

- Race
- Disability
- Age
- Sex (male or female)
- Sexual orientation
- Gender reassignment
- Pregnancy and maternity
- Marriage and civil partnership
- Religion or belief

I do hope you will take the time to read this Consultation Draft and provide feedback on our proposals. We are here to serve the people of Moray and we wish to have meaningful engagement with the people of Moray for all aspects of our work.

Yours sincerely,

Pam Gowans,
Chief Officer,
Moray Integration Joint Board

2. Why produce this report?

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 came into force on the 27th May 2012. One of the requirements of the Regulations is that public bodies such as the new Moray Integration Joint Board (MIJB) must produce and publish an Equality Outcomes Report by 30th April 2016, and every four years thereafter, setting out the objectives we wish to achieve in the field of equality and diversity in each four year period. This report covers the period 1st April 2016 to 31st March 2020.

This Outcomes Report details the work we propose to carry out to progress equality for each of the 8 "protected characteristics" as defined by the Equality Act 2010 that are relevant to the Public Sector Equality Duty. These 8 protected characteristics are:

- Race
- Disability
- Age
- Sex (male or female)
- Sexual orientation
- Gender reassignment
- Pregnancy and maternity
- Religion or belief

The law requires that equality outcomes are designed to help us progress the requirements of Section 149 (1) of the Equality Act 2010 to:

"(a) eliminate discrimination, harassment, victimization and any other conduct that is prohibited under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

The development of the Equality Outcome measures have been informed by a series of workshop events held with both the joint health and social care workforce and the wider public in 2014/5. These workshops focused on discussing the 9 high level outcomes for integration and their significance for people who use health and social care services in Moray.

The importance of social justice and equality in terms of how people would access these services were two key themes that emerged from these workshops. This feedback not only informed the development of the range of local performance indicators, including the equality outcomes, but also informed the development of the Moray Integration Joint Boards Vision Statement.

Following a consultation exercise, the Moray Integration Strategic Plan (2016-2019) was adopted by the MIJB in March 2016. This document featured joint performance

management reporting arrangements. This also relates to how the Equality Outcomes will be considered and used to improve the delivery of services.

Comments can be made in any language or format preferred and will be given the fullest consideration by the MIJB. Details of how to make comments are shown at Section 15 on page 18.

3. Information about Moray IJB

The new Moray IJB was formally established from the 6th February 2016 and came into being on the 1st April 2016, the latest date by which the MIJB can enter a "go live" state.

a) Services provided

The services provided on behalf of the MIJB via Directions to The Moray Council and NHS Grampian, are listed at **Appendix I**. In summary the MIJB will take on responsibility for directing the resources in accordance with the strategic plan and in meeting the 9 national health and wellbeing outcomes by which the MIJB's success will be measured. The services previously managed by the Moray Health and Social Care Partnership (MHSCP) will be operationally managed on behalf of the MIJB and parent bodies via the Moray Chief Officer with some additional adult health and social care services previously managed by NHS Grampian and The Moray Council included. For Moray this will include all of the mental health services delivered locally in the community and in secondary care and for community learning disabilities services.

Moray will also host Primary Care Contracting services and Primary Care Out of Hours services (GMED) on behalf of Aberdeenshire and Aberdeen City IJBs.

Childrens' services, previously managed locally within the MHSCP, will continue to be managed locally via the Chief Officer on behalf of NHS Grampian but are not part of the delegated arrangements of the MIJB.

b) Resources used

In 2012/13, the cost of NHS services and social care in Moray totalled £172 million. This was split £121 million for NHS care and £51 million for social care. The top five cost areas were:

Cost area	Expenditure	% of total spend
Emergency Hospital Admissions	£29 million	17%
Community Health Servicers	£22 million	12%
Care Homes	£17 million	10%
Prescriptions	£15 million	9%
Community Based Social Care	£15 million	9%

4. Moray Health Profile

Key observations
At the 2011 Census, the population of Moray was 93,295.

Moray's population is ageing, consistent with national trends. Increasing life expectancy is to be celebrated, and increasing age is observable as being associated with greater requirements for health and social care. The best health systems are proactive in maintaining and improving the health of their served population, not solely reactive to health problems only once they have occurred. Moray's 'older population' are young and middle-aged people now, so prevention efforts must include this whole population.

Moray tends to score well for the social and economic factors that underpin good health, when compared to the Scottish national average. However, its rurality is a known issue that can cause people difficulty in accessing services, and despite high average employment and low overall income deprivation, Moray has a higher proportion than average of households reported to be living in fuel poverty. Moray also has an above average level of road traffic accident casualties in Scotland. Moray tends to have an overall health profile that is better than the Scottish national average. However behind this lies evidence of variation in health status, with some communities reporting greater levels of health problems than others.

Key observations per protected characteristic
The data underlying the Moray Health Profile focuses mainly on the protected characteristics of age, disability and sex. The relatively small population of Moray makes it difficult to get meaningful data relating health inequalities to the protected characteristics of race, religion, sexual orientation and gender reassignment.

The National Records for Scotland estimates that mid-year population of Moray for 2014 is 94,750 of which 48,094 are female and 46,656 are male. According to the 2011 Census, 96% of the population of Moray was white British, 0.7% Asian, 0.2% African Caribbean and 0.3% from other ethnic groups. **[further explanation of how to obtain data covering other protected characteristics]**

5. Equality Outcomes

The Equality Outcomes presented in this report have been designed to complement the outcomes of the Moray Strategic Plan 2016 – 2019 and the strategy for unpaid carers. The strategic plan is based on a wealth of data summarised in the Moray Health Profile.

The main purpose of the Moray Strategic Plan is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The strategy covers all adults aged 18+, who use our health and social care services which are agreed as in scope of integrated services. These are listed in Appendix 1 of the Moray Strategic Plan.

By its nature, the emphasis in the Moray Strategic Plan is on the protected characteristics of age and disability. The strategic outcomes from the Strategic Plan are (Moray Strategic Plan 2016-2019: p.20):

1. More people will live well in their communities – the population will be responsible for their own health and wellbeing – the community will respond to individual outcomes.
2. Carers can continue their caring role whilst maintaining their own health and wellbeing.
3. Relationships will be transformed to be honest, fair and equal.
4. Invest in a seamless workforce to ensure that skills, competencies and confidence match the needs to enable people to maintain their wellbeing.
5. Technology enabled care considered at every intervention.
6. Infrastructure and redesign.

The strategic aims from the strategy for unpaid carers (Carry on Caring 2016 – 2019) are:

1. That unpaid carers have a life outside of their caring roles and are supported to feel less isolated. They are supported to recognise the skills and knowledge they have to enable them to use their expertise in other areas of their everyday life.
2. That unpaid carers have consistent, effective and available information that is relevant, appropriate and easy to find.
3. That unpaid carers are supported to be aware of and to look after their own health and wellbeing so that they can continue to care.
4. That unpaid carers have access to appropriate, flexible and individualised short breaks and/or respite services that meet the needs for them and the people they care for.
5. That unpaid carers are supported and enabled to identify themselves as a carer as well as receiving the same recognition for Health and Social Care and employers.
6. That unpaid carers have meaningful opportunities to be involved and listened to at a strategic level and that their profile is raised in the community so that our locality is more carer friendly.

Following on from the strategic aims, the equality outcomes for the MIJB are:

1. The rate per 1,000 people aged 65+ who receive intensive care at home will be 19 for each of the four years of these Equality Outcomes. This represents a slight increase from the current rate (18.75). The new target takes account of the expectation that people live longer and that there will be an increase of the number of people in the upper age range of this group and therefore an increase in the number of people with multiple conditions.
2. The rate per 1,000 people aged 65+ who are in permanent care will be 28 for each of the four years of these Equality Outcomes. This represents a slight drop from the current rate of 29.87.
3. Of people aged 65+ who receive care, 95% will report having more things to do for each of the four years of these Equality Outcomes. The current rate is 90%.
4. Of the people who receive care, 95% will report feeling safe for each of the four years of these Equality Outcomes. The current rate is 90%. The majority

of this group in Moray are older people (78%). The remaining group are people with a disability, broken down as Physical and Sensory Impairment (9%), Learning Disabilities (9%) and Mental Health (3%),

5. Of all unpaid carers for 95% will feel supported and capable to continue their role as a carer for each of the four years of these Equality Outcomes.

At the moment it is not possible to further develop these outcomes for other groups protected under the Equality Act 2010. This is because the information isn't available (religion, sexual orientation, gender reassignment), or because the numbers are very small as is the case in relation to race.

The 2011 census figures for ethnicity for those aged 65+ are:

Table 1: People in Moray aged 65+ by Ethnic Group

	All People	White: total	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African Total	Caribbean or Black: Total	Other Ethnic groups: Total
All	17,222	17,153	12	41	9	5	2
Male	7,600	7,574	5	14	5	2	0
Female	9,622	9,579	7	27	4	3	2

Over the next four years, work will be carried out to improve the equality data for the various service users and unpaid carers. The recent arrival of Syrian refugees in Moray, who are being supported by the Community Planning partners, gives an opportunity to gather qualitative data on access to health and social care for minority ethnic groups.

The outcomes outlined here and the activities that underpin them have relevance to all the three elements of the Public Sector Equality Duties. These are having due regard to the need to:

- **Eliminate discrimination, harassment, victimisation and other conduct prohibited by the Equality Act**. The overall aim of the outcomes is to ensure that older people and those with a disability are looked after in their community and feel safe. We aim to have supportive local communities which have the capacity to provide care and support with and for people. Growing community capacity that focuses on early intervention and a preventative approach will reduce isolation and loneliness, enable participation, improve independence and wellbeing and delay escalation of dependency and need for more complex care and support.

- **Promote equality of opportunity even if this means treating some groups more favourably than others**. The outcomes are underpinned by a range of activities to ensure that older people and people with a disability have access to the services they need as well as access to activities that they feel are meaningful. The activities undertaken will include further

development and use of technology enabled care, partnership working with The Moray Council to ensure that more accessible housing is made available, and investment in activities that promote positive mental health and wellbeing.

- **Foster good relations between groups that share a protected characteristic and those that don't.** Our developing relationship with the third sector will support us to continue the development of a moray based third sector network focused on health and wellbeing in our communities. It should be recognised that people living with multiple conditions can benefit greatly from peer support, either in person or online, and that this can help them to self-manage and build their personal resilience. Activities will include awareness raising to reduce the stigma of mental health, developing dementia friendly communities and developing networks to facilitate peer support locally in partnership with the third sector.

Reporting on outcomes

It is anticipated that during 2016, systems will be put in place to report quarterly on progress with the outcomes to the MIJB. A separate webpage will be created on the websites of the Moray Council and NHS Grampian where these reports will be made public.

Moray Integration Joint Board

Equality Mainstreaming Progress Report 2016-2018

This report provides an overview of progress made in achieving Moray Integration Joint Board's equality outcomes over the last two years. It identifies areas for improvement and priorities for the next year in relation to equalities mainstreaming. The report is compliant with the Equality Act 2010, supplementary regulations and guidance issued by the Equality and Human Rights Commission.

Background

The public sector equality duty, laid out in the Equality Act 2010 (the Act), came into force in Scotland in April 2011. This equality duty is often referred to as the "general duty" and it requires public authorities (including Integration Joint Boards) to have "due regard" to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general duty covers the following protected characteristics:

- Age
- Disability
- Sex
- Gender reassignment
- Pregnancy and maternity
- Sexual orientation
- Marriage and civil partnership
- Religion, belief or lack of religion/belief
- Race

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (the Regulations) also impose "specific duties" on Scottish public authorities to publish a set of Equality Outcomes and a report showing progress being made in mainstreaming equality at intervals of not more than 2 years.

The Moray Integration Joint Board's (MIJB) first Equality Outcomes and Mainstreaming Equalities Framework 2016/17 was published in April 2016 and can be found at:

http://www.moray.gov.uk/moray_standard/page_100266.html

It should be noted that as the MIJB does not employ staff directly there is no

requirement on it to produce or publish employee information. This information is reported by the two employing bodies (Moray Council and NHS Grampian). However, it is critical that access to employee information for functions delegated to the MIJB is in place to allow it to meet the general and specific equality duties with which it has to comply.

It is also recognised that the MIJB will actively participate in work undertaken by Moray Council and NHS Grampian to address employment provisions within the Act and to further equality mainstreaming within the delegated workforce.

Reporting

The MIJB Equality Outcomes and Mainstreaming Equalities Framework set out our intention to review our equality outcomes at that time. However, during our first year of operation it became clear that one year was not a sufficient time frame, given the wider context of complex organisational change, to make an informed assessment of the impact of activities on people with protected characteristics. In addition, the process of bringing together performance frameworks and data systems did not support reporting within a one year timescale and meant that relevant data could not be made available to inform update reporting or the process of reviewing equality outcomes.

Review of Equality Outcomes

A key priority for the short-life working group during 2018/19 will be to review the existing equality outcomes to ensure that they are fit for purpose and reflect the desired outcomes of affected communities. It is intended that a revised set of outcomes be available for submission to the MIJB in early 2019.

Establishment of Short life working group

The Integrated Strategic Planning Group has agreed that a short life working group will be established to give clear recommendations in relation to how Equality Issues are supported, governed, monitored and driven forward.

Progress against current outcomes

Outcome 1

The rate per 1,000 people aged 65+ who receive intensive care at home will be 19 for each of the four years of these Equality Outcomes. This represents a slight increase from the current rate (18.75). The new target takes account of the expectation that people live longer and that there will be an increase of the number of people in the upper age range of this group and therefore an increase in the number of people with multiple conditions.

Date	31/3/14	31/3/15	31/3/16	31/3/17
Rate	20.29	19.28	17.68	17.59

Source: Carefirst system.

The overall aim of the outcome is to ensure that older people and those with a disability are looked after in their community and live at home longer. We aim to have supportive local communities which have the capacity to provide care and support with and for people.

A limited amount of information is available in relation to outcomes for those with protected characteristics other than disability or age.

Care and Support services in Moray maintain high levels of performance in relation to Care Inspectorate Standards. 75% are graded as 'good' (4) or better overall.

A lower percentage of adults with intensive needs receive personal care at home, 38% in Moray compared to 62% nationally. The rise in this figure is expected due to the focus in relation to supporting more people with complex needs within the community.

Encouraging people to have choice and control over the services and supports. One indicator of this is the number of people who received Self-Directed Support (SDS) options 1 and 2 which allow them to exert the highest level of influence over their services and support. Overall spend has increased because the people who are receiving options 1 and 2 have complex packages of care, this provides an indication that individuals whose disability creates a high level of barriers to achieving outcomes have been enabled to have choice and control over how their outcomes are met.

Outcome 2

The rate per 1,000 people aged 65+ who are in permanent care will be 28 for each of the four years of these Equality Outcomes. This represents a slight drop from the current rate of 29.87.

Date	31/3/14	31/3/15	31/3/16	31/3/17
Rate	29.45	26.57	25.00	23.42

Source: Carefirst system.

Users of health and social care services, their families and carers will have improved physical and mental well-being, will experience fewer health inequalities and will be able to live independently and access support when they need it.

The reduction in permanent care rate we believe relates to the increase in extra care facilities available across Moray through the partnership arrangements with housing providers. This has given people different choices and this relates to people with a number of different challenging conditions, supporting them to reach their potential in maintaining independence and diverting from traditional permanent care settings. This is an area we will continue to monitor.

There has been an increase in hospital admission rate following a fall in the admission rate per 1,000 for those aged over 65 in Moray between 2012/13 and 2016/17. This increase may reflect an increase in numbers of older people with levels of increased frailty. This is an area we will continue to scrutinize and understand to inform further interventions towards improvement.

HSCM is working together with partners including NHS Grampian to reduce these rates.

Outcome 3

Of people aged 65+ who receive care, 95% will report having more things to do for each of the four years of these Equality Outcomes. The current rate is 90%.

Date	31/3/14	31/3/15	31/3/16	31/3/17
Rate	96.8%	95.8%	96.8%	97.2%

Source: Carefirst system.

Health Inequalities and Early Intervention/Prevention are included in our strategic priorities. Work is progressing towards supporting those who are furthest away from achieving outcomes to return them to a cycle of positive outcomes. In tandem with this, early intervention and preventive action is undertaken to maintain those who have positive outcomes to avoid these individuals moving into a cycle of negative outcomes.

Person-centred care and pathways of care form one of our strategic priorities. Work continues to progress this agenda as part of the Strategic and Commissioning Plan. It is anticipated that future recording will be more enhanced to extract additional information about protected characteristics. This will be invaluable in measuring our equality and fairness outcomes in the future and will help us to plan and evaluate actions to address inequality of outcomes for those with protected characteristics.

Users of health and social care services, their families and carers will be confident that information they provide, particularly in relation to the protected characteristics, will be used to make improvements to services and the way they are planned and delivered.

Outcome 4

Of the people who receive care, 95% will report feeling safe for each of the four years of these Equality Outcomes. The current rate is 90%. The majority of this group in Moray are older people (78%). The remaining group are people with a disability, broken down as Physical and Sensory Impairment (9%), Learning Disabilities (9%) and Mental Health (3%).

Date	31/3/14	31/3/15	31/3/16	31/3/17
Rate	96.8%	97.1%	97.4%	98.5%

Source: Carefirst system.

