MORAY INTEGRATION JOINT BOARD THURDSAY 29

JUNE 2017, 9.00AM – 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 29 June 2017** at **9.00am** to consider the business noted below.

Pam Gowans
Chief Officer

22 June 2017

AGENDA

1. Welcome and Apologies
2. Declaration of Member's Interests
3. Minute of the Meeting of the Integration Joint Board (IJB) dated 23 February 2017
4. Action Log of the Meeting of the IJB dated 23 February 2017
5. Minute of the Special Meeting of the IJB dated 30 March 2017
6. Action Log of the Special Meeting of the IJB dated 30 March 2017
7. Minute of the Special Meeting of the IJB dated 27 April 2017
8. Action Log of the Special Meeting of the IJB dated 27 April 2017
9. Minute of the Meeting of the IJB Audit and Risk Sub-Committee dated 15 December 2016
10. Minute of the Meeting of the IJB Clinical and Care Governance Sub-Committee dated 10 February 2017
11. Minute of the Meeting of the IJB Audit and Risk Sub-Committee dated 23 February 2017
12. Chief Officers Report – Report by the Chief Officer

ITEMS FOR APPROVAL

13. Membership of the Integration Joint Board and Committees – Report by the Chief Officer

14. Engagement, Communication and Branding – Report by the Chief Officer

15. Annual Performance Report 2016/17 – Report by the Chief Officer

16. Strategic Plan Review – Report by the Chief Officer

17. Complaints Handling – Report by the Chief Officer

18. Unaudited Annual Accounts – Report by the Chief Financial Officer

ITEMS FOR NOTING

19. Self-Directed Support Residential Care Project Evaluation Report– Report by the SDS Manager

20. Strategic Risk Register as at May 2017 – Report by the Chief Officer

STANDING ITEMS

21. Revenue budget Outturn for 2016/2017 – Report by the Chief Financial Officer

22. Performance Report – Delayed Discharges – Report by the Performance Officer

23. Revenue Budget 2017/18 – Report by the Chief Financial Officer

MEMBERSHIP

VOTING MEMBERS

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

NON-VOTING MEMBERS

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

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

THURSDAY 23 FEBRUARY 2017 at 9.00am

MAIN HALL, ELGIN TOWH HALL, ELGIN

PRESENT

Voting Members

Councillor Lorna Creswell (Vice-Chair)	Moray Council
Mrs Amy Anderson (substitution for Mrs Christine Lester)	Non-Executive Board Member, NHS Grampian
Dame Anne Begg	Non-Executive Board Member, NHS Grampian
Professor Amanda Croft	Executive Board Member, NHS Grampian
Councillor Patsy Gowans	Moray Council

Non-Voting Members

Mr Ivan Augustus	Carer Representative
Ms Pamela Gowans	Chief Officer, Moray Integration Joint Board (MIJB)
Mrs Linda Harper	Lead Nurse, MIJB
Dr Ann Hodges	Registered Medical Practitioner, Non Primary Medical Services, MIJB
Mrs Susan Maclaren	Chief Social Work Officer, Moray Council
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services, MIJB
Mrs Val Thatcher	Public Partnership Forum Representative
Mr Fabio Villani	tsiMORAY
Dr Lewis Walker	Registered Medical Practitioner, Primary Medical Services, MIJB

IN ATTENDANCE

Ms Lesley Attridge	OT & Intermediate Care Service Manager, Moray Council
Mr John Campbell	Provider Services Manager, Moray Council
Mr Graeme Davidson	Housing Strategy & Development Manager, Moray Council
Mrs Margaret Forrest	Legal Services Manager, Moray Council
Mr Darren Westmacott	Committee Services Officer, Moray Council as Clerk to the Board

APOLOGIES

Ms Christine Lester (Chair)	Non-Executive Board Member, NHS Grampian
Councillor Sean Morton	Moray Council
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
Mr Steven Lindsay	Staff Partnership Representative, NHS Grampian
Ms Jane Mackie Mrs	Head of Adult Health and Social Care, Health and Social Care Moray
Margaret Wilson	Chief Financial Officer, MIJB

1.	**CHAIR**
	In the absence of the Chair, Councillor Creswell, in her role as Vice-Chair of the Moray Integration Joint Board (MIJB), assumed the position of Chair.
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 MIJB DATED 10 NOVEMBER 2016**
	The minute of the meeting of the MIJB dated 10 November 2016 was submitted and approved.
4.	**ACTION LOG OF THE MIJB DATED 10 NOVEMBER 2016**
	The Action Log of the MIJB dated 10 November 2016 was discussed and the following points were noted:- Item 1: Dame Anne Begg advised that she had received a response from Mr Paterson on her query regarding housing benefit. Item 2: The Chief Officer (CO) advised that background papers were emailed in advance of the agenda for the Board being issued and noted that this was well received and that the practice would continue. Item 3: The CO advised that Mrs Forrest had updated the appendix. Item 4: The CO confirmed that the Members Handbook and all associated documents had been circulated to Board Members. Item 5: The CO advised that the Vice-Chair had not met with Mrs Mackie and noted that a presentation on the Moray Wellbeing Centre would be arranged for a Development Session. Item 6: The CO advised that she had not progressed the positions of Project Manager and Executive Assistant to permanent positions and that these roles would continue on a temporary basis, due to financial position. Item 8: The CO and Mrs Maclaren advised that discussions were underway on the possibility of a joint convener for both Adult Protection Committee and Child Protection Committee.
5.	**MINUTE OF SPECIAL MEETING OF THE MIJB DATED 26 JANUARY 2017**
	The minute of the special meeting of the MIJB dated 26 January 2017 was submitted and approved.
6.	**ORDER OF BUSINESS**
	The Board agreed to vary the order of business set down on the agenda and take Item 14 'Appointment of Chief Financial Officer (Section 95)' as the next

	item of business as it related to the contents of the minute of the special meeting on the MIJB dated 26 January 2017.
7.	**APPOINTMENT OF CHIEF FINANCIAL OFFIER (SECTION 95)**
	A report was submitted by the CO to consider the appointment of the Chief Financial Officer (Section 95) to the MIJB and the arrangements for recruitment and selection. **Following consideration, the Board agreed to:-** **(i) approve the proposed outline job description for the post of Chief Financial Officer (Section 95) to the MIJB, as set out in Appendix 1 to the report;** **(ii) approve the proposed process for recruitment and selection of a candidate, as detailed in paragraph 4.4 of the report; and** **(iii) establish an Appointments Committee, as set out in paragraph 4.5 of the report.**
8.	**ACTION LOG OF THE MIJB DATED 26 JANUARY 2017**
	The Board noted the Action Log of the MIJB dated 26 January 2017.
9.	**MINUTE OF MEETING OF THE MIJB AUDIT AND RISK SUB-COMMITTEE DATED 24 OCTOBER 2016**
	The Board noted the minute of a meeting of the MIJB Audit and Risk Sub-Committee dated 24 October 2016.
10.	**MINUTE OF MEETING OF THE MIJB CLINICAL AND CARE GOVERNANCE SUB-COMMITTEE DATED 16 SEPTEMBER 2016**
	The Board noted the minute of a meeting of the MIJB Clinical and Care Governance Sub-Committee dated 16 September 2016.
11.	**MINUTE OF MEETING OF THE MIJB CLINICAL AND CARE GOVERNANCE SUB-COMMITTEE DATED 25 NOVEMBER 2016**
	The minute of a meeting of the MIJB Clinical and Care Governance Sub-Committee dated 25 November 2016 was submitted for noting. In response to a query on the Joint Inspection of Children's Services, Mrs Maclaren advised that the Inspectors' report had been published and a report would be submitted to the Moray Community Planning Board on its outcomes. The Board agreed that a copy of the report to the Moray Community Planning Board be submitted to a future meeting of this Board for its information. **Thereafter, the Board agreed to note:-** **(i) the minute of the meeting of the MIJB Clinical and Care Governance Sub-Committee dated 25 November 2016; and** **(ii) that a copy of the report to the Moray Community Planning Board on the outcomes of the Joint Inspection of Children's Services would be submitted to a future meeting of the Board for its information.**
12.	**PROPOSED CHANGES TO MIJB MEETINGS DATES**
	A report was submitted by the CO to seek approval of a revision to the schedule of meetings of the MIJB, Clinical and Care Governance Sub-Committee and the Audit & Risk Sub-Committee.

	Following consideration, the Board agreed to:- **(i) endorse the revised schedule of meetings of the MIJB and Clinical & Care Governance Sub-Committee for 2017, as set out in Appendix 1 of the report; and** **(ii) approve the revised schedule of meetings of the MIJB Audit & Risk Sub-Committee for 2017, as detailed in paragraph 4.3 and Appendix 1 of the report.**
13.	**CHIEF OFFICER'S UPDATE**
	A report was submitted by the CO to provide the Board with an update on the current position within the MIJB and Health and Social Care Moray, projects, good news stories and management updates. **Following lengthy discussion, the Board agreed to note the CO's update on MIJB and Health and Social Care Moray.**
14.	**SHARED LIVES – LONG-TERM PLACEMENT PAYMENTS**
	A report was submitted by the Head of Adult Health and Social Care to inform the Board of the proposed payment rates for Long-Term Placements within the Shared Lives Service. Mr John Campbell, Provider Services Manager presented the report. Significant discussion took place around Share Lives, both in relation to the report and long term placements, but the wider understanding of this approach in short term placements also. Board Members were very interested in the detail of this approach and the potential for the future. Mrs Amy Anderson sought clarity on how this approach was monitored and received to which the Provider Services Manager was able to describe the detail. Dame Anne Begg expressing her interest and sought clarity on a number of accounts. Mrs Susan Maclaren queried the rigor and standards applied, offering the experience of fostering from children's services. The Provider Services Manager acknowledged that they had adopted much of the guidance from children's services and adapted to suite this adult services approach. It was acknowledged by the Board as an exciting and new approach that would be worthy of close monitoring to see the impacts and understand better the potential for the future. The Provider Services Manager highlighting this approach as one of a number of approaches and the importance of matching to those individuals who find this a preference to more traditional routes of care. In response to a query from Dame Anne Begg, the Provider Services Manager advised Board Members who were interested in meeting carers and management involved with long-term placements within Share Lives Services to contact him. **Following lengthy discussion, the Board agreed to:-** **(i) approve the proposed payment rates for Long-Term Placements within the Shared Lives Service, as set out in paragraph 4.6 of the report;** **(ii) direct the Moray Council accordingly; and** **(iii) note that any Board Member interested in meeting carers and management involved with long-term placements within Share Lives Services should contact the Provider Services Manager.**

15.	**ENGAGEMENT, COMMUNITCATIONS AND BRANDING**
	A report was submitted by the CO to inform the Board of the intention to develop a Communications and Engagement Strategy, to provide an update on the work being undertaken to develop a website for the MIJB and to ask the Board to formally note the MIJB's approval to use the logo, with a further report to the next MIJB meeting, setting out guidance for broader use across teams. The CO highlighted that to fully implement the use of the logo, guidance was being developed that ensured clarity alongside the NHS logo use and Council logo use and that this guidance will come to the Board in due course. Mr Villani requested that a copy of Platform PR's feedback report be circulated to Board Members for their information. The CO agreed to circulate a copy of the report. **Thereafter, the Board agreed to note:-** **(i) the findings of the communications report conducted by Platform PR and that the CO would circulate a full copy of Platform PR's feedback report to Board Members;** **(ii) the development of a Communications and Engagement Strategy, as detailed in Sections 3 and 4 of the report;** **(iii) that the draft strategy and associated action plan will be submitted to the next meeting of the MIJB;** **(iv) the development of a MIJB website, as detailed in paragraphs 3.5 and 4.5 of the report; and** **(v) the formal approval for use of the MIJB logo, as set out in paragraph 4.7 of the report, with a further report setting out guidance for broader use to be brought to the next meeting.**
16.	**ADAPTIONS**
	A report was submitted by the Head of Adult Health and Social Care to inform the Board of the establishment of an Adaptations Governance Group and the group's remit to oversee amendments to the Adaptations Process, which is the responsibility of the MIJB. Mrs Lesley Attridge, OT & Intermediate Care Service Manager presented the report. Mrs Margaret Forrest advised the Board that the recommendations of the report had been amended and the Board were now required to consider whether to establish an Adaptations Governance Group as part of the Board's Strategic Planning and Commissioning Framework and approve the Group's membership, role and remit, as detailed in Section 4 and Appendix 1 of the report. A number of questions were posted by the Board seeking to understand the detail of Aids and Adaptations budgets and service delivery, particularly the relationship with Housing. The OT & Intermediate Care Service Manager was able to give full assurance and examples of the close working relationship that exists with housing and a reminder of the OT post that is jointly funded by resources of the MIJB and the Housing Department of the Council. The CO, noting comments made by the Board, suggested that delegation be given to the CO to revise the Role & Remit of the Adaptations Governance Group, as set out in Appendix 1, to be more extensive and circulate the amended version to the Board for their information. This was agreed by the Board.

	Thereafter, the Board agreed:- **(i) to establish an Adaptations Governance Group as part of the Board's Strategic Planning and Commissioning Framework;** **(ii) the membership of the Adaptations Governance Group, as set out on paragraph 4.2 of the report; and** **(iii) to delegate authority to the CO to revise the Role & Remit of the Adaptations Governance Group to be more extensive and circulate the amended version to the Board for their information.**
17.	**NATIONAL HEALTH AND SOCIAL CARE DELIVERY PLAN & MEASURING PERFORMANCE UNDER INTEGRATION**
	A report was submitted by the CO to inform the Board of the publication of the National Health and Social Care Delivery Plan and the request from the Ministerial Steering Group for Health and Social Care Partnerships to measure objectives demonstrating progress against 6 key indicators. The CO clarified some of the anxieties that had been expressed in relation to the Scottish Government Ministerial Strategic Group seeking to monitor performance reporting across IJBs nationally. This related particularly to governance as the IJBs are accountable to the public and there is no provision that requires reporting to this group. The CO noted that at the recent national COs meeting this was discussed with the Scottish Government representatives and the consensus was that this was not a request to performance report but an attempt by the Ministerial Steering Group to establish a view as to whether integration was having the desired effect in shifting the balance of care and improving outcomes overall. The COs nationally were of a mind to recommend engagement in this request, noting the governance protocol. The CO confirmed that objectives were under development in relation to the 6 key indicators, noting that these were routinely monitored locally as the moment, so not a new activity for Moray. **Following discussion, the Board agreed to:-** **(i) note the publication of the National Health and Social Care Delivery Plan;** **(ii) note that an update will be provided at a future meeting on the implications on the Strategic Plan for Moray; and** **(iii) measure performance against the 6 key indicators, as set out at paragraph 1.2 of the report.**
18.	**SURVEY TO MIJB AND SUB-COMMITTEE MEMBERS**
	A report was submitted by the CO to inform the Board of the findings from a recent survey issued to members of the MIJB and its Sub-Committees (Clinical & Care Governance, Audit & Risk and Development Sessions) and to request that the consider any action required as a consequence of the survey findings. Mrs Maclaren left the meeting during consideration of this item. In response to a number of queries from the Board, the CO agreed to add the survey and the possibility for 'open sessions' at meetings of the MIJB to the agenda of a Development Session for discussion. **Following discussion, the Board agreed to:-**

	(i) note the survey findings, as detailed in Appendix 1 of the report; **(ii) note that the survey and the possibility for 'open sessions' at meetings of the MIJB will be added to the agenda of a Development Session for further discussion; and** **(iii) undertake a subsequent follow-up survey in October 2017.**
19.	**ANNUAL PERFORMANCE REPORT**
	A report was submitted by the CO to inform the Board of the progress being made in the development of MIJB's Annual Performance Report. The CO advised on the detail and process of achieving the annual performance report that must be published by July 2017 at the latest, noting that they will see versions of this prior to the request for final sign off at the June 2017 Board meeting **Following consideration, the Board agreed to note the:-** **(i) progress being made regarding the development of the 2016/17 Annual Performance Report, as detailed in Sections 3 and 4 of the report; and** **(ii) draft performance report will be submitted the June 2017 meeting of the Board for approval, prior to publication in July 2017.**
20.	**REVENUE BUDGET MONITORING QUARTER 3 FOR 2016/2017**
	A report was submitted by the Chief Financial Officer to update the Board on the current Revenue Budget reporting position as at 31 December 2016 and an estimated provisional forecast position for the year end for the MIJB core budgets. **Following consideration, the Board agreed to note the:-** **(i) financial position of the Board, as at 31 December 2016, is showing an overspend of £0.562 million, as set out in Appendix 1 of the report;** **(ii) estimated out-turn for 2016/17 is an overspend of £1.451million;** **(iii) revisions to staffing arrangements dealt with under delegated powers for the period 1 Oct to 31 December 2016, as detailed in Appendix 3 of the report; and** **(iv) actions being taken by the Senior Management Team (SMT) to address the deficit and budget pressures, as detailed in Sections 4 and 5 of the report.**
21.	**EXCEPTION REPORT : IMPROVING THE PUBLIC`S HEALTH AND REDUCING INEQUALITIES TARGETS AND STANDARDS 2016 -17**
	A report was submitted by Mrs Tracey Gervaise, Health and Wellbeing Lead (NHS Grampian) to inform the Board of the current local position against NHS Grampian's Improving the Public's Health and Reducing Inequalities Targets and Standards. **Following discussion, the Board agreed to:-** **(i) note the current position in Moray against NHS Grampian's Improving the Public's Health and Reducing Inequalities Targets and Standards; and** **(ii) support the actions identified so to mitigate, where appropriate, the underperformance of targets and standards.**

22.	**DATE OF NEXT MEETING**
	Next Development Session Thursday 30 March 2017, 10:30am to 3:00pm, Supper Room, Town Hall, Elgin Next Board Meeting Thursday 30 March 2017, 9:00am to 10:00am, Supper Room, Town Hall, Elgin

MEETING OF MORAY INTEGRATION JOINT BOARD
THURSDAY 23 FEBRUARY 2017

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Background Papers	Chief Officer (CO) to continue to circulate background papers by email in advance of the agenda for the Board being issued.	Ongoing action	CO
2.	Moray Wellbeing Centre	Mrs Mackie to provide a presentation on the Moray Wellbeing Centre to a future Development Session.	June 2017	Mrs Mackie/CO
3.	Joint Convener for Adult Protection Committee and Child Protection Committee	CO and Mrs Maclaren to continue discussions on the possibility of a joint convener for both Adult Protection Committee and Child Protection Committee.	April 2017	CO/Mrs Maclaren
4.	Joint Inspection of Children's Services	Mrs Maclaren to submit a copy of the report to the Moray Community Planning Board on the Inspectors' report and its outcomes to a future meeting of the MIJB for its information.	June 2017	Mrs Maclaren
5.	Long-Term Placement Payments in Shared Lives Service	Board Members to contact the Provider Services Manager if they are interested in meeting carers and management involved with long-term placements within Share Lives Services.	March 2017	MIJB/Provider Services Manager
6.	Platform PR	CO to circulate full copy of Platform PR's feedback report on communications and engagement to Board Members.	March 2017	CO
7.	Adaptations Governance Group	CO to revise the Role & Remit of the Adaptations Governance Group to be more extensive and circulate the	June 2017	CO

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
		revised version to the Board for their information.		
8.	MIJB Survey and 'Open Sessions'	CO to include the recent MIJB Survey and the possibility for 'open sessions' at meetings of the Board on the agenda for a future Development Session.	June 2017	CO
9.	Date of Next Meeting	Next Development Session Thursday 30 March 2017, 10:30am to 3:00pm, Supper Room, Town Hall, Elgin Next Board Meeting Thursday 30 March 2017, 9:00am to 10:00am, Supper Room, Town Hall, Elgin		Clerk

MINUTE OF SPECIAL MEETING OF THE MORAY INTEGRATION JOINT BOARD

THURSDAY 30 MARCH 2017, 9.00AM

LOUNGE, TOWH HALL, ELGIN

PRESENT

Voting Members

Ms Christine Lester (Chair)	Non-Executive Board Member, NHS Grampian
Councillor Lorna Creswell (Vice-Chair)	Moray Council
Dame Anne Begg	Non-Executive Board Member, NHS Grampian
Councillor Patsy Gowans	Moray Council
Councillor John Divers substituting for Councillor Sean Morton	Moray Council

Non-Voting Members

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
Ms Pamela Gowans	Chief Officer, Moray Integration Joint Board
Mrs Linda Harper Dr	(MIJB) Lead Nurse, MIJB
Ann Hodges	Registered Medical Practitioner, Non Primary Medical Services, MIJB
Mr Steven Lindsay	Staff Partnership Representative, NHS
Mrs Susan Maclaren	Grampian Chief Social Work Officer, Moray
Mrs Val Thatcher Mr	Council Public Partnership Forum
Fabio Villani Dr	Representative tsiMORAY
Lewis Walker	Registered Medical Practitioner, Primary Medical Services, MIJB
Mrs Margaret Wilson	Chief Financial Officer, MIJB

IN ATTENDANCE

Mrs Margaret Forrest	Legal Services Manager (Litigation and Licensing), Moray Council
Councillor Gordon	Moray Council
McDonald Mr David Pfleger (Item 3 Only)	Director of Pharmacy & Medicines Management, NHS Grampian
Mr Sandy Thomson (Item 3 only)	
Mrs Caroline Howie	Committee Services Officer, Moray Council as Clerk to the Board

ALSO PRESENT

Councillor Gordon McDonald	Moray Council

APOLOGIES

Professor Amanda Croft	Executive Board Member, NHS Grampian
Councillor Sean Morton	Moray Council
Ms Jane Mackie	Head of Adult Health and Social Care, Health and Social Care Moray
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services, MIJB

1.	**DECLARATION OF MEMBERS' INTERESTS**
	Mr Villani declared he had sent in his nomination papers to stand at the forthcoming Local Government elections and that he had updated his Register of Interests accordingly. There were no other declarations of Members' interests in respect of any item on the agenda.
2.	**REVENUE BUDGET 2017/18**
	A report was submitted by the Chief Financial Officer outlining the budget allocations to the Moray Integration Joint Board (MIJB) for consideration of the revenue budget for 2017/18 and the estimated funding gap. Lengthy discussion took place around the challenges being faced due to the gap in funding that has emerged since the December 2016 spending review outcome. It was noted that both NHS Grampian and Moray Council had taken action around budgets in line with the options open to them; this had resulted in a significant reduction proportionate to the overall budget. This will pose significant challenges for service delivery and decision making going forward for the Board. The Chief Officer (CO) advised she had met with the Chief Executives (CE) of the parent bodies (Moray Council and NHS Grampian) to discuss the changes in funding and she suggested that by June there would be a better understanding of what can be achieved with the funding available. It was recognised that a radical change is required to how work is currently carried out. The CO noted that the ability to achieve a balanced budget was in question for 2017/18 but committed to take all actions possible to achieve this. The CE of the parent bodies have committed to working closely with the CO to resolve this. Significant concern was expressed by the Board and the CFO recommended an acceptance of the budget as a working budget to allow operations to continue uninterrupted and to consider the savings plan being produced and put to the MIJB in June 2017. The Legal Services Manager (Litigation and Licensing) advised that the recommendation at 2.1 vi) of the report would require to be amended as new Directions would need to be issued in light of the new budget. **Thereafter the Board agreed:** **(i) to note the due diligence process that has been undertaken as part of the budget setting process;**

	(ii) to approve the proposed savings detailed in paragraph 6.1.1 of the report; **(iii) to accept that the Revenue Budget for 2017/18, as detailed in appendix 1 of the report, will be used as a working document to allow services to continue to be delivered and a robust recovery plan to be developed;** **(iv) to task the Chief Officer with her senior managers to identify further savings and to work with Moray Council and NHS Grampian to seek additional funding or agree de-commissioning of services;** **(v) that progress reports on reducing the funding gap will be a regular item on the Board's agenda; and** **(vi) that Directions to Moray Council and NHS Grampian to provide services for the forthcoming financial year be issued with indicative budget figures to allow those services to continue without disruption and to acknowledge that new Directions will be submitted for approval when revised figures are agreed.**
3.	**PRESCRIBING BUDGETS**
	Under reference to paragraph 13 of the Minute of the MIJB dated 10 November 2016 a report was submitted by the Chief Officer providing information in relation to actions being taken, or planned, by the Executive Team to address the identified risks. Mr Pfleger presented the report, outlining how it had been produced and reviewing the salient points for discussion. It was stated that the use of branded products versus generic products where the evidence supports that there is no material impact on outcomes for people should be considered as the standard for use and that the MIJB should support General Practice to implement this as routine practice. It was further stated that in some instances it is substantially cheaper to buy products over the counter in pharmacies rather than having them issued on prescription. It was agreed that work would be required to educate the general public in this area and consideration needs to be given to how this can be communicated and supported locally to spread the message. The MIJB was also asked to consider the predicted spend and cost pressures and to agree whether the Board were content to accept the budget based on the forecasting or would they wish to take an alternative position. It was confirmed that the Board would accept the forecast as set out in the report. Councillor Creswell noted that the report was too detailed and for Board members provided information that required more technical understanding to be able to translate. It was acknowledged by the CO that this would be taken into account for future reports, Mr Pfleger confirming that for this year he had maintained the previous approach to reporting but was willing to work with the Board in the future to meet the requirements in terms of appropriate information for the Board members in aiding their decision making.

	Following consideration, the Board agreed to: **(i) note the 2017/18 budget for primary care prescribing at £17,288k plus £307k for medicines use in community hospitals and community services;** **(ii) follow an assertive approach in pursuing medicines efficiencies including maximising the use of generic medication and removing patient choice for the branded product where not clinically indicated;** **(iii) acknowledge the level of financial risk associated with the underlying assumptions used to predict budget need and the influence of external factors to medicines use; and** **(iv) acknowledge the level of financial risk associated with the assumptions of achieving the maximal savings used in the budget assessment, especially relating to Pregabalin for the 2017/18 financial year which presents the biggest savings opportunity and therefore risk to the MIJB prescribing budget.** Mr Augustus entered the meeting during discussion of this item.
4.	**PROPOSED DELEGATION – AMPUTEE REHABILITATION**
	A report was submitted by the Chief Officer seeking agreement in principle to the proposal for the Aberdeen Health and Social Care Partnership to host Amputee Rehabilitation on behalf of the MIJB alongside the other two North East Integration Joint Boards (Aberdeenshire and Aberdeen City) for which change to the MIJB Integration Scheme hosting arrangements would be required should this be agreed in principle. During discussion on the benefits of Aberdeen Integration Joint Board hosting this service on behalf of the other Integration Joint Boards it was agreed a further report would be brought to the Board later in the year setting out the Moray picture and aspirations for the future. **Thereafter the MIJB agreed:** **(i) in principle that the future delegation of Amputee Rehabilitation services to the Moray IJB with Aberdeen City Health and Social Care Partnership hosting the service on behalf of the three North East IJBs would be appropriate, on the basis that adequate and sustained Resource Transfer for this service and additional staffing will be made available by NHS Grampian;** **(ii) to acknowledge that there is a requirement that all three North East IJBs agree to this proposed delegation and hosting arrangement and note that the report had been presented to the Aberdeen City IJB on 31 January 2017 and the Aberdeenshire IJB on 22 March 2017;** **(iii) to remit to officers to finalise the business case and resource transfer element and to bring the final costings and Resource Transfer agreement to the Board meeting in June to seek final approval in principle;**

	(iv) to note the Integration Scheme will need to be amended, in consultation with Legal Services colleagues and the Scottish Government, and the hosting agreement amended in consultation with Legal Services colleagues and the other IJBs should the delegation of Amputee Rehabilitation be given final approval in principle when it returns to the Board in June; **(v) a future report on Amputee Rehabilitation being brought before the Board.** Mrs Maclaren entered the meeting during discussion of this item.

SPECIAL MEETING OF MORAY INTEGRATION JOINT BOARD

THURSDAY 30 MARCH 2017

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
2.	Revenue Budget 2017/18	Senior managers to identify further savings and to work with Moray Council and NHS Grampian to seek additional funding or agree de-commissioning of services. Progress report on reducing the funding gap to be a regular item on the agenda. Issue interim directions and Submit new Directions for approval when revised figures are agreed.	June 2017 June 2017 March 2017 & June 2017	CO CO CO
4.	Proposed Delegation – Amputee Rehabilitation	Officers to finalise the business case and resource transfer element and to bring the final costings and Resource Transfer agreement to the Board meeting in June to seek final approval in principle. Further report on Amputee Rehabilitation to be taken to a future meeting.	TBC TBC	CO CO

MINUTE OF SPECIAL MEETING OF THE MORAY INTEGRATION JOINT BOARD

THURSDAY 27 APRIL 2017 AT 9:30 AM

INKWELL MAIN, ELGIN YOUTH CAFÉ

PRESENT

VOTING MEMBERS

Ms Christine Lester (Chair)	Non-Exec Board Member, NHS Grampian
Councillor Lorna Creswell (Vice-Chair)	Moray Council
Dame Anne Begg	Non-Exec Board Member, NHS Grampian
Councillor John Divers substituting for Councillor Sean Morton	Moray Council
Councillor Patsy Gowans	Moray Council

NON-VOTING MEMBERS

Mr Ivan Augustus	Carer Representative
Mr Sean Coady	Interim Hosted Services Manager, Moray Health and Social Care Partnership
Ms Pam Gowans	Chief Officer, Moray Integration Joint Board
Mrs Linda Harper	Lead Nurse, Moray Integration Joint Board
Dr Ann Hodges	Registered Medical Practitioner, Non Primary Medical Services
Mr Steven Lindsay	NHS Grampian Staff Partnership Representative
Mrs Susan Maclaren	Chief Social Work Officer, Moray Council
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services
Mrs Val Thatcher	PPF Representative
Mr Fabio Villani	tsiMoray

IN ATTENDANCE

Sean Hoath (Item 3 only)	Senior Solicitor, Moray Council
Alison Morris (Item 3 only)	Records and Heritage Manager, Moray Council
Margaret Bruce (Item 4 only)	Audit Scotland
Mrs Caroline Howie	Committee Services Officer, Moray Council as Clerk to the Board

APOLOGIES

Professor Amanda Croft	Exec Board Member, NHS Grampian
Councillor Sean Morton	Moray Council
Ms Jane Mackie	Interim Joint Operational Manager (Adult Services), Moray Health and Social Care Partnership
Dr Lewis Walker	Registered Medical Practitioner, Primary Medical Services

1.	**TRIBUTE TO COUNCILLORS**
	This being the last meeting of the Board prior to the Local Government Elections in May 2017 the Chair paid tribute to the Councillors for their contributions to the Board during their term of office and wished those standing for re-election best wishes on the day.
2.	**DECLARATION OF MEMBERS' INTERESTS**
	There were no declarations of Members' interests in respect of any item on the agenda.
3.	**FREEDOM OF INFORMATION (SCOTLAND) ACT 2002 – THE INTEGRATION JOINT BOARD'S PUBLICATION SCHEME**
	A report was submitted by the Chief Officer informing the Board of the duty to produce and publish a Publication Scheme and inviting it to consider and approve a new draft scheme. Discussion took place on the requirements of Freedom on Information (FOI) requests and the process to be followed. It was stated that most FOI requests were operational and would be dealt with under either Moray Council or NHS Grampian schemes. In response to a query the Records and Heritage Manager advised that any requests received that came under NHS Grampian would not be forwarded to NHS Grampian but would be returned to the requester with information on where they should send their request; this is due to strict deadlines for responses. It was advised that any requests for information already in the public domain are replied to with details on where the information can be found. **Following discussion the Board agreed to:** i) note the requirement to adopt a new Publication Scheme before 28 April 2017; ii) approve the draft Model Publication Scheme 2017 attached at Appendix 1 of the report; iii) instruct officers to submit the Draft to the Scottish Information Commissioner for approval and deal with any required amendments, publication and updating of the web pages; iv) approve the draft policy and arrangements for dealing with requests for information from the Integration Joint Board under FOI and Environmental Information (Scotland) Regulations 2004 (EIR) legislation attached at

	Appendix 2 of the report; and v) note the requirement to publish statistics on the number of requests for information under FOI and EIR legislation.
4.	**EXTERNAL AUDIT PLAN FOR THE YEAR ENDING 2016/17**
	A report by the Chief Financial Officer informed the Moray Integration Joint Board (MIJB) of the External Auditor's Annual Plan for 2016/17. It was stated that the Audit Plan would usually be presented to the Audit and Risk Sub-Committee however the external auditor had sought the opportunity to meet with the Board and therefore the Plan was being presented for consideration. The Plan was discussed and general queries were raised in order to gain an understanding of how the Plan was produced. **Thereafter the Board agreed to** note the contents of the External Auditor's Annual Plan for 2016/17.

SPECIAL MEETING OF MORAY INTEGRATION JOINT BOARD

THURSDAY 27 APRIL 2017

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
3.	Freedom of Information (Scotland) Act 2002 – The Integration Joint Board's Publication Scheme	Officers to submit the Draft Model Publication Scheme 2017 to the Scottish Information Commissioner for approval and deal with any required amendments, publication and updating of the web pages.		