Users of health and social care services, their families and carers will experience fair access to services that mitigate the impact of any protected characteristics as defined in the Equality Act 2010

Link Workers have been co-located with General Practices to maximise individual's benefits and finance, with the aim of improving health and wellbeing longer term and reducing inequalities. The aim of supporting people in their communities to integrate is central to the function of the link worker.

The Making Recovery Real initiative has improved the ways in which we involve people with mental health issues in developing recovery focused mental health services

Outcome 5

Of all unpaid carers for 95% will feel supported and capable to continue their role as a carer for each of the four years of these Equality Outcomes.

This data is no longer being collected due to the question on the form being changed. Performance Officer for MIJB will address via Health and Social Care Moray's Performance Management Group.

Frailty and ill health (including dementia) is prevalent in the increasing ageing population in Moray. The effect of this is an increased demand and usage of health and social care services and unpaid carers. HSCM will continue to address equality and fairness issues in achieving equality of outcome for Moray communities.

The figures reported in National Indicators 8 and 9 are from the Scottish Health and Care Experience Survey done biennially. (http://www.hace15.quality-health.co.uk/reports/health-and-social-care-partnership-reports/2452-moray-pdf/file).

The figures in this report are taken directly from our own outcomes reporting system in Carefirst. The difference is that the Scottish Survey one is exactly that, a Survey of 6,901 people registered to GP practices in Moray, of which only 1,514 responded

whereas our figures are derived from the actual outcomes reported of those receiving Health and Social Care services.

2018/2019 priorities

A number of key priorities have been identified for the coming year:

Engagement with Equality Groups

Equality and Human rights Commission guidance states that public authorities must take reasonable steps to involve people who share a relevant protected characteristic and anyone who appears to represent the interests of those people in reviewing a set of equality outcomes. The short-life working group will ensure that revised equality outcomes are co-produced with affected people, utilising and strengthening existing engagement mechanisms. It is recognised that this will require careful planning and significant expertise from across a range of stakeholders, including people who share protected characteristics.

We will work with our Community Planning Partners to ensure that equality groups are able to participate and engage with us in the planning, delivery and review of services. This will include not just those services targeted specifically at equality groups, but also our “mainstream” services and our community planning contributions.

Impact Assessment and Fairer Scotland Duty

From April 2018 the Fairer Scotland Duty, under Part 1 of the Equality Act 2010, came into force across Scotland. The new duty places a legal responsibility on public bodies, including Integration Joint Boards to ‘pay due regard’ to how they can reduce inequalities of outcome caused by socio-economic disadvantage when making strategic decisions. Public bodies will also be required to publish a short written assessment showing how they have fulfilled the duty. Interim guidance to support the implementation of the new duty was published in March 2018. The short-life working group will give consideration to how HSCM’s implementation of the Fairer Scotland Duty can be aligned within existing duty under the 2010 Act and existing commitments within the Strategic and Commissioning Plan to address health inequalities.

Working with our Partners

We will continue to work with our statutory partners to develop, implement and support an appropriate model of co-operation and mutual support in relation to the Public Sector Equality Duty, with a specific focus on employee information and procurement aspects of duties under the Act.

Links to Commissioning

We will explore how our commissioning activity, both internal and external, can better support the delivery of equality outcomes.

Future Reporting

In order to reflect our desire to fully mainstream our equalities work (including our obligations in relation to fairness) we will explore how we integrate our equalities (and fairness) reporting as part of the 2018/19 Annual Performance Report of the MIJB.

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

AUDIT AND RISK COMMITTEE

THURSDAY 14 DECEMBER 2017

THE INKWELL, ELGIN YOUTH CAFE

PRESENT

VOTING MEMBERS

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

NON-VOTING MEMBERS

Mr Steven Lindsay	NHS Grampian Staff Partnership Representative

IN ATTENDANCE

Ms Tracey Abdy	Chief Financial Officer
Ms Pam Gowans	Chief Officer
Mr Atholl Scott	Chief Internal Auditor
Mrs Tracey Sutherland	Committee Services Officer, Moray Council as Clerk to the Committee

APOLOGIES

Mr Fabio Villani	tsiMoray

1.	**WELCOME AND APOLOGIES**
	The Chair welcomed everyone to the meeting and noted the apologies received.
2.	**DECLARATION OF MEMBERS' INTERESTS**
	There were no declarations of Members' interests in respect of any item on the agenda.

3.	**MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD AUDIT AND RISK COMMITTEE DATED 29 SEPTEMBER 2017**
	The minute of the meeting of the Moray Integration Joint Board dated 25 May 2017 was submitted for approval and subsequently agreed.
4.	**ACTION LOG OF MEETING OF THE MORAY INTEGRATION JOINT BOARD AUDIT AND RISK COMMITTEE DATED 29 SEPTEMBER 2017**
	The Action Log of the Moray Integration Joint Board Audit and Risk Committee dated 29 September 2017 was discussed and the following points were noted: i) Follow up report to be presented to the next meeting on Payroll Care at Home; ii) Action Plan to be discussed at a future development session for IJB Budget Setting and Staff Governance; and iii) A report to the next Committee on Annual Scotland Report on Health and Social Care with annual report thereafter.
5.	**INTERNAL AUDIT UPDATE**
	A report by the Chief Internal Auditor (CIA) provided the Committee with an update on progress being made towards completion of the agreed audit plan. The CIA confirmed that work has started on all the identified items to be taken forward, however there has been insufficient work carried out to enable him to report back to the Committee at the current time. The CIA further added that he is hopeful the work will be fully complete by the end of the new year. He further added that the delay would not cause any significant risk. Thereafter the Committee agreed to note that the internal audit work is progressing towards delivery of the agreed audit plan albeit at a slower pace than envisaged due to new ways of working and extended lines of communication across the services in scope.
6.	**STRATEGIC RISK REGISTER**
	A report by the Chief Internal Auditor provided the Committee with an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks. Following discussion the Committee agreed to note the updated Strategic Risk Register as at November 2017.
7.	**LOCAL CODE OF CORPORATE GOVERNANCE**
	A report by the Chief Financial Officer (CFO) provided Committee with an opportunity to comment on the sources of assurance for informing the governance principles in the ongoing development on a local code of corporate governance for the Moray Integration Joint Board.

	The CFO confirmed that the local code of Corporate Governance summarises the principles and will need to be reviewed annually. The Chair sought clarification on whether the document had made a positive impact or muddied the waters. In response the CFO said that the document works as a point of reference and improves clarity for staff. Thereafter Committee agreed to: i) note the content of the report; ii) note the sources of assurance to be utilised in reviewing and assessing the MIJB's governance arrangements; and iii) approve the Local Code of Corporate Governance and the use of sources of assurance in preparation of future Annual Governance Statements.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 26 APRIL 2018**

SUBJECT: **REVISED HEALTH AND SOCIAL CARE INTEGRATION SCHEME FOR MORAY**

BY: **LEGAL SERVICES MANAGER (LITIGATION & LICENSING), MORAY COUNCIL**

1. REASON FOR REPORT

1.1 To consider the revised Moray Health and Social Care Integration Scheme.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board (MIJB) consider and note the:

i) terms of the Revised Moray Health and Social Care Integration Scheme attached at Appendix 1; and

ii) updated functions and services delegated to it in terms of Annex 1 and Annex 2 of the Scheme.

3. BACKGROUND

3.1 At its meeting on 25 February 2016, the Board noted the terms of the Moray Health and Social Care Integration Scheme prepared by the Moray Council (MC) and Grampian Health Board and approved by the Scottish Government (para. 8 of the minute refers).

3.2 At its meeting on 14 December 2017 the Board noted the provisions of the Carers (Scotland) Act 2016 and the mandatory requirement placed upon both the Council and Grampian Health Board to delegate certain of their functions from this Act to the Moray Integration Joint Board (para 13 of the Minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The main driver behind the changes to the Scheme is the Carers (Scotland) Act 2016 and the mandatory requirement placed upon both the Council and Grampian Health Board to delegate certain of their functions from this Act to the Moray Integration Joint Board. As with the rest of the scheme this would apply to services for those of 18 years and over. A summary of the changes to delegated functions are noted below:

4.2 Annexes 1 (Functions delegated by Health Board) and 2 (Functions delegated by Local Authority)

- inclusion of the Carers (Scotland) Act 2016 functions that must be delegated i.e. preparation of local carer strategy, setting of local eligibility criteria, and support for adult carers and deletion of repealed functions;
- inclusion of parts of the Adult Support and Protection (Scotland) Act 2007 re visits, interviews and examinations and moving adults at risk in pursuance of a removal order, that complement existing delegated functions.

4.3 Other changes to the scheme are to reflect the passage of time and where certain matters have moved on. A summary of changes in this regard are noted below:

- Section 1 (Definitions and Interpretation), Section 2 (Local Governance Arrangements), Section 3 (Board Governance) and Section 12 (Finance) – to reflect that the Moray Integration Joint Board has now been established and operating for almost two years and is a statutory Community Planning Partner;
- Section 6 (Corporate Support Services) – to update deadlines;
- Section 9 (Clinical and Professional Governance) – to reflect the establishment by the Moray Integration Joint Board of a Clinical and Care Governance Committee;
- Section 10 (Chief Officer) – to reflect that the Chief Officers Operational responsibilities have now been set out;
- Section 13 (Participation and Engagement) – to include reference to this consultation exercise and to reflect that a Communications and Engagement Strategy is now in place for the Integration Joint Board;
- Section 14 (Information Sharing) – to reflect that arrangements were confirmed;
- Section 15 (Complaints) – to delete reference to the Council's Social Work Complaints Review Committee, whose work has now been taken over by the Scottish Public Services Ombudsman;
- Section 17 (Risk Management) – to reflect that a Strategy and Risk Register is now in place;
- Annex 5 (Additional Local Information) – not formally part of the scheme and removed.

4.4 Moray Council and Grampian Health Board considered and approved the revisions to the Moray scheme at their meetings on 14 February (paragraph 14 of the MC Minute refers) and 1 March 2018, respectively and the Scheme was subsequently submitted to the Scottish Government for approval; confirmation of approval was received on 3 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

This report deals with changes to the Moray Health and Social Care Integration Scheme as referred to within this report.

(b) Policy and Legal

In terms of the Public Bodies (Joint Working) (Scotland) Act 2014, the Council, along with Grampian Health Board, was statutorily obliged to prepare and submit to the Scottish Government for approval, a Revised Integration Scheme for Moray by 2 March 2018 and once the Revised Integration Scheme was approved, they were obliged to publish it.

The Revised Scheme was submitted to the Scottish Government on 2 March 2018.

The Integration Scheme is a legally binding agreement and the Scheme, together with its associated agreements documents underpins the arrangements for the Board.

(c) Financial implications

There are financial implications associated with the new delegations. These have been considered and incorporated into the budget setting processes for the 2018/19 financial year.

(d) Risk Implications and Mitigation

The Integration Scheme makes arrangements for identifying and monitoring risks re integrated services.

(e) Staffing Implications

The changes to delegated functions are technical as carers support services and adult protection services are already listed in part 2 of Annex 2 of the Integration Scheme (services provided in pursuit of delegated functions) with staff already forming part of integrated services/teams.

(f) Property

None arising from this report.

(g) Equalities

An Equality Impact Assessment (EIA), informed by a consultation exercise, was completed for the original Moray Integration Scheme in 2015. It was noted at that time that whilst no equality concerns were received from the public or the joint workforce, consultation responses were not received from all protected group categories (i.e. young people, sexual orientation, gender reassignment, civil partnerships and maternity/pregnancy and race).

Whilst it was considered that due regard had been given to equalities in developing the Moray Integration Scheme and the consultation exercise was extensively promoted, it was recognised that efforts needed to be taken to engage with people from protected groups in the future development of integrated services in Moray. Further consultation was therefore taken to underpin the Integration Joint Board's Strategic Plan.

In relation to the amendments to the scheme, it was not considered that the changes required a reconsideration of the impacts already identified.

(h) Consultations

Consultation on this report has taken place with the Chief Officer; the Chief Financial Officer; and Caroline Howie, Committee Services Officer, Moray Council; who are in agreement with the contents of this report as regards their respective responsibilities.

Statutory consultation on the draft Revised Scheme was undertaken in January 2018 with all prescribed consultees. The consultation period was of necessity short given the short timeframe for submission of the Revised Scheme to the Scottish Government. There were no consultation responses.

6. CONCLUSION

6.1 The Revised Integration Scheme outlines revised arrangements for the delivery of health and social care services in Moray.

Author of Report: Margaret Forrest, Legal Services Manager (Litigation & Licensing), Moray Council

Background Papers:

Ref:

Signature: _____ Date: 13 April 2018

Designation: Chief Officer Name: Pam Gowans

APPENDIX 1
ITEM: 11

Health and Social Care Integration Scheme for Moray

March 2018

This document is also available in large print and other formats and languages, upon request. Please call NHS Grampian Corporate Communications on (01224) 551116 or (01224) 552245.

Introduction

This document outlines revised arrangements for how adult and older people care services will be integrated and delivered by The Moray Council and NHS Grampian and is prepared in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

In revising the2015 Integration Scheme we have engaged with carers, people who currently use health and social care services in Moray, and our joint workforce. We have also subjected the draft revised Scheme to an extensive consultation exercise and have made further changes to the document based on the views and comments expressed by people and the organisations who took the opportunity to respond.

During the consultation exercise we also informed people that the contents of this revised Integration Scheme will be final and it shall not be possible to make any modifications to the revised Integration Scheme without a further consultation and approval by Scottish Ministers. We also explained that the revised Integration Scheme will set out the parameters of our Strategic Plan which will present in more detail the changes to the way we propose to deliver integrated care services in Moray in the future.

At a time when the health and social care system is facing significant demographic and financial challenges, we consider that this Integration Scheme will provide a strong foundation to how we can best improve the quality of care we deliver to the people of Moray.

Aims and Outcomes of the Integration Scheme

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The Integration Scheme is intended to achieve the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act, namely:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

2. People, including those with disabilities or long term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

5. Health and social care services contribute to reducing health inequalities.

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

7. People using health and social care services are safe from harm.

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9. Resources are used effectively and efficiently in the provision of health and social care services.

Our Vision, Purpose, Principles and Values

In aiming to fulfil the above 9 National Health and Well-being Outcomes, the following Vision, Purpose, Local Principles and Values have been developed by listening to the views of people who presently use health and social care services in Moray or who are involved in the delivery of care and support.

Our Vision

- To enable the people of Moray to lead independent, healthy and fulfilling lives in active and inclusive communities, where everyone is valued, respected and supported to achieve their own goals.

Our Purpose

- Through health, social care and third sector professionals and commercial providers working together with patients, unpaid carers, service users and their families, we will promote choice, independence, quality and consistency of services by providing a seamless, joined up, high quality health and social care service. When it is safe to do so, we will always do our utmost to support people to live independently in their own homes and communities for as long as possible. We will strive to ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with longer term and often complex care needs; many of whom are older.

Our Local Principles

- **A single point of contact.** We will make it easier for people to access information and support by having a single point of contact for accessing health and social care services where it is appropriate to do so.

- **Continuity of Care**. We will appoint a single lead professional across health and social care to facilitate improved communication with people in need of support and when possible we will aim to provide continuity of care.
- **Health and social care professionals share information.** We will work to ensure that people will have to tell their story only once and that their information is shared with all relevant professionals.
- **Signposting**. Information and advice should be provided in a format that is right for the person and is readily available in their community.
- **Personalisation.** Our vision means that we do not provide the same service for everyone but the right service for each person. We will always aim to provide choice and control.
- **Community Outcomes.** We will aim to support local communities to determine their own health and well-being priorities and we will work in partnership towards the realisation of these agreed outcomes.
- **The conversation is at the heart of what we do and is the key to meaningful action**. Identifying positive outcomes that matter to people is based on a conversation with the service user, patient, unpaid carer and sometimes the whole community. This level of engagement is the essential first step in delivering an outcomes based service.
- **Best Value**. We will always endeavour to make the best use of public money by ensuring that our services are efficient, effective and sustainable.

Our values

- We will always work to support people to achieve their own outcomes and goals that improve their quality of life.
- We will always listen and treat people with respect.
- We will always value the support and contribution provided by unpaid carers.
- We will respect our workforce and give them the support and trust they need to help them achieve positive outcomes for the people of Moray.

Integration Scheme

The parties:

THE MORAY COUNCIL,

established under the Local Government etc (Scotland) Act 1994 and having its principal offices at Council Offices, High Street, Elgin, Moray IV30 1BX (hereinafter referred to as “the Council” which expression shall include its statutory successors);

And

GRAMPIAN HEALTH BOARD,

established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as “NHS Grampian”) and having its principal offices at Summerfield House, 2 Eday Road, Aberdeen AB15 6RE (hereinafter referred to as “NHS Grampian” which expression shall include its statutory successors)

(together referred to as “the Parties”, and each being referred to as a “Party”)

1. Definitions and Interpretation

1.1 In this Integration Scheme, the following terms shall have the following meanings:-

"Accountable Officer" means the NHS officer appointed in terms of section 15 of the Public Finance and Accountability (Scotland) Act 2000;

"Chief Officer" means the Officer appointed by the Integration Joint Board in accordance with section 10 of the Act;

"Clinical Lead" means the registered medical practitioner who delivers primary care services or some other registered health care professional who delivers services within a community context who is appointed by the Chief Officer and the Medical Director of NHS Grampian;

"Direction" means an instruction from the Integration Joint Board in accordance with section 26 of the Act;

"IJB" means the Moray Integration Joint Board established by Order under section 9 of the Act;

"IJB Order" means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014;

"Integrated Budget" means the Budget for the delegated resources for the functions set out in the Scheme;

"Integrated Services" means the functions and services listed in Annexes 1 and 2 of this Scheme;

"Joint Performance Management Plan" means a resource which provides a list of targets and measures for use within a performance framework;

"Outcomes" means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act;

"Payment" means all of the following: a) the Integrated Budget contribution to the Integration Joint Board; b) the resources paid by the Integration Joint Board to the Parties for carrying out directions, in accordance with section 27 of the Act and c) does not require that a bank transaction is made;

"Section 95 Officer" means the statutory post under the Local Government (Scotland) Act 1973 being the Accountable (Proper) Officer for the administration and governance of the financial affairs of the Council.

"Strategic Plan" means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults in accordance with section 29 of the Act;

"The Act" means the Public Bodies (Joint Working) (Scotland) Act 2014;

"The Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014;

"The Parties" means the Moray Council and NHS Grampian;

"The Scheme" means this Integration Scheme;

1.2 In implementation of their obligations under the Act, the Parties hereby agree as follows:

1.3 In accordance with section 1(2) of the Act, the Parties agreed that the integration model set out in sections 1(4)(a) of the Act would be put in place for the IJB, namely the delegation of functions by the Parties to a body corporate that is to be established by Order under section 9 of the Act. The Moray Integration Joint Board was established by Parliamentary Order on 6 February 2016.

2. Local Governance Arrangements

2.1 Requirements are contained in the Act including the detail of the remit and constitution of the IJB but for context the following is repeated here:

2.1.1 The remit of the IJB is to prepare and implement a Strategic Plan in relation to the provision of health and social care services to adults in their area in accordance with sections 29-39 of the Act.

2.1.2 The regulation of the IJB's procedure, business and meetings and that of any Committee of the IJB will follow the IJB Order and the Standing Orders which will be agreed by the IJB, and which may be amended by the IJB. The Standing Orders will be set out in a separate document.

2.1.3 NHS Grampian and the Council will continue to have in place an appropriate governance structure to ensure effective delivery of any functions or services not delegated as part of this Scheme.

2.1.4 NHS Grampian and the Council and any of their Committees will positively support through productive communication and interaction the IJB and its Committees to allow it to achieve its Outcomes and Vision. The IJB will similarly support through productive communication and interaction NHS Grampian and the Council and any of their Committees in their delivery of integrated and non-integrated services.

2.1.5 The IJB has a distinct legal personality and the autonomy to manage itself. There is no role for NHS Grampian or the Council to independently sanction or veto decisions of the IJB.

2.1.6 The IJB will create such Committees that it requires to assist it with the planning and delivery of integrated services.

2.1.7 The IJB is a statutory partner in the Community Planning Partnership in terms of s.4(1) and Schedule 1 of the Community Empowerment (Scotland) Act 2015 and as such will be a member of the Community Planning Board and shall, along with the other statutory partners, report to the Community Planning Board. The IJB shall assist in the identification of priorities for the Community Planning Board's strategic partnerships as appropriate.

3. Board Governance

3.1 The arrangements for appointing the voting membership of the IJB in accordance with the IJB Order are as follows:-

3.1.1 The Council shall nominate three councillors; and

3.1.2 NHS Grampian shall nominate three non-executive directors (if unable to do so then it must nominate a minimum of two non-executive directors and one executive director).

3.2 The voting membership of the IJB shall be appointed for a term of up to 3 years.

3.3 Provision for the disqualification, resignation and removal of voting members is set out in the IJB Order.

3.4 The IJB is required to co-opt non-voting members to the IJB.

3.5 The non-voting membership of the IJB is set out in the IJB Order and includes (subject to any amendment of the IJB Order):

a) the chief social work officer of the local authority;
b) the Chief Officer, once appointed by the IJB;
c) the proper officer of the integration joint board appointed under section 95 of the Local Government (Scotland) Act 1973;
d) a registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;
e) a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract; and
f) a registered medical practitioner employed by the Health Board and not providing primary medical services;

and at least one member of each of the following groups:

g) staff of the constituent authorities engaged in the provision of services provided under integration functions;
h) third sector bodies carrying out activities related to health or social care in the area of the local authority;
i) service users residing in the area of the local authority; and
j) persons providing unpaid care in the area of the local authority.

3.6 NHS Grampian will determine the non-voting representatives listed in d)-f) above, in terms of the IJB Order.

3.7 The arrangements for appointing the Chair and Vice Chair of the IJB are as follows:-

3.7.1 The first Chair was nominated by the Council.

3.7.2 The first term of the Chair began on the date the IJB was established and continued until 30 September 2016.

3.7.3 Further terms of Chair are for a period of 18 months, and the second term of Chair began on 1 October 2016.

3.7.4 The Parties are entitled to change the person appointed by them as Chair or Vice Chair during the appointed period.

3.7.5 After the term of the first Chair came to an end, the Vice Chair became the next Chair and the outgoing Chair's organisation then nominated the next Vice Chair, which the IJB appointed.

3.7.6 The Parties must alternate which of them is to appoint the Chair in respect of each successive appointing period. The organisation which has not nominated the Chair shall nominate the Vice Chair.

4. Delegation of Functions

4.1 The functions that are to be delegated by the Health Board to the Integration Joint Board are set out in Part 1 of Annex 1 and are subject to the exceptions and restrictions specified or referred to. The services to which these functions relate, which are currently provided by the Health Board and which are to be integrated, are set out in Part 2 of Annex 1. For the avoidance of doubt the functions listed in Part 1 of Annex 1 are delegated only to the extent that they relate to the services listed in Part 2 of Annex 1 and there are certain services in respect of which functions are delegated for all age groups and certain services in respect of which functions are delegated for people over the age of 18 only.

4.2 The functions that are to be delegated by the Local Authority to the Integration Joint Board are set out in Part 1 of Annex 2 and are subject to the exceptions and restrictions specified or referred to. The services to which these functions relate, which are currently provided by the Local Authority and which are to be integrated, are set out in Part 2 of Annex 2. For the avoidance of doubt the functions listed in Part 1 of Annex 2 are delegated only to the extent that they relate to the services listed in Part 2 of Annex 2 and are provided to persons of 18 years and over.

4.3 In the delegation of functions, the Parties recognise that they will require to work together, and with, the IJB, to achieve the Outcomes. Through local management, the Parties will put arrangements in place to avoid fragmentation of services provided to persons under 18 years. In particular, the community health services for persons under 18 years of age set out in Part 3 of Annex 1 shall be operationally devolved by the Chief Executive of NHS Grampian to the Chief Officer of the IJB who will be responsible and accountable for the operational delivery and performance of these services.

4.4 In exercising its functions, the IJB must take into account the Parties' requirements to meet their respective statutory obligations, standards set by government and other organisational and service delivery standards set by the Parties. Apart from those functions delegated by virtue of this Scheme, the Parties retain their distinct statutory responsibilities and therefore also retain their formal decision-making roles.

4.5 The delegation of functions from the Parties to the IJB shall not affect the legality of any contract made between either of the Parties and any third party, which relates to the delivery of integrated or non-integrated services. The IJB shall be mindful of the Parties' contracts and will enter into a joint commissioning strategy with the Parties.

4.6 Some integrated services may be hosted by the IJB on behalf of other integration authorities, or some integrated services may be hosted by another integration authority on behalf of the IJB. The IJB will consider and agree the hosting arrangements.

5. Local Operational Delivery Arrangements

5.1 The local operational arrangements agreed by the Parties are:

5.2 The responsibilities of the membership of the IJB in relation to monitoring and reporting on the delivery of integrated services on behalf of the Parties are as follows:-

5.2.1 The IJB is responsible for the planning of integrated services and achieves this through the Strategic Plan. It issues Directions to the Parties to deliver services in accordance with the Strategic Plan.

5.2.2 The IJB will continue to monitor the performance of the delivery of integrated services using the Strategic Plan on an ongoing basis and the Parties will report to the IJB regularly on performance in implementation of Directions to enable it to do so.

5.2.3 The IJB is required to publish an annual performance report on performance to deliver the Outcomes and will share this with the Parties.

5.3 The IJB will have operational oversight of integrated services, including those that it hosts but not the health services listed in Annex 4 or services which are hosted by another integration authority. NHS Grampian will be responsible for the operational oversight of the services listed in Annex 4 and through the General Manager of Acute Services will be responsible for the operational management of these services. NHS Grampian already has in place an existing mechanism for the scrutiny and monitoring of delivery of these services. Appropriate links will be made between this structure and any governance framework to be put in place by the IJB in terms of paragraph 5.6 below.

5.4 The IJB will take decisions in respect of integrated services for which it has operational oversight.

5.5 The IJB shall ensure that resources are managed appropriately for the delivery of integrated services for which it has operational oversight, in implementation of the Strategic Plan.

5.6 The Parties expect the IJB to develop a governance framework to provide itself with a mechanism for assurance and monitoring of the management and delivery of integrated services. This will enable scrutiny of performance and of appropriate use of resources. If required, the Parties will support the IJB in the development of this framework.

5.7 The IJB will, through the Chief Officer, have an appropriate role in the operational delivery of services by the Parties in the carrying out of integration functions. The Parties acknowledge that the Chief Officer's role in operational delivery will represent an important means by which closer integration of services, in accordance with the integration delivery principles specified in the Act, can be achieved. The duties of the Chief Officer are set out in section 10 but for the avoidance of doubt, the Chief Officer's role in operational delivery shall not displace:

(a) the responsibilities of each Party regarding compliance with directions issued by the IJB; or

(b) the principle that each Party's governance arrangements must allow that Party to manage risks relating to service delivery.

5.8 For integrated services that the IJB does not have operational oversight of, the IJB shall be responsible for the strategic planning of those services. The IJB shall monitor performance of those services in terms of outcomes delivered via the Strategic Plan.

5.9 NHS Grampian and the Council will be responsible for the operational delivery of integrated services in implementation of Directions of the IJB. The Parties shall provide such information as may be required by the Chief Officer, the IJB and the Strategic Planning Group to enable the planning, monitoring and delivery of integrated services.

5.10 NHS Grampian will provide such information as may be reasonably required by the Chief Officer or the IJB in respect of the delivery of integrated services provided within hospitals that the IJB does not have operational oversight of.

5.11 NHS Grampian and the IJB will work together to ensure that the planning and delivery of integrated (and non-integrated) hospital services are consistent.

6. Corporate Support Services

6.1 The Parties recognise that the IJB requires various corporate support services in order to fully discharge its duties under the Act.

6.2 In preparation for integration, a Transitional Leadership Group was set up by the Parties as a vehicle for joint working, and this was provided with corporate support by the Parties through joint "workstream groups". This allowed appropriate advice and support to be given on areas such as finance, legal, human resources, information sharing etc.

6.3 The Parties shall identify, and may review, the corporate resources required for the IJB for the period between April 2015 and April 2018, including the provision of any professional, technical or administrative services for the purpose of preparing a Strategic Plan and carrying out integration functions. This assessment will be informed by the support provided via the "workstream groups" referred to in paragraph 6.2 above and shall be made available to the IJB.

6.4 Between April 2015 and April 2018, the Parties shall be responsible for ensuring that the IJB has provision of suitable resources for corporate support to allow it to fully discharge its duties under the Act.

6.5 The Parties and the IJB shall reach an agreement in respect of how these services will be provided to the IJB which will set out the details of the provision.

6.6 Before the end of April 2018, the Parties and the IJB will review the support services being provided to ensure that these are sufficient. The Parties and the IJB shall agree on the arrangements for future provision, including specifying how these requirements will be built into the IJB's annual budget setting and review process.

7. Support for Strategic Planning

7.1 The Parties shall share with such other relevant integration authorities, the necessary activity and financial data for services, facilities or resources that relate to the planned use of services provided in the Moray area by those integration authorities for people who live within Moray.

7.2 The Strategic Plan is written for the residents of Moray. A number of individuals may be resident in the area of one integration authority but receive services in the area of another integration authority. NHS Grampian will provide support to enable the appropriate planning of such services for these individuals. This shall be done in pursuance of the duty under s30(3) of the Act.

7.3 The Parties shall consult with the IJB on any plans to change service provision of non-integrated services which may have a resultant impact on the Strategic Plan.

8. Targets and Performance Measurement

8.1 The Parties will identify a core set of indicators that relate exclusively to delegated functions, which the Parties expect the IJB to take account of as it discharges its functions. These indicators will be informed by the National Core Suite of Indicators published by the Scottish Government that are aligned to the overarching 9 National Health & Wellbeing Outcomes. The indicators will also support service improvement at a local level as a means of supporting continuous improvement.

8.2 The core set of indicators will be collated in a Joint Performance Management Plan and will provide information on the data gathering and reporting requirements to support continuous improvement and, where appropriate, will identify service improvement targets..

8.3 The Joint Performance Management Plan will also be used to identify any indicators or measures that relate to functions of the Parties, which are not delegated to the IJB, but which may be affected by the performance and funding of delegated functions and which are to be taken account of by the IJB.

8.4 The Joint Performance Management Plan will also be used to prepare a list of indicators that relate to both functions of the Parties, and functions delegated to the IJB, and for which responsibility for achieving targets will be shared between the IJB and relevant Party and which are to be taken account of by the IJB.

8.5 The Joint Performance Management Plan will be reviewed regularly to ensure the improvement indicators it contains continue to be relevant and reflective of the national and local Outcomes to which they are aligned.

8.6 The Joint Performance Management Plan will state where the responsibility for each indicator lies, whether in full, in part or shared and where shared, the Parties and the IJB will work together to deliver these.

8.7 The Parties recognise that the IJB will have an impact on key decisions regarding outcomes for the people of Moray.

8.8 The Strategic Planning Group's work shall enable the IJB to assure itself around the monitoring and performance of the delivery of integrated services in accordance with the Strategic Plan. A set of shared principles for targets, measures and indicators will be developed and agreed by the Parties and the IJB. This will take into account the Scottish Government's Guidance on the Outcomes and the associated core suite of indicators for integration.

8.9 The contents of the Joint Performance Management Plan also reflect the cultural shift towards embedding a personal outcomes approach to the delivery of services. Personal outcomes data along with data relating to the suite of indicators will also be referred to as part of an annual Performance Report.

8.10 All work required in relation to developing the Joint Performance Management Plan will be completed by the time the IJB assumes responsibility for integrated services.

8.11 The Parties will share all performance information, targets, indicators and the Joint Performance Management Plan with the IJB.

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9. Clinical and Professional Governance

9.1 Outcomes

9.1.1 The IJB will improve and provide assurance on the Outcomes through its clinical and professional governance arrangements. The Outcomes are as follows:

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

9.1.2 The Parties and the IJB will have regard to the integration planning and delivery principles and will determine the clinical and professional governance assurances and information required by the IJB to inform the development, monitoring and delivery of its Strategic Plan. The Parties will provide that assurance and information to the IJB.

9.2 General Clinical and Professional Governance Arrangements

9.2.1 The Parties and the IJB are accountable for ensuring appropriate clinical and professional governance arrangements for their duties under the Act.

9.2.2 The Parties remain responsible for the clinical and professional governance of the services which the IJB has instructed the Parties to deliver.

9.2.3 The Parties remain responsible for the assurance of the quality and safety of services commissioned from the third and independent sectors in line with the requirements set out in the Strategic Plan.

9.2.4 The IJB will have regard to healthcare and social care governance quality aims and risks when developing and agreeing its Strategic Plan and its corresponding Directions to the Parties. These risks may be identified by either of the Parties or the IJB, and may include professional risks.

9.2.5 The Parties and the IJB will establish an agreed approach to measuring and reporting to the IJB on the quality of service delivery, organisational and individual care risks, the promotion of continuous improvement and ensuring that all professional and clinical standards, legislation and guidance are met. This will be set out in a report to the IJB for it to approve.

9.3 Clinical and Professional Governance Framework

9.3.1 NHS Grampian seeks assurance in the area of clinical governance, quality improvement and clinical risk from the NHS Grampian Clinical Governance Committee, through a process of constructive challenge. The Clinical Governance Committee is responsible for demonstrating compliance with statutory requirements in relation to clinical

governance, authorising an accurate and honest annual clinical governance statement and responding to scrutiny and improvement reports by external bodies such as Healthcare Improvement Scotland (or any successor). To achieve this, the Committee oversees a governance framework including a strategy, annual work programme, infrastructure of governance groups and an annual report.

9.3.2 The Council is required by law to appoint a Chief Social Work Officer to oversee and make decisions in relation to specified social work services, some of which are delegated in relation to integration functions, and to report to and alert the Council and elected members of any matters of professional concern in the management and delivery of those functions. He or she has a duty to make an annual report to the Council in relation to the discharge of the role and responsibilities. The Chief Social Work Officer will be a non-voting member of the IJB. If required, he or she shall make an annual report to the IJB in relation to the aspects of his or her position which relate to the delivery of integrated functions. The Chief Social Work Officer will retain all of the statutory decision-making and advisory powers given by statute and guidance, and the Medical and Nursing Directors shall not be entitled to countermand or over-rule any decisions or instructions given by the Chief Social Work Officer in carrying out that statutory role.