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

AUDIT AND RISK SUB-COMMITTEE

THURSDAY 15 DECEMBER 2016

CONFERENCE ROOM, ALEXANDER GRAHAM BELL CENTRE, MORAY COLLEGE, ELGIN

PRESENT

VOTING MEMBERS

Councillor Sean Morton (Chair)	Moray Council
Dame Anne Begg	Non-Executive Board Member, NHS Grampian
Professor Amanda Croft	Executive Board Member, NHS Grampian
Councillor Patsy Gowans	Moray Council

NON-VOTING MEMBERS

Mr Steven Lindsay	NHS Grampian Staff Partnership Representative
Mr Fabio Villani	tsiMoray

IN ATTENDANCE

Ms Pam Gowans	Chief Officer, Moray Integration Joint Board
Mr Atholl Scott	Chief Internal Auditor, Moray Integration Joint Board
Mrs Caroline Howie	Committee Services Officer, Moray Council as Clerk to the Board

ALSO PRESENT

Ms Christine Lester	Chair, Moray Integration Joint Board

APOLOGIES

Mrs Margaret Wilson	Chief Financial Officer, Moray Integration Joint Board

1.	**WELCOME**
	The Chair welcomed everyone and apologised for the delay in holding the first quorate meeting of the Audit and Risk Sub-committee.

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 SUB-COMMITTEE DATED 24 OCTOBER 2016**
	The minute of the meeting of the Moray Integration Joint Board sub-committee dated 24 October 2016 was submitted for approval. Under reference to the attendance it was noted that all members had been listed as voting members; this is required to be changed to voting and non-voting members. With this change the minute was agreed.
4.	**TERMS OF REFERENCE**
	Under reference to paragraph 6 of the Minute of the Moray Integration Joint Board on 31 March 2016 a report by the Chief Officer (CO) asked the sub-committee to consider the Terms of Reference for the sub-committee. **The sub-committee agreed** to adopt the Terms of Reference as presented.
5.	**INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN 2016/17**
	Under reference to paragraph 6 of the Minute of the Moray Integration Joint Board dated 25 August 2016 a report by the Chief Internal Auditor (CIA) asked the sub-committee to consider the internal audit plan for the 2016/17 year for the IJB, in the context of separate internal audit plans and arrangements applicable to the Health Board and Local Authority. Mr Lindsay entered the meeting during discussion of this item. The CIA advised that priorities across NHS and Moray Council would need to be consolidated into one plan for next year, possibly to include jointly funded activities. During discussion Dame Anne sought clarification on who should decide which risk priorities would be included in the Audit Plan. The CIA advised it was for the Board to give direction however he and his team could offer guidance and suggested he submit a further report in February. **Thereafter the sub-committee agreed to**: i) note the content of the report; and ii) request a further report to the meeting in February.
6.	**RISK POLICY**
	Under reference to paragraph 10 of the Minute of the Moray Integration Joint Board (IJB) dated 28 April 2016 a report by the Chief Officer (CO) advised the sub-committee of the IJB Risk Policy. Mr Villani sought a change in the risk policy relating to the Board members responsibilities. Mr Lindsay sought a change to the wording on page 6 of the document, under the heading of staff, as not all staff of Moray Council and NHS Grampian have an involvement in the IJB.

	On discussion the CO acknowledged that there was some further work, in particular relating to the need to introduce a risk appetite statement, following the workshop led by Zurich. The CO undertook to amend the wording appropriately and review the need for an appetite statement. **Thereafter the sub-committee agreed to**: i) note the content of the Risk Policy; and ii) the CO to amend the policy in line with comments from the sub-committee.
7.	**RISK REGISTER**
	Under reference to paragraph 8 of the Minute of the Moray Integration Joint Board (IJB) dated 31 March 2016 a report by the Chief Officer (CO) advised the sub-committee of the IJB Risk Register. The CO advised that some risks had reduced from a red category and the risk register would be reviewed on an ongoing basis. In response to a query from Dame Anne the CO advised the risk register would be presented at every meeting of the sub-committee and that a cover report noting the changes would be prepared in order that members could track reductions, increases and new risks. **Thereafter the sub-committee agreed to**: i) note the risk register; and ii) that the risk register would be presented, along with a covering report, at every meeting of the sub-committee.
8.	**DATE OF FUTURE MEETINGS**
	Discussion took place on the frequency of future meetings. **The sub-committee agreed** to hold the next meeting at 1pm on 23 February 2017, following the Board meeting being held that morning. Thereafter meetings are to be held monthly at 1pm following either a development session or Board meeting.

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE SUB-COMMITTEE

FRIDAY 10 FEBRUARY 2017

ROOM 2, SPYNIE DENTAL CENTRE, ELGIN

PRESENT

VOTING MEMBERS

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

NON-VOTING MEMBERS

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

IN ATTENDANCE

Mr Sean Coady	Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services, Health and Social Care Moray
Mrs Liz Tait	Professional Lead for Clinical Governance and Interim Head of Quality Governance and Risk Unit
Ms Fiona Abbott (Item 13 only)	Community Hospital Manager
Ms Debbie Barron	Clinical Quality Facilitator
Mr John Campbell (Items 10 & 11 only)	Provider Services Manager
Mrs Caroline Howie	Committee Services Officer, Moray Council as Clerk to the Sub-Committee

APOLOGIES

Mr Ivan Augustus	Carer Representative
Dr Ann Hodges	Moray Integration Joint Board Secondary Care Advisor
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

1.	**DECLARATION OF MEMBERS' INTERESTS**

	There were no declarations of Members' interests in respect of any item on the agenda.
2.	**MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE SUB-COMMITTEE DATED 25 NOVEMBER 2016**
	The minute of the meeting of the Moray Integration Joint Board Clinical and Care Governance Sub-Committee dated 25 November 2016 was submitted and approved.
3.	**ACTION LOG DATED 25 NOVEMBER 2016**
	The Action Log of the Moray Integration Joint Board Clinical and Care Governance Sub-Committee dated 25 November 2016 was discussed. Under reference to item 1 of the action log 'Care Inspectorate Reports, National Care Standards' it was noted that a report was not being presented at this meeting as the work was still on-going. **The Sub-Committee agreed** to seek a report to a future meeting following conclusion of the inspection. Under reference to item 2 of the action log 'Falls Action Plan' the Chief Officer (CO) advised it that due to the significant workload involved it had not been possible to provide a report to this meeting. **The Sub-Committee agreed** to the report being deferred until the meeting in May 2017. Under reference to item 3 of the action log 'Adverse Event Reporting' the CO advised a written report was not available however Ms Abbott, Community Hospital Manager would be in attendance later in the meeting to speak on this.
4.	**REVIEW OF ROLE, REMIT AND FRAMEWORK OF MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE SUB-COMMITTEE**
	A verbal update by the Chief Officer (CO) informed the Sub-Committee of the requirement to review the framework. The CO advised of the intention to have the Operational Management Team review paperwork, processes and communications and to issue guidance to staff. **Thereafter the Sub-Committee agreed** to a report on progress being presented to the next meeting.

QUARTERLY SUMMARY REPORT ON EXTERNAL REPORTS, AUDITS AND REVIEWS FOR MORAY

5.	**RE-AUDIT OF G-MED PRACTITIONERS' CONSULTATIONS**
	A report by Mrs Harper informed the Sub-Committee of the audit carried out of the services. She advised the audit was completed annually and the outcome informed the content for future audits. **Following discussions the Sub-Committee agreed** to note the content of the audit. Ms Tait entered the meeting at this juncture.

6.	**JOINT INSPECTION CHILDREN'S SERVICES UPDATE**
	A verbal report by Mr Coady informed the Sub-Committee of the ongoing joint inspection of children's services. He advised the report by the Care Inspectorate is due to be issued on 16 February. **Following discussion the Sub-Committee agreed** to seek a report for noting to the next meeting following issue of the report.
7.	**ORDER OF BUSINESS**
	Due to the meeting progressing through reports quicker than envisaged the meeting agreed to vary the order of business as set down on the Agenda and take Item 11 "Health and Safety Executive Inspection – July 2016" and Item 12 "Hospital Standardised Mortality Ratios Data" as the next two items of business in order to allow the Provider Services Manager to be in attendance for Item 8 of the Agenda "Review of Clinical and Care Governance Arrangements – Care at Home".

QUARTERLY SUMMARY OF EXTERNAL REPORTS/GUIDELINES/REVIEWS RELEVANT TO MORAY BUT NOT SPECIFICALLY ABOUT MORAY

8.	**HEALTH AND SAFETY EXECUTIVE INSPECTION – JULY 2016**
	Mrs Tait provided the Sub-Committee with a verbal update on the Health and Safety Executive Inspection for NHS Grampian of July 2016. She advised several areas had been covered during the inspection e.g. sharps, falls, manual handling. Those classed as 'wet workers' i.e. workers who have to wash their hands more than 20 times each day, undergo skin surveillance on a 6-monthly basis to guard against skin issues. **Following discussion the Sub-Committee agreed** to seek a local written report for noting in May, with any concerns being highlighted for consideration.
9.	**HOSPITAL STANDARDISED MORTALITY RATIOS DATA**
	Mrs Tait provided the Sub-Committee with a report on Hospital Standardised Mortality Ratios which included information on Dr Gray's Hospital in Elgin and Aberdeen Royal Infirmary as a comparator. She advised there had been a higher number of deaths than predicted however reassured the Sub-Committee it was not a large number and work was being undertaken to review this. **Following discussion the Sub-Committee agreed** to note the report. Mr Campbell entered the meeting at this juncture.

QUARTERLY SUMMARY REPORT ON EXTERNAL REPORTS, AUDITS AND REVIEWS FOR MORAY

10.	**MORAY AUTISM STRATEGY DEVELOPMENT**
	A report by Mr Campbell informed the Sub-Committee on performance and delivery of the Moray Autism Strategy and Delivery Plan. He advised funding was due to stop in March 2017 for the Autism Development Co-ordinator post and that without additional resource it would not be possible to continue with the Strategy and Delivery Plan.

	During discussion it was queried if harm would be done if this was no longer being delivered, however it was advised that the Co -ordinator had left post in late 2016 and not been replaced and that there was no apparent impact. There was further discussion on the next steps and it was advised this would be reported to the Strategic Planning Board, followed by a report to the Moray Integration Joint Board and thereafter a further report would be presented to this Sub-Committee in August 2017. **Thereafter the Sub-Committee agreed** to a further report being presented in August 2017. Ms Abbott entered the meeting during discussion of this item.

SELF-ASSESSMENT REPORTS TO THE INTEGRATION JOINT BOARD

11.	**REVIEW OF CLINICAL AND CARE GOVERNANCE ARRANGEMENTS – CARE AT HOME**
	Mr Campbell provided the Sub-Committee with a report on the self-assessment of the Review of Clinical and Care Governance Arrangements – Care at Home. It was agreed this was a comprehensive report however it was felt detail was not required but rather an overview of progress; including the escalation of issues. Mr Campbell advised staff retention rates were improving and the service was now operating with smaller teams across Moray. **Thereafter the Sub-Committee agreed** to note the information provided. Mr Campbell left the meeting at this juncture. The Chief Officer left the meeting during discussion of this item.
12.	**COMMUNITY HOSPITALS**
	Ms Abbott provided the Sub-Committee with a report on the self-assessment of Community Hospitals. She advised a 'wound champion' had been developed within each hospital and training on wound management was being undertaken. A Standard Operating Procedure had been introduced for dealing with staff sickness which was helping to minimise the use of bank staff, therefore reducing costs. **Following discussion the Sub-Committee agreed** to note the report.

ADVERSE EVENTS REPORTING

13.	**FOLLOW UP REPORT ON PREVIOUS DATA PROVIDED (MEDICATION ERRORS AND PRESSURE ULCERS**
	This was noted on the agenda as being the responsibility of Mr Coady however he advised it should have been recorded as being from Ms Mackie. The Chair stated this should have been a written report to allow members time to review information and for future meetings this type of report needs to be written and not verbal.

	Thereafter Ms Abbott provided the Sub -Committee with a verbal report on medication errors and pressure ulcers. Monthly audits of the medication paperwork are carried out, any errors are challenged. Training is in place to provide support and reduce errors. It was noted that patient are sometimes transferred who already have pressure ulcers, this is referred back to where they have been transferred from and monitoring is ongoing. The Chair stated that NHS Grampian is part of the pilot for the Scotland wide "Care Assurance Model Excellence in Care". This is a nursing tool used to provide assurance on care provided and information can be drilled down to ward level if required. **Thereafter the Sub-Committee agreed** to note the information provided.

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD AUDIT AND RISK SUB-COMMITTEE THURSDAY 23 FEBRUARY 2017, 1:00 PM – 2:30 PM SUPPER ROOM, TOWN HALL, ELGIN

PRESENT

VOTING MEMBERS

Councillor Patsy Gowans	Moray Council
Dame Anne Begg	Non-Executive Board Member, NHS Grampian
Professor Amanda Croft	Executive Board Member, NHS Grampian

IN ATTENDANCE

Ms Pam Gowans	Chief Officer, Moray Integration Joint Board
Mr Atholl Scott	Chief Internal Auditor, Moray Integration Joint Board
Mrs Caroline Howie	Committee Services Officer, Moray Council as Clerk to the Board

APOLOGIES

Councillor Sean Morton (Chair)	Moray Council
Mr Steven Lindsay	NHS Grampian Staff Partnership Representative
Mr Fabio Villani	tsiMoray
Mrs M Wilson	Chief Financial Officer, Moray Integration Joint Board

1.	**WELCOME**
	In the absence of Councillor Morton Councillor Gowans assumed the role of Chair and welcomed those in attendance.
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 INTEGRATION JOINT BOARD AUDIT AND RISK SUB-COMMITTEE DATED 15 DECEMBER 2016**
	The Minute of the Meeting of the Moray Integration Joint Board Audit and Risk

	Sub-Committee dated 15 December 2016 was submitted and approved.
4.	**ACTION LOG OF THE MEETING OF THE INTEGRATION JOINT BOARD AUDIT AND RISK SUB-COMMITTEE DATED 15 DECEMBER 2016** The Action Log of the Moray Integration Joint Board Audit and Risk Sub-Committee dated 15 December 2016 was discussed and it was noted that all actions had been completed.
5.	**INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN UPDATE**
	A report by the Chief Internal Auditor (CIA) provided the Sub-Committee with further information around internal audit coverage and reporting for the remainder of 2016/17, and sought consideration of the arrangements for development of the internal audit plan for 2017/18. There was discussion on joint working between Aberdeen City Council, Aberdeenshire Council, Moray Council and the NHS. Information sharing works well and each party adapts to use within their own area. Discussion also took place on what could be included in the audit plan and it was agreed work needs to be done to ensure risk is minimised and pertinent areas are scrutinised. Dame Anne advised she didn't feel she was sufficiently qualified to decide what should be audited and in response the Chief Officer (CO) suggested it was for her and heads of service to make proposals to the Moray Integration Joint Board and to give guidance. The CIA advised that previous audits will inform what is required going forward but that there should be scope to follow-up and audit should an issue arise. **Thereafter the Sub-Committee agreed** to note the report.
6.	**AUDIT SCOTLAND REPORT – FOLLOW UP**
	A report by the Chief Officer provided the Sub-Committee with a further update in relation to the progress made against the recommendations reported in the Audit Scotland report on Health and Social Care Integration, published December 2015. **Following discussion the Sub-Committee agreed to**: i) note the recommendations made by Audit Scotland in their report published December 2015; ii) note and endorse the assessment of the progress made against the recommendations; and iii) it is beneficial to continue to develop the process as a mechanism for reporting progress at six-monthly intervals.
7.	**UPDATED RISK POLICY**
	A report by the Chief Officer presented the updated Risk Policy for the Sub-Committee's approval. The Sub-Committee noted the changes made to the Risk Policy.

	Thereafter the Sub-Committee agreed to approve the updated Risk Policy.
8.	**RISK REGISTER UPDATE**
	A report by the Chief Officer presented the updated Risk Register seeking to provide assurance that strategic risks are being adequately managed. **Following consideration the Sub-Committee agreed** to note the Risk Register, as attached as appendix 1 of the report.
9.	**REVISED VERSION OF STRATEGIC RISK REGISTER**
	A report by the Chief Officer requested the Sub-Committee consider a revised version of the Strategic Risk Register. The Sub-Committee noted the new format was easier to read than the previous format which was a more traditional style and agreed to alter the Risk Register so as to present this in the new format in the future. **Following consideration the Sub-Committee agreed to**: i) note the revised version of the Strategic Risk Register; ii) alter the current Risk Register to the new format; and iii) review the format of the Strategic Risk Register annually.

CHIEF OFFICERS REPORT TO THE MORAY INTEGRATION JOINT BOARD 29 JUNE 2017

There has been an increased focus in the last few months in relation to our financial position, much effort has be put into forecasting our outturn 2017/18 and beyond following the impact of the spending review in December 2015. The Operational Management Team under the leadership of the Heads of Service have scrutinised budgets to identify savings whilst trying to retain services and quality, this is extremely challenging and further work will be undertaken to both risk assess future decisions and expedite redesign where it is possible to do so. The formal papers at today's board will set the scene for going forward for the IJB and a need to complete further work on analysing our overall performance to inform further the strategic questions and subsequent actions required to live within our means whilst delivering services for the population of Moray.

There continues to be enthusiasm and effort to innovate and change across the leadership team and workforce and some of our tests of change are now going live and the coming months will determine the opportunities that may arise from this.

Locality Planning and Community Engagement

We have had two significant locality planning/public engagement exercises in relation to service redesign and change, both of which have proven to be successful. We have learned a lot about how we can take forward community engagement events successfully and attract good numbers of local folks in debate when discussing matters relevant to them.

Our first public engagement event of the year took place over two separate evenings and related to the provision of General Medical Services in Glenlivet, circa 100 local people attended each session and whilst there was some initial lively debate with good observations being put forward by the community, we were able to work with the community to a satisfactory appointment of a new provider, Grantown On Spey Medical Practice taking on the local contract. The Practice attended the second session and spoke first-hand about what they planned to do and how they planned to do it, allowing the community to comment, raise concerns and have their say.

The second event for which a report is being prepared was in Forres on the 9th June 2017, the purpose of the meeting was to work alongside the community giving them a flavour of the opportunities and challenges, sharing some information for debate and discussing the future of Leanchoil Hospital which has been an ongoing community concern for some time. Early indication was that this was a successful event with 80 community participants attending. There is a plan to meet again in August 2017 and the report will be shared with all who attended and Board members for information when completed.

Whilst our Community Development Team and Health Improvement Teams interact well with communities on a daily basis, the opportunity for Health and Social Care Moray to interact around locality planning is something we need to take forward more proactively in line with the policy direction for Scotland. We believe that these more recent experiences have proven to be more fruitful than previous approaches tested out.

Varis Court, Forres (Hanover)

This facility has been developed in partnership with Hanover Housing (Scotland), the 33 unit extra care facility will be formally opened in July 2017. The test site for the Augmented Care Units (ACU's) is now up and running and more detail will be provided on the experience of the first few months in the August CO report. This is a significant test of change that seeks to change how we work with people when experiencing a deterioration in their health and is based on the proposition that homely settings maintain independence when experience physical deterioration. This test of change will run for 12 months with a full evaluation and will be monitored through the Strategic Planning and Commissioning Group.

Urquhart Place, Lhanbryde

Following the completion of the construction phase, the first 4 service users from Maybank, in Forres will be moving into this development mid-August 2017. Additional members of staff have been recruited and an extensive induction and training programme has been implemented to support the new team members. Further recruitment is underway to support the 3 other future tenants who will be moving to this new development over the course of this year and the beginning of 2018.

This is an exciting and challenging new way of working; for clients and their families life changing, individuals moving from a residential setting to maintaining their own tenancy, having their own space, privacy and more opportunity to reach their potential.

For more information contact
robin.paterson@moray.gov.uk/alison.smart@moray.gov.uk

Jubilee Cottages Update

This new facility has been in use since April 2017 and is another test of change for Health and Social Care Moray. Occupiers have been given an intensive rehab package and returned to their own homes following this intervention, again the proposition is to maintain independence by changing the environment in which the intervention takes place and providing an intensive rehab programme. A full evaluation of the resource and impact in reducing hospital stays and meeting outcomes for individuals will be completed. The criteria for the use of this facility is being refined and developed following initial feedback to ensure that the use of the facility is maximised in line with the constraints of the trust requirements and to challenge ways of working across professions. There are some unresolved aspects around the future model and the provision of medical care which will be worked through in due course.

For more information contact Lesley.attridge@moray.gov.uk

General Practice Sustainability

The provision of general practice across Scotland is experiencing unprecedented challenges with recruitment/workforce supply and workload. This is reflected also in Moray and we do have practices identified or have identified themselves as vulnerable. Other areas in Scotland have experienced practices handing back the contract and Health and Social Care Moray are well engaged in the national arena learning and engaging in activities that will assist us in determining the future for general practice and the wider primary care team. The challenges before us are not straight forward and require collaborative working across the area and beyond. Contingency plans are being developed to ensure sufficient thinking and engagement is achieved to minimise disruption should it occur. This area of risk links right back to the need for change and redesign, the workforce projections and the principles set out in relation Public Sector Reform.

For further information contact sean.coady@nhs.net

Retiral of Ali Walker, Integration Service Manager, Mental Health Services

This month says farewell to Ali, who has worked in the NHS and latterly within our integrated health and social care services. Ali has worked in this field since joining the NHS in July 1978, he has been a dedicated member of many teams and has given much leadership, knowledge and experience to the services in which he has service. We wish him all the best in his retirement and thank him very much for his long services and commitment.

Author: PAM GOWANS, CHIEF OFFICER

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2017**

SUBJECT: **MEMBERSHIP OF THE INTEGRATION JOINT BOARD AND COMMITTEES**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To invite the Board to consider the membership of the Board and make appointments to the Board's committees in light of the resignation of the Third sector member and new Council appointments to the Board.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board:

i) note the new voting member appointments made by Moray Council as set out in paragraph 3.2; and in light of this

ii) agree new voting member appointments to both the Audit and Risk and Clinical and Care Governance Committees as set out in paragraphs 4.1 and 4.3;

iii) agree a new chair for the Audit and Risk Committee as set out in paragraph 4.2; and

iv) consider and agree a process for seeking nominations for a new third sector member of the Board.

3. BACKGROUND

3.1 The Public Bodies Joint Working (Scotland) Act 2014 ("the Act"), and the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the Order") make provisions about various matters including the membership of an Integration Joint Board (IJB) and the set up and operation of its Committees. One of these is that any Committee set up by an IJB must include an equal number of voting members appointed to the IJB by each of the Health Board and Local Authority. Another one is that the Board must appoint one member from a third sector body carrying out activities relating to health and social care in Moray.

3.2 Given the recent Local Government elections and the voting in of new Councillors, Moray Council has nominated 3 new voting members to the Board: Councillors Brown, Feaver and Morrison.

3.3 Moray Council has also identified named deputies for its voting members to ensure continuity of membership and the development of expertise in the functions of the IJB: Councillors Edwards, MacRae and Bremner.

3.4 On 25 February 2016, the Board agreed its discretionary membership and appointed a representative form the Third Sector (para. 4 of the minute refers). On 24 May 2017 that member indicated his resignation by email to the Chair. This vacancy in membership requires to be filled.

3.5 The Board currently has two Committees, Audit and Risk and Clinical and Care Governance. They were set up by the Board at its meetings on 31 March 2016 (para. 6 of the minute refers) and 28 April 2016 respectively (para. 4 of the minute refers).

3.6 Another provision set out in the Order and repeated within the Board's Standing Orders agreed by the Board at its meeting on 25 February 2016 (para. 7 of the minute refers) is that when a Committee is set up by the Board it must identify a chairperson for the Committee. When the Audit and Risk Committee was established by the Board it agreed that a Council voting member would chair it.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Audit and Risk Committee

4.1 The Board has agreed that 4 voting members will sit on this Committee and an appointment of 2 voting members from amongst the Council's 3 voting members must be made.

4.2 One of those appointed from amongst the Council's voting members must also be identified to chair this Committee.

Clinical and Care Governance Committee

4.3 The Board has agreed that 2 voting members will sit on this Committee and an appointment of 1 voting member from amongst the Council's 3 voting members must be made.

Third Sector member

4.4 In tendering his resignation the Third sector member of the Board recommended a replacement from within tsiMoray. The Board could take up the recommendation as to a replacement but equally it could decide on another process for identifying a new member from the third sector who will, when subsequently identified, be appointed as a member by the Board.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015-17 and Moray Integration Joint Board Strategic Commissioning Plan 2016-19

Good governance across the work of the Board supports delivery of the Strategic Commissioning Plan.

(b) Policy and Legal

Provisions regarding the membership of the Integration Joint Board and its Committees are set out in the Act, the Order and Standing Orders and have been referred to throughout this report.

It is important that the Board agree appointments to Committees to enable business to be progressed and replace the Third sector member to meet statutory requirements.

(c) Financial implications

There are limited financial implications arising from the consideration of this report relating to the payment of expenses to Board Members. It is anticipated that voting members will continue to make claims to their nominating organisation.

(d) Risk Implications and Mitigation

Legislation empowers the Council and NHS Board and non-voting members of the Board unable to attend a meeting, to arrange for a suitably experienced proxy to attend meetings on a member's behalf. The Council has agreed named deputies for its voting members. A new Third sector member would arrange their own proxy for meetings as needed.

(e) Staffing Implications

None arising from this report.

(f) Property

None arising from this report.

(g) Equalities

None arising from this report.

(h) Consultations

Consultation on this report has taken place with Caroline Howie, Committee Services Officer, Moray Council who is in agreement with the content in relation to her area of responsibility.

6. CONCLUSION

6.1 The membership of the Board and its committees needs to be revisited in light of fresh voting member appointments to the Board and the resignation of the Third sector member.

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

Background Papers: Public Bodies (Joint Working) (Scotland) Act 2014
The Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014
Moray Integration Joint Board Standing Orders

Ref: MAF

Signature: _____ Date : 21 June 2017

Designation: Chief Officer, Moray Integration Joint Board Name: Pam Gowans

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2017

SUBJECT: ENGAGEMENT, COMMUNICATION AND BRANDING

BY: PAM GOWANS, CHIEF OFFICER

1. REASON FOR REPORT

1.1 The purpose of this report is to present the Moray Integration Joint Board (MIJB) with the draft Communication and Engagement Strategy 2017-2019 and seek approval to adopt the document.

1.2 To present progress on the website and associated social media.

1.3 To update the MIJB on development of branding guidance for staff following formal approval of use of the logo.

2. RECOMMENDATION

2.1 It is recommended that the MIJB:

i) approve the Communication and Engagement strategy and associated action plan for implementation;

ii) approve the launch of the website and associated social media; and

iii) consider and approve replacing the current council and NHS logos on MIJB papers with the Health & Social Care Moray logo; consider retaining the council and NHS logos in the footer of documents; and note the roll out of branding guidance to staff.

3. BACKGROUND

Communications & Engagement Strategy

3.1 Health and Social Care Moray's (HSCM) Senior Leadership Team previously commissioned a local company, Platform PR to assist in the development of a communications strategy for the Moray IJB, with a draft feedback report received and considered by the Senior Leadership team.

MIJB website

3.2 To inform and engage with stakeholders, there is a need to develop and resource a dedicated website presence for the MIJB. Currently a mini-site is hosted on the Moray Council website to ensure key information is accessible to the public.

Branding

3.3 Having a single brand identity which is applied consistently through the use of our partnership logo, colours and typefaces will enable us to build a strong reputation, inform and engage with stakeholders more effectively and improve customer experience.

3.4 At the meeting of the MIJB on 23 February 2017 (para 15 of the Minute refers), the board agreed the internal development of a Communication and Engagement strategy, noted the development of the website, gave formal approval to the use of the logo and noted that branding guidance would be developed for staff.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Communication and Engagement Strategy (**APPENDIX 1**) has been informed by the corporate communication strategies of NHS Grampian and Moray Council and by the National Standards for Community Engagement which have been adopted and are monitored by the Moray Community Planning Partnership.

4.2 Implementation of the strategy will be overseen by the Senior Leadership Team and progress will be reported to the MIJB.

4.3 The first stage of the website development has been to create an initial platform to host information relevant to the MIJB.

4.4 The second stage will require detailed work to be carried out with services to scope their business requirements for provision of information, online referrals/application/assessments, payments and transitions. This will inform the business case for a multi-function website.

4.5 To coincide with the “go-live” of the website, a Facebook and Twitter presence for Health & Social Care Moray will also be established.

4.6 Following advice from the head of NHS corporate graphics, written consent is being obtained from the group which worked on the logo to relinquish any copyright claim. It is not anticipated this will be an issue.

4.7 Outline branding guidance to present a clear and consistent identity has been produced for staff (**APPENDIX 2**) to cover the use of the logo, corporate colours and standard font.

4.8 Once the logo is cleared for use, a suite of templates (letterheads, email signatures, report cover pages etc) will be produced.

4.9 A decision is required as to the continued use of the NHS and council logos in some form.

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 integrated strategy will support the MIJB and Health and Social Care Moray to deliver, as part of the Community Planning Partnership, on the Community Empowerment (Scotland) Act 2015, which creates new rights for citizens to be engaged in the planning, delivery and scrutiny of local services and new opportunities for communities to lead local services and projects where they can do so more effectively and responsively than public agencies.

It will also support the Moray Community Planning Partnership's drive to improve engagement with communities to achieve more engaged, better informed, more resilient, sustainable communities.

(b) Policy and Legal

Under the Public Bodies (Joint Working) (Scotland) Act 2014, MIJB has a statutory responsibility to communicate with its stakeholders.

(c) Financial implications

Cost for the development and running of the initial website are likely to be less than £100 a year.

(d) Risk Implications and Mitigation

Without a clear and consistent approach to communications there is a risk that the MIJB and HSCM do not engage with patients, service users and carers in the manner envisaged in the Public Bodies (Joint Working) (Scotland) Act 2014.

(e) Staffing Implications

Implementation of the strategy and branding guidance and the website development and maintenance will be achieved within existing staff resources.

(f) Property

There are no implications in terms of Council or NHS property directly arising from this report.

(g) Equalities

There are no equality issues directly arising from this report. The strategy recognises the need to identify and overcome the barriers to communication and engagement for all stakeholders.

(h) Consultations

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

- Legal Services Manager (Litigation and Licensing)
- Caroline Howie, Committee Services Officer
- Head of Adult Health and Social Care Services
- Head of Primary Care, Specialist Health Improvement Services and NHS Community Children's Services

6. CONCLUSION

6.1 This report recommends the MIJB:-

i) agree the adoption and implementation of the draft Communication and Engagement Strategy 2017-2019 and associated action plan;

ii) approve the launch of the website and associated social media;

iii) consider the MIJB use of the Health & Social Care Moray logo in relation to the council and NHS logos and note the planned roll-out of branding guidance to staff.

Author of Report: Fiona McPherson, Public Involvement Officer
Background Papers:

Signature: _____ Date: 20 June 2017

Designation: Chief Officer Name: Pam Gowans

Putting People First

Draft communication and engagement strategy 2017- 2019

Moray Integration Joint Board

Version 0.1
June 2017

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The Public Involvement Officer
Health & Social Care Moray
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New Elgin
IV30 6GR

Involvement@moray.gov.uk

01343 *567187*

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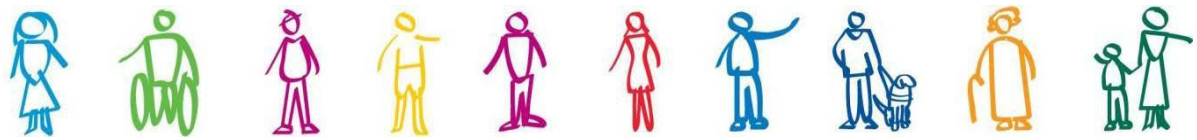
Version	Author/reviewer	Date	Amendments
0.1	Public Involvement Officer	05.06.17	



Foreword

As the Integration Joint Board of Health & Social Care Moray, we are responsible for creating a single, responsive and flexible health and social care system which achieves better outcomes for adults who use health and social care services.

We are committed to supporting people – particularly those whose needs are complex and involve support from health and social care at the same time – to live longer, healthier lives as independently as possible through the provision of proactive, joined-up services.

We want to be recognised as a successful organisation which has a positive impact on people lives, continuously improves the health and social care services people use and their experience of them, while delivering value for money by using resources effectively.

Having a mandate from an informed and engaged public - people who use our services or have an interest in them and those who plan and deliver them - will enable us to effectively improve service design and delivery, develop new models of care which respond to needs and aspirations, and move towards a more sustainable health and social care system.

This is particularly important during this time of challenge and change.

This strategy directs how communication and engagement will be improved over the next two years to support our work.

We will put our efforts into promoting mutual understanding, making sure people feel informed, can make their voice heard and have opportunities to be involved.

The success of the strategy will ensure people continue to be at the heart of all our work. This will enable us to deliver on our Strategic Plan 2016-19 and contribute to the success of Moray 2026, the plan of the Moray Community Planning Partnership.

The strategy and its action plan remain a live document. Progress will be monitored and reported regularly to the board, and the document will be reviewed on an annual basis.

Responsibility for its delivery lies with every member of the board and the Health & Social Care Moray workforce partnership.

We welcome views on how it can be built on and improved.

1. Introduction

> *"We must ensure that the Strategic Plan for Health and Social Care builds on the achievements to date and seeks to challenge the system further towards building community resilience and community engagement that has the community and services working together to maximise the opportunities for all."*
>
> **Moray Strategic Plan 2016-2019**

Our population faces significant health and care challenges. People are living longer, often with a growing number of complex conditions. Lifestyle continues to impact on physical and mental health. Pressure on resources is increasing year on year.

Integrating health and social care brings opportunities to more effectively improve the health and wellbeing of people who use those services, particularly those whose needs are complex and require support from health and social care at the same time.

As the Integration Joint Board we are committed having in place services that meet people's needs, achieving quality and consistency, providing a positive experience and enabling people to influence the decisions which affect their lives.