9.3.3 External scrutiny is provided by the Care Inspectorate (Social Care and Social Work Improvement Scotland) (or any successor), which regulates, inspects and supports improvement of adult social work and social care.

9.3.4 The Scottish Government's *Clinical and Care Governance Framework for Integrated Health and Social Care Services in Scotland, 2014* (or any updated version or replacement) outlines the proposed roles, responsibilities and actions that will be required to ensure governance arrangements in support of the Act's integration planning and delivery principles and the required focus on improved Outcomes.

9.4 Staff Governance

9.4.1 The Parties will ensure that staff working in integrated services have the right training and education required to deliver professional standards of care and meet any professional regulatory requirements.

9.4.2 The IJB and the Parties shall ensure that staff will be supported if they raise concerns relating to practice that endangers the safety of service users and other wrong doing in line with local policies and regulatory requirements.

9.4.3 Staff employed by NHS Grampian are bound to follow the NHS Staff Governance Standard. This Standard is recognised as being very laudable and the IJB will encourage it to be adopted for all staff involved in the delivery of delegated services. The Staff Governance Standard requires all NHS Boards to demonstrate that staff are:

- Well informed;
- Appropriately trained and developed;
- Involved in decisions which affect them;
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

9.4.4 The Standard places a reciprocal duty on staff to:

- Keep themselves up to date with developments relevant to their job within the organisation;
- Commit to continuous personal and professional development;
- Adhere to the standards set by their regulatory bodies;

- Actively participate in discussions on issues that affect them either directly or via their trade union/professional organisation;
- Treat all staff and patients with dignity and respect while valuing diversity; and
- Ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients and carers.

9.5 Interaction with the IJB, Strategic Planning Group and Localities

9.5.1 The IJB has established a Clinical and Care Governance Committee to oversee the clinical and professional governance arrangements for integrated services. The Clinical and Care Governance Committee brings together senior professionals representative of the range of professional groups involved in delivering health and social care services. This includes at least one lead from each of the Parties' senior professional staff, the Chief Social Work Officer and Nursing Director.

9.5.2 The three professional advisors of the IJB listed at 9.5.5 b)-d) are members of the Clinical and Care Governance Committee. These advisors will continue to report to the Nursing and Medical Directors.

9.5.3 The role, remit and membership of the IJB Clinical and Care Governance Committee is set out in the IJB's Scheme of Administration, which may be reviewed and amended by the IJB.

9.5.4 The Clinical and Care Governance Committee will provide clinical health care and professional social work advice to the IJB, the Strategic Planning Group, the Chief Officer and any professional groups established in localities as and when required. This can be done through the Chair of the Committee (or such other appropriate members) informing and advising the IJB, the Strategic Planning

Group, the Chief Officer and any other Group, Committee or locality of the IJB as and when required.

9.5.5 The IJB and the Chief Officer shall also be able to obtain clinical and professional advice from the IJB non-voting membership, which shall include (subject to any amendment of the IJB Order):

a) The Chief Social Work Officer;
b) A registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;
c) A registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract; and
d) A registered medical practitioner employed by the Health Board and not providing primary medical services.

9.5.6 The Clinical and Care Governance Committee will be represented on the established clinical and professional forums/groups of both the Council and NHS Grampian to address matters of risk, safety and quality. The Clinical and Care Governance Committee is aligned with both Parties' arrangements.

9.5.7 A Schematic showing the Clinical and Care Governance Committee's relationship to the NHS Grampian Clinical Governance Committee and the health board is set out in a separate document.

9.5.8 A similar Schematic is not available for the Council's assurance mechanisms, since this does not have a similar structure. The Chief Social Work Officer is a member of the Clinical and Care Governance Committee. The Chief Social Work Officer may report to the Council to provide any necessary assurance as required.

9.5.9 The NHS Grampian Area Clinical Forum (and clinical advisory structure), Managed Clinical and Care Networks, Local Medical Committees, other appropriate professional groups, and the Adult and Child Protection Groups and Committees will be available to provide clinical and professional advice to the IJB.

9.6 Professional Leadership

9.6.1 The Act does not change the professional regulatory framework within which health and social care professionals work, or the established professional accountabilities that are currently in place within the NHS and local government. The Act through drawing together the planning and delivery of services aims to better support the delivery of improved outcomes for the individuals who receive care and support across health and social care.

9.6.2 Medical Directors and Nursing Directors are ministerial appointments made through health boards to oversee systems of professional and clinical governance within the Health Board. Their professional responsibilities supersede their responsibilities to their employer. These Directors continue to hold responsibility for the actions of NHS Grampian clinical staff who deliver care through integrated services. They, in turn, continue to attend the NHS Grampian Clinical Governance Committee which oversees the clinical governance arrangements of all services delivered by health care staff employed by NHS Grampian.

9.6.3 In addition to the IJB's Clinical and Care Governance Committee, advice can be provided to the IJB and the Strategic Planning Group through the Clinical Executive Directors of NHS Grampian and the Chief Social Work Officer of the Council on professional / workforce, clinical / care and social care / social work governance matters relating to the development, delivery and monitoring of the Strategic Plan, including the development of integrated service arrangements. The

professional leads of the Parties can provide advice and raise issues directly with the IJB either in writing or through the representatives that sit on the IJB. The IJB will respond in writing to these issues where asked to do so by the Parties.

9.6.4 The key principles for professional leadership are as follows:

- Job descriptions will reflect the level of professional responsibility at all levels of the workforce explicitly.
- The IJB will name the Clinical Lead and ensure representation of professional representation and assurance from both health and social care. The Nurse and Medical Directors will continue to have professional managerial responsibility.
- All service development and redesign will outline participation of professional leadership from the outset, and this will be evidenced in all IJB papers.
- The effectiveness of the professional leadership principles will be reviewed annually.

10. Chief Officer

10.1 The IJB shall appoint a Chief Officer in accordance with section 10 of the Act. The arrangements in relation to the Chief Officer agreed by the Parties are:

10.2 An interim Chief Officer may be appointed at the request of the IJB by arrangements made jointly by the Chief Executives of both Parties in consultation with the Chair of the IJB.

10.3 The Chief Officer will be responsible for the operational management of integrated services, other than the health services listed in Annex 4 or the services hosted by another integration authority. Further arrangements in relation to the Chief Officer's responsibilities for operational management and strategic planning are set out in a separate document, which the IJB may amend from time to time.

10.4 The Chief Officer shall be accountable to the IJB for the management of integrated services for which the IJB has operational oversight. Accountability of the Chief Officer will be ensured by the IJB through appropriate scrutiny and monitoring of the delivery of integrated services under the Chief Officer's management, if necessary through an appropriate governance framework that the IJB may put in place.

10.5 The Chief Officer will be responsible for the development and monitoring of operational plans which set out the mechanism for the delivery of the Strategic Plan.

10.6 The Chief Executive of NHS Grampian will be the Accountable Officer for the delivery of the acute services that the IJB has strategic planning responsibility for and will provide updates to the Chief Officer on the operational delivery of those services provided and the set aside budget on a regular basis.

10.7 The Chief Officer will have a formal relationship with the acute sector management team to determine that appropriate progress is made on the delivery of the Strategic Plan. The Chief Officer will meet with the General Manager of Acute Services under chairmanship of the Chief Executive of NHS Grampian on a monthly basis at the NHS Grampian Operational Management Board. It is anticipated that these meetings will also be attended by the Chief Officers of Aberdeen City and Aberdeenshire integration authorities.

10.8 The Chief Officer will be a member of the appropriate senior management teams of NHS Grampian and the Council. This will enable the Chief Officer to work with senior management of both Parties to carry out the functions of the IJB in accordance with the Strategic Plan.

10.9 The Chief Officer will be line managed by the Chief Executives of the Parties. The Chief Officer shall also report to the IJB.

10.10 The Chief Officer will develop close working relationships with elected members of the Council and non-executive and executive NHS Grampian board members.

10.11 The Chief Officer will establish and maintain effective working relationships with a range of key stakeholders across NHS Grampian, the Council, the third and independent sectors, service users and carers, the Scottish Government, trade unions and relevant professional organisations.

10.12 The Chief Officer will work with trade unions, staff side representatives and professional organisations to ensure a consistent approach to their continued involvement in the integration of health and social care.

11. Workforce

11.1 The arrangements in relation to their respective workforces agreed by the Parties are:

11.2 The employment status of staff will not change as a result of this Scheme i.e. staff will continue to be employed by their current employer and retain their current terms and conditions of employment and pension status.

11.3 The Parties will develop a joint Workforce Plan that will be aligned to objectives set by the IJB. The joint Workforce Plan will relate to the development and support to be provided to the workforce who are employed in pursuance of integrated services and functions. The plan will cover staff communication, staff engagement, staff and team development, leadership development and the training needs for staff that will be responsible for managing integrated teams.

11.4 The process of developing integrated teams will be initiated during the first year of the IJB, building on preparatory work initiated in 2014.

11.5 The Organisational Development strategy for the Parties and the IJB will be informed by the Employee Engagement Process being followed as part of the Joint Outcomes work stream. This will encourage the development of a healthy organisational culture. The Parties and the IJB will work together in developing this plan along with stakeholders.

11.6 These plans will be presented to the IJB for approval by 31 March 2018, put in place as soon as approved and will be reviewed regularly through an agreed process to ensure that it takes account of the development needs of staff.

12. Finance

12.1 Financial Governance

12.1.1 The IJB will have no cash transactions and will not directly engage or provide grants to third parties.

12.1.2 The IJB will have appropriate assurance arrangements in place (detailed in the Strategic Plan) to ensure best practice principles are followed by the Parties for the commissioned services.

12.1.3 The IJB will be responsible for establishing adequate and proportionate internal audit service for review of the arrangements for risk management, governance and control of the delegated resources. The IJB will accordingly appoint Internal Auditors to report to the Chief Officer and IJB on the proposed annual audit plan, ongoing delivery of the plan, the outcome of each review and an annual report on delivery of the plan.

12.1.4 The Accounts Commission will confirm the external auditors for the IJB.

12.1.5 Further details of financial governance and Financial Regulations are contained in a separate document outwith this Scheme.

12.2 Payments to the IJB – General

12.2.1 The payment made by each Party is not an actual cash transaction for the IJB. There will be a requirement for an actual cash transfer to be made between the Parties to reflect the difference between the payment being made by a Party and the resources delegated by the IJB to that Party to deliver services. Any cash transfer will take place between the Parties monthly in arrears based on the annual budgets set by the Parties and the directions from the IJB. A final transfer will be made at the end of the financial year on closure of the annual accounts of the IJB to reflect in-year budget adjustments agreed.

12.2.2 Resource Transfer – The existing resource transfer arrangements will cease upon establishment of the IJB and instead NHS Grampian will include the equivalent sum in its budget allocation to the IJB. The Council payment to the IJB will accordingly be reduced to reflect this adjustment.

12.2.3 Value Added Tax (VAT) – the budget allocations made will reflect the respective VAT status and treatments of the Parties. In general terms budget allocations by the Council will be made net of tax to reflect its status as a Section 33 body in terms of the Value Added Tax Act 1994 and those made by NHS Grampian will be made gross of tax to reflect its status as a Section 41 body in terms of the Value Added Tax Act 1994.

12.3 Payments to the IJB

12.3.1 The payment that will be determined by each Party requires to be agreed in advance of the start of the financial year. Each Party agrees that the baseline payment to the IJB for delegated functions will be formally advised to the IJB and the other Party by 28th February each year.

12.3.2 The Chief Officer and the Chief Finance Officer of the IJB will develop a case for the Integrated Budget based on the Strategic Plan and present it to the Council and NHS Grampian for consideration as part of the annual budget setting process, in accordance with the timescales contained therein. The case should be evidence based with full transparency on its assumptions and analysis of changes, covering factors such as activity changes, cost inflation, efficiencies, legal requirements, transfers to / from the "set aside" budget for hospital services and equity of resource allocation.

12.3.3 The final payment into the IJB will be agreed by the Parties in accordance with their own processes for budget setting.

12.3.4 The IJB will approve and provide direction to the Parties by 31st March each year regarding the functions that are being directed, how they are to be delivered and the resources to be used in delivery.

12.4 Method for determining the amount set aside for hospital services

12.4.1 The IJB will be responsible for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway.

12.4.2 The IJB and the hospital sector will agree a method for establishing the amount to be set aside for services that are delivered in a large hospital as part of the emergency care pathway which will show consumption by the residents of the IJB.

12.4.3 The method of establishing the set aside budget will take account of hospital activity data and cost information. Hospital activity data will reflect actual occupied bed day and admissions information, together with any planned changes in activity and case mix.

12.5 Financial Management of the IJB

12.5.1 The Council will host the financial transactions specific to the IJB.

12.5.2 The IJB will appoint a Chief Finance Officer who will be accountable for the annual accounts preparation (including gaining the assurances required for the governance statement) and financial planning (including the financial section of the Strategic Plan) and will provide financial advice and support to the Chief Officer and the IJB. The Chief Finance Officer will also be responsible for the production of the annual financial statement (section 39 of the Act).

12.5.3 As part of the process of preparing the annual accounts of the IJB the Chief Finance Officer of the IJB will be responsible for agreeing balances between the IJB and Parties at the end of the financial year and for agreeing details of transactions between the IJB and Parties during the financial year. The Chief Finance Officer of the IJB will also be responsible for provision of other information required by the Parties to complete their annual accounts including Group Accounts.

12.5.4 Recording of all financial information in respect of the integrated services will be in the financial ledger of the Party which is delivering the services on behalf of the IJB.

12.5.5 The Parties will provide the required financial administration to enable the transactions for delegated functions (e.g. payment of suppliers, payment of staff, raising of invoices etc.) to be administered and financial reports to be provided to the Chief Finance Officer of the IJB. The Parties will not charge the IJB for this service.

12.6 Financial reporting to the IJB and the Chief Officer

12.6.1 Financial reports for the IJB will be prepared by the Chief Finance Officer of the IJB. The format and frequency of the reports to be agreed by the IJB, the Council and NHS Grampian, but will be at least on a quarterly basis. The Director of Finance of NHS Grampian and the Section 95 Officer of the Council will work with the Chief Finance

Officer of the IJB to ensure that the information that is required to produce such reports can be provided.

12.6.2 To assist with the above the Parties will provide information to the Chief Finance Officer of the IJB regarding costs incurred by them on a monthly basis for services directly managed by the IJB. Similarly, NHS Grampian will provide the IJB with information on use of the amounts set aside for hospital services. This information will focus on patient activity levels and not include unit costs; the frequency will be agreed with the IJB, but will be at least quarterly.

12.6.3 The Chief Finance Officer of the IJB will agree a timetable for the preparation of the annual accounts with the Director of Finance of NHS Grampian and the Section 95 Officer of the Council. The timetable for production of the annual accounts of the IJB will be set following the issue of further guidance from the Scottish Government.

12.6.4 In order to give assurance to the Parties that the delegated budgets are being used for their intended purposes, financial monitoring reports will be produced for the Parties in accordance with timetables to be agreed at the start of each financial year. The format of such reports to be agreed by the Director of Finance of NHS Grampian and the Section 95 Officer of the Council, in conjunction with the Chief Finance Officer of the IJB.

12.7 The process for addressing in year variations in the spending of the IJB

12.7.1 Increases in payment by Parties to the IJB

12.7.1.1 The Parties may increase in-year the payments to the IJB for the delegated services with the agreement of the IJB.

12.7.2 Reductions in payment by Parties to the IJB

12.7.2.1 The Parties do not expect to reduce the payment to the IJB in-year unless there are exceptional circumstances resulting in significant unplanned costs for the Party. In such exceptional circumstances the following escalation process would be followed before any reduction to the in-year payment to the IJB was agreed:-

a) The Party would seek to manage the unplanned costs within its own resources, including the application of reserves where applicable.

b) Each Party would need to approve any decision to seek to reduce the in-year payment to the IJB.

c) Any final decision would need to be agreed by the Chief Executives of both Parties and by the Chief Officer of the IJB, and be ratified by the Parties and the IJB.

12.7.3 Variations to the planned payments by the IJB

12.7.3.1 The Chief Officer is expected to deliver the agreed outcomes within the total delegated resources of the IJB. Where a forecast overspend against an element of the operational budget emerges during the financial year, in the first instance it is expected that the Chief Officer, in conjunction with the Chief Finance Officer of the IJB, will agree corrective action with the IJB.

12.7.3.2 If this does not resolve the overspending issue then the Chief Officer, the Chief Finance Officer of the IJB and the Director of Finance of NHS Grampian and the Section 95 Officer of the Council must agree a recovery plan to balance the overspending budget.

12.7.4 IJB Overspend against payments

12.7.4.1 In the event that the recovery plan is unsuccessful and an overspend is evident at the year-end, uncommitted reserves held by the IJB, in line with the reserves policy, would firstly be used to address any overspend.

12.7.4.2 In the event that an overspend is evident following the application of reserves, the following arrangements will apply for addressing that overspend:-

12.7.4.3 In the first complete financial year of the IJB – the overspend will be met by the Party to which the spending Direction for service delivery is given i.e. the Party with operational responsibility for the service.

12.7.4.4 In future years of the IJB, either:

a) A single Party may make an additional one off payment to the IJB,

or

b) The Parties may jointly make additional one off payments to the IJB in order to meet the overspend. The split of one off payments between Parties in this circumstance will be based on each Party's proportionate share of the baseline payment to the IJB, regardless of in which arm of the operational budget the overspend has occurred in.