We must make sure that joint health and social care budgets are used efficiently and effectively to bring about a shift in the balance of care from hospital and institutional care to more community based care.

We have prioritised communication and engagement as being fundamental to the success of our organisation in transforming services with and for the people of Moray.

1.1 Purpose of the strategy

This communication and engagement strategy will support us to achieve our strategic objectives.

It sets out our approach to communication and engagement both within our partnership workforce and externally with our many stakeholders in order to improve how we talk with, listen to, learn from and move forward together.

We consider a stakeholder to be any person, group or organisation that can affect or be affected by our work.

It sets out our foundations in terms of how we will:

- Build confidence in and manage our reputation;
- Improve awareness and understanding of our work;
- Communicate and engage effectively with our colleagues;
- Achieve active and meaningful engagement with stakeholders.

1.2 Developing the strategy

This draft has drawn on the existing communication strategies of Moray Council and NHS Grampian along with the Moray Community Planning Partnership's programme of improvement for community engagement and participation.

1.3 Embedding the strategy

Communication and engagement is "everyone's business". It goes on each day in every part of the organisation but in order to capitalise on it we need to ensure we do it consistently and to a high standard.

For us good communication and engagement means communicating, listening, learning and acting together in three key ways.

1) **Appropriately**: We will use established and innovative methods to ensure we communicate and engage with people in a way that suits them and will do so in a professional, appropriate and timely manner. We will continue using existing tools to have a two-way dialogue with people whilst developing and testing new methods such as across the developing range of digital platforms.

2) **Inclusively**: Health and social care affects everyone, so our communication and engagement needs to embrace a diverse range of people. We will include all groups in the community and ensure our communication and engagement activity is accessible to everyone.

3) **Meaningfully**: We will ensure that our communication and engagement activities are necessary and meaningful to the people taking part. We will share results and outcomes with people.

We will use varied ways so as to reach the widest possible audience. We will take all opportunities to talk to people about our work and what matters to them so that their views and input is used to inform and influence current services and future developments.

The Senior Leadership Team of Health & Social Care Moray will be responsible for driving the Communications and Engagement Strategy by actively applying its principles and standards to all aspects of work within their areas of responsibility.

2. Background to health and social care integration

The national and local context provides the backdrop against which our communication and engagement takes place.

2.1 National context

The Public Bodies (Joint Working) (Scotland) Act 2014 came into effect on 1 April 2014 and required Health Boards and Local Authorities to work together in planning and delivering a range of adult social care and community health services to improve the wellbeing of service users.

Integration of health and social care seeks to reduce fragmentation and delays and ensure service users receive care and support at the right time and in the right place to meet their individual preferences and goals.

The planning and delivery principles which describe the "how" of planning and delivering integrated care, set a clear expectation of respect, parity of esteem and genuine engagement.

They require services to be:

"Planned and led locally in a way which is engaged with the community including in particular service users, those who look after service users and those who are involved in the provision of health or social care."

Our strategy will support us to work to this principle.

2.2 Local context

Moray Council and NHS Grampian agreed to devolve governance for the planning and monitoring of the delivery of services for adults and older people to a new body corporate, the Moray Integration Joint Board.

The board was formally established in April 2016. There are six voting members; three elected members appointed by Moray Council and three appointed by the NHS Grampian Board. They are supported by non-voting members made up of leading officers from the council and NHS, and representatives of the third sector, service users and unpaid carers.

The Integration Joint Board is a member of the Moray Community Planning Partnership and with our partners we are working to make Moray a better place to live, work and visit.

Our Strategic Plan 2016-2019 describes how we intend to improve the health and wellbeing of adults in Moray through the design and delivery of integrated services.

By involving people and their communities in decisions that affect them and through more joined up working and delivery of services and support by the right people, in the right place and at the right time, it is intended that we will deliver on our own strategic priorities and meet the nine national outcomes for Health and Social Care Integration.

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.

National Outcomes

- Healthier living
- Independent living
- Carers are supported
- People are safe
- Engaged workforce
- Maintained or improved quality of life
- Positive experiences and outcomes
- Reduced health inequalities
- Effective resource use

Our Strategic Plan describes our values and principles and identifies our core aims as:

1. To ensure a high-quality and consistency of services for patients, carers, service users and their families;
2. To provide seamless, integrated, quality health and social care services to care for people in their homes, or a homely setting, where it is safe to do so;
3. To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

We are required to effectively deploy and manage our annual operating budget from Moray Council and NHS Grampian, ensuring this is targeted on need and the desired outcomes people who use services, their families and local communities.

Approximately 1,650 staff employed by either the council or NHS work in the services identified as being in the scope of integration. Together they make up the workforce partnership of Health & Social Care Moray which provides health and social care services to adults over the age of 18.

These services include:

- Adult Social Care;
- Adult Primary Care;
- Community and Acute Health Care;
- Some elements of Housing support;
- Older people;
- Physical and sensory disability;
- Learning disability;
- Autism;
- Mental health
- Drug and alcohol.

Our wider partnership also includes the Third and Independent sectors which are major providers of health and social care services.

2.3 Localities

Localities, which are a legislative requirement of integration, provide opportunities for communities and professionals to take an active role in, and provide leadership for, local planning of service provision.

Our Strategic Plan identifies five localities: Buckie/Cullen; Keith; Speyside; Elgin/Lossiemouth; and Forres. Each locality is uniquely placed to consider local needs and will play a powerful role in making integration a success across the whole of Moray.

They will function with the direct involvement and leadership of:

- Health and social care professionals who are involved in the care of people who use services;
- Representatives of the housing sector;
- Representatives of the third and independent sectors;
- Carers' representatives and patients'/service users' representatives;
- People managing services.

Everyone with an interest must have a meaningful role in localities to influence services and opportunities to engage meaningfully in co-production, working in equal partnership from the start to achieve an outcome.

The communication and engagement approaches set out in this strategy will be applied to our work to support the effectiveness of locality arrangements.

3. What we mean by communication and engagement

We communicate and engage with stakeholders about the issues which do or may impact on them – our strategies, services, policies, intentions and decisions. This includes information on who we are, what we do and how people can get involved.

We use a range of mechanisms, methods and approaches to inform, listen to and work with people and these will continue to be developed to ensure they meet the needs of our varied communities.

It is helpful to have a shared understanding of what we mean by the terms communication and engagement.

3.1 Communication

Communication describes the channels, methods and messages we use to promote our work; manage our reputation as an organisation; raise awareness of and support engagement in our activities; and establish a two-way dialogue with our stakeholders.

3.2 Engagement

There are a variety of interchangeable terms for engagement including involvement and participation.

In this strategy we mean all the activities designed to gather, understand and act on the experiences, views, aspirations and priorities of stakeholders. It is the ongoing and informed joint working which gives people opportunities to contribute to and lead on local decision making, the implementation of change and improved service delivery.

There are a number of progressive levels of engagement. Each requires a different commitment from those involved. Stakeholders may want to engage at different levels and at different times.

We recognise the importance of people having opportunities to engage in ways which suit them and to shift between the levels as they wish. For example, some people want to receive information and be kept informed, others want a means of sharing their thoughts and experiences with us, while some people want to be actively engaged in shaping new service models and decision making.

We strive to be as inclusive as possible in our reach to ensure that individuals or groups whose voices are not traditionally as strongly heard or represented are identified and involved so we do not miss out on their contribution.

The following table demonstrates the ladder of engagement.

LEVEL	DESCRIPTION	TOOLS
Inform (giving information)	Providing appropriate information about services, policies and decisions that might affect or interest people	Fact sheets Newsletters Leaflets Website Posters Displays/exhibitions
Engage and consult (asking opinions)	Obtaining feedback and views on services and future plans, options and proposals.	Open meetings and focus groups Self-completed questionnaires Options appraisals Feedback channels Social media Service user experience stories
Involve (participating)	Working directly with people to ensure needs, concerns and priorities are understand and considered in the planning, design and delivery of services.	Questionnaires Focus groups Workshops Reference groups and forums
Collaborate (working together)	Working together in partnership in all aspects of a decision, including the development of alternatives and the identification and delivery of the preferred solutions	Commissioning project groups Strategic Planning Reference Group Strategic Commissioning Group Integration Joint Board Locality planning
Empower (decision-making)	Final decision-making is in the hands of individuals, families and communities	Tender evaluation panels Participatory budgeting Asset transfer

3.3 Communities

Engagement can happen on a one-to -one basis such as between a person using a service and the person delivering the service.

This strategy is more focused on what is termed community engagement. This can be used to describe: a community of; a community of interest which brings together people who share a particular interest or experience; or a community defined by how people identify themselves or how they may be identified by others such as those of protected characteristics including age, disability, race and religion.

4. Why we communicate and engage

Public services have been charged by the Community Empowerment (Scotland) Act to strengthen local democracy and citizen participation. This can only be achieved by providing people with opportunities to influence and change both current and future services.

It is recognised that public services which engage with those who use or have an interest in their services are likely to be able to deliver better, more response services which are more relevant to the communities they serve and improve outcomes.

4.1 Benefits

Strong and effective relationships are particularly important at this time of significant challenge for public services. With increasing demand and difficult funding decisions having to be made, it is vital our focus reflects the priorities of our residents.

Communicating and engaging with people, empowering them to do more to improve their own health and wellbeing and actively involving them in decision making and in service planning, design and delivery, is central to enabling health and social care services to be more responsive in meeting the needs of our communities and to improving the quality of life of our citizens.

Among the benefits are:

- Increased awareness and understanding of services and how they operate;
- People are more active participants in managing their own health and wellbeing;
- People can build on existing skills and develop new ones by becoming involved, increasing confidence and self-esteem;
- People who use services receive new and better services that have changed and improved in response to their involvement;
- Increased community participation and capacity building;
- Improved reputation through recognition that service users will have a positive experience;
- Services will be more effective, more responsive, better targeted and received ;
- Constructive working relationships between organisations and the public with decisions more likely to be seen positively by those who have had a stake in making them;
- Opportunities for collaborative commissioning and delivery of services;
- Staff who feel engaged in the work they do and so strive for continuous improvement.

4.2 Challenges

Communicating and engaging well presents a challenge for any organisation, particularly one which is still in the infancy of its partnership arrangements, is going through transformational change, has staff based over multiple locations and delivering wide-ranging functions with a diverse and complex customer base.

There are challenges around meeting expectations and demands, addressing concerns over change and new ways of working, and maintaining positive relationships at a time of reducing resources.

Engagement needs to be genuine and offer real opportunities for people to influence decision making, redesign and improvement.

We must do more to ensure Moray's diverse communities have opportunities to become involved in our work. We recognise that different approaches will be required to reach different communities, and that some groups with protected characteristics will need bespoke work in order for us to establish two-way communication and proactive engagement.

4.3 Policy, legislation and guidance

The Scottish Government has built the principle of community engagement into policy and guidance to public services to emphasise the importance of designing and delivering public services in partnership with citizens.

Public services must strive to make the most efficient and effective use of available resources, while at the same time delivering services which are more personalised and meet the outcomes of the individual as well as local and national outcomes.

Legislation such as the Self Directed Support Act 2013, Children and Young People Act 2014 and Care Act 2014 seek to empower and support individuals, families and carers to have greater choice and control over how their care and support needs are met.

Along with the Public Bodies (Joint Working) (Scotland) Act 2014, there are several other key drivers which place a duty on the us as the board and Health & Social Care Moray as our service delivery partnership to communicate and engage with our stakeholders.

The **Christie Commission** was established by the Scottish Government to identify the best ways to address the challenges of delivering public services. It concluded that public services should be built around people and communities, their needs, aspirations, capacities and skills, and that work should be done to build up their autonomy and resilience.

The findings of the commission led to the **Community Empowerment (Scotland) Act 2015.** It empowers community bodies through the ownership of land and buildings, and by strengthening their voices in the decisions that matter to them. It also improves outcomes for communities by improving the process of community planning, ensuring that local service providers work together even more closely with communities to meet the needs of the people who use them.

Our Voice is a framework driven by the Scottish Government, the Scottish Health Council, Healthcare Improvement Scotland, The Alliance and COSLA. It supports people who use health and social care services, carers and members of the public to engage purposefully with health and social care providers to continuously improve and transform services.

NHS Boards are required to involve people in designing, developing and delivering the health care services provided for them. This is underpinned by, among others, **NHS Reform (Scotland) Act** and the **NHS Scotland Healthcare Quality Strategy**.

The **Public Sector Equality Duty** requires public bodies to consider all individuals when they carry out their day to day work, such as shaping policy, designing, commissioning and delivering services and in relation to their own employees.

It makes it a legal requirement to evidence how different people will be affected by their activities, so policies and services, for example, are appropriate and accessible to all and meet different people's needs.

This is an important element of our communication and engagement work.

5. Where we are now

Moray Council and NHS Grampian have their own corporate communication strategies.

The Moray Community Planning Partnership leads an ongoing programme to improve community engagement and participation.

5.1 Communication and engagement insights

Good and effective communication can be challenging for any organisation, particularly an integrated partnership such as Health & Social Care Moray which brings together staff from the local authority and NHS.

The following insights were gathered from workforce development sessions and interviews with Board members, service user and carer representatives, staff, community, Third and Independent sector representatives.

Brand/visual identity – Following engagement a logo has been developed to give a visual identity to the partnership but it is not yet being applied consistently.

External communications – There is limited awareness of the identity, role and function of the Board and the work of Health & Social Care Moray. Board meetings receive limited media coverage.

The board and partnership do not have their own distinct communication tools such as a website, Facebook and Twitter accounts.

Currently pages on the Moray Council website are used to present integration information.

Some staff and services use social media to promote their services or their role and activities, but most staff are unable to access social media in work settings.

Internal communications – Staff reported limited awareness around integration, organisational structure and their role in delivering the Strategic Plan. There was a lack of consistency in receiving information. They felt messages were not being cascaded down. Reliance on email communications means some staff are excluded.

Engagement – There is evidence of a wide range of engagement activity which informs our work but the depth and breadth of this tends to be limited.

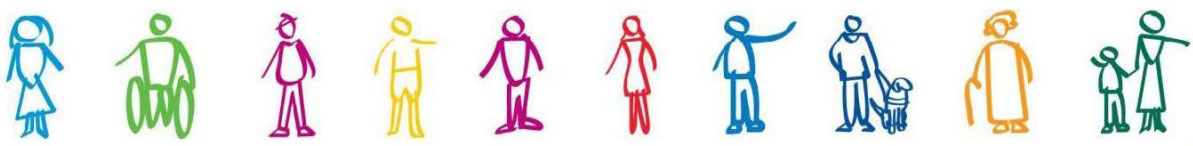
Membership of the Board includes a service user and unpaid carers and both would like to enhance their representative involvement on the board. They do not have an agreed role or remit.

Strategic engagement took place through the Strategic Planning Reference Group which brought together, by invitation, a diverse mix of stakeholders to develop and review the Strategic Plan.

There are two lay members on the Strategic Commissioning Group. They do not have an agreed role or remit so the expectation of their involvement is unclear.

Advice and support - Guidance and support for communications is provided by council and NHS corporate communication teams but roles, responsibilities and processes for sign-off still needs to be agreed.

Guidance and support for engagement is provided by the partnership's public involvement officer and Health Improvement Team, along with its Community Engagement and Participation Group which is made up of a range of stakeholders from the council, NHS, statutory and third sectors.



6. Where we want to be

We believe that it is really important to be able to communicate and engage with our many, varied and complex stakeholders to ensure transformation and improvement in health and social care is informed, influences and co-designed by people who use services, their families and unpaid carers, communities, staff and our wider partners.

This strategy will support us to:

- Raise awareness of our vision;
- Maintain a culture of two-way communication with all our stakeholders to ensure that feedback is consistently fed into service planning and delivery;
- Keep Moray residents well informed;
- Address negative or potentially damaging information about health and social care services;
- Support staff in their roles as ambassadors for the organisation;
- Support IJB members in their role as leaders;
- Reach all sections of the community;
- Keep abreast of technological developments and innovation which supports communication and engagement and embrace them where feasible;
- Promote respect and trust between the organisation and our stakeholders;
- Maintain a strong and consistent identity for the IJB and Health & Social Care Moray;
- Raise awareness of health and social care services to maximise access to them;
- Keep staff informed, promote understanding and engagement;
- Maintain and improve service user and carer satisfaction levels with our services;
- Achieve strong, active and inclusive communities who are informed and involved in decision-making, co-producing and improving services.

6.1 Vision

Our over-arching vision statement presents a statement of the change we want to see over the next two years as a result of this strategy.

"Our communication and engagement enables people to be informed, involved and empowered."

6.2 Aims and objectives

The delivery of our strategy is focused around four key aims and the objectives which will support them. The specific activity we will undertake is set out in the action plan (Appendix 1).

AIM A: THE IJB HAS A POSITIVE REPUTATION

We will:

A1 – Establish and maintain the identity of the IJB

A2 – Promote and protect the reputation of the IJB

A3 – Build stakeholder confidence in the IJB

AIM B: EXTERNAL STAKEHOLDERS ARE COMMUNICATED WITH EFFECTIVELY

We will**:**

B1 – Build public awareness of Health & Social Care Moray

B2 - Improve the quality and accessibility of service information

B3 – Actively encourage two-way communication using a range of mechanisms

B4 – Develop a monitoring and evaluation framework

AIM C: INTERNAL STAKEHOLDERS ARE COMMUNICATED AND ENGAGED WITH EFFECTIVELY

We will:

C1 – Improve accessibility of information

C2 – Develop and improve internal communication channels

C3 – Improve engagement mechanisms and opportunities

C4 – Celebrate the workforce

AIM D: ACTIVE AND MEANINGFUL ENGAGEMENT IS ONGOING WITH ALL STAKEHOLDERS

We will:

D1 – Identify our stakeholders and their engagement preferences

D2 - Establish channels and opportunities and build stakeholder awareness about how people can engage with us

D3 – Use direct experience and feedback to improve services

D4 – Build capacity through continuous and meaningful engagement with stakeholders to inform and influence transformation

D5 – Tell people the impact of their engagement

D6 – Support stakeholder participation in key decision-making processes

7. How we will get there

7.1 Our audience

To ensure high quality and effective communication and engagement we will identify and do more to understand all stakeholders who are impacted by our work and provide opportunities for them to engage in their own health and wellbeing and the services which affect them, as well as on a locality and strategic level.

Service users and carers

- People who use health and social care services
- Unpaid carers and families
- Their representatives such as advocates, welfare guardians and power of attorneys
- Health and social care engagement and reference groups
- Peer support groups and special interest groups

Staff

- Staff in the partnership (NHS and Council)
- Staff/Workforce Forum
- Trade unions
- Wider staff groups (NHS and Council)

Decision makers

- Integration Joint Board
- NHS Board members
- Council elected members
- Health & Social Care Moray Senior Management Team
- Strategic Commissioning Group
- Moray Community Planning partners
- MPs/MSPs who represent the Moray constituency
- Scottish Government

Third Sector

- Third Sector Interface
- Community bodies and groups
- Service providers
- Social enterprises
- Volunteers

Independent Sector

- Service providers
- Private businesses

Community

- Members of the public
- Community Councils and Area Forums

External organisations

- Care Inspectorate

Media

- Local/national print media
- Local/national broadcast media
- Social media
- Specialist publications

Stakeholders have varying needs and different stakeholders are entitled to different considerations.

We will strive to be as inclusive as possible in our reach to ensure that individuals or groups whose voices are not traditionally as strongly heard or represented are identified and involved.

7.2 Our standards for communication

We strive to communicate and engage with each of our stakeholders in ways which are right for them.

Our standards for communication will be in line with the following:

STANDARD	PRINCIPLE
OPEN AND CREDIBLE	Reasons are given for decisions. Questions and requests for information are welcomed and answered promptly. Credibility is earned by responsible, honest and timely communication.
CORPORATE AND CONSISTENT	Communication style and message is consistent with our aims and values. It is proactive and planned where possible and is the same for all audiences
TWO/THREE WAY	Systems exist to support communication up and down the way at all levels of the organisation as well as across teams, departments and services. Opportunities are available for open and honest feedback from all stakeholders so people have opportunities to share their experiences, contribute their ideas and opinions about issues and decisions.
TIMELY AND TARGETED	Communication is provided at the time it is needed, is relevant to the people receiving it and provided in the right way for people.
CLEAR AND CONCISE	Communication is jargon-free, in plain English, is easy to understand and relevant.
ACCESSIBLE	Communication is delivered using styles, formats and materials that are accessible and appropriate to the needs of the audience.

7.3 Channels for communication

The tools we use to communicate and engage are constantly changing. The developments seen over the last few years in social and digital media means that we need to work hard to respond and adapt to this fast pace of change.

The use of social media such as Twitter and Facebook has become the norm for people of all ages and this is now a quick and efficient way to reach a large audience and have conversations in ‘real time’.

That said, we need to be mindful of inclusion and consider the needs of those sections of the community who do not have access to digital channels.

Communications channels need to be endorsed and in place, and audiences need to be aware of them in order to get the correct messages to the correct people at the correct time.

For communications to be effective and successful, they must be two-way (both up and down and down and up) and even three-way (across).

Through our internal communications we aim to ensure that staff are informed, involved and engaged in achieving our strategic objectives.

It is important that stakeholders know which organisation is accountable for the services provided. Across all media and materials, our communications need to be branded and express and support our values and aims.

External communication channels:

- Media relations
- Face-to-face
- Advertising, graphic design and print services
- Emails, letters and telephone calls
- Printed material – newsletters; service information booklets; posters/flyers; campaigns
- Integration Joint Board meetings – agenda, minutes and reports
- Freedom of Information requests
- Events and presentations
- Short films
- Social media channels – Facebook, Twitter and YouTube
- Websites
- Corporate publications – strategic plans; annual reports; locality plans; Moray Community Planning Partnership Plans
- Specific initiatives to respond to local events and circumstances
- Campaigns and programmes

Internal communication channels:

- NHS and council intranet systems
- External websites
- Face-to-face briefings
- All-staff emails/bulletins
- Chief Officer's briefing
- Staff newsletter
- Social media channels
- Workforce development events
- Noticeboards
- Team meetings and individual supervision and support

7.4 Our standards for engagement

Our stakeholders can expect to be able to hold us to account for engaging with them where they are, about issues that matter to them and in ways and using language that makes sense to them. They will know how their involvement has made a difference and how we intend to improve on our engagement.

The **National Standards for Community Engagement** define community engagement as:

Developing and sustaining a working relationship between one or more public body and one or more community group, to help them both to understand and act on the needs or issues that the community experiences.

In carrying out our engagement objectives we will work to the National Standards.

The standards were launched in 2005 to support community engagement and service user involvement. They were revised and updated in 2016 to reflect the developing policy and legislation relating to community empowerment in Scotland and build on the growing range of good practice.

STANDARD	PRINCPLE
INCLUSION	We will identify and involve the people and organisations that are affected by the focus of the engagement.
SUPPORT	We will identify and overcome all barriers to participation.
PLANNING	There is a clear purpose for the engagement, which is based on a shared understanding of community needs and ambitions.
WORKING TOGETHER	We will work effectively together to achieve the aims of the engagement.
METHODS	We will use methods of engagement that are fit for purpose.
COMMUNICATION	We will communicate clearly and regularly with the people, organisations and communities affected by the engagement.
IMPACT	We will assess the impact of the engagement and use what we have learned to improve future community engagement.

The standards have been widely adopted by Community Planning Partnerships and serve as good-practice principles designed to inform, support and improve the process, experience, quality and result of community engagement.

7.5 Opportunities and tools for engagement

There are a number of mechanisms already in place to support participation and engagement in public services in general and health and social care in particular.

Moray Public Partnership Forum is open to anyone with an interest in championing communication and engagement in the planning, design and delivery of health and social care services in Moray. Members are represented on the Moray Integration Joint Board, the Strategic Planning Group and the Strategic Commissioning Group.

The Strategic Planning Group brings together a wide representation of people who use services, unpaid cares, health and social care professionals, community representatives and Third and Independent sectors representatives. The group has responsibility for the development and review of the Strategic Plan.

Moray has a wide range of forums and reference groups including the Public Partnership Forum (PPF), Third Sector Forums, Providers Forums, Patient Participation Groups linked to GP surgeries, Older People's Reference Group, Disability Forum, Equalities Forum etc.

There are also a wide range of groups and communities of interest which we engage with.

Council councils and area forums are established as the most localised tiers of local government and community planning.

We will seek to support and strengthen links with individuals, groups and organisations to ensure we hear as wide a range of different voices in Moray as possible.

9. Resources, monitoring and review

The extensive changes taking place within health and social care are made more challenging due to financial constraints and service pressures.

The delivery of this strategy is based on the required resources being in place to ensure our communication and engagement objectives can be taken forward.

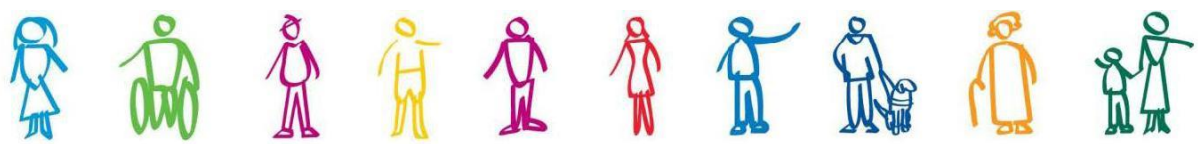
To test the success of our communications we will carry out monitoring surveys and evaluations with stakeholders to check whether our communication and engagement objectives are being achieved and to measure stakeholder satisfaction.

We will establish a set of measures to monitor and evaluate media enquiries and coverage, activity generated by promotions, web hits and social media activity.

We will undertake on-going evaluation of our engagement activities with those involved in order to develop and enhance our future approaches based on feedback.

In line with the National Standards for Community Standards, we will use the VOiCE (Visioning Outcomes in Community Engagement) planning and recording software to assist us to design and deliver effective community engagement.

Reports from VOiCE will form part of our monitoring to ensure our engagement meets the national standards.



Appendix 1 – Action plan

The action plan sets out measureable steps towards achieving the aims and objectives of the strategy. It will be monitored on a regular basis and actions will continue to be updated to be responsive to change.

	Objective	Action	Lead	Timescale
AIM A: THE IJB HAS A POSITIVE REPUTATION				
A1	Establish and maintain the identity of the IJB	□ Develop logo		
		□ Develop corporate branding and style guide for all documents and communications		
		□ Establish and promote organisational point of contact for enquiries to IJB		
A2	Promote and protect the reputation of the IJB	□ Promote and hold public sessions of board meetings ensuring venues are accessible		
		□ Publish minutes and agenda of board meetings		
		□ Develop and agree a media protocol to be adopted by board members and senior management team		
		□ Identity content of media interest pre and post board meetings		
A3	Build stakeholder confidence in the IJB	□ Develop the agree role and remit of all board members		
		□ Publish an annual report		
		□ Published a summary version of the reviewed strategic plan		
		□ Publish locality plans		
		□ Ensure processes are in place for complaint handling, Freedom of information requests		
		□ Develop excellent relationships with key stakeholders		

	Objective	Action	Lead	Timescale
AIM B: EXTERNAL STAKEHOLDERS ARE COMMUNICATED WITH EFFECTIVELY				
B1	Build public awareness of Health & Social Care Moray	□ Establish and promote organisational point of contact for enquiries to IJB		
		□ Develop corporate branding and style guide for all documents and communications		
		□ Develop promotional material (pop-up banners, campaign materials etc.)		
		□ Develop key messages		
		□ Develop and agree a media protocol to be adopted by board members and senior management team		
		□ Develop a forward plan to identify proactive media opportunities		
		□ Media releases are issued and published. Media inquiries are responded to within requested timescales		
B2	Improve the quality and accessibility of service information	□ Review, develop and promote accessible service information in appropriate formats		
		□ Develop, promote and maintain website to share information and signpost to services		
		□ Investigate licencing of My Life portal		
B3	Actively encourage two-way communication using a range of mechanisms	□ Produce and distribute stakeholder newsletter		
		□ Develop, promote and maintain social media sites		
		□ Develop and promote social media guidance for staff		
		□ Run learning sessions for Senior Management team to improve individual engagement with social media – Twitter accounts, blogs etc.		
B4	Develop a monitoring and evaluation framework for communication and engagement	□ Establish key indicators		

	Objective	Action	Lead	Timescale
AIM C: INTERNAL STAKEHOLDERS ARE COMMUNICATED AND ENGAGED WITH EFFECTIVELY				
C1	Improve accessibility of information	Ensure staff have access to key strategic documents		
		Develop organisational chart		
		Develop staff directory		
		Produce integration information for staff recruitment and induction		
		Investigate creation of joint intranet		
C2	Develop and improve internal communication channels based on staff needs	Survey internal communication needs of staff		
		Respond to communication and engagement issues identified through iMatters		
		Put processes in place to ensure staff receive regular, timely and relevant information from chief officer and senior management team		
		Strengthen links with Joint Staff Forum		
		Develop protocols for and access to social media		
		Support staff to have a better understanding		
		Develop staff newsletter – virtual and printed		
C3	Improve engagement mechanisms and opportunities	Communication and engagement to be standing item at all team meetings		
		Establish mechanisms for staff to share feedback and suggestions, ask questions and raise points for discussion with colleagues, the chief officer and Senior Management Team (SMT)		
		Produce schedule of chief officer/SMT service visits and face-to-face briefings		
		Establish programme of workforce development sessions		

	Objective	Action	Lead	Timescale
AIM C: INTERNAL STAKEHOLDERS ARE COMMUNICATED AND ENGAGED WITH EFFECTIVELY				
C4	Celebrate the workforce	Establish annual staff awards		
		Promote good news stories through internal and external media		
		Identify opportunities to contribute to regional and national events and apply for awards		

	Objective	Action	Lead	Timescale
AIM D: ACTIVE AND MEANINGFUL ENGAGEMENT IS ONGOING WITH ALL STAKEHOLDERS				
D1	Identify our stakeholders and their engagement preferences	Map stakeholders and existing engagement groups		
		Develop and maintain stakeholder engagement database to include areas of interest and preferred means of engagement		
		Increase membership of engagement database		
D2	Establish channels and opportunities and build stakeholder awareness about how people can engage with us	Produce online calendar of forthcoming engagement opportunities		
		Promote engagement channels and opportunities through internal and external communication channels		
		Develop online feedback form		
		Provide feedback materials (comments forms etc.) in all internal services		
		Require service user engagement opportunities be identified in all commissioned services and monitor		
		Build relationships to identify opportunities to engage with seldom heard groups		
D3	Use direct experience and feedback	Staff routinely gather and evidence the use of feedback		

	Objective	Action	Lead	Timescale
AIM D: ACTIVE AND MEANINGFUL ENGAGEMENT IS ONGOING WITH ALL STAKEHOLDERS				
	to drive service improvement	in their services		
D4	Build capacity through continuous and meaningful engagement with stakeholders to inform and influence transformation	Ensure resources are in place to address barriers and support stakeholder engagement		
		Implement communication and engagement plans to support all commissioning and decommissioning activity		
		Engage at all stages of the commissioning cycle to identify priorities and shape services		
		Use Visioning outcomes in community engagement (VOiCE) tool to evidence and report on standard of activity		
		Establish Engagement Assurance Group to review VOiCE self-assessment reports and to report on engagement activity, standards and impact to IJB		
D5	Tell people the impact of their engagement	Produce feedback reports on engagement activity for participants and wider stakeholders		
		Develop 'You said, we did' section on website and keep updated		
D6	Support stakeholder participation in key decision-making processes	Establish role and remit of service user and unpaid care representatives on the IJB		
		Establish role, remit and programme of meetings for		
		Strategic Commissioning Group to include stakeholder representatives and promote		
		Establish role, remit and programme of meetings for Strategic Planning Reference Group to include stakeholder representatives and promote		

	Objective	Action	Lead	Timescale
AIM D: ACTIVE AND MEANINGFUL ENGAGEMENT IS ONGOING WITH ALL STAKEHOLDERS				
		Establish and develop locality planning groups with role, remit and programme of meetings to include stakeholder representatives and promote		

For further information or to feedback on this strategy contact:

The Public Involvement Officer
Health & Social Care Moray
9c Southfield Drive
New Elgin
IV30 6GR

Involvement@moray.gov.uk

01343 *567187*

Health & Social Care Moray

Branding and style guide for staff

June 2017

1. Introduction

With the establishment of Moray Integration Joint Board and the operational partnership of Health & Social Care Moray, we need to make it much easier for those we work for and work with to understand who we are and what we do.

We need to present ourselves in a clear, consistent and coherent way to service users, public, partners and colleagues so we can be recognised and perceived in a positive way.

There are some more obvious things like letters and emails, service leaflets and posters that we often think of first when we talk about the importance of having a recognised identity.

While branding guidance may not be something all staff consider is relevant to their role, we need to all take responsibility for Health & Social Care Moray being recognised for the quality services, positive experiences and improved outcomes we deliver.

2. Our approach

We are committed to using the most appropriate channels of communication to reach our wide variety of stakeholders and it is important that we present a strong, consistent and recognisable identity throughout our communications.

Having a single brand identity through the use of our logo, colours and typefaces, will enable us to build a strong reputation, effectively inform, engage and improve stakeholder satisfaction.

It will not only help the public identify with our organisation but also build a sense of integration and belonging among staff.

This branding guidance is designed to help us use our corporate identity correctly, reassuring people that we are an integrated partnership and that our services are being delivered in line with our vision and values.