12.7.4.5 The recovery plan may include provision for the Parties to recover any such additional one off payments from their baseline payment to the IJB in the next financial year.

12.7.4.6 The arrangement to be adopted will be agreed by the Parties.

12.7.5 IJB underspend against payments

12.7.5.1 In the event of a forecast underspend the IJB will require to decide whether this results in a redetermination of payment or whether surplus funds will contribute to the IJB's reserves.

12.7.5.2 The Chief Officer and Chief Finance Officer of the IJB will prepare a reserves policy for the IJB, which requires the approval of the IJB and the Director of Finance of NHS Grampian and the Section 95 Officer of the Council. The reserves policy will be reviewed on a periodic basis.

12.7.5.3 In the event of a return of funds to the Parties, the split of returned payments between Parties will be based on each Party's proportionate share of the baseline payment to the IJB, regardless of which arm of the operational budget the underspend occurred in.

12.7.6 Planned Changes in Large Hospital Services

12.7.6.1 The IJB and the hospital sector will agree a methodology for the financial consequences of planned changes in capacity for set aside budgets in large hospital services.

12.7.6.2 Planned changes in capacity for large hospital services will be outlined in the IJB Strategic Plan. A financial plan (reflecting any planned capacity changes) will be developed and agreed that sets out the capacity and resource levels required for the set aside budget for the IJB and the hospital sector, for each year. The financial plan will take account of :-

- activity changes based on demographic change;
- agreed activity changes from new interventions;
- cost behaviour;
- hospital efficiency and productivity targets;

- an agreed schedule for timing of additional resource / resource released.

12.7.6.3 The process for making adjustments to the set aside resource to reflect variances in performance against plan will be agreed by the IJB and the Health Board. Changes will not be made in year and any changes will be made by annual adjustments to the Strategic Plan of the IJB.

12.8 Capital

12.8.1 The use of capital assets in relation to integration functions

12.8.1.1 Ownership of capital assets will continue to sit with each Party and capital assets are not part of the payment or “set aside”.

12.8.1.2 If the IJB decides to fund a new capital asset from revenue funds then ownership of the resulting asset shall be determined by the Parties.

12.8.1.3 The Strategic Plan will drive the financial strategy and will provide the basis for the IJB to present proposals to the Parties to influence capital budgets and prioritisation.

12.8.1.4 A business case with a clear position on funding is required for any change to the use of existing assets or proposed use of new assets. The Chief Officer of the IJB is to develop business cases for capital investment for consideration by NHS Grampian and the Council as part of their respective capital planning processes.

12.8.1.5 The Chief Officer of the IJB will liaise with the relevant officer within each Party in respect of day to day asset related matters including any consolidation or relocation of operational teams.

12.8.1.6 It is anticipated that the Strategic Plan will outline medium term changes in the level of budget allocations for assets used by the IJB that will be acceptable to the Parties.

12.8.1.7 Any profits or loss on sale of an asset will be held by the Parties and not allocated to the IJB.

12.8.1.8 Depreciation budgets for assets used on delegated functions will continue to be held by each Party and not allocated to the IJB operations in scope.

12.8.1.9 The management of all other associated running costs (e.g. maintenance, insurance, repairs, rates, utilities) will be subject to local agreement between the Parties and the IJB.

13. Participation and Engagement

13.1 A comprehensive joint consultation on the December 2015 Scheme took place between November 2014 and February 2015. Consultation on this revised Scheme took place in January 2018

13.2 Media notifications were issued for the public and a newsletter for staff alerting them to the proposed revisions to the Scheme.
An email address was supplied for people to send their views.

13.3 The consultation draft revised Scheme was presented to NHS Grampian Board and elected members of the Council.

13.4 Principles endorsed by the Scottish Health Council and the National Standards for Community Engagement were followed in respect of the consultation process, which included the following:

13.4.1 It was a genuine consultation exercise: the views of all participants were valued.

13.4.2 It was transparent: the results of the consultation exercise were published.

13.4.3 It was an accessible consultation: the consultation documentation was provided in a variety of formats.

13.4.4 It was being led by the Chief Officer: the Chief Officer and the IJB will be answerable to the people of Moray in terms of the content of the revised Scheme.

13.4.5 It is an on-going dialogue: the revised Integration Scheme will establish the parameters of the future strategic plans of the IJB.

13.5 The stakeholders consulted in the development of this revised Scheme were:

Health professionals;
Users of health care;
Carers of users of health care;
Commercial providers of health care;
Non-commercial providers of health care;
Social care professionals;
Users of social care;
Carers of users of social care;
Commercial providers of social care;
Non-commercial providers of social care;
Staff of NHS Grampian and the Council who are not health professionals or social care professionals;
Non-commercial providers of social housing;
Third sector bodies carrying out activities related to health or social care and;
Other local authorities operating with the area of NHS Grampian preparing an integration scheme.

13.6 The Parties enabled the IJB to develop a Communications and Engagement Strategy by providing appropriate resources and support. The Communications and Engagement Strategy ensures significant engagement

with, and participation by, members of the public, representative groups and other organisations in relation to decisions about the carrying out of integration functions. The Parties will encourage the IJB to access existing forums that the Parties have established, such as Public Partnership Forums, Community Councils, groups and other networks and stakeholder groups with an interest in health and social care.

14. Information Sharing and Confidentiality

14.1 The Parties shall agree to an appropriate information sharing accord and procedures for the sharing of information in relation to integrated services. These shall set out the principles, policies, procedures and management strategies around which information sharing is carried out. They will encapsulate national and legal requirements.

14.2 The Parties will work together to progress the specific arrangements, practical policies and procedures, designated responsibilities and any additional requirements for any purpose connected with the preparation of an integration scheme, the preparation of a strategic plan or the carrying out of integration functions.

14.3 The Parties shall be assisted in this process by a Joint Information Sharing Group. This group reviewed the existing Memorandum of Understanding and Information Sharing Protocol to see whether these were suitable for the purposes of integration, or whether replacements, modifications or supplements were considered necessary. The Group reported that the existing Memorandum of Understanding was sufficient.

14.4 If the Joint Information Sharing Group consider that a further high level accord or information sharing protocol is required, or if amendments are necessary to existing ones, they shall assist the Parties and the IJB by preparing these and

making them available with their recommendation to the IJB in the first instance for comment.

14.5 The information sharing accord and procedures may be amended or replaced by agreement of the Parties and the IJB. Regard will be taken of the SASPI template when revising or replacing these.

14.6 The Parties will continue to develop information technology systems and procedures to enable information to be shared appropriately and effectively between the Parties and the IJB.

15. Complaints

15.1 The Parties agree the following arrangements in respect of complaints:

15.2 Complaints should continue to be made to the Council and NHS Grampian using the existing mechanisms.

15.3 Complaints can be made to the Parties through any member of staff providing integrated services. Complaints can be made in person, by telephone, by email, or in writing. On completion of the complaints procedure, complainants may ask for a review of the outcome. At the end of the complaints process, complainants are entitled to take their complaint to the Scottish Public Services Ombudsman (or any such successor). Where appropriate, complainants will also be advised of their right to complain to the Care Inspectorate.

15.4 The Parties shall communicate with each other in relation to any complaint which requires investigation or input from the other organisation. This shall ensure that complaints procedures operate smoothly and in an integrated and efficient manner for the benefit of the complainant.

15.5 The Chief Officer will have an overview of complaints made about integrated services and subsequent responses. Complaints about integrated services will be recorded and reported to the Chief Officer on a regular and agreed basis.

15.6 Complaints will be used as a valuable tool for improving services and to identify areas where further staff training may be of benefit.

15.7 The Parties will ensure that all staff working in the provision of integrated services are familiar with the complaints procedures and that they can direct individuals to the appropriate complaints procedures.

15.8 The complaints procedures will be clearly explained, well-publicised, accessible, will allow for timely recourse and will sign-post independent advocacy services.

15.9 The Parties will aspire to have a streamlined and integrated process for complaints and will work to ensure that any future arrangements for complaints are clear and integrated from the perspective of the complainant. When this is achieved, the Scheme will be amended using the procedure required by the Act.

15.10 In developing a streamlined and integrated process for complaints, the Parties shall ensure that all statutory requirements will continue to be met, including timescales for responding to complaints.

15.11 In developing a single complaints process, the Parties will endeavour to develop a uniform way to review unresolved complaints before signalling individuals to the appropriate statutory review authority.

16. Claims Handling, Liability & Indemnity

16.1 The Parties and the IJB recognise that they could receive a claim arising from or which relates to the work undertaken on behalf of the IJB.

16.2 The Parties agree to ensure that any such claims are progressed quickly and in a manner which is equitable between them.

16.3 So far as reasonably practicable the normal common law and statutory rules relating to liability will apply.

16.4 Each party will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.

16.5 Each party will assume responsibility for progressing and determining any claim which relates to any heritable property which is owned by them. If there are any heritable properties owned jointly by the Parties, further arrangements for liability will be agreed upon in consultation with insurers.

16.6 In the event of any claim against the IJB or in respect of which it is not clear which party should assume responsibility then the Chief Officer (or his/her representative) will liaise with the Chief Executives of the Parties (or their representatives) and determine which party should assume responsibility for progressing the claim.

16.7 If a claim is settled by either party, but it subsequently transpires that liability rested with the other party, then that party shall indemnify the party which settled the claim.

16.8 Claims regarding policy and/or strategic decisions made by the IJB shall be the responsibility of the IJB. The IJB may require to engage independent legal advice for such claims.

16.9 If a claim has a “cross boundary” element whereby it relates to another integration authority area, the Chief Officers of the integration authorities concerned shall liaise with each other until an agreement is reached as to how the claim should be progressed and determined.

16.10 The IJB will develop a procedure for claims relating to hosted services with the other relevant integration authorities. Such claims may follow a different procedure than as set out above.

16.11 Claims which pre-date the establishment of the IJB will be dealt with by the Parties through the procedures used by them prior to integration.

17. Risk Management

17.1 A shared risk management strategy is in place, which includes risk monitoring and a reporting process for the Parties and the IJB. This will be updated as needed and particularly when this scheme is revised and any additional functions delegated so that it is updated by the time such functions are delegated to the IJB. In developing this shared risk management strategy, the Parties reviewed the shared risk management arrangements in operation, including the Parties' own Risk Registers.

17.2 There will be shared risk management across the Parties and the IJB for significant risks that impact on integrated service provision. The Parties and the IJB will consider these risks as a matter of course and notify each other where the risks may have changed.

17.3 The Parties will provide the IJB with support, guidance and advice through their respective Risk Managers, to enable the IJB to maintain an ongoing fit for purpose risk management strategy to ensure that the risk management of the IJB is delivered to a high standard.

17.4 Any changes to the risk management strategy shall be requested through formal paper to the IJB.

17.5 A single Risk Register has been developed for the IJB. The process used in developing a single Risk Register was to involve members of the IJB establishing a risk framework by identifying risks to the development of the Strategic Plan. This risk framework in turn was used by operational units of integrated services and each unit was required to contribute towards the Risk Register by identifying relevant risks and mitigation of those risks.

17.6 The single Risk Register will continue to be developed alongside the Strategic Plan, and will be modified as necessary in line with the development of the Strategic Plan..

18. Dispute resolution mechanism

18.1 This provision relates to disputes between NHS Grampian and the Council in respect of the IJB or their duties under the Act. This provision does not apply to internal disputes within the IJB itself.

18.2 Where either of the Parties fails to agree with the other on any issue related to this Scheme and/or the delivery of integrated health and social care services, then they will follow the process as set out below:

(a) The Chief Executives of NHS Grampian and the Council and the Chief Officer of the IJB will meet to resolve the issue;

(b) If unresolved, NHS Grampian and the Council and the IJB will each prepare a written note of their position on the issue and exchange it with the others within 21 calendar days of the meeting in (a).

(c) Within 14 calendar days of the exchange of written notes in (b) the Chief Executives and Chief Officer must meet to discuss the written positions.

(d) In the event that the issue remains unresolved, the Chief Executives and the Chief Officer will proceed to mediation with a view to resolving the issue. The Chief Officer will appoint a professional independent mediator. The cost of mediation, if any, will be split equally between the Parties. The mediation process will commence within 28 calendar days of the meeting in (c).

(e) Where the issue remains unresolved after following the processes outlined in (a)-(d) above and if mediation does not allow an agreement to be reached within 6 months from its commencement, or any other such time as the parties may agree, either party may notify Scottish Ministers that agreement cannot be reached.

(f) Where the Scottish Ministers make a determination on the dispute, that determination shall be final and the Parties and the IJB shall be bound by the determination.

Annex 1

Part 1

Functions delegated by the Health Board to the Integration Joint Board

The functions which are to be delegated by the Health Board to the Integration Joint Board are set out in this Part 1 of Annex 1 and are subject to the exceptions and restrictions specified or referred to. The services to which these functions relate are set out in Part 2 of this Annex 1.

Functions prescribed for the purposes of section 1(8) of the Act

Column A	*Column B*
The National Health Service (Scotland) Act 1978	

All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of—
	
	section 2(7) (Health Boards);
	
	section 2CB([1]) (Functions of Health Boards outside Scotland);
	
	section 9 (local consultative committees);
	
	section 17A (NHS Contracts);
	
	section 17C (personal medical or dental services);
	
	section 17I([2]) (use of accommodation);

([1]) Section 2CA was inserted by S.S.I. 2010/283, regulation 3(2).
([2]) Section 17I was inserted by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2 and amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4. The functions of the Scottish Ministers under section 17I are conferred on Health Boards by virtue of S.I. 1991/570, as amended by S.S.I. 2006/132.

section 17J (Health Boards' power to enter into general medical services contracts);

section 28A (remuneration for Part II services);

section 38([3]) (care of mothers and young children);

section 38A([4]) (breastfeeding);

section 39([5]) (medical and dental inspection, supervision and treatment of pupils and young persons);

section 48 (provision of residential and practice accommodation);

section 55([6]) (hospital accommodation on part payment);

section 57 (accommodation and services for private patients);

section 64 (permission for use of facilities in private practice);

([3]) The functions of the Secretary of State under section 38 are conferred on Health Boards by virtue of S.I. 1991/570.

([4]) Section 38A was inserted by the Breastfeeding etc (Scotland) Act 2005 (asp 1), section 4. The functions of the Scottish Ministers under section 38A are conferred on Health Boards by virtue of S.I. 1991/570 as amended by S.S.I. 2006/132.

([5]) Section 39 was relevantly amended by the Self Governing Schools etc (Scotland) Act 1989 (c.39) Schedule 11; the Health and Medicines Act 1988 (c.49) section 10 and Schedule 3 and the Standards in Scotland's Schools Act 2000 (asp 6), schedule 3.

([6]) Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

section 75A([7]) (remission and repayment of charges and payment of travelling expenses);
section 75B([8])(reimbursement of the cost of services provided in another EEA state);

section 75BA ([9])(reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);

section 79 (purchase of land and moveable property);

section 82([10]) use and administration of certain endowments and other property held by Health Boards);

section 83([11]) (power of Health Boards and local health councils to hold property on trust);

section 84A([12]) (power to raise money, etc., by appeals, collections etc.);

([7]) Section 75A was inserted by the Social Security Act 1988 (c.7), section 14, and relevantly amended by S.S.I. 2010/283. The functions of the Scottish Ministers in respect of the payment of expenses under section 75A are conferred on Health Boards by S.S.I. 1991/570.
([8]) Section 75B was inserted by S.S.I. 2010/283, regulation 3(3) and amended by S.S.I. 2013/177.
([9]) Section 75BA was inserted by S.S.I. 2013/292, regulation 8(4).
([10]) Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 7) section 1(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.
([11]) There are amendments to section 83 not relevant to the exercise of a Health Board's functions under that section.
([12]) Section 84A was inserted by the Health Services Act 1980 (c.53), section 5(2). There are no amendments to section 84A which are relevant to the exercise of a Health Board's functions.

section 86 (accounts of Health Boards and the Agency);

section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);
section 98 ([13]) (charges in respect of non-residents); and

paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);

and functions conferred by—

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ([14]);

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302;

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000/54;

The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004/114;

([13]) Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.S.I. 1991/570.

([14]) S.I. 1989/364, as amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/455; S.S.I. 2005/572 S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

	The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004;
	The National Health Service (Discipline Committees) Regulations 2006/330;
	The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006/135;
	The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183;
	The National Health Service (General Dental Services) (Scotland) Regulations 2010/205; and
	The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55([15]).

Disabled Persons (Services, Consultation and Representation) Act 1986

Section 7 (Persons discharged from hospital)	

Community Care and Health (Scotland) Act 2002

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	

([15]) S.S.I. 2011/55, to which there are amendments not relevant to the exercise of a Health Board's functions.

Mental Health (Care and Treatment) (Scotland) Act 2003

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (Approved medical practitioners); section 34 (Inquiries under section 33: co-operation)([16]); section 38 (Duties on hospital managers: examination notification etc.)([17]); section 46 (Hospital managers' duties: notification)([18]); section 124 (Transfer to other hospital); section 228 (Request for assessment of needs: duty on local authorities and Health Boards); section 230 (Appointment of a patient's responsible medical officer); section 260 (Provision of information to patients); section 264 (Detention in conditions of excessive security: state hospitals); section 267 (Orders under sections 264 to 266: recall);

([16]) There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.
([17]) Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards under that Act.
([18]) Section 46 is amended by S.S.I. 2005/465.

section 281([19]) (Correspondence of certain persons detained in hospital);

and functions conferred by—

The Mental Health (Safety and Security) (Scotland) Regulations 2005([20]);

The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005([21]);

The Mental Health (Use of Telephones) (Scotland) Regulations 2005([22]); and

The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008([23]).