We will look to brand our work consistently, ensuring a single brand identity by:

- Direction on the use of the name Health & Social Care Moray;
- Making sure staff have access to templates (letterheads, business cards, email signatures, service leaflets, newsletters etc);
- Using a uniform font type and size;
- Ensuring the brand is reinforced through visual media such as advertising;

- Following a style guide to “speak” in one voice which reinforces the same message and tone.

3. One name and one logo

Health & Social Care Moray is the service delivery partnership of Moray Council and NHS Grampian staff working under the direction of the Moray Integration Joint Board.

We deliver a wide range of services so we’ll always be having different kinds of conversations with different audiences depending and that’s fine. However, the name and logo we use should always be the same.

Staff should no longer be using the old name Moray Community Health and Social Care Partnership.

When referring to the partnership, use Health & Social Care Moray in that order, using the ampersand (&) in written communication and starting each work with a capital letter.

In communications always use the full name in the first instance. In subsequent mention of the organisation the name can be shortened to H&SC Moray.

Our logo shows overlapping circles in pink, green and purple. It should appear on all items produced by Health & Social Care Moray.

It replaces the Moray Council and NHS Grampian logos being used together to signify joint working between staff/services in the scope of integration.

It is important we use the logo correctly and consistently across all applications.

For use on the A5 paper the logo should be 25mm in height; for A4 it should be 35mm and for A3 45mm.

If the logo should need to be used outwith the standard sizes then it should always appear in its entirety and not be distorted. Do not add any effects to the logo such as shadow or outline.

The placement of the logo should preferably be towards the left hand top corner.

The ribbon logo incorporated the circles logo above a standard X ribbon on which is mounted our strap line: XXXXXX.

The ribbon logo should be used on the cover of corporate documents such as strategies, annual reports and service leaflets.

Placement should be as either a header or footer.

The logo should appear at the **top left** hand corner of websites, newsletter front pages and other documents like forms, reports and letters.

The logo should appear at the **bottom right** hand corner on all promotional materials like posters, leaflets, banners and so on.

The web address – **XXXXXXX** – must appear on all documentation and literature.

Working with partners

When three or more community planning partners are working together, the Moray Community Planning Partnership (CPP) branding replaces the branding of the individual partners.

Please refer to the guidance on the Moray CPP website www.yourmoray.org.uk.

4. Corporate colours

The core palette of our logo are pink, green and purple. These will be used on our communications and documents to present a consistent identity.

	Red	Green	Blue
Pink	**217**	**28**	**92**
Green	**0**	**166**	**156**
Purple	**43**	**56**	**143**

5. Typeface

As a public body, we have a responsibility and duty to ensure our communications follow guidelines in being clear and readable.

For use on computer-based documents such as Word or Powerpoint, Arial in 12pt is the font which should be used for body text under most circumstances.

Arial regular
abcdefghijklmnopqrstuvwxyz
ABCDEFGHIJKLMNOPQRSTUVWXYZ

Arial bold
abcdefghijklmnopqrstuvwxyz

ABCDEFGHIJKLMNOPQRSTUVWXYZ

Always left-justify text in letters and general documents, but centred text can be used where appropriate on flyers and posters. Never fully justify text as this can be difficult to read.

For large print documents use a minimum of 16 point.

Templates have been approved for:

- Letterheads
- Email signatures
- Agenda and minutes
- Powerpoint presentation
- Reports
- Business cards
- Service leaflets

These templates should not be changed.

Additional templates will be created on request to XXXX.

6. Language and writing style

It isn't always what we say that matters – it's the way we say it. People want to be able to understand all our publications quickly and easily, without having to re-read them.

As set out in our Communication and Engagement strategy, in all our work the language we use should be friendly, open, clear and simple.

Always consider who you are writing for - your audience – and their needs. If you don't understand what you're writing about, it is unlikely they will. If you're writing for the public, put yourself in shoes of a service user, family member/carer or member of the public and ask what it means to you.

Try to write as if you're explaining something in conversation so your language is not overly formal and get to the point.

If you don't keep their interest, some people may only read as far as the first sentence. Less is often more in terms of the written word and sentences should be kept short.

Numbers – Spell out one to nine, and use figures for numbers 10 and above, except when it is the first word of a sentence where the number needs be spelt out. Use commas to break up large numbers: e.g. 7,000 or 70,000.

For places, use first, second, third, fourth up to ninth, thereafter use 10th, 11th

Times & dates – Use the twelve hour clock with no full points for am and pm, e.g. 7.30am, 12 noon, 8.15pm.

Express dates as, for example, 3 June 2017 with no letters following the numbers ('th', 'st', 'nd' or 'rd') and use spaces to separate date, month and year.

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2017

SUBJECT: ANNUAL PERFORMANCE REPORT 2016/17

BY: PAM GOWANS, CHIEF OFFICER

1. REASON FOR REPORT

1.1 To present the draft Moray Integration Joint Board's Annual Performance Report 2016/17 for approval (**APPENDIX 1**). The report aims to show how, through effective leadership from the Moray's Integration Joint Board (MIJB), Health and Social Care Moray has:

- worked towards delivering against our strategic priorities;
- performed in relation to the National Health and Wellbeing Outcomes;
- performed in relation to local measures;
- performed financially within the current reporting year; and achieved best value;
- progressed locality planning arrangements; and
- performed in inspections carried out by scrutiny bodies

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board:

i) approve the draft 2016/17 Annual Performance Report for publication in July 2017, subject to further design formatting; and

ii) instructs the Chief Officer to provide copies of the annual performance report to the IJB's partner organisations Moray Council and NHS Grampian.

3. BACKGROUND

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to produce an Annual Performance Report, setting out an assessment of performance against those functions for which they are responsible.

3.2 Regulations, the Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014, and Statutory Guidance published by the Scottish Government on the content of the Annual Performance report, set out minimum expectations with regards to the content of the report. *(The guidance can be accessed here: http://www.gov.scot/Resource/0049/00498038.pdf)*

3.3 The Scottish Government has not produced a standard template for statutory performance reports, the layout of which is a matter for local determination. However, it indicates that the report must assess performance against the National Health and Wellbeing Outcomes and how the Strategic Plan is impacting upon these.

3.4 In demonstrating progress, IJB's are expected to incorporate the Core National Health and Wellbeing Outcome Integration Indicators, of which there are 23 (and reported regularly to MIJB).

3.5 In addition to a review of performance, this will include other elements specified within the regulations and guidance such as financial performance, locality structures and arrangements and details of any inspections carried out within the reporting year.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Annual Performance Report is required to be published within 4 months of the end of each reporting year. The first year for which IJB's must report is 2016/17, therefore publishing no later than 31 July 2017.

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 makes reference to a range of indicators that inform the Moray 2026 and are set out within the MIJB Integration Scheme. The Annual Performance Report is aligned to national and locally agreed priorities underpinning National Health and Wellbeing Outcomes.

(b) Policy and Legal

None directly arising from this report.

(c) Financial implications

There are no financial implications directly arising from this report.

(d) Risk Implications and Mitigation

None directly arising from this report.

(e) Staffing Implications

There are no staffing implications directly arising from this report.

(f) Property

There are no implications in terms of Council or NHS property directly arising from this report.

(g) Equalities

There are no equality issues directly arising from this report.

(h) Consultations

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

- Legal Services Manager (Litigation & Licensing)
- Caroline Howie, Committee Services Officer
- Heads of Service, Health and Social Care Moray
- Service Managers, Health and Social Care Moray

6. CONCLUSION

6.1 This report recommends the Board approve the draft 2016/17 Annual Performance Report, prior to its publication in July 2017.

Author of Report: Catherine Quinn
Background Papers: With Author
Ref: q:\ijb\june 17

Signature: _____ Date : 21 June 2017

Designation: CHIEF OFFICER Name: PAM GOWANS

Contents

Chief Officer's Introduction

This has been a busy year in the moray Partnership, After extensive consultation and partnership working across the integrated landscape, our strategic plan (2016-19) was endorsed by the Moray IJB 31st March 2016.

We have taken a cautious approach to our ICF investment as we developed our strategic framework and implementation plan, ensuring our investments are prioritised. This provides a significant step forward in progressing change The intention to develop our overarching understanding of the system as it stands and therefore how it can be in the future gives significant opportunity going forward.

We have progressed a strategic framework and implementation plan to ensure clarity about our approach, outcomes and detailed actions in our strategic plan.

Building on learning from the reshaping care programme we have applied a strategic logic model, Reshaping Care for all adults in moray. The model represents four bundles of approaches and activities and the related enablers which collectively improve outcomes for adults.

It sets out the detail of the current landscape relating to reshaping care for adult integrated services across Moray alongside population health and wellbeing, including existing activities underway in terms of change and modernisation within our existing joint strategies.

Also set out in the framework is Moray Partners in Care which is being adopted by integrated services to ensure the philosophy of care supports a proactive approach to changing relationships that makes a difference.

We have agreed to create a single implementation plan which incorporates the activities and work programmes across the system, inclusive of the ICF investment and other funding streams e.g. delayed discharge, primary care.

ICF has been instrumental in supporting the related enablers which collectively will support us to improve outcomes for adults and contribute to the national health and wellbeing outcomes. For example:

- Enhanced TSI capacity through employing a flexible team to create community capacity and build community resilience.
- Enhanced management capacity in Carers provider service to meet the current demand for carers assessment and drive forward funding applications and projects
- Development of carers strategy, consultation events, and respite for carers to attend
- Engagement of service users through a number of strategic workshops

A number of locality implementation groups (with cross sector membership) have progressed around specific pieces of work ensuring that local communities have a voice around service redesign and are involved in planning solutions to meet local needs. As they develop this will strengthen co-production within our localities

Sustainability

The principle of sustainability is aligned with our strategic framework; more integrated care provision, integrated connections between service providers, empowered service users, improved use of technology, support self-care and management of long term conditions.

As a part of our local monitoring arrangements, we are developing quarterly performance reporting and ask all projects to consider exit strategies for their initiatives in relation to longer term sustainability.

We recognise the shift that needs to take place in order to make the resources work adequately, however we are concerned as to how sustainable this will be with the demographic changes expected, the increase in multi-morbidities, the reduction in working population, the increasing age of unpaid carers and the workforce challenges.

It is difficult to evidence that specific initiatives are sustainable as most are not embedded in the system and some have a preventative nature.

We will strive to ensure we implement sustainable practices which demonstrate change at a local level and improve outcomes for the adult population.

Successes

It is unlikely that specific initiatives have made an impact on the high level measures as most are not quite embedded in the system yet. However there are pockets of improved performance.

An increase in both the delivery and flexibility of respite provision based on local demand.

An increase in the number of people of adults over 65 receiving 10+ hours of home care.

Engagement of Housing has been very successful with plans for older peoples housing which meets their needs included in the draft local housing plan. Further plans are being developed around extra care sheltered housing and the recruitment of an officer to examine the process around adaptations. This has enhanced our relationship with housing and the work we are progressing regarding outreach housing support and the development work with sheltered housing.

The engagement of wider stakeholders particularly GP's has been vital to the planning, developing and implementing of our change fund programme. All partners have developed a shared understanding of the priorities for older people in Moray and have a better awareness of what commissioning is and the principles that underpin excellent commissioning.

Most change fund activity in Moray was around community based services to build community capacity and further develop an anticipatory and preventative approach to care. It will be a number of years down the line before we see the impact of these changes.

This included the investment in additional short term beds in care homes which reduced the pressure on community hospitals to take out of area patients and provided an alternative to hospital admission

Challenges

Significant challenges that the partnership has faced as we develop integrated arrangements have included:

Moray is a small area and the sheer scale and pace of change, and how to make long term shifts towards prevention in the face of immediate and short term pressures from the rising demand and significantly reduced funding was a major challenge in our small partnership.

Commissioning Approach

Leads across the partnership now have a shared understanding of commissioning and the principles underpinning it.

This has included an element of Cultural change in the way that health and social care work together to provide better outcomes for all adults and use our total resources more efficiently and effectively which in turn supports the work in relation to the integration agenda.

Carers indirect impact

Our largest investment in increasing the capacity of community based health and social services within the preventative and anticipatory care workstream will lead to proactive rather than reactive care and will support sustainability of the caring role alleviating the stress and worry of increasing and complex needs of people often dealing with multiple long-term conditions and at risk of hospital admission. Improving the outcomes for the care-for person by supporting the carer to support them in self-management and ultimately avoid hospital admission.

Strategic Context

Health and Social Care Moray was formally established in April 2017 and brings together a wide range of health and social work services in to a single operational system. The Moray Integration Joint Board (MIJB) is responsible for planning and overseeing the delivery of a full range of community health and social work/social care services and is also responsible for a number of Grampian health services relating to Primary Care.

Throughout the course of 2016/17, the MIJB has taken key decisions in relation to the establishment of the Partnership including the appointment of Officers, the delegation of functions and operating and governance arrangements.

"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."

It has also agreed the Strategic Plan 2016-19; and the establishment of a committee structure responsible for overseeing health and care governance, performance and audit, risk management, health and safety and other matters. Our vision was developed by listening to the views of people who use health and social care services, unpaid carers and those who deliver services in Moray and the wider community:

Reshaping Care for Older People: programme and associated Change Fund enabled the partnership to accelerate local progress and to develop plans to drive sustainable improvements in the national outcomes that relate to the care of older people. It enabled us not only to shift the location of care (from institution to community) but also to transform the culture and philosophy of care from reactive services provided to people towards preventative, anticipatory and co-ordinated care and support at home delivered with people.

Housing as Partners: Housing has become a key partner in our joint commissioning process. The partnership acknowledges the vital contribution that housing can make to improving health and wellbeing outcomes.

Community Care Redesign: programme aims to meet future demand. A single point of access to community care is established. The access service provides an early intervention and preventative approach to care with greater choice and control over the support people need.

Moray Partners in Care: Community care has developed a new model of care and support in the community which promotes independence and supports greater choice and control and improved outcomes. It is based on three offers – Help to help yourself, help when you need it and ongoing support for those that need it.

Improvement Programmes currently underway in Moray include:

- Modernisation of Primary Care
- Focus on Dementia
- Self-Directed Support
- Unscheduled Care
- Older People in Acute Care
- Patient Safety Programme
- Long Term Condition Action Plan

All of these components co-exist and as we move forward we will seek to continue to build on this good work, evolving through the identification of local needs with the aim of building community resilience in Moray.

Moray tends to have a health profile that is better than the Scottish national average. Overall Moray has:

- above average educational attainment, employment, income
- below average crime, homelessness, alcohol-related mortality and hospital admissions
- average smoking rates
- health condition prevalence rates that are similar to, and often lower than, the national average; some emergency hospital admission rates that are higher than elsewhere in Grampian, lower multiple admission rates nationally
- above average fuel poverty, traffic accident casualties, and potential geographical challenges to equal access to services

National Outcomes

The 9 National Outcomes guide the activity of Health and Social Care Moray are:

Health and Wellbeing Outcomes

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 well-being.

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.

National Health and Wellbeing Outcomes

The National Health and Wellbeing Outcomes, are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. These outcomes provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using these services, carers and their families.

The following pages provide an assessment of our performance against these outcomes; and against agreed core national integration indicators linked to these outcomes. The core integration indicators provide an indication of progress towards the outcomes that can be compared across Partnerships and described at a national level over the longer term.

Performance against the National Health and Wellbeing Outcomes

Performance against each of the National Health and Wellbeing Outcomes and associated National Performance Indicators is detailed in the following pages. Where relevant, performance against associated Local Performance Indicators is also provided. The extent to which implementation of the Strategic Plan 2016-19 is contributing towards meeting the National Health and Wellbeing Outcomes is noted below with each associated action cross referenced within the foot-notes.

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

National Health and Wellbeing Indicators

An associated core suite of 23 National Performance Indicators has been developed, drawing together measures that were felt to evidence the nine National Health and Wellbeing Outcomes. Of the 23 indicators, 14 evidence the operational performance of Health and Social Care Moray - with the data provided by the NHS Information Services Division (ISD). The data for the remaining 9 indicators is taken from responses from the Scottish Government's biennial Scottish Health and Care Experience Survey.

Outcome 1

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

To support our strategic outcome 'more people will live well in their communities', we are committed to growing community capacity that focuses on early intervention and a preventative approach. Our approach is to provide care, based on co-production principles, developing new community driven models of care, and to help people maintain their independence wherever possible.

Our 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.

We have commissioned 6 Mental Health GP Link Workers across Moray to signpost to a range of alternative community and non-medical resources, services and opportunities that can contribute to people's health and wellbeing. These include arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help. People can also get support with issues relating to employment, benefits, housing, debt, advocacy support, legal advice or parenting.

The referral rate has been high so far with some link workers already having caseloads of 40+. The nature of the contact is that subsequent to a holistic assessment the link worker remains in touch with a person for 'up to 12 months' depending on the circumstance and only as appropriate. The individual works on tasks/goals that they have defined and touches base with the link worker to review their progress on them. It has been found that some people have needed a bit more practical support in the initial stages.

It is important to people with addictions that they are seen as early as possible and a national target has been set – 90% of people referring for drug and alcohol support must be seen within three weeks. We have performed above this national target, and well above the Scottish average.

Performance has improved throughout 2016 with the Moray team successfully seeing 100% of service users within 3 weeks.

To further develop our locally provided community based services, Mental health charity Penumbra was commissioned to provide a new mental health and wellness centre in Elgin. The service acts as a 7-day per week, single access point for a range of adult services designed to promote positive mental health and support people to recover from mental ill health, concentrating on prevention, early intervention and education whilst also supporting people to access a range of advice and information in other areas, such as finances, benefits, housing, healthcare, and employment and educational services. Health and Social Care Moray will provide the charity with funding totalling nearly £1.2 million over the next three years to provide the service. The Centre is part of Moray's new Mental Health and Wellbeing Strategy, Good Mental Health for All in Moray. The Centre opened in March 2017, initially to provide a service for Elgin residents before service provision is expanded to include all of Moray in April 2018.

We are continuing to promote community wellbeing by working with our partners to deliver a range of groups and events across our localities. Vintage Tea Parties are being held with the aim of developing resilient communities promoting a culture of choice, independence, positive health and wellbeing for older people.

Vintage teas have been delivered in: Keith, Elgin, Forres, Fochabers, Buckie and Lossiemouth to date.

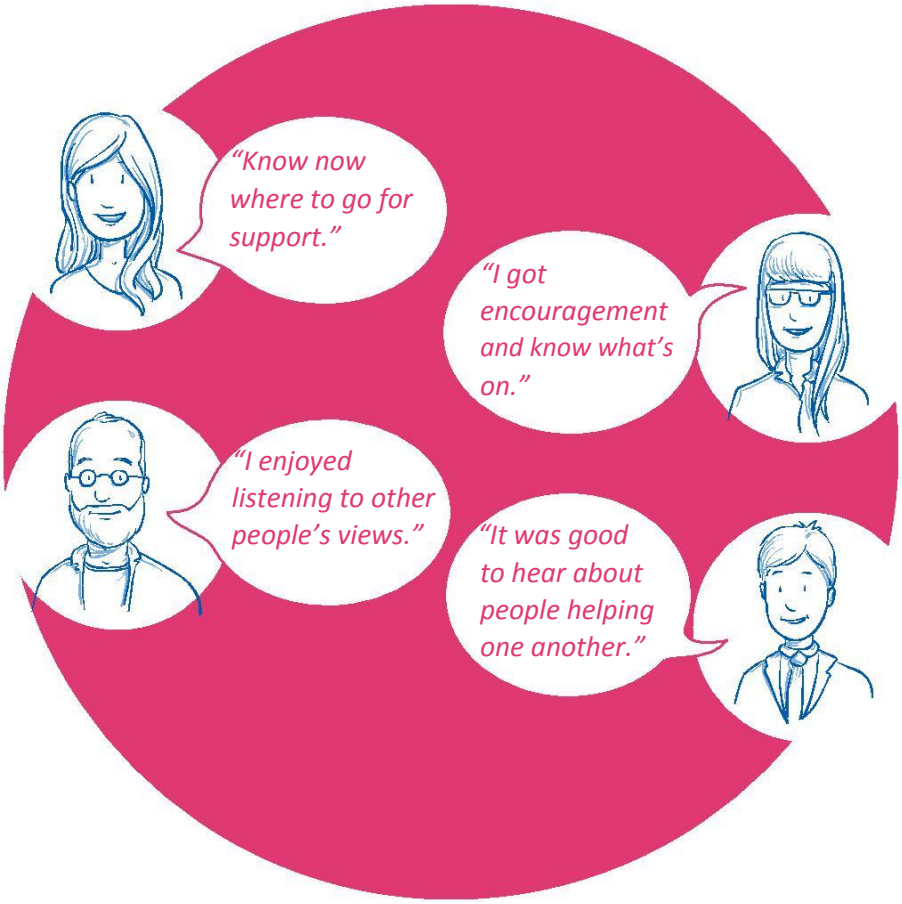
Over 600 older people have engaged and participated in the events.

Priorities are identified in each locality which support self care/ self management and people living independently at home for as long as possible.

Impact reports with recommendations are presented to each locality lead officer and support the Older People's day service review.

Outcomes to date have included Men's Shed development, peer befriending (increased volunteering opportunities both formal and informal) and increased access and awareness of community and public transport services.

A key asset in working in and with communities is the Outreach Mobile Information Bus. Working in collaboration with communities and Community Planning partners, the OMIB Service enables us to address health inequalities and promote social inclusion, by taking a more integrated and focused approach to supporting vulnerable and often more isolated communities; strengthened community partnerships will improve health and wellbeing outcomes.



Our partnership approach; delivered through the OMIB Service helps us:

- Build relationships, trust and capacity within communities, maximising opportunities for health gain.
- Increase community engagement and involvement by providing another mechanism for two-way communication with communities, not only giving but gathering information related to unmet health and social needs in the local areas.
- Increase access to approved information, advice and support to enhance community resilience.
- Support specific/targeted interventions through planned programmes as well as providing as a rapid response service.

Outcome 2

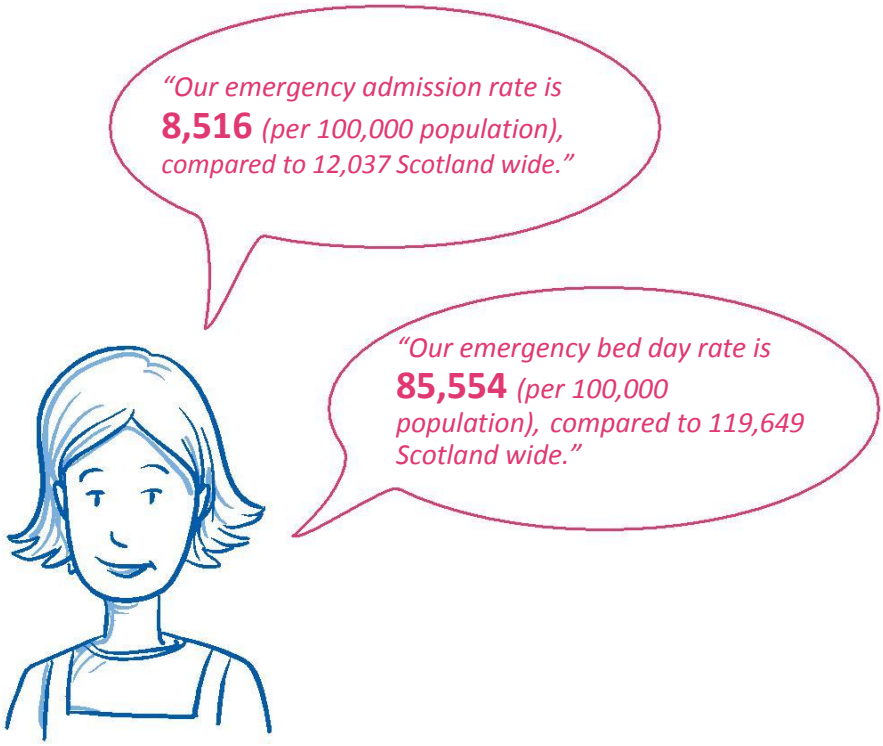
People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Addressing the issue of unscheduled care was a key driver of the Integrated Care Fund programme for 2016/17. Moray is currently below the National average for both Emergency Admissions and Bed day rates.

A lower percentage of adults with intensive needs receive personal care at home at 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.

The proportion of people who spend the last 6 months of life at home or in a community setting (90%) has remained level over the past year and remains close to the national average of 86%.

The Urquhart Place project underlines our commitment to support people to life as independently as they can. Construction of a £2.5 million housing development in Lhanbryde is nearing completion and preparations are underway to welcome the first four tenants. All are adults with severe learning disabilities who need support to carry out daily living tasks, look after their general health and wellbeing and take part in social activities. The bungalows at Urquhart Place will be fitted with technology such as door and bed sensors and an alarm call system. This will reduce the need for the tenants to have staff with them around the clock so they can stay safe while enjoying the privacy of living in their own home.



In partnership with Hanover Scotland and Moray Council, Varis Court is a purpose built development to provide 'close to home nursing care' for older people including dementia and extra care facilities. The development provides 33 individual flats with additional communal facilities including 2 courtyards. Staff onsite will support people to manage their tenancy, provide meals and extra care depending on the tenancy. The dementia friendly properties include bespoke communal facilities including dining area and access to prepared meals, activity and relaxation areas along with staff facilities. Tenants of the extra care flats will have access to care and support provided by onsite staff.

In February 2017, 6 vacant houses were transformed into halfway homes for people ready to leave hospital. The £120,000 project provides a homely environment where people can work on regaining their independence. During their short stay in the cottages, they are supported by a team of staff to manage everyday living tasks such as getting in and out of bed and preparing meals. The specific rehabilitation aimed at the Jubilee Cottages differs from standard rehabilitation in the way that the service is provided in a low risk, controlled home environment through high intensity and collaborative rehabilitation to foster an encouraged independence to return home in a maximum of 6 weeks. The rehabilitation service is provided free of charge by the Community Care Department and cottages are equipped with a telecare service to provide a 24-hour on call response. The project opened in February 2017 and currently has 3 residents.

"Some carers diligently carry out their tasks and offer excellent support. Others take less time and care."

"Personal care always done with respect and dignity."

"The care could not be better and the ladies attending my wife are so pleasant and efficient. Quality rating 100%."

"The carers are friendly, put me at my ease and I feel secure that they will assist me at the beginning and end of each day. I depend on them and trust them. They are all very kind and considerate of both myself and my husband and we appreciate that a lot."

During the final quarter of 2016/17, we worked to deliver the aims and aspirations in the Scottish Government's 6 Essential Actions to Improving Unscheduled Care Programme (Winter Plan). This plan set out the need for Health and Social Care Moray to provide safe and effective care, ensuring flow through additional surge capacity and ensuring continuity of Social Care access for people.

Our staff demonstrated the highest levels of commitment and endeavour in supporting people to remain at home.

"Excellent care service, allows me to be independent and stay in my own home."

Outcome 3

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

The SDS Residential Care Project focuses primarily on older people and people with learning disabilities; its aim is to explore the potential benefits Self Directed Support (SDS) can offer people living in residential care or residential accommodation and its impact on people, providers and processes. The Moray project is one of two test pilots in Scotland and will be used to inform both local and national learning.

To further support our commitment of shifting the balance of care, in early 2016, we established a Dementia Action Group for people with dementia who wanted to become involved in training or service development, utilising their personal experience of dementia.

*"**78%** of adults receiving care or support rated it as good or excellent. That's an increase of 3% since 2013-14. The national average is 81%, and at our presnet rate of improvement we should attain that during 2017-18."*

*"**87%** reported positive experiences of care within their GP practices, an increase of 2% since 2013-14, putting Moray above the national average!"*

*"**72%** of adults are supported at home agreed that they had a say in their help, care or support. The national average is 79%"*

Outcome 4

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

In early 2016, we extended the team at Ardach GP practice with an ICF funded project designed to assess, provide and co-ordinate person centred care in the frail, complex patient with multi-morbidity. A Frail Elderly Nurse Co-ordinator was appointed to identify frail older people with complex multi morbidity, with or without co-existing dementia and coordinate access to assessment services and re-enablement with the aim of reducing hospital admissions, out of hours contacts and A&E attendances. The project effectively promoted frail elderly to remain safely in their own homes utilising prevention and early intervention tools.

The majority of co-morbidity of physical and mental illness in acute hospitals affecting older people is due to three disorders: Dementia, Depression and Delirium. These conditions are a predictor of increased length of stay. We tested out an older adult liaison service with staff based in the Acute hospital to increase the detection, recognition and early treatment of older adults inpatients with co-morbidity, physical and mental illness.

The report 'Pulling Together – transforming urgent care for the people of Scotland' was led by Professor Sir Lewis Ritchie OBE and recommended developing a set of national standards for urgent out of hours care and the development of an implementation plan to support these recommendations. During 2016, we established a Transforming Urgent Care Group across Grampian to ensure our services are fit for purpose in providing services underpinning the 28 recommendations within the report. Our services will be shaped to ensure we:

- Deliver high quality, safe and clinically sustainable services
- Increase in use of alternative service
- Focus on prevention & self care
- Ensure patient's receive the right advice, care at the right time and place
- Connecting urgent care services together more efficiently
- Design a better service to include the right skill mix of professional support for people during the OOH period
- Reduce attendance in Emergency Department and Out of Hours

Good Mental Health for All: we set out a shared vision of change developed by people with lived experience of mental health, their family members and people involved in health and social care working together. The strategy was launched in 2016, written for everyone of all ages to provide opportunities for better promotion, prevention and early intervention in mental health while creating more responsive and effective recovery focused services for people with mental health problems. The strategy has

Case study
Frail elderly co-ordinator

Mrs and Mrs C are both in their eighties.

Mrs C has a number of long-standing health issues including breathlessness and dizziness and is unable to walk for any distance. Her husband is concerned about going out and leaving her on her own.

The couple felt medical professionals never got to the bottom of her condition despite a number of hospital admissions.

They struggled with their home not being suitable for Mrs C's needs. Mr C has made changes to their sleeping and living arrangements to try to ease his wife's condition and has been supported by their family.

The frail elderly co-ordinator visited the couple at home. She carried out a blood pressure check and was concerned over Mrs C's variable heartbeat. She arranged an ECG at Ardach and Mrs C was admitted to ARI to be fitted with a pacemaker.

The co-ordinator arranged for handrails to be fitted on the stairs which enables Mrs C to continue sleeping in the bedroom.

Mr C said: *"The co-ordinator was very helpful and sympathetic. It was reassuring to know she could come here and visit us at the house. Someone like her should be visiting all older people."*

been informed by what people have said is important to them, an analysis of available evidence about mental health needs and issues, best practice and national evidence of what works in addressing mental health and wellbeing. The strategy sets out priorities for what a new mental health strategy should aim to achieve over the next decade and where mental health issues need to be considered in a range of other policy areas.

The Making Recovery Real in Moray programme via the Moray Recovery Partnership consisting of the Scottish Recovery Network, local partners and those with lived experience of mental health problems will be a key driver in the delivery of the strategies recovery focused priorities and objectives. This will ensure that recovery focused principles and values, and the experience of those with mental health problems are at the centre of delivering upon our shared vision for good mental health for all in Moray.

The Learning Disability Transformation Project is a 15 month initiative that takes a whole systems approach to improving the way that the Integrated Learning Disability Team supports the delivery of better outcomes for people who access learning disability services in Moray. The overarching aim is to help adults with learning disabilities achieve their aspirations for independence.

The project will focus on 3 key work streams; professional practice development (CLDT), commissioning support and in-house support. At the end of the initiative, the project will have supported the Moray learning disability team to support the delivery of better personal outcomes for people in a more financially sustainable way.

Outcome 5

Health and social care services contribute to reducing health inequalities.

Quarriers Arrows Service was commissioned to provide drug and alcohol support for anyone worried about drug and alcohol use, whether their own or their loved one's. The service was established in August 2015. Arrows supports anyone with any concerns about drinking, drugs or legal highs. It also supports friends and family to understand and discuss problematic substance use with their loved ones. One-to-one peer group support helps to build motivation, set goals and manage addictions/dependency using Cognitive Behavioural Therapy approaches and Motivational Interviewing.

In the planning and development of the pop up cafes, Arrows have developed links with community assets and groups, receiving positive and encouraging feedback in terms of inclusion and recovery support. This has encouraged both staff and service users and is a successful first step in establishing a recovery friendly community. Our cafes were successful in engaging a different user group in the consultation process and we now have a more solid foundation of broader feedback and evidence from which our year 2 development plan will be built.

Making every Opportunity Count is an ambitious, integrative and transformative 3-tiered approach for cultural shift with everyone, every system and service doing a little to enable service users, and providers, to keep well. MeOC is designed to support a common way of preventive working suitable for all public and third sector services by providing a simple approach to the 'how'; the principles and practice are embedded within Health and Social Care services as part of core business. This approach is endorsed by the Health and Social Care Partnership Moray.

MeOC supersedes and builds on the principles of Keep Well health inequalities sensitive programme; supporting the transition from a funded, target driven programme to a set of clearly identified, sustainable processes and flexible tools to address health inequalities.

Health & Social Care Moray Keep Well Performance: 2016-17						
	Wellbeing Checks			Wellbeing Brief Interventions		
	Annual Target	Achieved	Achieved as % of target	Annual Target	Achieved	Achieved as % of target
Moray performance against its share of the NHSG annual targets	170	301	177%	58	150	259%

The target has been achieved and exceeded; through Primary Care and links with a range of Community Planning Partners, such as Quarriers (carers), Department of Working Pensions, and Health and Social Care workforce.

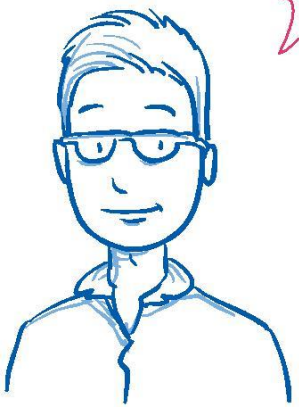
Outcome 6

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

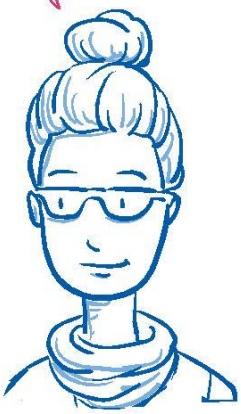
In line with the Carers Act 2016, we undertook extensive consultation with unpaid carers and professionals to develop our new Carer's Strategy. Carry on Caring 2016 – 2019 was launched in 2016. We undertook extensive consultation ensuring ownership of the strategy for carers. The strategy has built on all the work that has been achieved by previous strategies as well as supporting the development of current services and information for carers.

Carers in Moray state that they want to be able to continue in their caring role. The Social Care (Self Directed Support) (Scotland) Act 2013 introduced the principles of Self Directed Support into mainstream delivery of Community Care. Through the implementation of SDS, we have been able to devise new paperwork to assist with assessment and support planning enabling us to promote choice, control and flexibility, the ethos of SDS. Moray was one of two successful bids to the Scottish Government to look at testing all of the SDS options with Residential Care. A project team has been recruited for this test project and work is underway in relation to this. There will be liaison with Scottish Government, East Renfrewshire (other successful local authority) to look at SDS and residential care over the next two years. We will be working alongside providers of residential care in Moray to develop the process to test out the viability of allowing all four of the SDS options to be chosen when accessing residential care, in particular that of Direct Payments (Option 1 of SDS).

*"**217** people have completed a carer's assessment in Moray."*



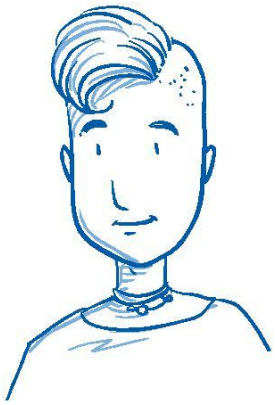
*"**7,809** people in Moray provide unpaid care, thats about 8% of the population."*



*"**43%** said they felt supported to continue in their caring role, +2% over the national average."*

"Employers should interview and employ people with disabilities. It is all very well to have reasonable adjustments once you have the job. It is all those people with hidden disabilities that fall between a physical and a mental impairment who are excluded from work and benefits. Not only do carers lose money as they often work part time, they are caring for someone with no prospect of employment which can result in mental health problems including low self-esteem for both the carer and the cared for."

"As someone caring indirectly for elderly parents in failing health and a disabled child and having to work full time, knowing that when I contact the council someone will ring me back would be good. Having rung social work more than once regarding my parents and never getting a response was really frustrating."



"Ensure that all carers are identified and that they are fully aware of the support, help and guidance that is available to them, and what benefits they may be entitled to as unpaid carers. Ensure that all the services and officials that they come into contact with are understanding and sympathetic to their needs."

"Since I began receiving support through the Quarriers Carers Support Service (Moray) I have felt less alone as a carer and feel significantly more confident in my caring role. Also the knowledge that there is support there (should I use it or not) helps me get through the tougher times."

"I think that it is important that people be assisted to think about the future when they care for someone e.g. if the cared for person's care needs increase; if the wellbeing of the carer decreases; and such practical issues as Power of Attorney, encouraging people to express their wishes for their future."

Case Study
Self Directed Support

Paul and Barbra Zealand use Self Directed Support to employ a team of five part-time personal assistants to enable their two sons to live life to the full.

That means Alex (21) is able to run his own business mowing lawns and cleaning windows, while Callum (18) works and trains at a social enterprise project near Banff, as well as working alongside his big brother.

Mrs Zealand said: *"There is no need for people with disabilities to sit on the side lines and watch life go by. Having a job and the self-worth that brings and being able to be part of the community – we always said we didn't see why people with disabilities shouldn't have that."*

With employment prospects limited for Alex, the family – who live near Buckie – used his SDS Direct Payment to make the change he wanted in his daily life.

"We started off employing two care workers three years ago. It was nerve-wracking as we didn't know how things were going to work out. What would we do if someone called in sick or they just didn't work out for instance?" Mrs Zealand explained.

"We have just learned so much as we've gone on and found that things have fallen into place. As long as you are open and honest and care for your care workers, they will do the same for you."

The team of care workers grew to five once Callum left school and they now work with both boys.

"They are employed to enable the boys to live their lives - lives which mean going to work, going swimming and going to see a film. Alex and Callum need their care workers alongside them to enable them to have that," Mrs Zealand added.

Alex was attending a local day service but wanted to work and he started off by cutting grass two days a week for elderly residents who would struggle to carry out the task themselves.

Demand for his hard work and enthusiasm grew, so much so that Alex now works four to five days a week, carrying out a range of tasks which have expanded to include power washing patios, repairing garden furniture and making wooden planters. He now has his own workshop.

Mr Zealand said: *"Six months on he started walking tall and looking you straight in the eye. He is very proud of the work he does."*

Callum and his parents decided that Boynie offered a great opportunity to work, be with other people and learn new skills. He attends two days a week with one of his care workers, travelling by bus each day, and works with Alex for two days.

Mr and Mrs Zealand believe that when people are asked by their social worker what they want for themselves or their family member, they often don't know be-cause they don't know what is out there. They would urge others to think about using a Direct Payment to employ their own staff and enable them to go for their goals.

"We have to be imaginative in Moray and SDS is the way to do that," said Mrs Zealand. *"Don't worry that everything is set in concrete from the start, you can change things as you go along. That's the beauty of SDS – you can tweak it and make it work your way."*

The family do their own accounts as they like to have a real-time overview of how things are adding up. It's important, they stress, that you realise it's not your money to go and spend; it's public money so you have to be able to account for it.

Mr Zealand added: *"People do worry about getting it wrong and so do nothing and that's the worse thing."*

Outcome 7

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

We resurrected our Falls Steering Group in order to provide governance and guidance around the uninjured falls pathway and the falls response team pilot. The group is currently looking at the pathway for follow up care post hospital discharge and osteoporosis patients who are frequent fallers.

Another development over the year was our pilot of a Falls Response Team. The Falls Officer interfaces with Out of Hours Social Work, Independent Living Service, Marie Curie (Out of Hours) carers, Community Alarm, volunteer responders, GMED, Fire, Police, Ambulance and 999 call handlers. An attendance and lift, if faller uninjured the pathway leads to a level 1 screening tool being filled out and forwarding on to the relevant District Nurses for onward care. More engagement is needed with the out of hours pathway to ensure reliability and it is anticipated interface with the Out of Hours Social Work pilot project will accomplish this.

With support from the clinical lead GP on the Integration Joint Board, a joint letter has been circulated to all GPs in Moray to open the door for engagement around falls. It is anticipated that this will allow data sharing in identifying our population most at risk of falls and work towards a preventative pathway.

UPDATE CHART – TONI LEE GETTING

People supported at home reporting feeling safe stood at 81% which was an increase of 5% from 2015/16. However, this remains lower than the national average of 85% and we continue to address this.

The aim of the Scottish Patient Safety Programme is to reduce the number of events which could cause avoidable harm from care delivered in any setting. Work has been undertaken in the following areas in Primary Care: Safety Culture, High Risk Medicines and Safer Medicines, Pressure Area Care, Safety at the interface including results handling.

In Mental Health, monitoring the use of non-pharmacological interventions are being used before issue of as required medicines, implemented a communication tool in order that both medical and nursing staff receive the right level of information to determine whether they agree to an admission/transfer of a patient from the acute sector of the hospital. This will be tested and changed where indicated. Nursing and medical staff are determining whether changes are required to nursing/medical documentation in order to monitor whether patients have had the offer of relevant health checks where their stay in hospital has missed this opportunity e.g mammogram, dentist, smear test, 50 year old bowel cancer check.

Within our Out of Hours Primary Care (GMED) service, in order to ensure practitioners were delivering safe and effective care for patients, an “Audit of GMED Practitioner’s Consultations” was carried out. The sample included Salaried GPs, Nurses and Paramedics. The aim was to examine the documentation, consultation and diagnostic skill and treatment plans. In total 463 consultations were reviewed. Overall there has been little change in the results from the first audit carried out in 2011 to this audit in 2016, although a significant improvement in the quality of record keeping from 2011 to 2016 has been made. For the majority of patients seen by both GPs and Nurse Practitioners, the assessment, diagnosis and treatment plans were satisfactory. It is reassuring for patients, staff and management that in the majority of cases clinicians are providing safe and effective care to patients Out of Hours.

Feedback on the audit results was provided to all Practitioners as this is an important method of facilitating learning. A GP will also provide teaching sessions to the Advanced Nurse Practitioners on their case results. We will re-audit again later in 2017.

Outcome 8

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

Workforce development and planning is being taken forward on a number of levels and this is being translated into an Integrated Workforce Plan and an agreed Organisational Development Plan underpinned by current activities. A Workforce Forum has been established to support employee relations and is focused on encouraging a healthy organisational culture. We are measuring our success by the implementation of the iMATTER programme rolled out across all our teams in November 2016. The iMATTER programme seeks to empower staff in fulfilling their potential as teams. Our 2016 results were as follows:

iMatter Questions	Staff Experience Employee Engagement Components	Average Response Percentage
I am clear about my duties and responsibilities	Role Clarity	86%
My direct line manager is sufficiently approachable	Visible and Consistent Leadership	85%
I would recommend my team as a good one to be a part of	Additional question	83%
I feel my direct line manager cares about my health and well-being	Assessing Risk and Monitoring Work Stress and Workload	83%
My work gives me a sense of achievement	Job Satisfaction	82%
I am treated with dignity and respect as an individual	Valued as an Individual	82%
My team works well together	Effective Team Work	81%
I have confidence and trust in my direct line manager	Confidence and Trust in my management	81%
I am treated fairly and consistently	Consistent Application of Employment Policies and Procedures	80%
I understand how my role contributes to the goals of my organisation	Sense of Vision, Purpose and Values	79%
I get the information I need to do my job well	Clear, Appropriate and Timeously Communication	78%
I would be happy for a friend or relative to access services within my organisation	Additional question	78%
I have sufficient support to do my job well	Access to Time and Resources	77%
I am confident performance is managed well within my team	Performance Management	76%
I am confident my ideas and suggestions are listened to	Listened to and Acted Upon	74%
I feel involved in decisions relating to my team	Empowered to influence	74%
I would recommend my organisation as a good place to work	Additional question	73%
I get enough helpful feedback on how well I do my work	Performance Development and Review	72%
I feel appreciated for the work I do	Recognition and Reward	72%
I am given the time and resources to support my learning growth	Learning and Growth	71%
I am confident my ideas and suggestion are acted upon	Listened to and Acted Upon	69%
I feel involved in decisions relating to my job	Empowered to influence	69%
I feel my organisation cares about my health and wellbeing	Health and Wellbeing Support	69%
I get the help and support I need from other teams and services within the organisation to do my job	Appropriate Behaviours and Supportive	

iMatter Questions	Staff Experience Employee Engagement Components	Average Response Percentage
Relationships	69%	
I am confident performance is managed well within my organisation	Performance Management	62%
I have confidence and trust in senior managers responsible for the wider organisation	Confidence and Trust in my management	62%
I feel senior managers responsible for the wider organisation are sufficiently visible	Visible and Consistent Leadership	60%
I feel involved in decisions relating to my organisation	Partnership Working	56%

Gold for Moray

We celebrated maintaining the Gold Healthy Working Lives (HWL) award. The accolade from Health Scotland recognises the organisation as an employer who strives to create a safer, healthier and more motivated workforce and helps improve the health, safety and wellbeing of everyone.

Moray was the first sector within NHS Grampian to achieve Gold status in 2010 and is seen as an exemplar HWL client. The award has been achieved by offering a wide range of activities, opportunities and information to staff to help address their needs. Staff engagement really is at the heart of business. One of the most successful initiatives has seen the innovative staff Weight Management Programme which has seen sustained weight loss for the vast majority of those attending a variety of sessions bringing together exercise, cookery and psychological support.

"Our greatest achievement is that HWL is now seen as part of core business rather than simply an award"

HWL working group member

During August and September 2016, we delivered 4 single days of development for Home Care workers. 420 care workers were invited to attend the conferences and 314 people attended. Home Care staff were asked during the evaluation how they felt at present, with where they are now in Care at Home. Of those that took part in the evaluation, some 224 people, 81.7% noted a positive attitude and recognised the benefits of behaviour change in regards to the subjects covered. Furthermore staff spoke of how they felt appreciated and valued. It gave them according to a number of respondents, an increased sense of self-worth. Just 27 people, 12% felt that the day had no effect on them in either positive or negative ways. The feedback wall gave us a host of information and overall the comment that care workers made was, that they need to feel communicated with. Many of the comments noted that it recent months there had been huge strides made in this area in positive ways. Safe Administration of Medication was clearly a concern for many and the exercises and workshop completed on the day were very popular with 79.4 % of attendees commenting positively on the section. Clearly this is an area that needs improvement.

Our staff embraced the move from one of our key sites at Spynie Hospital to a new purpose-built accommodation. The Spynie site had a significant backlog maintenance cost, with the buildings deteriorating over the years. Some 130 staff moved to new accommodation in February 2017, with the majority moving to Southfields in Glassgreen, Elgin. The move gives us the opportunity to maximise capacity across our other sites and crucially has provided staff with an open plan arrangement the benefit of enhanced flow of information and team work.

Outcome 9

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

The number of people waiting to be discharged from hospital when they are ready (Delayed Discharges) peaked within 2016/17. This is due to recording timeframes of 72 hours being implemented, and as a result the incidents appear to increase.

Homecare has been reported as well coordinated and delivered within Moray, scoring 77% over the national average of 75% within Scotland. There has been a major shift within the delivery of home care, staff are now working with increased flexibility and availability rather than working fixed packages and with the successful launch of Varis Court supporting the reablement and recovery of people who have recently been discharged from hospital.

Through our Delayed Discharge funding, we operated a 7 day service which has ensured patients were assessed within 24 hours of referral by physiotherapy and Occupational Therapy at Dr Grays Hospital.

Healthpoints and heathline offer free and confidential health advice from trained staff on a wide range of topics:

- Practical ways to improve your health
- Your health concerns
- Support groups and organisations
- How to access NHS services
- Long term conditions e.g. Diabetes, Asthma
- Access to free condoms
- Access to smoking cessation services

The number of enquires in 2016/17 = 11112

The top 3 enquiries were focused on: Nutrition/weight management, Physical Activity, Request for NHSG services.

There were 36 requests for Carer's information.

There were 41 requests in relation to social welfare

Case study
Health Point

Kevin, a diabetic in his fifties, recently lost both big toes through complications associated with diabetes.

During his weekly visits to podiatry, he visited healthpoint for advice on how to make changes to improve his health and wellbeing. Since his 'drop-in' visit in January 2017, Kevin has been supported to lose just over 5 stone (15% of his body weight); he is absolutely delighted and feels great.

Kevin used to take a taxi for his return journey to his podiatry appointment at DGH, but now he walks and uses the 'taxi' money to pay for two sessions at a local gym.

Reporting on Localities

The delivery of health, social and community care is changing. From April 2017 the Integration of Health and Social Care brings services together in a way that will deliver coordinated care that is easy to access and is focused on the best outcome for the individual person.

In practice this will mean NHS and Council staff and those from the third and independent sectors working with service users, carers and community-based groups to plan and deliver care and support that is designed for the individual.

This is known as 'locality planning' and it is a key part of health and social care integration. It is also a legal requirement under the Public Bodies (Joint Working) (Scotland) Act, 2014

Significant progress has been made in 2016/17 on the development and approval of a locality planning framework for Moray which will be at the centre of efforts towards changes in the balance of care by growing capacity in local communities, developing local assets, and through locality planning groups providing local forums where local people and professionals from across the sectors can meet to discuss local needs and priorities and seek to have these inform and be reflected in the Partnership's Strategic Plan.

Lead Partnership Responsibilities

The MIJB is the lead for the following services on behalf of the three North East IJBs:

This means that the MIJB is responsible for the strategic planning and operational budget of these services.

COPY AND PASTE FROM STRATEGY

Inspection of Services

Internal Services

Internal care services, such as Home Care, Day Care and Respite are regulated and inspected by the Care Inspectorate. In 2016/17, x care services were inspected and the table below shows the evaluations awarded to each service. The table also indicates whether any recommendations were made by the Care Inspectorate. Appendix x provides further detail on the actions taken by each service to address the recommendations.

REPLACE…

A joint inspection of services for children and young people in Moray under the auspices of Moray's Community Planning partners was carried out between August and November 2016, led by the Care Inspectorate with input from other inspection agencies.

Whilst the report indicated that individual services were operating well, there were significant findings in relation to how partners were working together to improve outcomes for children, young people and families.

The report indicates areas of strength such as:

The report has however indicated a number of areas for improvement, namely:

Initial activity post-inspection has been undertaken in the following areas:

- formation of a Chief Officers' Group
- improvement Plan prepared
- visit to Dumfries and Galloway
- initial supportive visit from the Care Inspectorate
- temporary structure in place to lead improvements

External Services

Commissioning Officers are responsible for managing the relationship between external providers and our service users.

Any concerns raised about the quality of care provided by an external provider are recorded and considered against other known information about the provider, such as previous concerns raised; and reports produced by the Care Inspectorate.

Where a concern has been raised, providers are responsible for developing and delivering an action plan identifying planned improvement activity which satisfies the MIJB (and Care Inspectorate if they are involved). This action plan will be monitored by Commissioning Officers to ensure it is being progressed and that improvements are being delivered within agreed timescales. This level of contract monitoring activity will continue until such times until the MIJB is satisfied that the provider has made the necessary improvements to ensure the care, safety and wellbeing of residents.

Where no improvement is evidenced, the Senior Management Team will take decisions in relation to any further action required to address on-going concerns, such as reductions in rates paid, increased monitoring activity such as on-site visits, and imposing conditions on the service until issues are resolved or contracts are terminated. Any action taken to address concerns raised about provider's service provision will attempt to do so in ways that put the best outcomes for service users first and which promote safety and wellbeing.

LIZ – INSPECTIONS

Financial Performance and Best Value

Financial performance forms part of the regular reporting cycle to the MIJB. Throughout the year the Board, through the reports it receives is asked to consider the financial position at a given point and any management action deemed as necessary to ensure delivery of services within the designated financial framework. From the mid-point in the financial year, the Board are presented with financial information that includes a forecast on the likely financial outturn at the end of the financial year.

Revenue Summary 2016/17

The financial performance for the MIJB in 2016/17 was:

Service Area	Budget £'000	Actual £'000	Variance Fav / (Adverse) £'000
Community Hospitals	5,301	5,520	(219)
Community Health	3,638	3,653	(17)
Learning Disabilities	5,299	5,262	37
Mental Health	7,174	7,351	(187)
Addiction	198	196	2
Adult Protection & Health Improvement	174	175	9
Care Services Provided In-House	13,074	13,047	27
Older People & Physical and Sensory Disability	17,647	17,882	(235)
Intermediate Care & Occupational Therapy	1,371	1,532	(171)
Care Services Provided by External Contractors	9,882	9,690	192
Other Community Services	7,121	7,179	(48)
Administration & Management	3,753	3,636	117
Primary Care Prescribing	17,888	17,356	(468)
Primary Care Services	14,878	14,890	(12)
Hosted Services	3,623	3,681	(58)
Out of Area Placements	669	525	144
Improvement Grants	969	974	(5)
Total Net Expenditure	**109,640**	**110,529**	**(880)**

Tracey to add narrative on pressures / overspend etc

Main Reasons for Variances Against Budget

Overall, the MIJB core services resulted in an overspend of £0.787m. This position has been improved considerably when the slippage on strategic funds are taken into consideration resulting in an overall underspend of £2.704m.

Community Hospitals – Overspends have occurred within community hospitals in each of the four Elgin, Buckie, Forres, Keith/Speyside totalling £0.219m to the year-end. These are historical overspends arising from maintaining staff cover alongside cumulative efficiency targets. At the same time, non-financial objectives, including meeting waiting times, patient safety and delayed discharge targets still require to be maintained. A review is ongoing and will be addressed service re-design in support of the Moray population.

Mental Health - Mental Health services were overspent by £0.187m at the year end. This includes senior medical locum staff costs, nursing and other staff I addition to an efficiency target still to be met. Services have continued to be delivered where funding has been reduced or withdrawn.

Older People and Physical and Sensory Disability Services - This budget has overspent by £0.235m at the end of the year. The end of year position includes an over spend for domiciliary care in the area teams of £0.298m and bad debts were higher than anticipated by £0.047m. The overspend is reduced in part by and underspend in permanent care of £0.085m and an over achievement of income within this area of £0.024m. The variances within this overall budget reflect the shift in the balance of care to enabling people to remain in their homes for longer.

Intermediate Care and Occupational Therapy – This budget has overspent by £0.161m at the end of the year. Primarily this relates to overspends on Aids & Adaptations of £0.096m, a year-end stock adjustment of £0.030m and a community alarm and telecare equipment overspend of £0.020m. In addition there were minor variances of £0.015m all of which can be attributed to the facilitation of helping people remain in their own homes.

Primary Care Prescribing - The primary care prescribing budget is reporting an over spend of £0.416m for the twelve months to March 2017. The average unit cost per item prescribed varies throughout the year and can vastly affect the pressure on the budget.

Integrated Care Fund

The additional funding received from the Scottish Government for the Integrated Care Fund (ICF) for 2016/17 was £1.59m.

The ICF is used to deliver change in the way services are delivered with the overall aim of shifting the balance of care from a hospital based setting to the community. Further information on the ICF and how this funding was utilised can be found on page x of this report.

Financial Outlook

One of the major risks facing the MIJB and its ability to deliver the services delegated to it within the context of the Strategic Plan is the uncertainty around the funding being made available from the partners and Scottish Government.

The Scottish Government 2017/18 funding settlements, for both health boards and local authorities, announced in December 2017 were significantly more challenging than was anticipated and so had an adverse impact on the onward negotiation of funding to the MIJB. Whilst the strategic outcomes and intent remain unchanged, the challenge is to ensure that the economic impacts of decisions taken are highlighted as there is likely to be insufficient funding to maintain current levels of service in future years.

The reduced funding levels, combined with the demographic challenges we are facing in a period of ambitious reform present defined risks and uncertainties that require monitoring and managing on an ongoing basis. The ageing population and increasing numbers of people with long term conditions and complex needs will generate demands which cannot be met unless alternative service delivery models are generated. There is an on-going commitment to provide care to those in the greatest need while providing those services within the resource available.

Best Value

NHS Grampian and Moray Council have delegated functions and associated budgets of these functions to the MIJB. It is the responsibility of the MIJB to decide how to use these resources to achieve the objectives of the strategic plan.

The governance framework comprises the systems of internal control and the processes, culture and values, by which the MIJB is directed and controlled. It demonstrates how the MIJB conducts its affairs and enables the MIJB to monitor progress towards the achievement of its strategic priorities and to consider whether those priorities have led to the delivery of cost-effective services.

The MIJB ensures proper administration of its financial affairs through the appointment to the Board of a Chief Financial Officer, in line with Section 95 of the Local Government (Scotland) Act 1973.

Financial Reporting on Localities

The financial reporting for 2016/17 has not been presented at locality level. This has been highlighted as a priority in development terms for 2017/18.

Reporting on the Integrated Care Fund

MIJB received a total of £1.59m from the Scottish Government's Integrated Care Fund (ICF) in 2017/17 to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and early intervention and further strengthen our approach to tackling inequalities. A further allocation of £1.59m was also received in 2016/17 to assist the continuation of programme delivery and in line with the overarching strategic policy drivers outlined in the Strategic Plan. Over the financial years 2016/17 and 2017/18 has focussed on delivering the following key themes:

Allocation to date of the ICF resources can be summarised as follows:

Theme	2015/16 Allocation £ 000	2016/17 Allocation £000	Total Spend to Date £000	Overall Underspend to Date £000
Promoting Community Wellbeing	128	97	117	110
Staying Independent, Self-Management of Long Term Conditions	348	213	290	271
Recovery, Rehabilitation & Enablement	235	173	250	148
Intensive Support	137	0	117	20
Related Enablers	267	560	482	345
Unallocated Balance	111	557	0	668
Total ICF spend – 2017/17	**1,226**	**1,590**	**1,254**	**1,562**

The Year Ahead

Annual Review of the
Partnership's Strategic Plan

Review of Strategic Plan: this new plan seeks to build on the learning gained during the first year of operation and includes initial locality planning priorities; updated performance indicators; an updated Strategic Risk Register and an updated Implementation Plan. In 2018, following the initial 3 year period covered by the original document, the Plan will be completely re-written and a new Strategic Plan produced.

Key Areas for Improvement and Development in 2017/18

Dementia Active Communities in Moray: This project aims to engage with communities in Moray raising awareness of the profound and isolating impact that Dementia is having on citizens within their community and that with their support, people with Dementia and their families can remain active participants involved in new and existing local activities.

Technology enabled care: we are actively engaged in exploring the potential of digital healthcare and other solutions which might add value to the future potential of services.

Infrastructure: we will be focussed on efficiency and productivity, this will take account of buildings, IT systems and technology enabled smart working.

Carers: our priorities for the next 3 years include the creation of a website information hub for carers, work with GPs regarding information sharing and further use of social media. Additionally, we have a duty to support carers using SDS and we must work together as professionals and carers to prepare for this. SDS has the potential to change a lot for carers and it is imperative that they understand the process.

Out of Hours Primary Care (GMED): the service averages 12,000 contacts per month across Grampian, with a majority of these patients over 75 years of age. Service delivery remains challenging, in line with the national picture for a variety of reasons mainly: increasing activity and demand, complexity of people presenting and challenges with recruitment and retention leading to uncovered shifts. 2016/17 below.

Priorities to be agreed.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2017**

SUBJECT: **STRATEGIC PLAN REVIEW**

BY: **PAM GOWANS, CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To inform the Integration Joint Board (IJB) of the progress being made with the Strategic Commissioning Plan 2016-2019.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board:

i) consider and note the views of the Strategic Planning and Commissioning Group on progress with the Moray Strategic Plan 2016-2019;

ii) agree that the Strategic Planning and Commissioning Group seek to review the performance and financial framework during 17/18 ensuring the ambitions of the strategic plan continue to be met; and

iii) agree that a process for 18/19 is established that will lead to a full review and new plan being delivered in 2019 and beyond.

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 1st April 2016.

3.2 As part of their remit to prepare and implement a Strategic Plan the IJB established a Strategic Planning Group April 2015 in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. An IJB is to seek and have regard to the views of its Strategic Planning Group when developing and reviewing its Strategic Plan.

3.3 The Strategic Plan 2016-19 sets out the plans for carrying out the integrated functions, and how these arrangements are intended to meet the changing needs of local people and achieve the nine national health and wellbeing outcomes.

3.4 The Moray Integration Joint Board Strategic Plan 2016-19 was approved at the MIJB meeting 31 March 2016 (para 4 of the Minute refers) and adopted by the Strategic Planning and Commissioning Group with a plan to developing a high level implementation plan.

3.5 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.

3.6 The high level Strategic Implementation Plan was approved at the MIJB meeting 10th November 2016 (para 8 of the Minute refers) and seeks to pull out some of the key activities that will bring about significant change and assist in our modernisation agenda.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires IJBs to review the strategic plan every three years as a minimum, an IJB may choose to review more frequently and/or at a particular point in time.

4.2 There is a large amount of activity going on across all service delivery areas, with third and independent sector partners and this is well documented within our strategic framework and implementation plans.

4.3 The strategic implementation plan is dynamic and will be continually reviewed and updated as our understanding and learning develops. Work continues at a population level to support activity contributing to community resilience and healthier citizens.

4.4 It is early days to measure our successes and some areas are tests for change . A light touch review was completed in the form of a Strategic Planning group workshop " Reviewing the Plan" on 3rd April 2017, Elgin Town Hall (**APPENDIX 1**).

4.5 24 attendees including the wider Strategic Planning Reference Group participated in a café style event where they considered and discussed progress around four key themes facilitated by senior managers who were implementing within these themes:

- Promoting Community Wellbeing
- Staying independent and self-management of long term conditions
- integrated Recovery rehabilitation and enablement and
- intensive supports.

4.6 The workshop aimed to discuss: What was achieved so far, what lessons had been learned, how these lessons in the context of the financial landscape could be drawn apon and our future priorities. Detailed feedback is included in **APPENDIX 1.**

4.7 The workshop confirmed that progress is being made in the right direction. It is early days to review some of the work, test of change are still to complete. There is no significant changes required to the existing strategic plan at this time.

4.8 It is recommended that a full review of the Strategic Commissioning Plan, with a full strategic needs assessment, be carried out 2018/19. It is expected that analysis and review of the tests of change projects mentioned in paragraph 4.7 will be completed during 2017/18.

4.9 The IJB must publish an annual performance report which will set out progress towards the nine National Health and Wellbeing outcomes. The first annual report is due to be published in July 2017 in line with the guidance and is a substantive item on the IJB agenda 29th June 2017. If during the reporting year, a review of the Strategic Plan was carried out, then it must include a statement of the reasons for the review, whether following the review a revised Strategic Plan was prepared and if so, describing any changes made.

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 outwith the overall budget position. These implications are reported via the financial reporting system in place for the MIJB

(d) Risk Implications and Mitigation

The oversight of the plan and its review sits with the IJB who takes account of the views of the Strategic Planning and Commissioning Group

(e) Staffing Implications

Significant work will be undertaken to continue with staff engagement and development during the review of the strategic 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 strategic plan has an associated Equalities Assessment, equalities Outcome Report and Equalities Monitoring Report. Any revised Strategic Plan would call for an updated Equalities 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
Head of adult Health and Social Care services
Head of Primary Care

6. CONCLUSION

6.1 The high level Strategic implementation Plan sets out aroute map and key activities to take forward the changes in health and social care that will realise the ambitions of the 9 national health and wellbeing outcomes.

Author of Report: Sandra Gracie, Strategy Development Officer

Background Papers: with author
Ref:

Signature: _____ Date : 20 June 2017

Designation: Chief Officer Name: Pam Gowans

Strategic Planning Group – Reviewing the Moray Strategic Plan (03/04/2017)

Workshop activity: Café style event where 24 attendees from management, staff and service users considered and discussed progress against key themes in relation to the Strategic Plan. The aims of the workshop were to discuss with wider stakeholders group

- What have we achieved so far?
- What lessons have we learned?
- How we draw on these lessons and plan in the context of the financial landscape for future priorities?
- Our Future Priorities in Moray

Theme: Promoting Community Wellbeing (public Health, TSI, Community Development etc)			
Progress	**Stop**	**Start/Continue**	**Improve/Good Use of Resources?**
Examples given of variety of community groups/initiatives supported individually or jointly by TSI, public health team or community development team Better understanding and response to cultural societal differences across Moray Increase population understanding re looking after yourself Strengthened communication and partnership working	Working in silos at HSCP and CPP level	"Making Every Opportunity Count" programme – SF and RS – keen to adopt Growth and sustainability of a Prevention and Early intervention workforce. Wider Public health and Early Intervention and Promotion activity gains to be had It takes time to evolve prevention and Early intervention there are little quick wins Strengthen monitoring and evaluation ? Adequate transport arrangements for those less able to get to groups	Provide key information and support to inform and give guidance to community/ third sector/community groups/so that their vision and plans/contribution better responds to the Moray position Community hospitals – scope for third sector engagement and work with public, patients, visitors, staff Organogram

Other information: Digital shared assessment (similar to red book)

Key Points going forward in relation to Promoting Community Wellbeing Theme:

- **Continue on the direction of travel**
- **Agree mechanism/model for a whole system approach e.g. "Making Every Opportunity Count" programme**
- **Provide guidance and support to community/ third sector so their contribution better responds to the Moray position**
- **Strengthen monitoring and evaluation**

Theme: Staying independent and self-management of long term conditions (care at home, falls prevention, peer support MH etc)			
Progress	**Stop**	**Start/Continue**	**Improve/Good Use of Resources?**
House of Care Peer support in various settings Peer support and mental wellbeing developments Good first years – need to prevent focus on mental health maybe coming through and causing further stigma?	Thinking in terms of single conditions – "People not Conditions"	Care models should be modelled more around personal outcomes House of Care: De-medicalise. Effects rather than diagnosis. Person centred - Not condition focused. Holistic needs assessment Model ? How do we get efficiency but deliver person centred care? Challenge to rural isolation – virtual presence but need to consider tech access and ability Be aware of fracturing of family support networks	Still a lot of work to do Currency – time - e.g. Dr – 10 mins – what can you do? How do we create a system that is not reductionist? Peer support model - needs to be positive: think of Trip Adviser, negative to positive comments about the same experience – different views One size does not fit all - Solutions need to be variable/varied in line with what is best for the individual
Other: Space – physical – what does this need to be? – potential to use fire service buildings – urban and rural prescience			

Key Points in relation to Staying independent and Self-management of Long term Conditions Theme:

- **Continue on the direction of travel but look to ensure holistic, person centred approach across all services**
- **Improved monitoring, evaluation and review of outcome measures**

Theme: Integrated Recovery, rehabilitation and enablement (This group focused on mental health recovery)			
Progress	**Stop**	**Start/Continue**	**Improve/Good Use of Resources?**
• New developments - mental Health and Wellbeing Centre (linking with senior case workers) • GP link workers for mental health • Making Recovery Real initiative: positive – strengthened community networks; tackled stigma; making in-roads on how to tap into current contacts • Vintage teas and Community Champions – positive, lots of community champions in place	• Maybe continue/ maybe stop/Needs further consideration: there are lots of link workers or support workers – including new ones in GP practices. Confusing - be clear on remit/Is there overlap? How do service users/public know who they are and what they do? • Public concerns about how a holistic approach is taken i.e. Who is taking the overview of care if lots of support workers are involved? • Stop missed opportunities to tell the positive messages about what is going on. Shift the balance from negative stories about what isn't going on or what isn't being funded to what is being done (example the press coverage around ceasing Horizons funding – this catered for approx. 30 individuals, but with same money created a wellbeing centre for the whole of Moray	• Continue focus on mental health recovery • Continue to work on better coordination; example discussed of the new Mental health Wellbeing Centre with a senior case worker linking in and includes links to psychology staff • Continue building relationships and to make connections between services, build relationships and share information • Continue removing barriers and easier access • Continue tackling stigma re mental health e.g. Link worker title (generic) • Continue the commissioning process • Continue evaluating projects • Mental health: fire service can get "in the door"- start sharing info and developments so signposting can be added to fire safety visits • Start- co-ordinate press	• Start/Improve - Localities clarify are they up and running? Who from each community is involved or can be involved e.g. Community councils unaware. How can we engage with everyone? Is there a role for the Scottish health council in terms of public involvement?