([19]) Section 281 is amended by S.S.I. 2011/211.

([20]) S.S.I. 2005/464, to which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

([21]) S.S.I. 2005/467. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

([22]) S.S.I. 2005/468. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

([23]) S.S.I. 2008/356. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

Education (Additional Support for Learning) (Scotland) Act 2004

Section 23 (other agencies etc. to help in exercise of functions under this Act**)**	

Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by— section 31(Public functions: duties to provide information on certain expenditure etc.); and section 32 (Public functions: duty to provide information on exercise of functions).

Patient Rights (Scotland) Act 2011

All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36([25]).

Carers (Scotland) Act 2016

Section 31([24]) (Duty to prepare local carer strategy)	

([24]) Inserted by Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Amendment Regulations 2017/381 (Scottish SI) reg. 2 (December 18, 2017)

([25]) S.S.I. 2012/36. Section 5(2) of the Patient Rights (Scotland) Act 2011 (asp 5) provides a definition of "relevant NHS body" relevant to the exercise of a Health Board's functions.

Part 2

Services currently provided by the Health Board which are to be delegated

A

Interpretation of this Part 2 of Annex 1

1. In this part—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

"general medical practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004([26]); and

"the public dental service" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

([26]) S.S.I. 2004/115.

B

Provision for people over the age of 18

The functions listed in Part 1 of this Annex 1 are delegated only to the extent that:

a) the function is exercisable in relation to persons of at least 18 years of age;
b) the function is exercisable in relation to care or treatment provided by health professionals for the purpose of health care services listed at numbers 2 to 7 below; and
c) the function is exercisable in relation to the following health services:

2. Accident and Emergency services provided in a hospital.

3. Inpatient hospital services relating to the following branches of medicine—

(a) general medicine;
(b) geriatric medicine;
(c) rehabilitation medicine;
(d) respiratory medicine; and
(e) psychiatry of learning disability.

4. Palliative care services provided in a hospital.

5. Inpatient hospital services provided by General Medical Practitioners.

6. Services provided in a hospital in relation to an addiction or dependence on any substance.

7. Mental health services provided in a hospital, except secure forensic mental health services.

8. District nursing services.

9. Services provided outwith a hospital in relation to an addiction or dependence on any substance.

10. Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

11. The public dental service.

12. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([27]).

13. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([28]).

14. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([29]).

15. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([30]).

([27]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.

([28]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.

([29]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.

([30]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28),

16. Services providing primary medical services to patients during the out-of-hours period.

17. Services provided outwith a hospital in relation to geriatric medicine.

18. Palliative care services provided outwith a hospital.

19. Community learning disability services.

20. Mental health services provided outwith a hospital.

21. Continence services provided outwith a hospital.

22. Kidney dialysis services provided outwith a hospital.

23. Services provided by health professionals that aim to promote public health.

24. Sexual health services provided in the community.

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section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

C

Provision for people under the age of 18

The functions listed in Part 1 of Annex 1 are also delegated to the extent that:

a) the function is exercisable in relation to persons of less than 18 years of age; and

b) the function is exercisable in relation to the following health services:

25. The public dental service.

26. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([31]).

27. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([32]).

28. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([33]).

29. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([34]).

([31]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.

([32]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.

([33]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.

([34]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28), section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

Part 3

Services currently provided by the Health Board to those under 18 years of age, which are to be operationally devolved to the Chief Officer of the Integration Joint Board.

30. Health Visiting

31. School Nursing

32. All services provided by Allied Health Professionals, as defined in Part 2A of this Annex 1, in an outpatient department, clinic, or outwith a hospital.

Annex 2

Part 1

Functions delegated by the Local Authority to the Integration Joint Board

The functions which are to be delegated by the Local Authority to the Integration Joint Board are set out in this Part 1 of Annex 2 and are subject to the exceptions and restrictions specified or referred to. The services to which these functions relate are set out in Part 2 of this Annex 2.

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A	*Column B*
Enactment conferring function	*Limitation*
National Assistance Act 1948([35])	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958([36])	
Section 3 (Provision of sheltered employment by local authorities)	

([35]) 1948 c.29; section 48 was amended by the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 39, paragraph 31(4) and the Adult Support and Protection (Scotland) Act 2007 (asp 10) schedule 2 paragraph 1.

([36]) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
The Social Work (Scotland) Act 1968([37])	
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.

([37]) 1968 c.49; section 1 was relevantly amended by the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Children Act 1989 (c.41), Schedule 15; the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), schedule 10; S.S.I. 2005/486 and S.S.I. 2013/211. Section 4 was amended by the 1990 Act, Schedule 9, the Children (Scotland) Act 1995 (c.36) ("the 1995 Act"), schedule 4; the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ("the 2003 Act"), schedule 4; and S.S.I. 2013/211. Section 10 was relevantly amended by the Children Act 1975 (c.72), Schedule 2; the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 13; the Regulation of Care (Scotland) Act 2001 (asp 8) ("the 2001 Act") schedule 3; S.S.I. 2010/21 and S.S.I. 2011/211. Section 12 was relevantly amended by the 1990 Act, section 66 and Schedule 9; the 1995 Act, Schedule 4; and the Immigration and Asylum Act 1999 (c.33), section 120(2). Section 12A was inserted by the 1990 Act, section 55, and amended by the Carers (Recognition and Services) Act 1995 (c.12), section 2(3) and the Community Care and Health (Scotland) Act 2002 (asp 5) ("the 2002 Act"), sections 8 and 9(1). Section 12AZA was inserted by the Social Care (Self Directed Support) (Scotland) Act 2013 (asp 1), section 17. Section 12AA and 12AB were inserted by the 2002 Act, section 9(2). Section 13 was amended by the Community Care (Direct Payments) Act 1996 (c.30), section 5. Section 13ZA was inserted by the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 64. Section 13A was inserted by the 1990 Act, section 56 and amended by the Immigration and Asylum Act 1999 (c.33), section 102(2); the 2001 Act, section 72 and schedule 3; the 2002 Act, schedule 2 and by S.S.I. 2011/211. Section 13B was inserted by the 1990 Act sections 56 and 67(2) and amended by the Immigration and Asylum Act 1999 (c.33), section 120(3). Section 14 was amended by the Health Services and Public Health Act 1968 (c.46), sections 13, 44 and 45; the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Guardianship Act 1973 (c.29), section 11(5); the Health and Social Service and Social Security Adjudications Act 1983 (c.41), schedule 10 and the 1990 Act, schedule 9. Section 28 was amended by the Social Security Act 1986 (c.50), Schedule 11 and the 1995 Act, schedule 4. Section 29 was amended by the 1995 Act, schedule 4. Section 59 was amended by the 1990 Act, schedule 9; the 2001 Act, section 72(c); the 2003 Act, section 25(4) and schedule 4 and by S.S.I. 2013/211.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982([38])	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986([39])	

([38]) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.
([39]) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000([40])	
Section 10 (Functions of local authorities.)	
Section 12 (Investigations.)	

([40]) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions.
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions.
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions.
The Housing (Scotland) Act 2001([41])	
Section 92 (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002([42])	

([41]) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.
([42]) 2002 asp 5.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 5 (Local authority arrangements for of residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003([43])	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	

([43]) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	
Section 259 (Advocacy.)	
The Housing (Scotland) Act 2006([44])	
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007([45])	
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	
Section 6 (Duty to consider importance of providing advocacy and other.)	
Section 7 (Visits)	

([44]) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.

([45]) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 8 (Interviews)	
Section 9 (Medical Examinations)	
Section 10 (Examination of records etc)	
Section 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 16 (Moving adult at risk in pursuance of removal order)	
Section 18 (Protection of moved persons' property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Social Care (Self-directed Support) (Scotland) Act 2013([46])	
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	

([46]) 2013 asp 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
Carers (Scotland) Act 2016([47])	
Section 6([48]) (Duty to prepare of adult carer support plan)	
Section 21([49]) (Setting of local eligibility criteria.)	
Section 24([50]) (Duty to provide support)	
Section 25([51]) (Provision of support to carers: breaks from caring)	
Section 31([52]) (Duty to prepare local carer strategy)	
Section 34([53]) (Information and advice service for carers)	
Section 35([54]) (Short breaks services statements)	

([47]) Section 21 was inserted into the Schedule of the Public Bodies (Joint Working) (Scotland) Act 2014 by paragraph 6 of the schedule of the Carers (Scotland) Act 2016 (asp 9).
([48]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([49]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017/190 (Scottish SI) reg. 2(2) (June 16 2017).
([50]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([51]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([52]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([53]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([54]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A	*Column B*
Enactment conferring function	*Limitation*
The Community Care and Health (Scotland) Act 2002	
Section 4([55]) The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([56])	

([55]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 62(3).
([56]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

Part 2

Services currently provided by the Local Authority which are to be integrated

The functions listed in Part 1 of this Annex 2 are delegated only to the extent that:

a) the function is exercisable in relation to persons of at least 18 years of age; and

b) the function is exercisable in relation to the following services:

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptions
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare

Annex 3

Hosted Services

NHS Grampian has noted the services that are currently hosted across the areas of the Grampian IJBs and offer this for consideration to the IJB as they take forward strategic planning:

Service	Current Host
Sexual Health Services	Aberdeen City
Woodend Assessment of the Elderly (including Links Unit at City Hospital)	Aberdeen City
Woodend Rehabilitation Services (including Stroke Rehab, Neuro Rehab, Horizons, Craig Court and MARS)	Aberdeen City
Marie Curie Nursing	Aberdeenshire
Heart Failure Service	Aberdeenshire
Continence Service	Aberdeenshire
Diabetes MCN (including Retinal Screening)	Aberdeenshire
Chronic Oedema Service	Aberdeenshire
HMP Grampian	Aberdeenshire
Police Forensic Examiners	Aberdeenshire

Annex 4

This Annex lists the services provided within hospitals which the IJB will have strategic planning responsibilities for which will continue to be operationally managed by NHS Grampian:

Services:

- Accident & Emergency Services provided in a hospital;
- Inpatient hospital services relating to: general medicine, geriatric medicine, rehabilitation medicine, respiratory medicine and psychiatry of learning disability; and
- Palliative Care services provided in a hospital.

In so far as they are provided within the following hospitals:

- Hospitals at the Foresterhill Site, Aberdeen (which includes Aberdeen Royal Infirmary, Royal Aberdeen Childrens Hospital and Aberdeen Maternity Hospital)
- Hospitals in Elgin (which includes Dr Gray's Hospital)

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 26 APRIL 2018

SUBJECT: AUDIT AND RISK COMMITTEE ASSURANCE REPORT

BY: CHIEF FINANCIAL OFFICER

1. REASON FOR REPORT

1.1 To inform the Board of a summary of matters considered and actioned during 2017/18 at the Audit and Risk committee.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board (MIJB) consider and note:

i) the content of this report;

ii) the Strategic Risk Register attached at Appendix 1; and

iii) the External Audit Plan attached at Appendix 2.

3. BACKGROUND

3.1 As part of the governance arrangements surrounding the MIJB, the Audit and Risk Committee was established in April 2016. At a meeting of the MIJB on 31 March 2016 the Board appointed a Chair, its Members and approved the Terms of Reference of the Audit and Risk Committee (para 6 of the minute refers).

3.2 An effective Audit and Risk Committee is key to a strong governance culture and to assist in ensuring a robust framework is in place to provide assurance on risk management, governance and internal control, provide effective scrutiny of the MIJB's functions and to consider the changes necessary to improve on these arrangements.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Throughout the 2017/18 financial year, the Audit and Risk Committee has held four formal meetings. The Chief Internal Auditor has reported to each of these meetings and the Chief Officer and Chief Financial Officer have been present in order to allow the committee to provide the scrutiny function as determined

4.2 During the financial year 2017/18 the Audit and Risk Committee have:

i) Considered and noted the internal audit delivery arrangements involving the provision of audit assurances on the overarching governance, risk and control arrangements within the MIJB, supplemented and informed by the work of the internal auditors for NHS Grampian and the Moray Council;
ii) Approved the MIJB internal audit annual plan for the year
iii) Considered at each meeting updates from the Chief Internal Auditor on progress made towards delivery of the audit plan on topics including:
- IJB budget setting and staff governance
- Payroll Care at Home
- Use of Strategic (Change)Funds
- Self-directed support

iv) Continued to monitor progress on matters arising from the first Audit Scotland Report on Integration published December 2015.
v) Considered a progress report relating to the Family Health Services contract management internal audit carried out in 2016/17
vi) Considered and noted the External Audit Annual Plan attached at **Appendix 2** to this report
vii) Requested that the Chief Internal Auditor considers providing information on audit coverage in recent years and on any other relevant factors, to place in context the rationale for selecting areas for audit going forward.

4.3 The Strategic Risk Register is a standing agenda item of the Audit and Risk Committee and is reviewed and updated throughout the year. The most recent version of the Strategic Risk Register was presented and approved at the meeting of 29 March 2018 and is attached at **Appendix 1** to this report (paragraph 7 of the draft Minute refers).

4.4 On 29 March 2018 the external auditor, Audit Scotland, presented their annual audit plan for the 2017/18 year to the Audit and Risk Committee (paragraph 5 of the draft Minute refers). The Plan sets out the scope of the audit work and the auditors approach. The Plan details the initial risks identified and the planned work to be undertaken for the audit of the financial statements for the year ending 2017/18. The audit plan is attached at **Appendix 2** to this report.

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

This report forms part of the governance arrangements of Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019.

(b) Policy and Legal

Scottish Government guidance relating to the Public Bodies (Joint Working) (Scotland) Act 2014 suggests that adequate and proportionate arrangements should be made as an audit provision. The Audit and Risk Committee was established as a committee of the MIJB to fulfil this obligation.

(c) Financial implications

There are no financial implications associated with this report

(d) Risk Implications and Mitigation

The strategic risk register is routinely monitored by the senior management team and any changes or issues will be reported to Audit and Risk Committee for consideration.

(e) Staffing Implications

There are no staffing implications arising from this report

(f) Property

There are no Property implications arising from this report

(g) Equalities

None directly arising from this report

(h) Consultations

Consultation on this report has taken place with the Chief Officer, the Chief Financial officer; Atholl Scott, Chief Internal Auditor; the Legal Services Manager (Litigation and Licensing); and Caroline Howie, Committee Services Officer, Moray Council; who are in agreement with the content of this report as regards their respective responsibilities.

6. CONCLUSION

6.1 This report provides a summary of the business addressed by the Audit and Risk Committee throughout the 2017/18 financial year.

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

Signature: _____ Date: 13 April 2018

Designation: Chief Financial Officer Name: Tracey Abdy

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT MARCH 2018

RISK SUMMARY

1. The Moray Integration Joint Board (MIJB) does not function as set out within the Integration Scheme, Strategic Plan and in-line with Standing Orders and fails to deliver its objectives or expected outcomes.

2. There is a risk of MIJB financial failure with demand outstripping available budget. Savings requiring to be made by either Partner adversely impacts on services and budgets.

3. Inability to recruit and retain qualified and experienced staff whilst ensuring staff are fully able to manage change.

4. Inability to demonstrate effective governance and ineffective communication with stakeholders.

5. Inability to deal with unforeseen external emergencies or incidents is compromised by inadequate emergency planning and resilience.

6. Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.

7. Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance falls below acceptable level.

8. Risk of major disruption in continuity of ICT operations and data security is compromised.

9. Requirements for IT and Property are not prioritised by NHS Grampian and Moray Council.

RISK RATING	**LOW**	**MEDIUM**	**HIGH**	**VERY HIGH**
RISK MOVEMENT	**DECREASE**	**NO CHANGE**	**INCREASE**	

The process for managing risk is documented out with the MIJB Risk Control Policy.

1	
Description of Risk: *Political:* The Integration Joint Board (IJB) does not function as set out within the Integration Scheme, Strategic Plan and Schemes of Delegation and fails to deliver its objectives or expected outcomes.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high	**Rationale for Risk Rating:**
HIGH	Failure of the IJB to function is a fundamental risk which would impact on all strategic priorities. Given the wide range and variety of services that support the IJB from NHS Grampian and Moray Council which has a potential risk of under or non-performance. Management capacity to fully complement structure could be a potential risk.
Risk Movement: increase/decrease/no change	**Rationale for Risk Appetite:** The MIJB has zero appetite for failure to meet its legal and statutory requirements and functions.
NO CHANGE	
Controls: • Integration Scheme. • Strategic Plan. • Governance arrangements formally documented and approved.	**Mitigating Actions:** SMT regular meetings and directing managers and teams to focus on priorities.

• Agreed risk appetite statement. • Performance reporting mechanisms. • Business Management Team being developed.	System re-design and transformation.
Assurances: • Audit and Risk Committee oversight and scrutiny. Reporting to Board.	**Gaps in assurance:** None known
Current performance: Meeting requirements. Current milestones being met. Annual Performance Report 2017/18 being developed for publishing in July 2018.	**Comments:** Performance Management Framework, aligned to strategic planning and resources has been presented to MIJB. Implementation of framework being discussed through HSCM Performance meetings, with further development aligned to new Strategic Plan.