	Stop using confusing names for services or initiatives	releases and share info across services. Think public awareness and communication strategies, publicity and increase good news stories Promote community safety partnership – wide remit/share info through this mechanism Start to ask people how would they like to be informed? Variety of communication methods/Social media Start a kindness, compassion movement	
Other: Gov policy regarding patient involvement/service users participation standards has no “teeth”. Need commitment to act upon and improve quality, match performance. Other – where or how does the link come with young people’s services (adult v children's) and transitions?			

Key Points in relation to Integrated Recovery, Rehabilitation and Enablement Theme:

- **Continue on the direction of travel**
- **Review developments to avoid duplication and clarity ?**
- **Improve public information about commissioning decisions/service redesigns**
- **Improve community awareness of and input to development of localities/ locality planning**

Theme: Intensive supports (frail elderly CGA, palliative, end of life care, community hospitals)			
Progress	**Stop**	**Start/Continue**	**Improve/Good Use of Resources?**
Continue to change culture in community hospitals Creating community team opportunities- share the load	Too early to stop anything!	Continue to change culture in community hospitals Create community team opportunities Improve MDT communication – working in community hospitals Define intensive support	Mindset challenges/ opportunities Structures required

Key Points in relation to Intensive Support Theme:

- **Continue on the direction of travel**
- **Clearly define what intensive support is. Ensure key services have clear roles, responsibilities and remit and other community stakeholders are supported to achieve their role and contribution?**
- **Improved monitoring, evaluation and review of outcome measures**

Strategic Planning Group – Reviewing the plan 3rd April 2017, Elgin Town Hall 09.00 – 12:30

Aims of workshop Discuss with wider stakeholders group

- What have we achieved so far?
- What lessons have we learned?
- How should we draw on these lessons and plan in the context of the financial landscape
- Our future priorities in Moray?

Item	Time	Topic	Presenter /facilitator
1.	09.00	Tea and coffee on arrival	ALL
2.	09:30	Welcome/introductions	Pam Gowans
3.	9:40	Setting the scene - Strategic priorities - Financial framework	 S Gracie P Gowans
4.	10:00	**Workshop activity**: Café style where everyone will consider and discuss each of the following facilitated themes in relation to the Strategic Plan. Moving round every twenty minutes - **Promoting Community Wellbeing** – public Health, TSI, Community Development - **Staying independent and self-management of long term conditions –** care at home, falls prevention, peer support MH - **Integrated Recovery, rehabilitation and enablement –** nurse led Forres, AHP led Ashgrove, MH Recovery, - **Intensive supports –** frail elderly CGA, palliative, end of life care, community hospitals **Brief** Discuss progress around each theme and use: stop, improve, start, is this good use of resources? approach	 Tracey Gervaise, martin Robertson, Ann Hay Holly for Heidi, L Bernard, Chris Littlejohn Julie Mackay, Kirsteen Pyatt Jane Mackie, Anne McKenzie
5.	11:30	Feedback: A spokesperson from each of the four groups will summarise the key points from each table.	ALL
6.	12:00	Next Steps: As one whole group there will be discussion to sense check our strategic priorities	ALL
7.	12:30	Close	

Attendance List

Strategic Planning Group – Reviewing the plan 3rd April 2017, Elgin Town Hall 09.00 – 12:30

Ivan Augustus,	IJB member(carers)
Fire service	representation
Martin Robertson	TSI moray
Ann Hay Tracey	Community Development Team
Gervaise	Health and Wellbeing Lead
Graham Findlay	North East Sensory
Julie MacKay	Operational Manager, mental Health
Kirsteen Pyatt	Community Mental Health
Aileen Marshall	OPRG member
Ann Earle	PPF member
Pauline Maloy	Health Intelligence
Wendy Johnston	Project Support
George McLean	Primary Care manager
Jamie Hogg	Clinical Lead
Sean Coady	Head of primary Care
Chris Littlejohn	Public Health Lead
Pam Gowans	Chief Officer
Holly Hendry	TSI Moray
Lorna Bernard	Project manager
Roddy Huggans	Commissioning and Performance Manager
Ann MacKenzie	Service Manager
Irena Paterson	OPRG, Alliance
Jane Mackie	Head of operations
Sandra Gracie	Strategy Development officer

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2017

SUBJECT: COMPLAINTS HANDLING

BY: CHIEF OFFICER

1. REASON FOR REPORT

1.1 To ask the Board to approve arrangements in relation to the handling of complaints.

2. RECOMMENDATION

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

i) consider and approve the Complaints Handling Policy and Procedures, attached as Appendix 1;

ii) agree that the Chief Officer submit the agreed Complaints Handling Policy and Procedures to the Scottish Public Services Ombudsman together with a compliance statement and self assessment no later than 3 July 2017;

iii) consider and approve the local processs for Complaints Against Board Members, attached as Appendix 2;

iv) authorise the Chief Officer to agree any changes to the Complaints Hanlding Policy and Procedures suggested by the Scottish Public Services Ombudsman; and

v) agree that the Moray Council's "How to Complain – A Guide" be adapted and used for the Board's purposes.

3. BACKGROUND

3.1 Complaints fall into three broad areas:

- Complaints about integrated services;
- Complaints about the IJB; and
- Complaints about individual Board members.

3.2 Regarding integrated services, previously Social Work and Health operated two distinct statutory complaints procedures. The social work system, based on the Social Work (Scotland) Act 1968 and the health system, based upon the Patient Rights (Scotland) Act 2011. Following legislative change, these became fully (or near fully) aligned from 1 April 2017 when Moray Council and NHS Grampian updated their respective policies and procedures. This allows for the integration of complaints handling for integrated services.

3.3 Complaints about integrated service delivery will remain the responsibility of the Council and Health Board. In practice the staff who will process these complaints will be part of Health and Social Care Moray. Under arrangements set out in the Health and Social Care Integration Scheme for Moray (section 15.5), the Board's Chief Officer will have an overview of these complaints as they will be recorded and reported to the Chief Officer regularly.

3.4 As regards the IJB, it is a new public body and complaints may be raised against the Board in relation to the way it exercises its functions, such as strategic planning, and in respect of a direction that the Board has issued to the Council and/or Health Board where this is specific about operational delivery. Complaints against the Board are separate from, and will not be covered under, either existing or new Council and Health Board complaints procedures. Therefore the Integration Joint Board needs to establish its own complaints procedure.

3.5 At its meeting on 10 November 2016 the Board agreed the operational responsibilities of the Chief Officer (para. 6 of the minute refers). These covered, as regards integrated service complaints:- quarterly complaints reports by the Council and Health Board to the Chief Officer, the Chief Officer review role in the Council's complaints process and her oversight of recommendations from the Social Work Complaints Review Committee. Additionally this covered, as regards complaints against the Board, the Chief Officer's responsibility to operate any complaints process as may be agreed by the Board from time to time. Note that the Social Work Complaints Review Committee was abolished from 1 April 2017 when the new social work and health procedures were applied.

3.6 As regards complaints about individual Board members, at its meeting on 30 June 2016, the Board adopted a Code of Conduct (para. 4 of the minute refers), which was subsequently approved by Scottish Government Ministers. Complaints may be made by members of the public, officers or by fellow Board members where any Board Member is alleged to have breached the Board's Code of Conduct. Provisions for dealing with alleged breaches of the Code of Conduct and the sanctions that can be applied by the Standards Commission for Scotland in the event of a breach are set out in the Code.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Amendments to regulations laid before Parliament changed the Scottish Public Services Ombudsman Act 2002 to provide that Integration Joint Boards become listed authorities under the Act. The effect of this is that the IJB is subject to the jurisdiction of the Ombudsman and is also required to have a complaints handling procedure in place that complies with principles published by the Ombudsman, usually in the form of a Model Complaints Handling Procedure (CHP).

4.2 The Ombudsman is the final stage for complaints and will independently investigate the actions of the Board in carrying out its duties, or any service failure attributable to the Board, but not the merits of a decision taken within

the Board's discretion, unless the established processes have not been followed in making that decision.The Ombudsman is also the final stage for complaints about the Council and Health Board in relation to integrated services.

4.3 On 15 December 2016, the Ombudsman wrote to the Chief Officer to advise that he was that day publishing The Social Work Model CHP and an associated Guide to Implementation and that the new CHP would bring social work complaints in line with the model being used by local authorities generally and the new CHP for health issued by the Scottish Government in October 2016, with both coming into effect from 1 April 2017. (This is the legislative change mentioned at paragraph 3.2 above.) Subsequently on 2 May 2017, the Ombudsman wrote to the Chief Officer with a link to the new model CHP for IJB's to adapt and adopt. A compliance statement and self - assessment is to be returned to the Ombudsman together with the agreed Moray IJB CHP no later than 3 July 2017.

4.4 Moray Council's Complaints Officer has produced a draft IJB Complaints Handling Policy and Procedures, which is attached at **Appendix 1** for the Board's consideration. This follows the model recommended by the Ombudsman.

4.5 The draft CHP has been submitted to the Scottish Public Services Ombudsman (SPSO) for a compliance check and should any issues be raised by them, they will be reported verbally at the meeting. If however, information is not available at that time then authority is sought for the Chief Ofifcer to agree any necessary changes with the SPSO to ensure compliance.

4.6 It is expected that there will only be a small number of complaints against an Integration Joint Board that can be investigated – most issues raised about, for example, strategic planning, will likely be about the merits of a decision rather than in relation to the process e.g. carrying out a consultation.

4.7 Work is still required to develop a CHP Information Leaflet to advise the public of the CHP procedures. This will be progressed once the CHP is agreed by the Board and approved by the SPSO. The Moray Council Complaints Officer suggests that the Board could adopt the existing Council "How to Complain – A Guide" and with suitable rebranding for the IJB this would be the quickest way to provide an information leaflet for the public.

4.8 It is not a requirement, but it is recommended by the Standards Officer that Board members consider adopting a local process for resolution of complaints made against them as regards the Code of Conduct. How to Make a Complaint against an MIJB Member – see **Appendix 2** – is attached for the Board's consideration. This is similar to the process in place for Moray Councillors. This would not affect the right to make a complaint to the Commissioner for Ethical Standards in Public Life in Scotland at any stage

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future; Moray Corporate Plan 2015-17; and Moray Integration Joint Board Strategic Commissioning Plan 2016-2019

An effective CHP is used to ensure the efficient and sustainable delivery of services to meet priorities.

(b) Policy and Legal

In terms of the Scottish Public Services Ombudsman Act 2002, section 16C, the Ombudsman may specify any listed authority to which a model CHP is relevant and notify the relevant authority about this. The IJB has received a notice and must ensure that they have a CHP that complies with the model CHP specified and submit this to the Ombudsman. Modifications to the CHP are possible only with the consent of the Ombudsman and to the extent that they are necessary for the effective operation of the CHP.

(c) Financial implications

There may be modest expenses involved with producing and publicising Information leaflets about the CHP for the public and this can be absorbed within existing budgets.

(d) Risk Implications and Mitigation

Performance reporting is a statutory requirement of the model CHP. Failure to report may result in the Ombudsman making a declaration of non-compliance against the IJB. Non-compliance would present risk in terms of reputational damage and a loss of public confidence in the IJB's ability to deliver quality improvements based on complaints analysis, and ultimately to maintaining and improving standards.

(e) Staffing Implications

Staffing resources will require to be devoted to dealing with complaints about the Integration Joint Board.

(f) Property

None arising from this report.

(g) Equalities

The analysis of complaints and the identification of common complaint issues and any learning arising will help to ensure that complaints are not arising from situations where customer diversity needs have not been considered or addressed, e.g. disability or cultural issues.

(h) Consultations

Consultation on this report has taken place with Margaret Wilson, Chief Financial Officer of the Integration Joint Board; Alasdair MacEachan, Standards Officer of the Integration Joint Board; John Black, Complaints Officer, Moray Council; and Caroline Howie, Committee Services Officer, Moray Council. Any comments received have been considered in writing this report.

6. CONCLUSION

6.1 The Board needs to make arrangements for the handling of complaints and this Report sets out proposals in this regard for the Board's consideration.

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

Background Papers:

Ref:

Signature: _____ Date : 20 June 2017

Designation: Chief Officer, Moray Integration Joint Board Name: Pam Gowans

Complaints Handling Procedure (CHP)

Moray Integration Joint Board (IJB)

Foreword by Pam Gowans, Chief Officer

Our complaints handling procedure reflects our commitment to valuing complaints. It seeks to resolve dissatisfaction and to conduct thorough, impartial and fair investigations of complaints so that, where appropriate, we can make evidence-based decisions on the facts of the case.

The procedure introduces a standardised approach to handling complaints across integration authorities, which complies with the SPSO's guidance on a model complaints handling procedure. This procedure aims to help us 'get it right first time'. We want quicker, simpler and more streamlined complaints handling with local, early resolution.

Complaints give us valuable information we can use in terms of how we fulfil our responsibilities. Our complaints handling procedure will enable us to address dissatisfaction and may also prevent the same problems that led to the complaint from happening again. Handled well, complaints can give customers a form of redress when things go wrong, and can also help us continuously improve.

Resolving complaints early saves money and creates better customer relations. Sorting them out locally and quickly means they are less likely to escalate to the next stage of the procedure. Complaints that we do not resolve swiftly can greatly add to our workload.

It will help us keep the public at the heart of the process, while enabling us to better understand how to improve how we do our work by learning from complaints.

How to use this Complaints Handling Procedure (CHP)

This CHP has been provided to the SPSO Complaints Standards Authority and is compliant in accordance with the Scottish Government Model CHP.

This document explains how the IJB will handle complaints. It will compliment our CHP Information Leaflet that advises customers on the complaints procedure. Together, these form our complaints handling procedure.

It contains references and links to more details on parts of the procedure, such as how to record complaints, and the criteria for signing off and agreeing time extensions. These explain how to process, manage and reach decisions on different types of complaints.

When using this document, please also refer to the 'SPSO Statement of Complaints Handling Principles' and best practice guidance on complaints handling from the Complaints Standards Authority at the SPSO.

http://www.valuingcomplaints.org.uk

What is a complaint?

The Moray Integration Joint Board's (IJB) definition of a complaint is:

> 'An expression of dissatisfaction by one or more members of the public about IJB's action or lack of action, or about the standard of service the IJB has provided in fulfilling its responsibilities as set out in the Integration Scheme'.

The Integration Scheme is the 2015 Health and Social Care Integration Scheme for Moray that outlines the framework for how adult and older people care services are integrated, planned for and delivered in Moray. The IJB plans for and oversees delivery of health and social care services that are delivered for it by Moray Council and Grampian Health Board in a Health & Social Care Partnership (HSCP).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..

Issues that are not covered by this definition are likely to be covered by other CHPs, relating to either health or social work services that are delivered for us by Moray Council and NHS Grampian.

A complaint may relate to dissatisfaction with:

- the IJBs policies
- the IJBs decisions
- the administrative or decision-making processes followed by the IJB in coming to a decision

This list does not cover everything.

A complaint is **not**:

- a first time request made to the IJB
- a request for compensation only
- issues that are in court or have already been heard by a court or a tribunal
- disagreement with a decision where a statutory right of appeal exists
- an attempt to reopen a previously concluded complaint or to have a complaint reconsidered where we have already given our final decision.

We will not treat these issues as complaints, but will instead direct the customer raising them to use the appropriate procedures.

Handling anonymous complaints

We value all complaints. This means we treat all complaints including anonymous complaints seriously and will take action to consider them further, wherever this is appropriate. Generally, we will consider anonymous complaints if there is enough information in the complaint to enable us to make further enquiries. If, however, an anonymous complaint does not provide enough

information to enable us to take further action, we may decide not to pursue it further. Any decision not to pursue an anonymous complaint must be authorised by a senior HSCP manager

If an anonymous complaint makes serious allegations, it will be considered by a senior HSCP manager immediately.

If we pursue an anonymous complaint further, we will record the issues as an anonymous complaint on the complaints system. This will help to ensure the completeness of the complaints data we record and allow us to take corrective action where appropriate.

What if the customer does not want to complain?

If a customer has expressed dissatisfaction in line with our definition of a complaint but does not want to complain, tell them that we do consider all expressions of dissatisfaction, and that complaints offer us the opportunity to improve services where things have gone wrong. Encourage them to submit their complaint and allow us to deal with it through the CHP. This will ensure that they are updated on the action taken and receive a response to their complaint.

If, however, the customer insists they do not wish to complain, we will record the issue as an anonymous complaint. This will ensure that their details are not recorded on the complaints database and that they receive no further contact about the matter. It will also help to ensure the completeness of the complaints data recorded and will still allow us to fully consider the matter and take corrective action where appropriate.

Who can make a complaint?

Anyone who is affected by the decisions made by the IJB can make a complaint. This is not restricted to people who receive services overseen by the IJB and their relatives or representatives. Sometimes a customer may be unable or reluctant to make a complaint on their own. We will accept complaints brought by third parties as long as the customer has given their personal consent.

Complaints involving the Health & Social Care Partnership or more than one organisation

A complaint may relate to a decision that has been made by the IJB, as well as a service or activity provided by the HSCP. Initially, these complaints should all be handled in the same way. They must be logged as a complaint, and the content of the complaint must be considered, to identify which services are involved, which parts of the complaint we can respond to and which parts are appropriate for the HSCP to respond to. A decision must be taken as to who will be contributing and investigating each element of the complaint, and that all parties are clear about this decision. The final response must be a joint response, taking into account the input of all those involved.

Where a complaint relates to a decision made jointly by the IJB and the Health Board or Local Authority, the elements relating to the IJB should be handled through this CHP. Where possible, working together with relevant colleagues, a single response addressing all of the points raised should be issued.

Should a member of staff who represents the HSCP receive a complaint in relation to the IJB, and they have the relevant and appropriate information to resolve it, they should attempt to do so. If the staff member feels unable to offer a response, the complaint should be passed to the IJB team as early as possible for them to resolve.

If a customer complains to the IJB about services of another agency or public service provider, but the IJB has no involvement in the issue, they will be advised to contact the appropriate organisation directly.

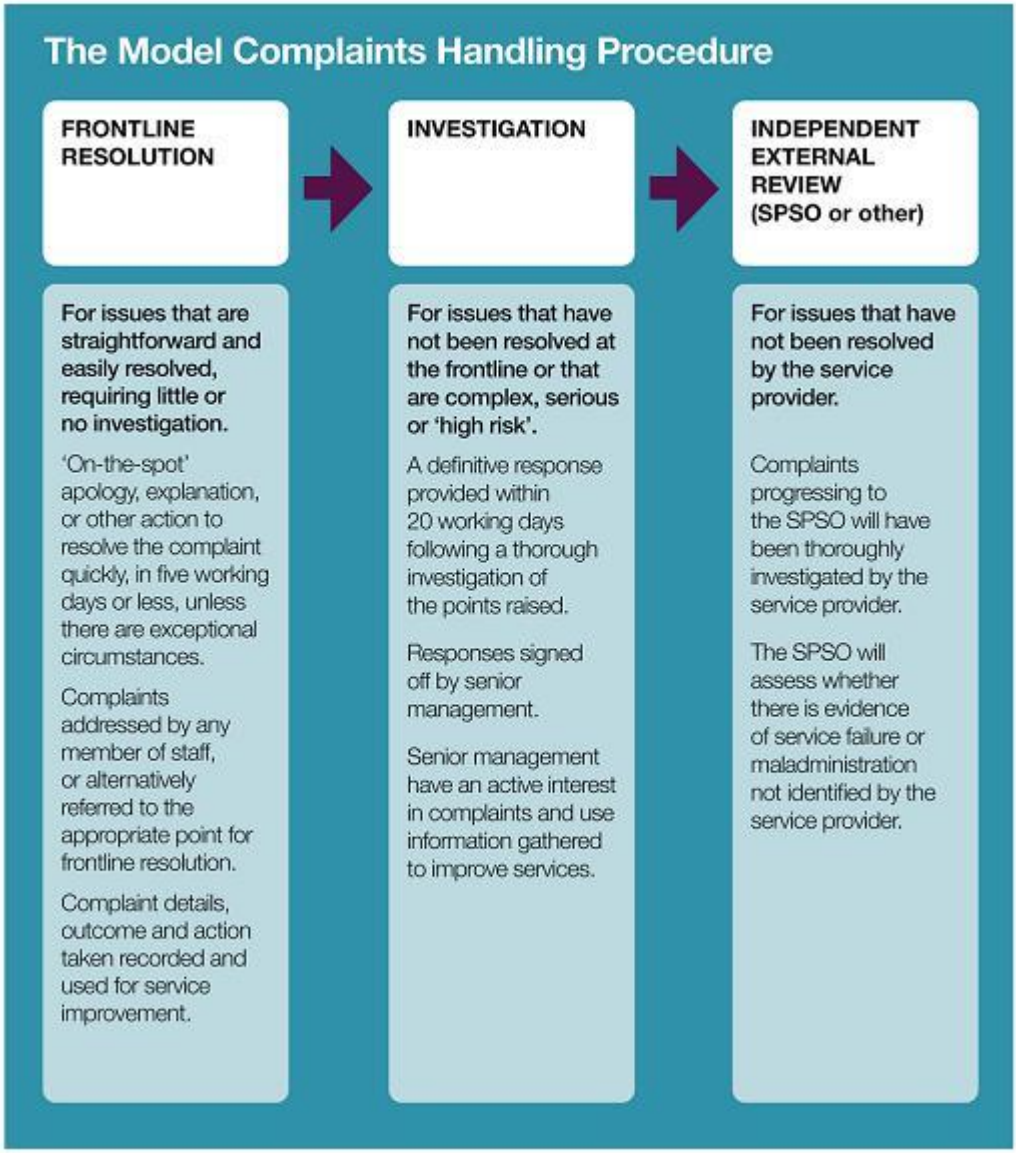
If we need to make enquiries to an outside agency in relation to a complaint we will always take account of data protection legislation and SPSO guidance on handling our customer's personal information. The Information Commissioner has detailed guidance on data sharing and has issued a data sharing code of practice.

The complaints handling process

The CHP aims to provide a quick, simple and streamlined process for resolving complaints early and locally by capable, well-trained staff.

Our complaints process provides two opportunities to resolve complaints internally:

- **frontline resolution**, and
- **investigation**.



For clarity, the term 'frontline resolution' refers to the first stage of the complaints process. It does not reflect any job description within the IJB but means seeking to resolve complaints at the initial point of contact where possible.

Stage one: frontline resolution

Frontline resolution aims to quickly resolve straightforward customer complaints that require little or no investigation. Any member of staff of the HSCP supporting the work of the IJB may deal with complaints at this stage; if the member of staff receiving the complaint is not able to provide a response, then it should be referred on to a more appropriate member of staff.

The main principle is to seek early resolution, resolving complaints at the earliest opportunity. This may mean a face-to-face discussion.

Whoever responds to the complaint, it may be settled by providing an on-the-spot apology where appropriate, or explaining why the issue occurred and, where possible, what will be done to stop this happening again. They may also explain that, as an organisation that values complaints, we may use the information given when we review policies and processes in the future.

A customer can make a complaint in writing, in person, by telephone, by email or online, or by having someone complain on their behalf. Frontline resolution will always be considered, regardless of how the complaint has been received.

The IJB has two officers of its own, its Chief Officer and Chief Finance Officer. The IJB does not employ staff directly and instead the HSCP, as well as delivering health and social care services for the IJB, also provides the services of some of their staff to support the work and operation of the IJB.

What we will do when we receive a complaint

1 On receiving a complaint, we will first decide whether the issue can indeed be defined as a complaint. The customer may express dissatisfaction about more than one issue. This may mean we treat one element as a complaint, while directing them to pursue another element through an alternative route.

2 If we have received and identified a complaint, we will record the details on our complaints system.

3 Next, we will decide whether or not the complaint is suitable for frontline resolution. Some complaints will need to be fully investigated before we can give the complainant a suitable response. A senior HSCP manager will escalate these complaints immediately to the investigation stage.

4 Where we consider frontline resolution to be appropriate, we will consider four key questions:

- What exactly is the complaint (or complaints)?
- What does the complainant want to achieve by complaining?
- Can I achieve this, or explain why not?
- If I cannot resolve this, who can help with frontline resolution?

What exactly is the complaint (or complaints)?

It is important to be clear about exactly what the customer is complaining about. Staff may need to ask the supplementary questions to get a full picture.

What does the complainant want to achieve by complaining? At the outset, staff will seek to clarify the outcome the complainant wants. Of course, they may not be clear about this, so there may be a need to probe further to find out what they expect and whether they can be satisfied.
Can I achieve this, or explain why not? If staff can achieve the expected outcome by providing an on-the-spot apology or explain why they cannot achieve it, they will do so. If they consider an apology is suitable, they may wish to follow the SPSO's guidance on the subject, which can be found on the SPSO website. The customer may expect more than we can provide. If their expectations appear to exceed what the organisation can reasonably provide, the officer will tell them as soon as possible in order to manage expectations about possible outcomes. Decisions at this stage may be conveyed face to face or on the telephone or via e-mail. In those instances, you are not required to write to the customer as well, although you may choose to do so. A full and accurate record of the decision reached must be kept, including the information provided to the customer..
If I can't resolve this, who can help with frontline resolution? If the complaint raises issues which you cannot respond to in full because, for example, it relates to an issue or area of service you are unfamiliar with, pass details of the complaint to more senior staff who will try to resolve it.

Timelines

Frontline resolution must be completed within **five working days** of the IJB receiving the complaint, although in practice we would often expect to resolve the complaint much sooner.

Staff may need to get more information or seek advice to resolve the complaint at this stage. However, they will respond to the complainant within five working days, either resolving the matter or explaining that the IJB will investigate their complaint.

Extension to the timeline

In exceptional circumstances, where there are clear and justifiable reasons for doing so, senior HSCP management may agree an extension of no more than five working days with the complainant. This must only happen when an extension will make it more likely that the complaint will be resolved at the frontline resolution stage.

If, however, the issues are so complex that they cannot be resolved in five days, it will be appropriate to escalate the complaint straight to the investigation stage.

If the customer does not agree to an extension but it is unavoidable and reasonable, a senior HSCP manager can still decide upon an extension. In those circumstances, they will then tell the complainant about the delay and explain the reason for the decision to grant the extension.

Such extensions will not be the norm, though, and the timeline at the frontline resolution stage will be extended only rarely. All attempts to resolve the complaint at this stage will take no longer than **ten working days** from the date the IJB received the complaint.

The proportion of complaints that exceed the five-day limit will be evident from reported statistics. These statistics will be presented to the IJB on a quarterly basis.

Appendix 1 provides further information on timelines.

Closing the complaint at the frontline resolution stage

When staff have informed the customer of the outcome, they are not obliged to write to the customer, although they may choose to do so. The response to the complaint must address all areas that we are responsible for and must explain the reasons for our decision. Staff will keep a full and accurate record of the decision reached. The complaint will then be closed and the complaints system updated accordingly. The complaints resolved at the frontline stage will be reported to the IJB on a quarterly basis.

When to escalate to the investigation stage

The IJB will escalate a complaint to the investigation stage when:

- frontline resolution has been attempted but the customer remains dissatisfied and requests an investigation. This may happen immediately when the decision at the frontline stage is communicated, or sometime later
- the customer refuses to take part in frontline resolution
- the issues raised are complex and require detailed investigation
- the complaint relates to serious, high-risk or high-profile issues.

When a previously closed complaint is escalated from the frontline resolution stage, the complaint should be reopened on the complaints system.

We will take particular care to identify complaints that might be considered serious, high risk or high profile. The SPSO defines potential high-risk or high-profile complaints as those that may:

- involve a death or terminal illness
- involve serious service failure, for example major delays in providing, or repeated failures to provide, a service
- generate significant and ongoing press interest
- pose a serious risk to an organisation's operations
- present issues of a highly sensitive nature, for example concerning:
  - a particularly vulnerable person
  - child protection.

Stage two: investigation

Not all complaints are suitable for frontline resolution and not all complaints will be satisfactorily resolved at that stage. Complaints handled at the investigation stage of the complaints handling

procedure are typically complex or require a detailed examination before we can state our position. These complaints may already have been considered at the frontline resolution stage, or they may have been identified from the start as needing immediate investigation.

An investigation aims to establish all the facts relevant to the points made in the complaint and to give the complainant a full, objective and proportionate response that represents our final position.

What we will do when we receive a complaint for investigation

It is important to be clear from the start of the investigation stage exactly what is being investigated, and to ensure that all involved – including the customer - understand the investigation's scope. It may be helpful for an investigating officer from the HSCP to discuss and confirm these points with the customer at the outset, to establish why they are dissatisfied and whether the outcome they are looking for sounds realistic.

In discussing the complaint with the customer, the investigating officer will consider three key questions:

1. What specifically is the complaint or complaints?
2. What does the complainant want to achieve by complaining?
3. Are the complainant's expectations realistic and achievable?

It may be that the customer expects more than we can provide. If so, staff will make this clear to them as soon as possible.

Where possible we will also clarify what additional information we will need to investigate the complaint. The customer may need to provide more evidence to help us reach a decision.

Details of the complaint must be recorded on the system for recording complaints. Where appropriate, this will be done as a continuation of frontline resolution. The details must be updated when the investigation ends.

If the investigation stage follows attempted frontline resolution, staff will ensure that all relevant information will be passed to the officer responsible for the investigation, and record that they have done so.

Timelines

The following deadlines are appropriate to cases at the investigation stage:

- complaints must be acknowledged within **three working days**
- the IJB will provide a full response to the complaint as soon as possible but not later than **20 working days** from the time they received the complaint for investigation.

Extension to the timeline

Not all investigations will be able to meet this deadline. For example, some complaints are so complex that they require careful consideration and detailed investigation beyond the 20-day limit. However, these would be the exception and we will always try to deliver a final response to a complaint within 20 working days.

If there are clear and justifiable reasons for extending the timescale, senior HSCP management will set time limits on any extended investigation, as long as the complainant agrees. They will keep the customer updated on the reason for the delay and give them a revised timescale for completion. If the customer does not agree to an extension but it is unavoidable and reasonable, then senior management can consider and confirm the extension. The reasons for an extension might include the following:

- Essential accounts or statements, crucial to establishing the circumstances of the case, are needed from staff, customers or others but they cannot help because of long-term sickness or leave.
- Further essential information cannot be obtained within normal timescales.
- Operations are disrupted by unforeseen or unavoidable operational circumstances, for example industrial action or severe weather conditions.
- The customer has agreed to mediation as a potential route for resolution.

These are only a few examples, and senior HSCP management will judge the matter in relation to each complaint. However, an extension would be the exception and we will always try to deliver a final response to the complaint within 20 working days.

As with complaints considered at the frontline stage, the proportion of complaints that exceed the 20-day limit will be evident from reported statistics. These statistics will be presented to the IJB on a quarterly basis.

Appendix 1 provides further information on timelines.

Mediation

Some complex complaints, or complaints where customers and other interested parties have become entrenched in their position, may require a different approach to resolving the complaint. Where appropriate, we may consider using services such as mediation or conciliation using suitably trained and qualified mediators to try to resolve the matter and to reduce the risk of the complaint escalating further.

Mediation will help both parties to understand what has caused the complaint, and so is more likely to lead to mutually satisfactory solutions.

If the IJB and the customer agree to mediation, revised timescales will need to be agreed.

Closing the complaint at the investigation stage

We will inform the customer of the outcome of the investigation, in writing or by their preferred method of contact. This response to the complaint will address all areas that we are responsible for and explain the reasons for the decision. We will record the decision, and details of how it was communicated to the customer, on the system for recording complaints. The complaint will then be closed and the complaints system updated accordingly. The complaints resolved at the investigation stage will be reported to the IJB on a quarterly basis.

In responding to the customer, we will make clear:

- their right to ask SPSO to consider the complaint
- the time limit for doing so, and
- how to contact the SPSO.

Independent external review

Once the investigation stage has been completed, the customer has the right to approach the SPSO if they remain dissatisfied. The SPSO considers complaints from people who remain dissatisfied at the conclusion of our complaints procedure. The SPSO looks at issues such as service failures and maladministration (administrative fault), as well as the way we have handled the complaint.

We will use the wording below to inform customers of their right to ask SPSO to consider the complaint. The SPSO provides further information for organisations on the Valuing Complaints website. This includes details about how and when to signpost customers to the SPSO.

Information about the SPSO

The Scottish Public Services Ombudsman (SPSO) is the final stage for complaints about public services in Scotland. This includes complaints about the Scottish Government, NDPBs, agencies and other government sponsored organisations. If you remain dissatisfied with an organisation after its complaints process, you can ask the SPSO to look at your complaint. The SPSO cannot normally look at complaints:

- where you have not gone all the way through the organisation's complaints handling procedure
- more than 12 months after you became aware of the matter you want to complain about, or
- that have been or are being considered in court.

The SPSO's contact details are:

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Freepost SPSO

Freephone: **0800 377 7330**
Online contact **www.spso.org.uk/contact-us**
Website: **www.spso.org.uk**

Governance of the Complaints Handling Procedure

Roles and responsibilities

As per the Public Bodies (Joint Working) (Scotland) Act 2014 and as specified within the Health and Social Care Integration Scheme for Moray, the Chief Officer's role is to provide a single senior point of overall strategic and operational advice to the IJB. In line with this, overall responsibility and accountability for the management of complaints lies with the Chief Officer.

Our final position on a complaint must be signed off by an appropriate senior HSCP officer and we will confirm that this is our final response. This ensures that our senior HSCP management own and are accountable for the decision. It also reassures the customer that their concerns have been taken seriously.

The roles of are staff are summarised as:

Chief Officer:

The Chief Officer provides leadership and direction in ways that guide and enable us to perform effectively across all services. This includes ensuring the effective operation of our complaints handling procedure; with a robust investigation process that demonstrates how we learn from the complaints we receive. The Chief Officer may take a personal interest in or deal with all or some complaints, at any stage of the CHP. Regular management reports assure the IJB of the quality of complaints performance.

Members of the HSCP Senior Management Team:

Members of the Senior Management Team of the Health & Social Care Partnership may be responsible for:

- *managing complaints and the way we learn from them*
- *overseeing the implementation of actions required as a result of a complaint*
- *investigating complaints*

However, members of the HSCP Senior Management Team may decide to delegate some elements of complaints handling (such as investigations and the drafting of response letters) to other senior HSCP staff. Where this happens, senior management should retain ownership and accountability for the management and reporting of complaints. They may also be responsible for preparing and signing decision letters to customers, so they should be satisfied that the investigation is complete and their response addresses all aspects of the complaint.

Complaints investigator:

The complaints investigator, is appointed by a senior HSCP manager and is responsible and accountable for the management of the investigation. They may work in a service delivery team or as part of a centralised customer service team, and will be involved in the investigation and in co-

ordinating all aspects of the response to the customer. This may include preparing a comprehensive written report, including details of any procedural changes in service delivery that could result in wider opportunities for learning across the organisation.

All HSCP staff:

A complaint may be made to any member of staff so all staff must be aware of this CHP and how to handle and record IJB complaints at the frontline stage. They should also be aware of who to refer a complaint to, in case they are not able to personally handle the matter. We encourage all staff to try to resolve complaints quickly to prevent escalation.

IJBs SPSO liaison officer:

Our SPSO liaison officers role will be undertaken by Moray Council's SPSO liaison officer and may include providing complaints information in an orderly, structured way within requested timescales, providing comments on factual accuracy on our behalf in response to SPSO reports, and confirming and verifying that recommendations have been implemented.

Complaints about HSCP Senior Managers and Chief Officers

Complaints about senior staff can be difficult to handle, as there may be a conflict of interest for the staff investigating the complaint. When serious complaints are raised against ~~Chief Officers~~ senior staff, it is particularly important that the investigation is conducted by an individual who is independent of the situation. We must ensure we have strong governance arrangements in place that set out clear procedures for handling such complaints.~~; Guidance for handling such complaints is set out in the~~ The Chief Officer will ensure that an appropriate and independent person is appointed to investigate such complaints. If the complaint involves the Chief Officer or Chief Finacial Officer then the Chair and Vice Chair of the IJB will take independent advice on how to proceed.

Recording, reporting, learning and publicising

Complaints provide valuable customer feedback. One of the aims of the complaints handling procedure is to identify opportunities to improve services across the IJB. We must record all complaints in a systematic way so that we can use the complaints data for analysis and management reporting. By recording and using complaints information in this way, we can identify and address the causes of complaints and, where appropriate, identify opportunities for improvements.

Recording complaints

To collect suitable data it is essential to record all complaints in line with SPSO minimum requirements, as follows:

- the complainant's name and address
- the date the complaint was received
- the nature of the complaint
- how the complaint was received
- the date the complaint was closed at the frontline resolution stage (where appropriate)
- the date the complaint was escalated to the investigation stage (where appropriate)
- action taken at the investigation stage (where appropriate)

- the date the complaint was closed at the investigation stage (where appropriate)
- the outcome of the complaint at each stage
- the underlying cause of the complaint and any remedial action taken.

We have structured systems for recording complaints, their outcomes and any resulting action.

Reporting of complaints

Complaints details are analysed for trend information to ensure we identify procedural failures and take appropriate action. Regularly reporting the analysis of complaints information helps to inform improvement actions.

We publish on a quarterly basis the outcome of complaints and the actions we have taken in response. This demonstrates the improvements resulting from complaints and shows that complaints can influence our processes. It also helps ensure transparency in our complaints handling service and will help the public to see that we value their complaints.

We must:

- publicise on a quarterly basis complaints outcomes, trends and actions taken
- where and when possible, use case studies and examples to demonstrate how complaints have led to improvements.

This information should be reported regularly (and at least quarterly) to the IJB.

Learning from complaints

At the earliest opportunity after the closure of the complaint, officers involved in handling the complaint will make sure that the customer and relevant staff in the HSCP understand the findings of the investigation and any recommendations made.

Senior HSCP management will review the information gathered from complaints regularly and consider whether processes could be improved or internal policies and procedures updated.

As a minimum, we must:

- use complaints data to identify the root cause of complaints
- take action to reduce the risk of recurrence
- record the details of corrective action in the complaints file, and
- systematically review complaints performance reports to improve processes.

Where we have identified the need for improvement:

- the action needed to improve services must be agreed by the IJB
- senior HSCP management will designate the 'owner' of the issue, with responsibility for ensuring the action is taken
- a target date must be set for the action to be taken
- the designated individual must follow up to ensure that the action is taken within the agreed timescale

- where appropriate, performance should be monitored to ensure that the issue has been resolved
- we must ensure that the IJB learns from complaints.

Publicising complaints performance information

We also report on our performance in handling complaints annually in line with SPSO requirements. This includes performance statistics showing the volumes and types of complaints and key performance details, for example on the time taken and the stage at which complaints were resolved.

Maintaining confidentiality

Confidentiality is important in complaints handling. It includes maintaining the complainant's confidentiality and explaining to them the importance of confidentiality generally. We must always bear in mind legal requirements, for example, data protection legislation, as well as internal HSCP policies on confidentiality and the use of customer's information.

Managing unacceptable behaviour

People may act out of character in times of trouble or distress. The circumstances leading to a complaint may result in the complainant acting in an unacceptable way. Customers who have a history of challenging or inappropriate behaviour, or have difficulty expressing themselves, may still have a legitimate grievance.

A customer's reasons for complaining may contribute to the way in which they present their complaint. Regardless of this, we must treat all complaints seriously and properly assess them. However, we also recognise that the actions of customers who are angry, demanding or persistent may result in unreasonable demands on time and resources or unacceptable behaviour towards our staff. We will, therefore, work with the Health Board and the Council to apply the relevant organisational policies and procedures to protect staff from unacceptable behaviour such as unreasonable persistence, threats or offensive behaviour. Where a decision is made to restrict access to a customer under the terms of an unacceptable actions policy, the relevant procedure will be followed to communicate that decision, notify the customer of a right of appeal, and review any decision to restrict contact with us. This will allow the customer to demonstrate a more reasonable approach later.

Supporting the complainant

All members of the community have the right to equal access to our complaints handling procedure. Customers who do not have English as a first language may need help with interpretation and translation services, and other customers may have specific needs that we will seek to address to ensure easy access to the complaints handling procedure.

We must always take into account our commitment and responsibilities to equality. This includes making reasonable adjustments to our processes to help the customer where appropriate.

Several support and advocacy groups are available to support individuals in pursuing a complaint and customers should be signposted to these as appropriate.

Time limit for making complaints

This complaints handling procedure sets a time limit of six months from when the customer first knew of the problem, within which time they may ask us to consider the complaint, unless there are special circumstances for considering complaints beyond this time.

We will apply this time limit with discretion. In decision making we will take account of the Scottish Public Services Ombudsman Act 2002 (Section 10(1)), which sets out the time limit within which a member of the public can normally ask the SPSO to consider complaints. The limit is one year from when the person first knew of the problem they are complaining about, unless there are special circumstances for considering complaints beyond this time.

If it is clear that a decision not to investigate a complaint will lead to a request for external review of the matter, we may decide that this satisfies the special circumstances criteria. This will enable us to consider the complaint and try to resolve it.

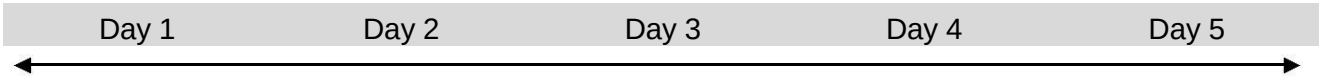
Appendix 1 - Timelines

General

References to timelines throughout the complaints handling procedure relate to working days. When measuring performance against the required timelines, we do not count non-working days, for example weekends, public holidays and days of industrial action where our service has been interrupted.

Timelines at frontline resolution

We will aim to achieve frontline resolution within five working days. The day the IJB receives the complaint is day 1. Where they receive it on a non-working day, for example at the weekend or on a public holiday, day 1 will be the next working day.



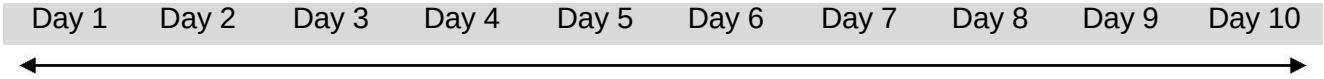
Day 1:
Day *the* IJB receives the complaint, or next working date if date of receipt is a non-working day.

Day 5:
Frontline resolution achieved or complaint escalated to the investigation stage.

[*The date of receipt will be determined by the IJB's usual arrangements for receiving and dating of mail and other correspondence.]*

Extension to the five-day timeline

If *the* IJB has extended the timeline at the frontline resolution stage in line with the procedure, the revised timetable for the response will take no longer than 10 working days from the date of receiving the complaint.



Day 1:
Day *the* IJB receives the complaint, or next working date if date of receipt is a non-working day.

In a few cases where it is clearly essential to achieve early resolution, *the* IJB may authorise an extension within five working days from when the complaint was received. They must conclude the frontline resolution stage within 10 working days from the date of receipt, either by resolving the complaint or by escalating it to the investigation stage.

Day 10:
Frontline resolution achieved or complaint escalated to the investigation stage.

Transferring cases from frontline resolution to investigation

If it is clear that frontline resolution has not resolved the matter, and the complainant wants to escalate the complaint to the investigation stage, the case must be passed for investigation without delay. In practice this will mean on the same day that the complainant is told this will happen.

Timelines at investigation

The IJB may consider a complaint at the investigation stage either:

- after attempted frontline resolution, or
- immediately on receipt if they believe the matter to be sufficiently complex, serious or appropriate to merit a full investigation from the outset.

Acknowledgement

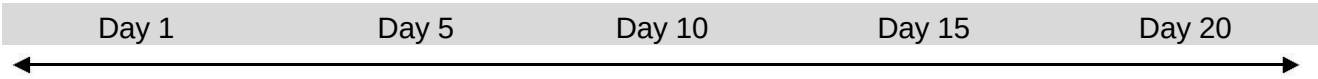
All complaints considered at the investigation stage must be acknowledged within **three working days** of receipt. The date of receipt is:

- the day the case is transferred from the frontline stage to the investigation stage, where it is clear that the case requires investigation, or
- the day the complainant asks for an investigation after a decision at the frontline resolution stage. It is important to note that a complainant may not ask for an investigation immediately after attempts at frontline resolution, or
- the date *the* IJB receives the complaint, if it is sufficiently complex, serious or appropriate to merit a full investigation from the outset.

Investigation

The IJB will respond in full to the complaint within **20 working days** of receiving it at the investigation stage.

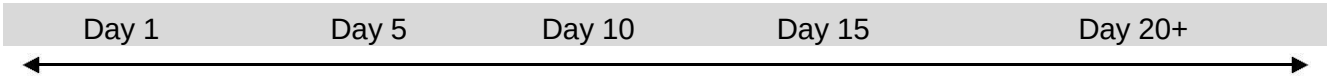
The 20-working day limit allows time for a thorough, proportionate and consistent investigation to arrive at a decision that is objective, evidence-based and fair. We have 20 working days to investigate the complaint, regardless of any time taken to consider it at the frontline resolution stage.



Day 1:
Day complaint received at investigation stage, or next working day if date of receipt is a non-working day. Acknowledgement issued within three working days.

Day 20:
The decision issued to complainant or agreement reached with them to extend deadline

Exceptionally you may need longer than the 20-day limit for a full response. If so, the IJB will explain the reasons to the complainant, and agree with them a revised timescale.

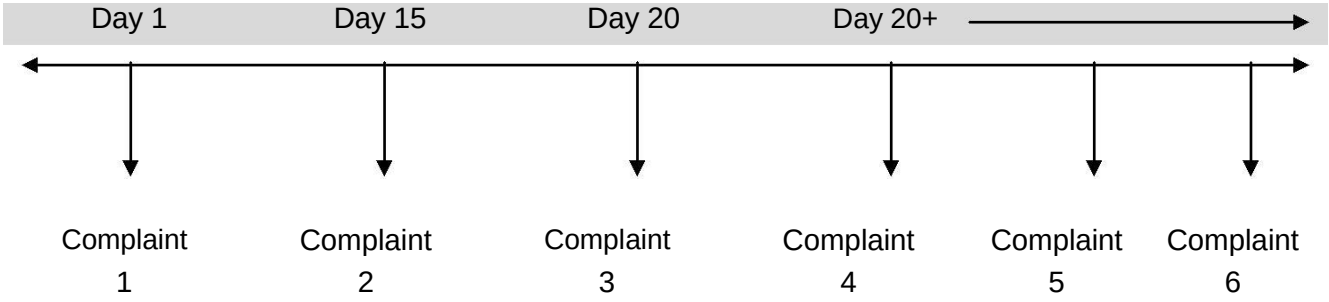


Day 1:
Day complaint received at investigation stage, or next working day if date of receipt is a non-working day. Acknowledgement issued within three working days.

By Day 20:
In agreement with the complainant where possible, decide a revised timescale for bringing the investigation to a conclusion.

By agreed date:
Issue our final decision on the complaint

Timeline examples
The following illustration provides examples of the point at which we conclude our consideration of a complaint. It is intended to show the different stages and times at which a complaint may be resolved.



The circumstances of each complaint are explained below:

Complaint 1
Complaint 1 is a straightforward issue that may be resolved by an on-the-spot explanation and, where appropriate, an apology. Such a complaint can be resolved on day 1.

Complaint 2
Complaint 2 is also a straightforward matter requiring little or no investigation. In this example, resolution is reached at day three of the frontline resolution stage.

Complaint 3

Complaint 3 refers to a complaint that we considered appropriate for frontline resolution. We did not resolve it in the required timeline of five working days. However, we authorised an extension on a clear and demonstrable expectation that the complaint would be satisfactorily resolved within a further five days. We resolved the complaint at the frontline resolution stage in a total of eight days.

Complaint 4

Complaint 4 was suitably complex or serious enough to pass to the investigation stage from the outset. We did not try frontline resolution; rather we investigated the case immediately. We issued a final decision to the complainant within the 20-day limit.

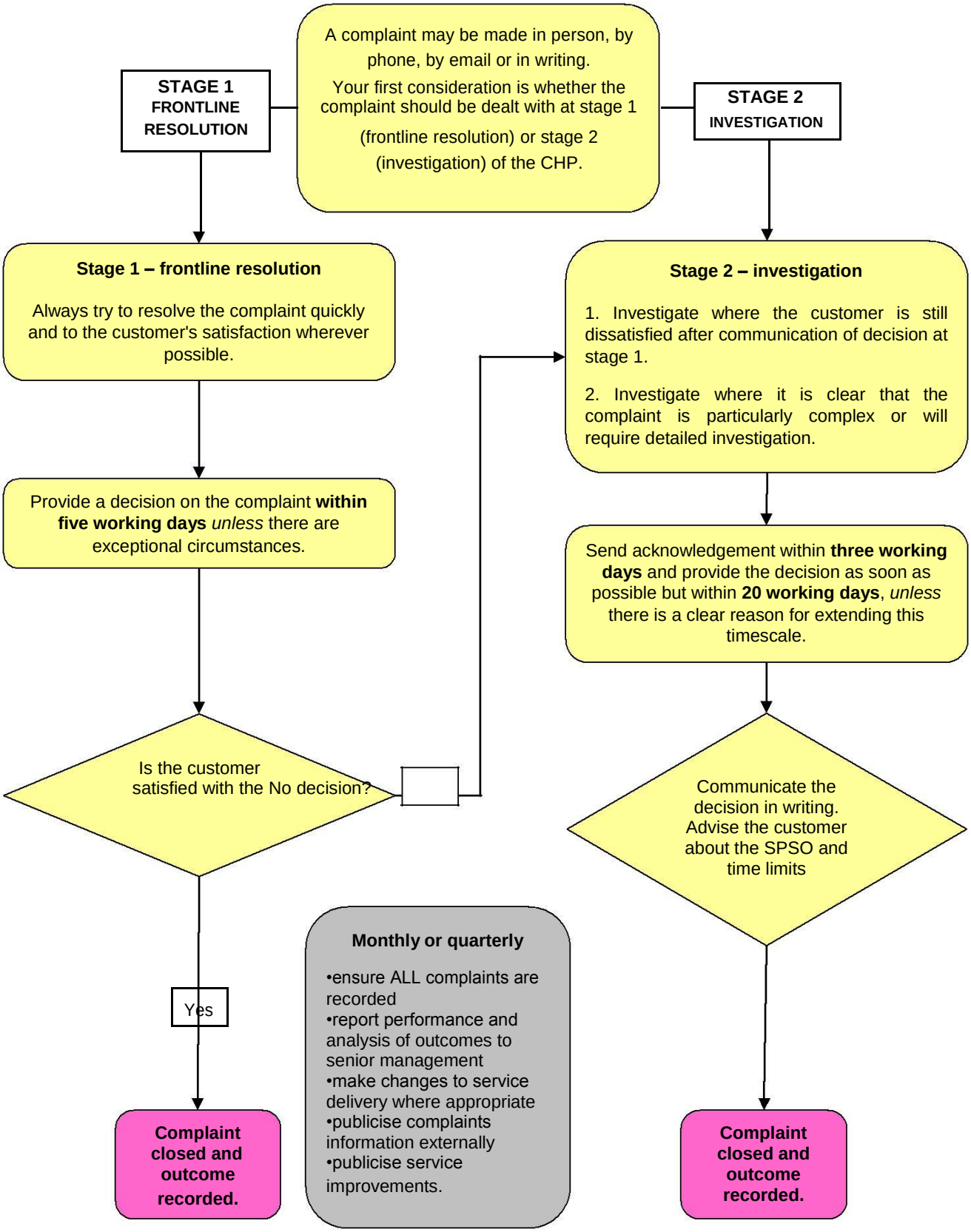
Complaint 5

We considered complaint 5 at the frontline resolution stage, where an extension of five days was authorised. At the end of the frontline stage the complainant was still dissatisfied. At their request, we conducted an investigation and issued our final response within 20 working days. Although the end-to-end timeline was 30 working days we still met the combined time targets for frontline resolution and investigation.

Complaint 6

Complaint 6 was considered at both the frontline resolution stage and the investigation stage. We did not complete the investigation within the 20-day limit, so we agreed a revised timescale with the customer for concluding the investigation beyond the 20-day limit.

Appendix 2 - The complaints handling procedure



How to Make a Complaint Against a Moray Integration Joint Board Member

This document explains how you can make a complaint against a Moray Integration Joint Board member. Complaints may be made by members of the public, officers or by fellow Board members.

Nothing in this document affects your right to make a complaint to the Commissioner for Ethical Standards in Public Life in Scotland at any stage. Their address is:

Commissioner for Ethical Standards in Public Life in Scotland
39 Drumsheugh Gardens
EDINBURGH
EH3 7SW

Tel: 0300 011 0550
Web: www.ethicalstandards.org.uk

Section 1	**Preliminary Stage – For Complaints by fellow Board Members Only**
Section 2	**Informal Resolution Stage – This stage will be used by Members of the Public and officers. It is also the second stage for Complaints by Board Members.**

SECTION 1

Where any Board Member is alleged to have breached the Board's Code of Conduct ("the Code of Conduct") the following procedure will apply. The procedure is in two stages with the aim of achieving a satisfactory outcome for all involved – Preliminary Stage and Informal Resolution Stage, but at any point the complaint may be referred to the Commissioner for Ethical Standards in Public Life in Scotland.

PRELIMINARY STAGE

The Preliminary Stage should be used for complaints by a Board Member against a Board Member and only if this fails to produce a satisfactory outcome should the Informal Resolution Stage be invoked. Complaints by officers and members of the public will proceed directly to the Informal Resolution stage.

1. The Complainer who alleges the breach of Code of Conduct will discuss the issue with the member who is alleged to be in breach of the Code of Conduct. Both parties should seek to resolve the complaint at this stage. The Standards Officer will on request provide relevant information about the Code of Conduct but shall not at this stage take a view on whether a breach has occurred.

2. If the Complainer is not willing to speak to the member who is the subject of the complaint directly, he/she will approach the Chair of the Board who will assist in attempting to resolve the issue informally through discussion directly with both parties separately/ together.

3. If the Chair of the Board is the subject of the allegation, the Vice Chair will assist the Complainer in attempting to achieve a resolution of the complaint.

4. If the Complainer is not satisfied after the Preliminary Stage, he/she may proceed to the Informal Resolution stage (Section 2). The Preliminary Stage should be completed within no more than 15 working days of the issue which is the subject of the complaint arising.

INFORMAL RESOLUTION STAGE

The Informal Resolution Stage is the first stage for complaints by members of the public and officers, and the second stage for complaints by a Board Member.

How to make a complaint

1. Any complaint about the conduct of a Board Member should be sent in writing to the Board's Standards Officer. The complaint must also include the following details:-

   (a) The name and address of Complainer

   (b) The name of the member against whom the complaint is being made

   (c) The nature of the misconduct alleged

   (d) The part of the Board's Code of Conduct ("the Code of Conduct) which is alleged to have been breached. The Code of Conduct may be viewed at: …

   (e) Any supporting evidence

   (f) Reference to whether the Preliminary Stage has been completed and if not, an explanation as to why this stage has been bypassed for all complaints by members

   [NOTE: At this stage the Standards Officer is required to advise the Chief Officer that a complaint has been made].

Evidence of alleged criminal offence

2. If at any stage during the course of the complaints procedure evidence that a criminal offence may have been committed comes to the attention of the Standards Officer, the police may be informed. In that event, the complaints procedure will be suspended until after the outcome of any police investigation or criminal prosecution.

Acknowledgement of Complaint

3. The Standards Officer shall record the date of receipt of every valid complaint; shall issue an acknowledgement of receipt to the complainer within 5 working days with a copy of the complaints procedure. The Standards Officer shall advise the Complainer that the full details of his/her complaint will be sent to the member. The Standards Officer may seek clarification from the complainer in relation to any aspect of the complaint. This should be provided by the complainer within no more than 5 working days. The date of receipt of such clarification shall then be deemed to be the date of receipt of the complaint.

Intimation of the Complaint to the Member

4. Within 5 working days of the date of receipt of the complaint, the Standards Officer shall intimate the complaint to the member who shall be informed of the following:

   (a) Identity of the complainer;
   (b) The exact nature of the complaint;
   (c) The provisions of the Code of Conduct which he/she is alleged to have contravened.

   The member shall be sent a copy of the complaints procedure.

5. Before processing the complaint the Standards Officer requires to be satisfied that the Preliminary Stage has been exhausted and/or was not appropriate.

6. The Standards Officer may arrange for such investigation(s) to be carried out as he/she considers appropriate, in order to clarify or resolve the complaint. This will include taking a statement from the member detailing their response to the complaint. That statement, once approved by the member, will be issued to the Complainer.

7. In the event that the Standards Officer determines that the complaint is without any merit, he/she will advise the parties accordingly and give his/her reasoning, making specific reference to the right of the Complainer to refer the matter on to the Commissioner for Ethical Standards in Public Life in Scotland. A local decision that a complaint is without any merit will be issued within no more than 15 working days after the date of receipt of the complaint (or as soon as possible thereafter).

Mediation Meeting

8. Where a complaint is accepted as potentially of some merit following investigation by/on behalf of the Standards Officer, the parties and Standards Officer will be invited to attend an informal mediation meeting, facilitated by the Chief Officer to be held no later than 25 working days after the date of receipt of the complaint (or as soon as possible thereafter). (Note: This meeting is intended to allow parties to explore the possibility of a mutually satisfactory resolution. It is described as mediation only in terms of the common usage of that word and it should not be inferred that formal mediation practice will be followed as this is not the case.) At the mediation meeting parties will discuss the results of the Standards Officer's investigation with a view to agreeing a mutually satisfactory resolution to the complaint. That may involve a number of outcomes including withdrawal of the complaint or the issuing of an apology.

Acceptance of Complaint

9. In the event that the member accepts that the complaint is well founded and the Complainer is satisfied with the outcome, the Standards Officer shall be entitled to treat the matter as resolved. If the Complainer is not satisfied with the outcome following stage 7, or indeed at any stage of the process, he/she may refer the complaint to the Commissioner for Ethical Standards in Public Life in Scotland.

Unacceptable Behaviour

10. Occasionally the behaviour or actions of an individual will make it very difficult for the Standards Officer to deal with their complaint. Examples of such behaviour include aggressive or abusive behaviour and unreasonable use of the complaints process. When this happens, the Standards Officer will write to the Complainer advising them that their complaint will no longer be handled in terms of this policy and reminding them of their right to complain directly to the Commissioner for Ethical Standards in Public Life in Scotland. The sort of situations in which the behaviour or actions of a Complainer may be considered as unacceptable are detailed in the Scottish Public Services Ombudsman's Unacceptable Actions Policy a copy of which will be attached to any letter advising that the complaint will not be progressed any further due to unacceptable behaviour.

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2017

SUBJECT: UNAUDITED ANNUAL ACCOUNTS

BY: MARGARET WILSON, CHIEF FINANCIAL OFFICER

1. REASON FOR REPORT

1.1 To consider the unaudited Annual Accounts of the Moray Integration Joint Board (MIJB) for the year ended 31 March 2017.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board :

i) consider the unaudited Annual Accounts prior to their submission to the external auditor, noting that all figures remain subject to audit;

ii) note the Annual Governance Statement contained within the unaudited Annual Accounts; and

iii) note the accounting policies applied in the production of the unaudited Annual Accounts, pages 36 to 38 of the accounts included as Appendix 1.

3. BACKGROUND

3.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 requires that an integration joint board is subject to the audit and accounts regulations and legislation of a body under Section 106 of the Local Government (Scotland) Act 1973.

3.2 The Local Accounts (Scotland) Regulations 1985 (as amended) ('the Regulations'), places a statutory obligation on the MIJB to submit draft Annual Accounts for the year ended 31 March 2017 to its external auditors by 30 June 2017. Copies of the unaudited 2016/17 accounts are attached at **APPENDIX 1**

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Annual Accounts have been prepared in accordance with the 2016/17 Code of Practice on Local Authority Accounting in the United Kingdom.

4.2 Under Regulation 9(1) of the Local Authority Accounts (Scotland) Regulations 2014, notice has been given and copies of the unaudited Annual Accounts will be available for public inspection at named locations for the period 30 June 2017 to 20 July 2017.

4.3 Audit Scotland as appointed external auditors will audit the accounts. They are required to complete their audit by 30 September 2017. The audited accounts and the External Auditor's report will be submitted to the MIJB when complete.

4.4 The Comprehensive Income and Expenditure Statement shows a surplus of £2.704m on the provision of services for the year. This translates to a closing balance as at 31 March 2017 in the Movement in Reserves Statement of £2.704m as there were no reserves brought forward at the start of the 2017/18 financial year due to the MIJB only becoming operational from 1 April 2017.

4.5 As at 31 March 2017 there were significant variances between budget and actual on several services. These are evident in the Comprehensive Income and Expenditure Statement and are detailed in a separate report being presented to this Board entitled '*Revenue Budget Outturn for 2016/17*'. A summary on the major variances is included within the Management Commentary as part of the Unaudited Annual Accounts.

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 unaudited Annual Accounts have been completed and are available for audit within the specified timescale.

(b) Policy and Legal

The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the MIJB is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973. In producing Annual Accounts for the 2016/17 financial year, the MIJB have complied with statute and mandatory guidance through attention to the 2016/17 Code of Practice on Local Authority Accounting in the United Kingdom.

(c) Financial implications

The Annual Accounts provide all required information about the MIJB in relation to its financial position at 31 March 2017. The overriding principle in relation to annual accounts preparation is to provide a true and fair view.

(d) Risk Implications and Mitigation

There are no risk issues arising directly from this report. The Unaudited Annual Accounts will be subjected to audit by external auditors, Audit Scotland which will provide assurance that the Accounts for 2016/17 give a true and fair view of the financial position and expenditure and income of the MIJB for the 2016/17 financial year.

(e) Staffing Implications

None arising directly from this report.

(f) Property
None arising directly from this report.

(g) Equalities
None arising directly from this report.

(h) Consultations
In preparation of the unaudited Annual Accounts, consultations have taken place between finance staff of both Moray Council and NHS Grampian. The Chief Officer and other key senior officers have been consulted for comment where appropriate. Any comments received have been considered in writing this report.

6. CONCLUSION

6.1 The draft Annual Accounts, subject to audit, show an underspend position of £2.7m for MIJB for the year ending 31 March 2017. This consists of a £0.8m overspend on core services which has been offset by applying an underspend on strategic funds of £3.5m

Author of Report: Tracey Abdy, Senior Project Officer
Background Papers: with author
Ref: TA/LJC/

Signature: Date: 21 June 2017

Designation: Chief Financial Officer Name: Margaret Wilson

APPENDIX 1

UNAUDITED ACCOUNTS

MORAY INTEGRATION JOINT BOARD

ANNUAL ACCOUNTS

FOR THE YEAR ENDED

31 MARCH 2017

CONTENTS

MORAY IJB MEMBERS

Voting Members

Christine Lester (Chair)	The Grampian Health Board
Cllr. Lorna Creswell (Vice-Chair)	Moray Council
Dame Anne Begg	The Grampian Health Board
Professor Amanda Croft	The Grampian Health Board
Cllr. Patsy Gowans	Moray Council
Cllr. Sean Morton	Moray Council

Non-Voting Members

Pamela Gowans	Chief Officer
Margaret Wilson	Chief Financial Officer
Susan Maclaren	Chief Social Work Officer
Linda Harper	Lead Nurse
Dr Ann Hodges	Registered Medical Practitioner
Dr Lewis Walker	Registered Medical Practitioner
Dr Graham Taylor	Registered Medical Practitioner
Fabio Villani	tsiMoray
Val Thatcher	Public Partnership Forum Representative
Ivan Augustus	Carer Representative
Steven Lindsay	The Grampian Health Board Staff Partnership Rep.
Tony Donaghey	UNISON, Moray Council

Co-Opted Members

Jane Mackie	Head of Adult Health and Social Care
Sean Coady	Head of Primary Care

MANAGEMENT COMMENTARY

Introduction

The management commentary is intended to support its readers in understanding the strategic priorities and objectives of the Moray Integration Joint Board (MIJB). It provides an overview of the business the MIJB has engaged in throughout the first year of establishment and assesses the financial performance in the year. Additionally, it provides information on the principal risks and uncertainties which are likely to affect the future development and performance of the MIJB.

The Role and Remit of the Moray Integration Joint Board

The Public Bodies (Joint Working) (Scotland) Act 2014 requires that Moray Council and The Grampian Health Board prepared an Integration Scheme for the area of the local authority detailing the arrangements for the integration of health and social care services. Following formal notification of approval of the Integration Scheme from the Cabinet Secretary for Health, Wellbeing and Sport, the Order to establish Moray Integration Joint Board came into force on 6 February 2016 and the MIJB was legally established as a body corporate. This new body following approval of the Moray Strategic Plan 2016 -2019 became fully operational from 1 April 2016 taking on its role as a strategic planning body with operational oversight for the delivery of services integrated under the Integration Scheme for Moray.

Moray is one of 31 Integration Authorities across Scotland that has been set up to work with health and social care staff, communities and the third and independent sectors to ensure a person centred approach to the design and delivery of care services. The MIJB has replaced the previous Moray Community Health and Social Care Partnership arrangements within a new legislative framework and is a separate legal entity from both Moray Council and The Grampian Health Board.

Moray has a population of some 96,000 which represents 1.8% of Scotland's national population (5.4 million).