2	
Description of Risk: *Financial:* There is a risk of MIJB financial failure with demand outstripping available budget. Financial settlements to the MIJB continue to reduce	
Lead: Chief Officer/Chief Financial Officer	
Risk Rating: low/medium/high/very high	**Rationale for Risk Rating:**
VERY HIGH	Funding cuts from Moray Council have been significant 2017/18 (£1.3m) and 2018/19 (£1.8m). NHS Grampian provided no uplifts for pay and price increases in 2017/18 creating increased pressure. Analysis of current budget pressures known and expected in the Public Sector in Scotland. Understanding of financial pressures on both partner organisations (Moray Council and NHS Grampian). Demand on services. Legislative changes impact adversely on financial pressures
Risk Movement: increase/decrease/no change	**Rationale for Risk Appetite:**
NO CHANGE	The MIJB has a low risk appetite to financial failure and understands it's the importance of having a balanced budget. However the MIJB also recognises the significant range of statutory services it is required to meet within that finite budget and has a zero appetite for risk of harm to people.
Controls: Chief Finance Officer appointed to - this role is crucial in ensuring sound financial information and supporting sound financial decision making, budget reporting and escalation. Savings Plan presented to MIJB in June 2017. Further Savings will	**Mitigating Actions:** Risk remains the MIJB can deliver transformation and efficiencies at the pace required. Financial information is reported regularly to both the MIJB and

be presented as part of the 2018/19 budget setting process.	Senior Management Team. . The Chief Officer and Chief Financial Officer have engaged in the budget setting processes of both NHS Grampian and Moray Council to outline the significance of reduced funding and the subsequent risk to the partners as part of the risk sharing arrangement that exists..
Assurances: MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.	**Gaps in assurance:** None known
Current performance: Indicative budget for 17/18 not approved on 30 March 2017 by MIJB members. It was however accepted as a working budget and was approved alongside the recovery plan in June 2017. The outlook for the 2018/19 revenue budget is concerning. The indicative budget shows budget shortfall of £4.5m	**Comments:** Senior managers to work with Chief Officer and Chief Financial Officer to address the budget shortfall and provide regular update reports to the MIJB, Moray Council and NHS Grampian as part of the risk sharing arrangement in place .

3	
Description of Risk: *Human Resources (People):* Inability to recruit and retain qualified and experienced staff whilst ensuring staff are fully able to manage change.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Risk felt to be moderate given controls with potential risks in respect of mitigating actions. Roll out plans for full implementation of HSE requirements being finalised. Increasing workload experienced – being managed by effectively recruiting to senior posts.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** The MIJB has zero appetite for harm happening to people.
Controls: Management structure in place with updates reported to the MIJB. Organisational Development and Workforce Plans being developed and aligned to service priorities. These will presented to MIJB in March 2018. Continued activity to address specific recruitment and retention issues. Management competencies being developed. Communication Strategy developed and approved in June 2017. A review of this will be presented to the MIJB in 2018.	**Mitigating Actions:** System re-design and transformation. Joint Workforce Planning. Lead Managers are involved in regional and national initiatives to ensure all learning is adopted to improve this position. Lead Managers and Professional Leads are linked to University Planning for intakes and programmes for future workforce development.

Incident reporting procedures in place. Council and NHS performance systems remain in place with single reporting in development.	
Assurances: operational oversight by Moray Workforce Forum and reported to MIJB.	**Gaps in assurance:** joint or single system not yet agreed for incident reporting.
Current performance: iMatter tool rolled out across all operational areas and action plans developed and progressed. Representation on NHS Grampian's HSE Expert Group. Organisational Development Plan presented and approved at MIJB in January 2018.	**Comments:** Regular reporting and management control in place

4	
Description of Risk: *Regulatory:* Inability to demonstrate effective governance and ineffective communication with stakeholders.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Locality planning considered medium in relation to ability to work at the pace required and current workforce capacity.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** The MIJB has a low risk appetite to failure.
Controls: Annual Governance statement produced as part of the Annual Accounts and signed off by External Audit. Performance reporting mechanisms. Locality planning arrangements and communication engagement being reviewed.	**Mitigating Actions:** Annual Performance Report was published in July 2017.
Assurances: Oversight and scrutiny by Clinical and Care Governance Sub-Committee and MIJB.	**Gaps in assurance:** None known
Current performance: Communications Strategy developed and approved by MIJB in June 2017.	**Comments:** Regular and ongoing reporting.

5	
Description of Risk: *Environmental:* Inability to deal with unforeseen external emergencies or incidents is compromised by inadequate emergency planning and resilience.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Resilience standards and implementation plan agreed. Business Continuity Plans in place for most services.
Risk Movement: increase/decrease/no change **DECREASE**	**Rationale for Risk Appetite:** The MIJB should understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act.
Controls: Lead Officer identified working alongside Emergency Planner. Local resilience plan developed. NHS Grampian Resilience Standards Action Plan approved (3 year).	**Mitigating Actions:** Table top exercise for MIJB to be undertaken in Spring 2018 focusing on business continuity planning.
Assurances: Audit and Risk Committee and NHS Grampian Civil Contingencies Committee oversight and scrutiny.	**Gaps in assurance:** Primary Care Out of Hours (GMED) Business Continuity Plan to be developed by Autumn 2017. Training to be further rolled out and will be co-ordinated via Moray's Civil Contingencies Group.
Current performance: 3 year plan being developed.	**Comments:** Regular and ongoing sector reporting.

6	
Description of Risk: *Reputational:* Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Considered medium risk due to the reporting arrangements being relatively new and testing required in first full year of operation.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** The MIJB has some appetite for reputational risk relating to testing change and being innovative. The MIJB has zero appetite for harm happening to people.
Controls: Clinical and Care Governance Sub-Committee established and has overview of inspection processes and reports. Operational Risk Register being reviewed. Complaints procedure in place.	**Mitigating Actions:** This is discussed regularly by the three North East Chief Officers.
Assurances: Audit and Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny.	**Gaps in assurance:** None known
Current performance: Monitor progress and actions against Audit Scotland report (Dec 15).	**Comments:**

7	
Description of Risk: *Operational Continuity and Performance:* Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance falls below acceptable level.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Wide range of services in place to support the MIJB from NHS Grampian and Moray Council.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** Zero tolerance of harm happening to people as a result of action or inaction.
Controls: Performance Management reporting framework in place. Strategic Plan and Implementation Plan developed and approved. Performance regularly reported to MIJB. Revised Scorecard being developed. Best practice elements from each body brought together to mitigate risks to MIJB's objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process. Varis Court in Forres opened in July 2017 - five 2-bedroom flats for elderly and 7 dementia units built to support people continuing to live independently. Jubilee Cottages in Elgin refurbished to provide short term high	**Mitigating Actions:** Ability to deal competently with unforeseen events is compromised by inadequate business continuity planning and resilience. The introduction of significant changes in working practices has the potential to cause major disruption to service delivery. Unplanned admissions or delayed discharges place additional cost and capacity burdens on the service.

intensity rehab so people can leave hospital sooner, freeing up vitally needed NHS beds.	
Assurances: Audit and Risk Committee oversight. Operationally managed by SMT.	**Gaps in assurance:** None known
Current performance: Communication Strategy developed and approved by MIJB in June 2017. Close monitoring and performance management in place. Prevention covered in strategic plan.	**Comments:** Regular and ongoing reporting.

8	
Description of Risk: *IT:* Risk of major disruption in continuity of ICT operations and data security is compromised.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **LOW**	**Rationale for Risk Rating:** Corporate IS policies in place.
Risk Movement: increase/decrease/no change **DECREASE**	**Rationale for Risk Appetite:** MIJB has a low tolerance in relation to not meeting requirements.
Controls: Computer Use Policies and HR policies in place for NHS and Moray Council. Business Continuity Plans being updated to fully reflect IT disruption. PSN accreditation secured. Guidance regularly issued to staff. Guidance on effective data security measures issued to staff.	**Mitigating Actions:** Protocol for access to systems by employees of partner bodies to be developed. Information Management arrangements to be developed and endorsed by MIJB.
Assurances: Strict policies and protocols in place with NHS Grampian and Moray Council.	**Gaps in assurance:** None known
Current performance: Training programme to be developed on records management, data protection and related issues for staff working across and between partners.	**Comments:**

9	
Description of Risk: *Infrastructure:* Requirements for IT and Property are not prioritised by NHS Grampian and Moray Council.	
Lead: Chief Officer	
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Changes to processes and necessary stakeholder buy-in still bedding in.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** Low tolerance in relation to not meeting requirements.
Controls: Chief Officer has regular meetings with partners. Infrastructure Programme Board established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT	**Mitigating Actions:** Dedicated project Manager in place – monitoring/managing risks of the Programme Membership of the Board reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities. Process for ensuring infrastructure change/investment requests developed Project Manager linked into other Infrastructure groups within NHSG & Moray Council to ensure level of 'gatekeeping'
Assurances: Infrastructure Programme Board function to provide robust governance and decision-making through collaboration, and reports to Strategic Planning and Commissioning Group.	**Gaps in assurance:** Need to strengthen communications to ensure adherence to the stated governance Need to review all existing processes in relation to infrastructure changes/projects/investments and streamline to avoid duplication of effort.
Current performance:	**Comments:**

Development of the projects/pieces of work to prioritise under the Programme for kick-off from early 2018. Links with corporate PMO for overall management and opportunity to upskill staff.	The development of the processes around the Infrastructure Board and its governance positioning are still a work in progress but we are already beginning to see positive engagement with outline mandates for new projects beginning to be submitted to the Board.

Moray Integration Joint Board

Annual Audit Plan 2017/18

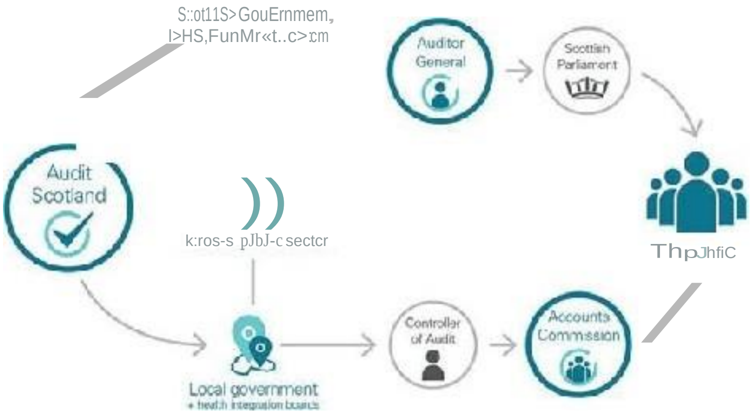
AUDIT SCOTLAND

Prepared for Moray Integration Joint Board
March 2018

Who we are

The Auditor General, the Accounts Commission and Audit Scotland work together to deliver public audit in Scotland:

- The Auditor General is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.
- The Accounts Commission is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.
- Audit Scotland is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



About us

Our vision is to be a world-class audit organisation that improves the use of public money.

Through our work for the Auditor General and the Accounts Commission, we provide independent assurance to the people of Scotland that public money is spent properly and provides value. We aim to achieve this by:

- carrying out relevant and timely audits of the way the public sector manages and spends money
- reporting our findings and conclusions in public
- identifying risks, making clear and relevant recommendations

Contents

HEALTH & SOCIAL CARE MORAY

Risks and planned work

1. Thiannual aucit plar c3nta ns an overvie·11of ltle pam!d sco:Je and t mingo' our aucit Jnd lG carried out in accor::Jamc wit1Internal omlStJndardc on fiUciting (ISAs), the C of Audit p;oetice and ar.1ot·E>r reiE>vant gLidance. r,;S plar idcnbfics or audit \•York to rovidc an opi1io1on the finJncial &a:cmcrts and reate: m3tters and meet he wider scope requiremen:s :.f pubfic sector audrt i1cl dirg the ne'" approacr to Best Val e.

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Audit risks

3. Rase<i on our ciscus on<; with siA'f, atten:1ame r.ommitle?. m?.etings ancf a review of s pp:r1in·;information we have idarti'ied fhe follc'"ing ma n risk areas for Moray Integration Joint lloer<i We have categorised these risks into 'inane alsks and wider dime1sion rtsks. The key aud1risks, which requi•e soeotfic audit testing, are detatled tn Lx11bt .

Exhibit 1
2017118 Key audit risks

Audit Risk	Source of assurance	Planned audit work
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Audit Risk	Source of assurance	Planned audit work
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Reporting arrangements

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Gi

5. Matters arising'•em oJr audt will be raporte::t on a timely basis and will include ag-eec action plans. Draft Mana ement reports will be issued to the rel vant omocrs to confirM fatual accuracy.

6. liVe will p·ovi:le an independent auditors report to Moray Integration Joint Board ond the .1\ocoJrts CorrmiSSIOn sctbng out our op1n1oro en the omt.alnocounts.We w ll prcvice the C ie'OFcer ard t1e 1\c:ounts Com-nis£ior wrth an annualreport onte audit containi,l; observ!tio,s and recommerdaons onsi,:pificant ratt ·s wnic1have arisen n the COJrse of the aud t.

Exhibit2

2017118 Audit outputs

Audit Output	Target date	Audit & Rtsk Committee date
Annual Audit Report	t 3 S><ul.,.,u.., 201a	27 Sc t.,111u. . 2318
Signed Independent Auditor's Report	28 September 2018	N!A

Audltfee

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Responsibilities

Audit & Risk Commit!tee and Chief FinancialOffi r

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10. I h'" aud1t othP. tJna1c1al stat ?merts does not rehevl? management or thP..Aud t & RisK Corrminee, as t-ose cll31 ed witgovernance, of their responsibilities.

Appointed auditor

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12. Au::litors in :he public sector give an ndependert ooinion on the financial sra·ements and o·her sr.€Cifiect informanr.naor.or-pan'(ing th?. finA1<:ial statemeris W alw re·,iew a11d lil:Jorlon lhe a""nyrrenlwih nU1e <Judled ood; lorn<Jr'lag its perforance,regularity and use of resources. Indoing this,we aim to support improver-en\ Gnd aocourto ility.

Appendix 2

ITEM: 12

PAGE: 27

Audit scope and timing

Financi al statements

13. The .o,t..,hrtr:ry fir..,n .i..,l ,..,,,.,1'"\..,nt""'"lit will h"' th"' fn11nrli!fion ..,nrl <;Nine tn· tc m jority' of the ou:lit work necessary to support our judgcmcrts ard o;u1,.;h,r:; Ull>. Wid <l,;;u:;un>i<.lldl lll,; w u.,, ..,l'tilu1 lllldlll''\l ct1<11 ""Ill$ l< ciny ll,. pt..blic sector. Otr aud:approach incluces:

- understend1ng the bus1ness ol Mcray Integration Jo1nt L!card ano the associated ris'<S whiChcould impact :m the financial sta:emencs
- identifyiii'J maju1 llansact.cn"'l'e"rns, ba< mo;s i lt: areaof 8 trnation anJ unders:andhg how Moray Integration Joint Board will inc ude :hese in t1e finAn ialMAtp,m..,nt
- assessing the rlsl<s 0f IT'atcr at m sstatcmcnt 11the Tlnancl3l statcmcn:s
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14. We wil give ar1 opiri'On on lhe finanti<l bia€nlen s as !o wheth€1 U1ey

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- h3ve been prepue:::t n accordance w1t' the reqLa·e11ents ot t1e Lo:;al Guv1 mne11-. (S otlan.l) Act 1973, tile Lut:<l A J liUiil•(Acc.x;unls (Scollond) Regu ations 2014, ar d the Local Govemmen! n Scotland Act 2:303.

MatenaiJty

15. We apply the :cnc pt of IT'ate·il in planring ndpetfcrning the audit. It is used in cvolue;ting the c:•cct of idrtificd m sstotcmcnts on the audit, and of any urcorracted misstatafT'ent;;, en the financ al stataTents and n ro-ming our opinion 1r1 the auditor's report.

16. We calcLiate mater allty a:clterent levels as descnbed below I he calculated naterialiVa'ues lor l<lo·ay tn:egrafion Joirt Bo3r:l are set ou: in-

III

Exhibit3
Materiality values

Materiality level	Amount
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Performance materiality--his a;ts as a !rigger p:>irt If the a!J!:lregate of err --. 1dentlhcd dunng the tmam1alstatements udr: exceeds pcrtormJrcc matcnal1ty this wou t1 intlicale 11ialfutllllllautli .(JlOQeWJes slioulu l.>e oonsi e1etl. UBinou1 p·o1essional.L.d ement we h3ve calculated pertonnance matenahty at !>0% ot pannng inotc·iality.	£C.G -nillion
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source:Mcn)'Integ:riOn JOint 3<lGl'dRevoenu& eud:x<*2J17li&*

11. We review and report on other inforrration pJblichod with :he financia o;:atements in;luding te management commentarv, anl'l.lelgovemance statement aM the remunerat1cn repon. A1y 1ssue t:lentne:l will be reponed to the AUdit & Ri!;.Cornrnillt>e.

Timetable
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Exhibit4
financial statements timetable

Key stage	LJ Date
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Late->$Ubmis$ion date of t.naJdiled an·ual accounl:;with comj:lete woli·ing ape pocl<cgc	28 June 2016
Latest: date for f nal clearance meeting with Chief Financial Officer	31.A uo;l2C18
,AQreement of Jnsgned aud ed ameall sccounts	-3 September 2018
Isoua of Annual Autlit R 'Ort 11c odirg ISA 2c0 rapctllo those c< rgsd with Qi'IP.rm:mr.e	
Independent aud or's reocrt s gnec	2·9 September 201El

Internal audit

19. Audting standerds ·equire 1nte•nal anc externalauclt:ors In w:xk clcse y tcgether to make oest Jse of available audit resour es. We seek to ·ely or, the wo1k of 111temal audit wheJeveJ po ible aqc ap;ul or cu1 pl;;nlll'lg pwces W'd carry OLt an assessMent of the inte•nal audit functicn. In:ernalaudit is provided b·y rein-1nuse imerrall e1.d:section et ::>rey Col.l'lnil overseen b'{the Intern?. I Au:1it Marager.

Adequacy of lnle1 nal Audil

20. Our review of the council·s rternal audtt section identified that an assessment P.(!ain11<\ P11hliSe t<'lr lnt,o,rMI A ldit SIMriMrl(PR AS) hA'" n<>lheP.r undertaken andsc in:erral aud:cannot dilMonstr;;rte compliance with :llese Sllr1dartls (includill"=' orting oil cH!:las clnon-wrn liancdl o lhe ALdil& Risk Committee).Flans are, OWe\'er, 111pla:e for the Internal audit functu:lf'" tc be cxtcrf\311y' SC$(;cdin June 2018. !In intcn31accccsmcnt is currcrtly underway ;;r:d the JE£ulls 'llilll>t! ltlporlt!tl wiUin lnlt!'flal A.u it's 20'7/18 Amuai eporl.

21. Despite the abo·oe, or assessment ooncluded that the inte·nal audit section nas tre !Hflls, experience anri r.ompetenr.e to enable us tc place f rmal rAianoo 3n tl·eir work int·1e a1eas set out oelow.Once corn plel;;d we will1eview U" e wo1k urdertaken !c corfinn:1at the work meets our re":luirements a-.d that app ::.priate 0C1dlnrenta ion sfanr1arc1s an<'lre[lr.rtin() [lrOOec1UrAS alA i1piA:€

Areas of Internal Audit reliance

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Audit dimensions

23. Our audit is based on fcur audit dunensions th&t frame tl-e wider scope ::>f rlt bliC Se<'.IM P.lldir r ()ltiremP.n'"'hnvm in ll<hilhit *5*

Exhibit 5

Audit dimensions

Source: Code of Audit Practice

1C l

24. In t·clocaI government sector.:1c appcIntcd aud tor's annLaI :oncluslons on these four dimensions will heto contribute to an overall assessment a1d assura1ce or best value.

Financial sustainabil ity

25. As a1Jditors we c:onsider the a propriateness r.f thuse r.f th going c: nc:ern basis of accounting as part of the arnua aud t. We will also commert on the body's financia sustainability n the longer term We defire thls as mecium tenn *(110* :c fivP. yP.1l'-") 1ln<11nCQP.r tP.rm (lnCQP.r tMn fivP. 'y'MI'S) ll<'t1linhility 'NA will c:11rry O1.1 worl\ ond oon:>ludo on:

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26. Fine nciolrrlcn< genenl is conc<:rlled with linarciclcaj.;ocity, wurd budgetary processes an::! whether te cdr·ol ervuorment an::!1ntemallcontrols are OJ:e(atlrg effectively We will reView, concfu.je and report on;

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- how IJ1oray ntegration Joint Soard has assurec i!::;elf that its fhanc al capacity and skills are approJ:rrate
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27. Go•temance P.nd trar<!parenc-y is concerned with the effectivenes:'l of cruiin · ard governance arranger1erts, leacership and decision rmking and transparert ı f.'Jrliii!J. or i lli:lrl'i;;d ;;flU JJ<:rfun11(;111'-'" illfur lltdtiuu W will r ;vi ;w, wm;lk<Jo; '"r<J report 01.

- whether Mo·ay Integraticn Joirt Board can demonstrate thathe gcve·nance ar,angern1lh;in poeare app1upriate am.l opera.iny eTeclively
- whether there is effective scrutiny', challenge a1d transparency on the declslon-rrak ng and trnance and oertormance reports
- t ,e quality' ann timeliness ::>f finRnc:ialand perfo·manc:e repnnng

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28. \'.31-e for money refers to using reroJrces effectively and continually iTproving servlces. *Over* ou'ive 'lear app:>intment, we will review conclude and reort on wheter Mnrey 11tegrllt on,lorm·l llrd c:P.r provide eVldenc:e fhllt t ts dcmonctratng value fer money 1n the uce of its rocourocc and aohicv rrcnt of octcorres

Independence and objectivity

29. Auditors apr.;ointed by :1e AcccL.nts Commission or AL.cit::>r Gene·al must comply wicn the Cod;) of 1\udi?raotice andrclev.Jnt suppor.ing guidamc. When auditing the finanoi31 statements audrtcrs must also colTply w th professional standards ISSJed by the Fhancia lReporti1g Counci and tl1osa of the p-ofess1onal accountency bcdies. These standards impose stri1gent rules to ensu·e the 1ndeFendence anc objecbVJty ot audttcrs..Audtt t;cotlanc has tnplace ·obust arrange rents to ensure coTpliancc with these standards i1cludirg a13nrA.Jal " ftt and proper" declaration for all memoers of staff. T1e arranger1erts are overseen *by* ltie CittlC0I of Audit SeiYiCeo, wl·o oetveo as Aud I SooUard'o Ehi<--s Pculner.

30. The engagement ' ead for Moray iniegratior J::>int Board is Brian Howarth, Assistant Director. Auditing snd ethicalstandards requ.re the appointee auditor to communicate any rclationsrips that m:;y affect the independence and objcotiv ty of audit staff. We are not aware of any sJch relationships pertai1ing to ;he audit of Mora·,.- Integration Joint Boa·d.

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Adding value

34. Th•ough ou·audit work we a·m to acd value t:> Moray ltT.egralio1Joint Board. We will do this by ensuring our AnnualAUdit Report provides a summary of the audit wcrk done in tile year together with clear.udge'Tlents ard conciJsions on hO\< well Mcray Integration Joint Beard has discharged s responsibilities and how well it has demonstrated the effectiveress of its arrangeorents. Wh re it is appropriate we will recomr1e11d actions that supp:>i cort.rLous improvement and summartsE.' areas ct good r;;rac.t1ce tdentt - ed trom our aud t work.

Moray Integration Joint Board

Annual Audit Plan 2017/18

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REPORT TO: MORAY INTEGRATION JOINT BOARD ON 26 APRIL 2018

SUBJECT: CLINICAL CARE AND GOVERNANCE COMMITTEE ASSURANCE REPORT

BY: CHIEF OFFICER

1. REASON FOR REPORT

1.1 To inform the Board of the summary of matters considered and actioned during 2017/18 at the Clinical Care and Governance committee.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board (MIJB) consider and note the report.

3. BACKGROUND

3.1 The Clinical and Care Governance Framework for the MIJB was agreed at the MIJB meeting on 28 April 2016 (para 4 of the minute refers). The arrangements described in the framework are designed to assure the MIJB, NHS Grampian and Moray Council that the quality and safety of services delivered, and the outcomes achieved from the delivery of those services, are the best for the people of Moray.

3.2 The MIJB agreed at its meeting on 31 August 2017 (para 7 of the minute refers) updated Standing Orders for the MIJB and its Committees. A Scheme of Administration, including Care and Clinical Governance Committee, was deemed to form part of these Standing Orders, and this superseded the Clinical and Care Governance Framework.

3.3 The Clinical Governance Committee is responsible for demonstrating compliance with statutory requirements in relation to clinical governance, authorising an accurate and honest annual clinical governance statement and responding to scrutiny and improvement reports by external bodies.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Throughout the 2017/18 financial year, the CCG Committee has held four formal meetings.

4.2 During the financial year 2017/18 the Clinical and Care Governance Committee have:

- considered and approved a Falls Action Plan for Moray;
- considered the consultation on new National Health and Social Care Standards;
- examined adverse events and feedback from Health and Social Care – this is reviewed at every meeting.is scrutinised by the Committee;
- scrutinised Health and Safety workstreams (including a progress report on HSE Improvement Notice work);
- considered the findings of the Joint Inspection of Children's Services in Moray;
- Considered the new Duty of Candour arrangements being implemented from 1st April 2018,
- Considered internal and external audits promoting learning.

4.3 A key item on each CCG Committee are the self-assessments on clinical governance arrangements by all delegated services within Health and Social Care Moray, these have been presented on a rolling programme basis throughout the year. This has supported an in-depth review of quality, safety and improvement activity across the services, giving the committee assurance whilst allowing services the opportunity to showcase good practice and seek further support where challenges were faced.

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

This report forms part of the governance arrangements of Moray Integration Joint Board Strategic Commissioning Plan 2016 - 2019

(b) Policy and Legal

The Moray Integration Scheme requires robust governance arrangements to be in place covering clinical and professional standards, legislation and guidance. This is critical to ensure high quality, safe and effective care across the services directed by the MIJB.

(c) Financial implications

There are no direct financial implications associated with this report

(d) Risk Implications and Mitigation

Moray IJB, Moray Council and NHS Grampian could find themselves exposed to significant risks if good governance is not in place. The purpose being to oversee the processes to ensure that appropriate action is taken in response to adverse events, scrutiny reports/action plans, safety action notices, feedback, complaints and litigation, and those examples of good practice and lessons learned are disseminated widely.

(e) Staffing Implications

There are no staffing implications arising from this report

(f) Property

There are no Property implications arising from this report

(g) Equalities

None directly arising from this report

(h) Consultations

Consultation on this report has taken place with the Chief Officer, MIJB, Chief Financial Officer to MIJB, Legal Services Manager (Licencing and Litigation) and Caroline Howie, Committee Services Officer, Moray Council; who are in agreement with the content of this report as regards their respective responsibilities.

6. CONCLUSION

6.1 This report provides a summary of the business addressed by the Clinical Care and Governance Committee throughout the 2017/18 financial year.

Author of Report: Jeanette Netherwood, Corporate Manager
Background Papers:
Ref:

Signature: Date: 17 April 2018

Designation: Chief Officer Name: Pam Gowans

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 26 APRIL 2018

SUBJECT: STRATEGIC PLAN REVIEW

BY: PAM GOWANS, CHIEF OFFICER

1. REASON FOR REPORT

1.1 To inform the Moray Integration Joint Board of the progress being made with the review of the Strategic Commissioning Plan 2016-2019.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board (MIJB) consider and note that a process for 2018/19 is established that will lead to a full review and new Strategic Commissioning Plan being delivered in 2019 covering the period 2019 – 2022.

3. BACKGROUND

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on Integration Authorities to develop, review, and if necessary replace a Strategic Plan. The first plan was to be in place by 1 April 2016.

3.2 As part of their remit to prepare and implement a Strategic Plan the MIJB established a Strategic Planning Group in April 2015 in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. MIJB is to seek and have regard to the views of its Strategic Planning Group when developing and reviewing its Strategic Plan.

3.3 The MIJB Strategic Plan 2016-19 was approved at the MIJB meeting on 31 March 2016 (para 4 of the Minute refers) and a Strategic Planning & Commissioning Executive Group (SPCEG) established with the remit to develop a high level implementation plan for this (para 5 of the minute refers). The establishment of the SPCEG was agreed by the MIJB with the ongoing wider stakeholders group remaining as the Strategic Planning Reference Group.

3.4 It was agreed that a light touch review on an annual basis throughout the life of the plan be completed to ensure that the intentions remained relevant.

3.5 The SPCEG worked well in supporting the completion of the Strategic Plan 2016-19 and has demonstrated excellent partnership working throughout review and monitoring of the Strategic Plan.

3.6 In a report submitted to the MIJB on 29 June 2017 (paragraph 16 of the Minute refers) it was recommended that a process be established that would lead to a full review of the Strategic Plan and a new plan being delivered in 2019 and beyond.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires integration authorities to review their Strategic Plans every three years as a minimum, an integration authority may choose to review more frequently and/or at a particular point in time.

4.2 MIJB must publish an annual performance report which sets out progress towards the nine National Health and Wellbeing outcomes. The first annual report was published in July 2017 in line with the statutory guidance. The second annual performance report will be published by 31July 2018.

4.3 In addition to the SPCEG, a Strategic Planning Reference Group was established to ensure the public engagement function could be fulfilled. This group includes stakeholders across Health, Social, Independent and Third Sector, commissioned service providers and other members of the public who belong to existing populations groups across Moray. This group has participated in four workshops at key points in the commissioning and monitoring process alongside the strategic Planning Group during 2017/18.

4.4 A light touch review of the existing Strategic Plan was completed in the form of a Strategic Planning group workshop entitled “Reviewing the Plan” on 3 April 2017 at Elgin Town Hall.
The aims of the workshop were to discuss with the wider stakeholder groups:

- What has been achieved so far
- What lessons have been learned
- How to draw on these lessons and plan in the context of the financial landscape
- Future priorities in Moray

4.5 Following the workshop, feedback was summarised in a report to the Strategic Planning and Commissioning Group and the wider Strategic Planning Reference Group.

4.6 A further two workshops in July 2017 and October 2017 considered achievements in two key priority areas – Reshaping Care for Older People and Promoting Community Health and Wellbeing. The aims of both workshops were to reflect on the outcomes for adults and older people, take stock of improvements so far, hear about existing models of care that are emerging in Moray and agree locality planning actions.

4.7 Analysis and review of the tests of change projects undertaken in 2017/18 will be completed during 2018 and highlighted in the annual performance report. The scope of the revised Strategic Plan was considered at an MIJB development session in February 2018. The group completed a joint commissioning strategy implementation planning tool to assess and inform the scope of the revised strategic plan. The report was summarised and shared with the Strategic Planning and Commissioning Executive Group.

4.8 To ensure focus and drive the development of the next Strategic Plan, the role, remit and membership of the SPCEG will be reviewed and any subsequent proposals for amendment will be presented to a future meeting for consideration.

4.9 A programme of work has been agreed by the SPCEG which includes a large amount of commissioning activity to develop a revised Strategic Plan. This includes a full health needs assessment, service mapping across integrated services, review of national strategic policy direction and mapping of services to need and demand.

4.10 A range of workshops at key points in the commissioning process will drive forward the development of the revised Strategic Plan.

4.11 A programme brief will be disseminated across the Strategic Partnership to inform all stakeholders across the organisations ensuring an inclusive and wide ranging engagement in the activities carried out throughout 2018/19. Public involvement will also be a strong requirement in achieving a Plan fit for the future and understood by all as the organisation seeks to achieve transformation of the system.

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

Progress with the Strategic Plan is in line with the national and local agreed priorities and the national health and wellbeing outcomes.

(b) Policy and Legal

None directly arising from this report.

(c) Financial implications

There are no immediate financial implications out with the overall budget position. These implications are reported via the financial reporting system in place for the MIJB. The Strategic Commissioning Plan is the main process by which we will determine the future in line with the budget available and as such is significant in terms of MIJB decision making and budget agreements.

(d) Risk Implications and Mitigation

The oversight of the plan and its review sits with the MIJB who takes account of the views of the Strategic Planning & Commissioning Executive Group and wider stakeholder Reference Group.

(e) Staffing Implications

Significant work will be undertaken to continue with staff engagement and development during the review of the Strategic Plan. The Strategic Plan will also be underpinned by a Workforce Plan that fits with the strategic intent of the plan.

(f) Property

There are no immediate impacts on property as a result of this report however property is an area that will be considered as a full health needs analysis and service mapping is progressed.

(g) Equalities

Tackling inequalities and improving access for those individuals or families who struggle to connect with services and appropriate support is at the heart of what is being aimed to achieve, as it relates to the implementation of legislation designed to improve outcomes for people using health and social care services. The revised Strategic Plan would call for an updated Equalities Impact Assessment and Housing Impact Assessment.

(h) Consultations

Consultations have been undertaken with the following people who agree with the content of this report with regard to their area of responsibility:
Chief Officer, Moray Health and Social Care, Chief Financial Officer and Corporate Manager.

6. CONCLUSION

6.1 The high level Strategic Plan sets out a route map and key activities to take forward the changes in health and social care that will realise the ambitions of the nine national health and wellbeing outcomes.

Author of Report: Sandra Gracie, Strategy Development Officer
Background Papers: with author
Ref:

Signature: _____ Date: 17 April 2018

Designation: Chief Officer Name: Pam Gowans

ITEMS FOR THE ATTENTION OF THE PUBLIC
- DISCUSSION

MORAY INTEGRATION JOINT BOARD

THURSDAY 26 APRIL 2018

CONFIDENTIAL ITEMS

ITEM 16 – FUNDING OF SHOPMOBILITY MORAY

ITEM 17 – FUNDING OF MORAY HANDYPERSON SERVICES

These are confidential items of business to be discussed with the press and public excluded in terms of Section 6.2 of the Moray Integration Joint Board Standing Orders.

These reports contain information which the Chair wishes to be considered in private as the Board is still in the process of developing proposals or its position on the matter and need time for private deliberation.

Should you require clarification or have any queries regarding this item, please contact Committee Services at Moray Council on (01343) 563302.