Moray Council and The Grampian Health Board, as the parties to the Integration Scheme, each nominate three voting members to sit on the MIJB. The Council nominates three councillors as MIJB members and The Grampian Health Board nominates three Health Board non-executive directors as MIJB members or if unable to do so, a minimum of two non-executive directors and one executive director as MIJB members. From the date of establishment, 6 February 2016, Councillor Creswell was appointed as Chair from the Council members. This was a formal appointment to an arrangement that had been in place through the shadow year of the MIJB. With effect from 1 October 2016, the position of Chair has been held by Christine Lester, a non -executive member of The Grampian Health Board. This current appointment will run for a period of 18 months.

MANAGEMENT COMMENTARY

The Role and Remit of the Moray Integration Joint Board (cont'd)

Under the new legislation, a range of health and social care functions have been delegated from Moray Council and The Grampian Health Board to the MIJB who has assumed responsibility for the planning and operational oversight of delivery of integrated services. These functions and associated services are listed in the Integration Scheme. During 2016, it was considered necessary to develop an identity for the staff employed by The Grampian Health Board and Moray Council who are involved in the day-to-day delivery of these integrated services. Staff were consulted and reached agreement on 'Health and Social Care Moray' as being the designation they would identify with.

MIJB also has a role to play in the strategic planning of unscheduled acute hospital based services provided by The Grampian Health Board. Such budgets for large hospital services continue to be managed on a day to day basis by the Grampian Health Board Acute Sector. However, MIJB has an allocated "notional" budget of £10m of which the intention is that this figure represents the consumption of these services by the resident population of Moray. The IJBs will be responsible for the strategic planning of these services in partnership with the Acute Sector. The overall aim of this mechanism is to shift the balance of care by reducing unnecessary unplanned emergency admissions to hospitals whilst having alternative community arrangements that prevent this from happening.

Hosted services also form part of the MIJB budget. There are a number of services which are hosted by one of the 3 integration joint boards (IJB) within The Grampian Health Board area on behalf of all IJBs. Responsibilities include the planning and operational oversight of delivery of services managed by one IJB on a day to day basis. MIJB has responsibility for hosting services relating to Primary Care Contracts and the Grampian Medical Emergency Department (GMED) Out of Hours service.

Key Objectives and Strategy

In recent years there has been an increasing recognition that health and social care services for the population of Scotland will need to change in order to meet demands and expectations through early intervention and prevention. Demographics, economics and increasing care complexities are all factors that have been considered when looking at how services will be planned, co-ordinated and delivered effectively. The ultimate aim is that through integrating the design and delivery of our services in Moray, we will achieve the nine National Health and Wellbeing Outcomes as prescribed by the Scottish Ministers, namely;

MANAGEMENT COMMENTARY

Key Objectives and Strategy (cont'd)

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

Key Objectives and Strategy (cont'd)

On a local level and to assist in our purpose to succeed in our mission to achieve the nine health and wellbeing outcomes, we have developed our Vision by listening to the views of the people who use health and social care services, unpaid carers and those who deliver services in Moray and the wider community.

Our Vision is supported by six key strategic outcomes. MIJB has been working towards the achievement of these outcomes throughout 2016/17.

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.

Key Objectives and Strategy (cont'd)

The six strategic outcomes are the focus of the Strategic Plan 2016 – 19. This plan was developed for the adult population of Moray, consulted and agreed in partnership with health, social care, voluntary and independent sectors and the public, prior to being formally approved by the Board. The Strategic Plan describes how working in partnership is key to effective service delivery and how the integrated arrangements will improve the health and wellbeing of adults in Moray through the design and delivery of services. This Strategic Plan is a live document and we will continue to engage with all those with an interest in health and social care to deliver the outcomes as described.

In April 2017 a workshop was held, inviting all key stakeholder groups to review the Strategic Plan in the context of the strategic priorities and financial framework and provide an assessment of the perceived level of progress to date. The workshop provided facilitated discussion and consideration of key themes contained within the Strategic Plan and encouraged open and constructive feedback. The outcome of the session confirmed that a light-touch review of the Strategic Plan was appropriate in the interim with consideration for a complete refresh in a years' time with a full needs analysis and progress against the Plan to be visible.

MANAGEMENT COMMENTARY

Operational Performance – A Year in View

2016/17, being our first year of operation has been exciting, yet challenging, but even in these early stages we have started to see some stimulating transformational change take place in the facilities and services we provide to the adult population of Moray. Below is an insight to the initiatives which have been developed at Health and Social Care Moray.

The first major project to be taken forward by MIJB is a new housing development purpose built for adults with complex care and support needs is in progress. Work began in August 2016 on the development named as Urquhart Place in Lhanbryde which consists of 10 purpose-built bungalows to provide permanent homes and respite accommodation for adults with autism and communication difficulties. The development includes available space for respite accommodation, communal space and office and accommodation for staff providing care on a 24/7 basis. This new development replaces the residential

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The capital funding for the development has been provided by Moray Council with the operational responsibility for the services provided within the facility sitting with Health and Social Care Moray. The programme of work is transformational for individuals and their families who have traditionally shared accommodation in a residential care setting. They will be provided with their own space, privacy and tenancy, a big step forward for all. Families will be able to be more involved in

supporting individuals. We are keen to see, and will monitor closely, the impact on individuals in terms of quality of life.

Operational Performance – A Year in View (cont'd)

In March 2017, work was completed on a conversion project turning derelict cottages into rehabilitation accommodation for patients leaving hospital and prior to returning to their own homes. This intervention is one of intensive rehabilitation. It is also intended to prevent hospital admission where this is deemed appropriate, for example, falls management. The cottages in Victoria Road, Elgin were built to celebrate Queen Victoria's diamond jubilee and are held in trust by Moray Council but had become unfit for purpose and required refurbishment.

The cottages were converted and have been fully furnished and are already accommodating elderly patients who have been discharged from hospital. A wide range of health care professionals are fully integrated into the process to allow for a period of rehabilitation before the patients are able to make the transition and regain their independence. The principle here again is to support individuals' confidence and independence by accommodating in a non-clinical environment. There is also the added value of privacy and the ability for families to remain involved. The cottages can accommodate up to 5 service users at any one time.

The terraced cottages in Elgin's Victoria Crescent provide a homely setting in which to deliver intense rehabilitation which will facilitate hospital discharge and hospital admission avoiding additional pressure being placed on community hospitals

Operational Performance – A Year in View (cont'd)

Another area where our extra care facilities are being developed is through our arrangements with Hanover Housing Association. This is an area of transformation where purpose built accommodation will support older people with complex needs enabling them to continue to live independently with care on site to support them in their own tenancy. The first facility is Varis Court in Forres. This facility has a specific area where people suffering from dementia can hold tenancies and have appropriately skilled support to assist them. The MIJB has also approved a test of change in using 5 of the flats for health and social care interventions when hospital admission is not appropriate but additional support is required. This demonstrates wide partnership working with a housing partner with the aim of improving provision of services for a local community. This is due to become operational during 2017.

Performance reporting is viewed as a key part of the governance processes of the MIJB. Arrangements for the targets and measures for reporting performance were carried out as part of the strategic planning process and considered as part of the Integration Scheme. The MIJB has a range of national and local performance indicators against which it reports on a quarterly basis by exception, highlighting any areas of concern and bringing these to the attention of the Board together with proposals for action.

Developments are in place to consider further the way in which performance is reported at Board level. This process, once complete will ensure that performance reporting is meaningful, and will assist decision making.

In addition to the regular performance reporting of progress against the identified performance indicators, There is a requirement under the Public Sector (Joint Working) (Scotland) Act 2014 for the MIJB to produce and publish an Annual Performance Report setting out an assessment of performance in planning and carrying out the integration functions for which they are responsible. The purpose of the performance report is to provide an overview of performance in planning and carrying out integrated functions and is produced for the benefit of Partnerships and their communities. The Annual Performance Report has to be published no later than four months after the end of the reporting year which means that the deadline for the MIJB annual report to be published is 31 July 2017.

Financial Review

MIJB is subject to the audit and accounts provisions of a body under the terms of section 106 Local Government (Scotland) Act 1973. Accordingly, the MIJB is required to prepare its financial statements in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom. This duty falls to the Chief Financial Officer (CFO) under section 95 of the Local Government (Scotland) Act 1973 who is responsible for the proper administration of the financial affairs of the MIJB.

Financial Review (cont'd)

Financial performance forms part of the regular reporting cycle to the MIJB. Throughout the year the Board, through the reports it receives is asked to consider the financial position at a given point and any management action deemed as necessary to ensure delivery of services within the designated financial framework. From the mid-point in the financial year, the Board was presented with financial information that forecast a likely overspend position at the end of the year. This had been primarily down to a small range of services that were under pressure for various reasons.

Service Area	Budget £000's	Actual £000's	Variance (Over)/ under spend	Note
Community Hospitals	5,301	5,520	(219)	**1**
Community Health	3,638	3,653	(15)	
Learning Disabilities	5,325	5,288	37	
Mental Health	7,218	7,405	(187)	**2**
Addictions	825	823	2	
Adult Protection & Health Improvement	174	165	9	
Care Services Provided In-House	13,074	13,047	27	
Older People	16,032	16,267	(235)	**3**
Intermediate Care & OT	1,468	1,629	(161)	**4**
Care Services Provided by External Contractors	10,137	9,945	192	
Other Community Services	7,121	7,169	(48)	
Administration & Management	2,821	2,703	118	
Primary Care Prescribing	16,888	17,304	(416)	**5**
Primary Care Services	14,878	14,890	(12)	
Hosted Services	3,623	3,681	(58)	
Out of Area Placements	669	525	144	
Improvement Grants	969	930	39	
Total Core Services	**110,161**	**110,944**	**(783)**	
Strategic Funds	4,364	877	3,487	
TOTALS	**114,525**	**111,821**	**2,704**	

Financial Review (cont'd)

The table above reflects the budget managed by the MIJB during 2016/17. It excludes the notional Set Aside budget of £10.163m. The hosted services figures represent MIJB's share of all the hosted services that are hosted on a Grampian wide basis.

A number of services have experienced budget pressures over the course of the 2016/17 financial year.

Note 1 Community Hospitals – Overspends have occurred within community hospitals in each of the four localities, Elgin, Buckie, Forres, Keith/Speyside totalling £0.219m to the year-end. These are historical overspends arising from maintaining staff cover alongside cumulative efficiency targets. At the same time, non-financial objectives, including meeting waiting times, patient safety and delayed discharge targets still require to be maintained. A review is ongoing and will be addressed through service re-design and support to the population of Moray.

Note 2 Mental Health - Mental Health services were overspent by £0.187m at the year end. This includes senior medical locum staff costs, nursing and other staff in addition to an efficiency target still to be met. Services have continued to be delivered where funding has been reduced or withdrawn.

Note 3 Older People and Physical and Sensory Disability Services - This budget has overspent by £ 0.235m at the end of the year. The end of year position includes an overspend for domiciliary care in the area teams of £0.298m and bad debts were higher than anticipated by £0.047m. The overspend is reduced in part by and underspend in permanent care of £0.085m and an over achievement of income within this area of £0.024m. The variances within this overall budget reflect the shift in the balance of care to enabling people to remain in their homes for longer.

Note 4 Intermediate Care and Occupational Therapy - This budget has overspent by £0.161m at the end of the year. Primarily this relates to overspends on Aids & Adaptations of £0.096m, a year-end stock adjustment of £0.030m and a community alarm and telecare equipment overspend of £0.020m. In addition there were minor variances of £0.015m all of which can be attributed to the facilitation of helping people remain in their own homes.

Note 5 Primary Care Prescribing - The primary care prescribing budget is reporting an over spend of £0.416m for the twelve months to March 2017. The average unit cost per item prescribed varies throughout the year and can vastly affect the pressure on the budget.

Financial Review (cont'd)

Overall, the MIJB core services resulted in an overspend of £0.787m. This position has been improved considerably when the slippage on strategic funds are taken into consideration resulting in an overall underspend of £2.704m. It is worth emphasising that the favourable net position after regard to slippage on strategic funds is a one-off fortuitous benefit and longer term cost reduction plans and service redesign will be necessary in future years.

Risks, Uncertainties and Future Developments

One of the major risks facing the MIJB and its ability to deliver the services delegated to it within the context of the Strategic Plan is the uncertainty around the funding being made available from the partners and Scottish Government. The financial settlement announced by the Cabinet Secretary for Finance and the Constitution on 15 December 2016 had the following key statements which related to Integration Joint Boards for 2017/18, specifically in relation to the minimum settlement that Integration Joint Boards should expect from their funding partners.

- NHS contributions to Integration Joint Boards for delegated health functions will be maintained at least at 2016/17 cash levels;
- Local authorities will be able to adjust their allocations to Integration Joint Boards by up to their share of £80 million below the level of budget agreed in 2016/17; and;
- An additional £107m of Social Care funding, routed through Health Boards, in addition to the £250m received in 2016/17.

As part of the budget setting process the Chief Officer of the MIJB prepared a case in support of the 2017/18 budget proposals for the Board. The paper set out the financial position and identified the current level of risk relating to MIJB's financial performance to date and highlighted the significant issues affecting the delivery of a balanced position for 2017/18. Despite the efforts of the Chief Officer, both Moray Council and The Grampian Health Board restricted their budget allocations to the MIJB by the maximum permitted whilst remaining within the boundaries set by Scottish Government. The results of which can be summarised as follows;

- The Grampian Health Board funded the MIJB at 2016/17 cash levels with no increases for pay awards, inflationary increases or other budget pressures;
- Moray Council adjusted their allocation by £1.3m below the revised budget level agreed for 2016/17; and

Risks, Uncertainties and Future Developments (cont'd)

- An additional £1.74m of Social Care funding, routed through Health Boards as part of the £107m announcement will come to Moray to assist with social care budget pressures (mainly the commitment to the Scottish Living Wage).

Work is currently underway to address a funding gap in the 2017/18 budget. This will include a savings and efficiencies programme alongside close monitoring of identified budget pressures where no funding has been provided. MIJB will continue to work with its partners to close the gap.

The reduced funding levels, combined with the demographic challenges we are facing in period of ambitious reform, result in a number of risks and uncertainties which can be summarised as follow;

- Political uncertainty and consideration to the recent local government elections and the impact this will have on the MIJB. There are currently no known changes to NHS Board appointments.
- The ongoing impact of the implementation of the Living Wage and other nationally agreed policies that may present.
- Operational risks that sit with the Partners that have a direct impact on the operational aspects of MIJB, namely the recruitment and retention of staff.
- Public Sector financial funding uncertainties acknowledging the one year only settlements for the MIJB partners.

1 April 2018 sees the implementation of the Carers (Scotland) Act. The Act is designed to provide support to carers, based on carer's identified needs which meet the local eligibility criteria. With the implementation of this Act is likely to be considerable financial pressure which we will be working through during 2017/18 to provide as efficient a process as possible.

Risks, Uncertainties and Future Developments (cont'd)

Optimising health and social care services remain critical to the ambitious programme of reform as laid out in the Public Bodies (Joint Working) (Scotland) Act 2014. In line with the Act, the MIJB has established plans for the future which are contained within the Strategic Plan 2016-19 and will be part of an ongoing review process. The Strategic Planning and Commissioning Group has set out a number of key programmes of work as follows:

- Older Peoples Programme Board
- Out of Hours and Urgent Care Programme Board
- Learning Disabilities Accommodation Review
- Mental Health and Well Being Group – commissioning of new models of care
- Health Improvement and Community Wellbeing review
- Palliative and End of Life Review
- Infrastructure Programme Board encompassing opportunities for cross system redesign and efficiency as well as establishing a clearer digital footing locally to support change.

Key to these developments is the workforce. The first iteration of a Joint Workforce Plan and Organisational Development Plan was established in 2016/17. This will be confirmed and approved for implementation during 2017. The Joint Moray Workforce Forum will have oversight of this and associated processes.

Achieving the long term vision requires that people, communities, unpaid carers and staff from a range of different public services, the third and independent sectors will unite to design and deliver future services in order to achieve the best possible outcomes for adults in Moray. It is acknowledged that this requires a whole systems approach, partnership working and involvement of the whole community and MIJB will continue to work and develop ways in which to ensure integration is a success.

STATEMENT OF RESPONSIBILITIES

Responsibilities of the IJB

- To make arrangements for the proper administration of its financial affairs and to secure that it has an officer responsible for the administration of those affairs. In Moray Integration Joint Board, that officer is the Chief Financial Officer as appointed by the Board at its meeting of 25 February 2016;

- To manage its affairs to achieve best value in the use of its resources and safeguard its assets;

- Ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003); and

- To approve the Annual Accounts.

Christine Lester

Chair of Moray IJB

29 June 2017

STATEMENT OF RESPONSIBILITIES

Responsibilities of the Chief Financial Officer

The Chief Financial Officer is responsible for the preparation of the Moray Integration Joint Board's Annual Accounts which, in terms of the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (''the Code of Practice''), is required to give a true and fair view of the financial position of the Moray Integration Joint Board at the financial year end and its income and expenditure for the year then ended.

In preparing the Annual Accounts the Chief Financial Officer has:

- Selected suitable accounting policies and applied them consistently;
- Made judgements and estimates that were reasonable and prudent;
- Complied with legislation; and
- Complied with the local authority code (in so far as it is compatible with legislation)

The Chief Financial Officer has also:

- Kept proper accounting records which were up to date; and
- Taken reasonable steps for the prevention and detection of fraud and other irregularities.

Statement of Accounts

I certify that the financial statements give a true and fair view of the financial position of the Moray Integration Joint Board for the year ending 31 March 2017 and the transactions for the year then ended.

Margaret Wilson CPFA

Chief Financial Officer

29 June 2017

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REMUNERATION REPORT

Introduction

This Remuneration Report is provided in accordance with the Local Authority Accounts (Scotland) Regulations 2014 (SSI2014/200) as part of the MIJB annual accounts. There are no employees of the MIJB itself. The staff within Health and Social Care Moray are employed by either The Grampian Health Board or Moray Council. This report discloses information relating to the remuneration and pension benefits of specified MIJB members.

Moray Integration Joint Board

The voting members of MIJB are appointed through nomination by Moray Council and the Grampian Health Board. There is also provision within the Order to identify a suitably experienced proxy or deputy member for both the voting and non-voting membership to ensure that business is not disrupted by lack of attendance by any individual.

MIJB Chair and Vice-Chair

Councillor Lorna Creswell was formally appointed as the Chair of the MIJB on 25 February 2016. The appointment ran until 30 September 2016 after which she assumed the role of Vice-Chair. Councillor Creswell is paid a senior councillor salary by Moray Council.

Christine Lester was formally appointed as Vice -Chair of the MIJB on 25 February 2016. This appointment ran until 30 September 2016 after which she assumed the role of Chair. Christine Lester is paid by The Grampian Health Board for her duties and responsibilities as a Board member.

The MIJB does not provide any additional remuneration to the Chair, Vice-Chair or any other board members relating to their role on the MIJB. The MIJB does not reimburse the relevant partner organisations for any voting member costs borne by the partner.

The MIJB does not have responsibilities in either the current or in future years for funding any pension entitlements of voting MIJB members. Therefore no pension rights disclosures are provided for the Chair or Vice-Chair.

Officers of the MIJB

The MIJB does not directly employ any staff in its own right; however specific post-holding officers are non-voting members of the Board.

REMUNERATION REPORT

Officers of the MIJB (cont'd)

Chief Officer

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the integration joint board has to be appointed and the employing partner has to formally second the officer to the Board. The employment contract for the Chief Officer will adhere to the legislative and regulatory framework of the employing partner organisation. The remuneration terms of the Chief Officer's employment are approved by the Board.

In February 2016 the MIJB formally appointed Pamela Gowans as Chief Officer to the Board. The Chief Officer to the MIJB is employed by The Grampian Health Board and is funded jointly by The Grampian Health Board and Moray Council.

The remuneration of the Chief Officer is determined by the Scottish Government under Ministerial Direction and in accordance with Pay and Conditions of Service (PCS) of which the latest is PCS (Executive and Senior Management) 2015/2.

Other Officers

No other staff are appointed by the MIJB under a similar legal regime. Other non-voting board members who meet the criteria for disclosure are included in the disclosures below.

Total 2015/16	Senior Employees	Salary, Fees & Allowances	Taxable Expenses	Total 2016/17
£		£	£	£
12,942 (FYE 87,480)	Pamela Gowans Chief Officer	90,299	2,989	93,288

Pension Benefits

The Chief Officer participates in the National Health Service Superannuation scheme for Scotland which is an unfunded notional defined benefit scheme where contributions are credited to the Exchequer and the balance in the account is deemed to be invested in a portfolio of Government securities.

From 1 April 2015 the NHS Pension Scheme (Scotland) 2015 was introduced. This scheme is a Career Average Re-valued Earnings (CARE) scheme. Members will accrue 1/54 of their pay as pension for each year they are a member of the scheme. The accrued pension is re-valued each year at an above inflation rate to maintain its buying power. This is currently 1.5% above increases to the Consumer Prices Index (CPI). This continues until the member leaves the scheme or retires. In 2015-16 members paid tiered contribution rates ranging from 5.2% to 14.7% of pensionable earnings. The normal retirement age is the same as the State Pension age.

REMUNERATION REPORT

Pension Benefits (cont'd)

Members can take their benefits earlier but there will be a deduction for early payment. All members, unless covered by agreed protection arrangements, automatically joined the NHS 2015 scheme on 1 April 2015. Further information is available on the Scottish Public Pensions Agency (SPPA) web site at www.sppa.gov.uk

In respect of officers' pension benefits the statutory liability for any future contributions to be made rests with the employing partner organisation. On this basis there is no pension liability reflected on the balance sheet of MIJB for the Chief Officer. MIJB has however, responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the MIJB. The following table shows the MIJB's funding during the year which supports the Chief Officer' pension benefits. The table also shows the total value of accrued pension benefits which includes benefits earned in other employment positions.

	In Year Pension Contributions		Accrued Pension Benefits		
	Year to 31/03/16	Year to 31/03/17		As at 31/03/2017	Difference from 31/03/2016
	£	£		£ 000's	£ 000's
Pamela Gowans Chief Officer	11,985	12,371	Pension	27	2
			Lump Sum	72	2

Disclosure by Pay bands

As required by the regulations, the following table shows the number of persons whose remuneration for the year was £50,000 or above, in bands of £5,000.

Number of Employees in Band 2015/16	Remuneration Band	Number of Employees in Band 2016/17
1	£85,000 - £89,999	-
-	£90,000 - £94,999	1

REMUNERATION REPORT

Exit Packages

There were no exit packages agreed by the MIJB during 2016/17 financial year, or in the preceding year.

ANNUAL GOVERNANCE STATEMENT

The Annual Governance Statement describes the Moray Integration Joint Board's (MIJB) governance arrangements and reports on the effectiveness of the MIJB's system of internal control.

Corporate governance is an expression used to describe how organisations direct and control how they operate. For the MIJB this also includes how it relates to the communities it serves.

Scope of Responsibility

The MIJB is responsible for ensuring that its business is conducted in accordance with the law and relevant standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

In discharging this responsibility, the MIJB has established arrangements for its governance which includes the system of internal control. This system is intended to manage risk and support the achievement of the MIJB's policies, aims and objectives. Reliance is placed on The Grampian Health Board and Moray Council systems of internal control that support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, to the extent that these are complementary to those of the MIJB. The system provides reasonable but not absolute assurance of effectiveness.

The Purpose of the Governance Framework

The governance framework comprises the systems of internal control and the processes, culture and values, by which the MIJB is directed and controlled. It demonstrates how the MIJB conducts its affairs and enables the MIJB to monitor progress towards the achievement of its strategic priorities and to consider whether those priorities have led to the delivery of cost-effective services.

The Governance Framework

The CIPFA/SOLACE framework for 'Delivering Good Governance in Local Government' was updated in 2016 and defines the principles of good governance. The overall aim of the framework is to 'ensure that resources are directed in accordance with agreed policy and according to priorities, that there is sound and inclusive decision making and that there is clear accountability for the use of those resources in order to achieve desired outcomes for service users and communities'.

The Governance Framework (cont'd)

Whilst the Framework was written specifically for Local Government, the principles can be adopted by other public sector organisations including Integration Joint Boards.

A governance framework was progressed in the shadow year of the MIJB and has continued to be developed during 2016/17, the first year of operation. The Board of the MIJB comprises six voting members, nominated by either The Grampian Health Board (three) or Moray Council (three), as well as non-voting members including a Chief Officer appointed by the Board.

The key elements of the MIJB's governance arrangements are described in terms of the seven principles of good governance defined in the Framework and summarised below:

Governance Principle 1 – Behaving with integrity, demonstrating strong commitment to ethical values and respecting the rule of law

The roles and responsibilities of MIJB Members and the processes to govern the conduct of business are defined in the constitutional documents. These consist of standing orders, code of conduct and financial regulations. In addition, there are formally approved documents pertaining to the membership, quora and remit of the established sub-committees of the MIJB.

With reference to the Code of Conduct for the Board, the Scottish Government, in conjunction with the Commissioner for Ethical Standards and the Standards Commission prepared a template Code specific to integration joint boards with the expectation that this be implemented in full. At its meeting of 30 June 2016 the MIJB agreed to approve a Code of Conduct for onward submission to Scottish Government for approval. The Code was formally approved by Scottish Government on 5 July 2016. The Code of Conduct exists to ensure Members exercise leadership through exemplary standards of behaviour and that values are established and replicated effectively throughout the organisation. In January 2017, a development session was led by the Standards Officer on the roles and responsibilities of Board members in the context of the Code of Conduct. This process will be repeated at appropriate intervals.

Separately, the MIJB appointed Alasdair McEachan (Head of Legal and Democratic Services, Moray Council) as the Standards Officer of the MIJB at its meeting of the Board on 28 April 2016 for a period of 18 months. At the same meeting, the MIJB also approved two deputes to the Standards Officer appointment for the same period and from existing Moray Council staff. The Standards Officer assumes responsibility for a number of duties which includes holding various key documents for the Board and advising and guiding Members of the Board on issues of conduct and propriety whilst others are in terms of a liaison role with the Standards

The Governance Framework (cont'd)

Commission and the Commissioner for Ethical Standards in Public Life. The Standards Officer ensures the Board keeps Registers of Interests and records of Gifts and Hospitality.

Governance Principle 2 – Ensuring openness and comprehensive stakeholder engagement

Throughout 2016/17, the MIJB's decision making processes have been established such that major decisions are taken by the MIJB or one of its two sub-committees. As part of the decision making process, appropriate legal, financial and other professional advice is considered.

The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 obliges the MIJB to agree Standing Orders to regulate its meetings and those of its committees. Provision is made within MIJB's Standing Orders for public and press access to meetings and reports. Agendas, reports and minutes are available for members of the public to access in order for an assessment to be made on whether decisions have been made in the public interest.

Both the voting and non-voting membership arrangements of the MIJB are set out in the Health and Social Care Integration Scheme for Moray and are in line with the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014. The non-voting membership comprises six professional members and five stakeholder members representing the following groups: staff, third sector bodies carrying out activities in relation to health and social care, service users and unpaid carers, and two additional non-voting members.

The Community Empowerment (Scotland) Act 2015 places a statutory duty on MIJB and its Community Planning Partners to engage with communities on the planning and delivery of services and securing local outcomes. The MIJB in developing new, and building on existing strategies has consulted with stakeholders in order to include them in the progress towards achieving the National Health and Wellbeing Outcomes. During the year there was extensive stakeholder engagement through specific consultation and engagement in the development of the '*Carers' Strategy for Moray'* and '*Good Mental Health for All in Moray'*. The level of consultation has led to clear strategies which are now in the process of being implemented.

The MIJB engage in a diverse range of methods to ensure understanding of the views of the public and service users in particular. During the year, Vintage Tea Parties were held across Moray which had a focus on older adults with the aim of determining opinions on health and wellbeing in the context of local services.

The Governance Framework (cont'd)

Community Planning engagement activities have taken place through face-to-face communication and social media where feedback was invited around specific areas of business. Throughout the year the Chief Officer has visited community councils and area forums to enable communities to express views and observations about the services being delivered.

Governance Principle 3 – Defining outcomes in terms of sustainable economic, social and environmental benefits

In March 2016 the MIJB agreed a draft budget for the 2016/17 financial year and presented indicative levels of finance required for the following two financial years. At this point in time, assumptions were made that funding levels from the Partners would continue at similar levels. The Scottish Government 2017/18 funding settlements, for both health boards and local authorities, announced in December 2016 were significantly more challenging than was anticipated and so had an adverse impact on the onward negotiation of funding to the MIJB. Whilst the strategic outcomes and intent remain unchanged, the challenge is to ensure that the economic impacts of decisions taken are highlighted as there is likely to be insufficient funding to maintain current levels of service in the current and future years.

During 2016/17, following an extensive period of consultation with a wide ranging group of key stakeholders, the Strategic Plan 2016-19 was finalised and approved. The Plan sets out the proposals for improving the health and wellbeing for adults in Moray through design and delivery of integrated services in times of changing need. To support this process the Strategic Planning and Commissioning Group remains active with the aim of driving forward the Strategic Plan by overseeing these elements of delivery on behalf of the MIJB and to ensure adequate governance arrangements are in place. The Strategic Planning Group that operated throughout the shadow year in drafting the Strategic Plan continues to operate as an advisory group in support of the Plan and any future developments.

To support this governance principle and the core principles of the MIJB, programme boards have been established for specific areas of business that will support the process to identify new models of care that are financially sustainable whilst ensuring quality of care.

The Governance Framework (cont'd)

Governance Principle 4 – Determining the interventions necessary to optimise the achievement of intended outcomes

The intended outcomes of MIJB are defined in the Strategic Plan 2016 - 19 that was developed by an overarching group of stakeholders and approved by the Board in March 2016. MIJB recognises the significant challenges it faces, and, through its committee structure and development sessions provided by officers, Members have been informed of the constraints on resources whilst considering the options for future service delivery and the strive for shifting the balance of care. Underlying themes in this process are the recognition that change is inevitable and that new ways of working will be required in order to achieve the intended outcomes within the challenging financial climate within which the Board operates. Transformation has been progressed during the year through two major supported housing projects where the intention is to assist in maintaining independence and maximising individuals' and their families' outcomes.

Governance Principle 5 – Developing the capacity and capability of members and officers to be effective

This element of governance is designed to ensure that both members and officers have the knowledge, skills and capacity to enable them to fulfil their respective roles effectively. There has been acknowledgement at Board meetings that certain officers are finding things difficult in terms of capacity as many duties associated with the work of the MIJB are in addition to their existing daily duties. This has been the case in particular of the Chief Financial Officer, where agreement has now been reached to appoint a full-time independent officer to carry out the statutory duties in accordance with section 95 of the Local Government (Scotland) Act 1973.

Training and development for members is provided mainly in the form of briefings and development sessions. Workshops are provided to cover emerging issues, these being provided by staff from Moray Council and The Grampian Health Board, or by representatives from other government agencies and partner bodies.

The Moray Joint Workforce Forum has been established and has agreed terms of reference. The forum is chaired by the Head of Adult Health and Social Care with the Vice-Chair role being fulfilled by the staff side member, The Grampian Health Board. The membership of the forum includes representatives from management, trade unions, professional organisations and human resources from both Moray Council and The Grampian Health Board. The aim of the forum is to support the development and achievement of common goals and objectives for staff working under the direction of the MIJB in relation to health and safety as well as other key areas of training and development.

The Governance Framework (cont'd)

Governance Principle 6 – Managing risk and performance through robust internal control and strong public financial management

The MIJB has arrangements in place covering risk, performance management, internal control and financial management.

MIJB have in place both an approved risk policy and a strategic risk register. The strategic register is a standing item on the Audit and Risk sub-committee and is reviewed regularly. In the early stages of establishment MIJB Members agreed that the risk policy would also be reviewed regularly and updated to ensure its adequacy. During the year a risk themed development session was held for Members and Officers which was led by the Moray Council's insurers, which led to the risk policy being refined to include a statement on risk appetite. Operational risk registers are also in place across both The Grampian Health Board and Moray Council. These are regularly reported through Joint Operational Management Team, allowing staff to review progress and assess risks on an ongoing basis.

A performance management framework has been developed for MIJB. Quarterly reporting sets out the performance for Moray against key indicators relating to hospital admissions and community care. Additional reports have been created in relation to designated health improvement targets and delayed discharge which are reported on a quarterly basis by exception to the Board and on a monthly basis to the operational Adult Services Management Group. Performance is also monitored through quarterly review meetings. Here, the Chief Executives of The Grampian Health Board and Moray Council together with other key senior officers meet with the Chief Officer to discuss performance over the review period.

The internal control system links closely with those of the Partners, given their operational remit for delivery of services under direction of the MIJB. MIJB internal control arrangements are specified in the Financial Regulations developed to be used in conjunction with The Grampian Health Board and Moray Council's financial regulations and the Moray Integration Board Scheme. Establishing and maintaining an effective system of internal control is a management function. An Audit and Risk sub-committee through its consideration of reports monitors the effectiveness of internal control procedures.

Section 26 of The Public Bodies (Joint Working) (Scotland) Act 2014 requires that an integration joint board must give a direction to each of the partners to carry out the delegated functions. As part of the 2016/17 budget setting process, a direction was issued to the partners in line with the Act.

The Governance Framework (cont'd)

As part of the future developments outlined for 2017/18, a robust process will be introduced to ensure that Directions are issued according to the legislation.

Strong financial management procedures are secured through the work of the Chief Financial Officer appointed in terms of s. 95 of the Local Government (Scotland) Act 1973. This officer is an appointment to the Board and provides advice to the MIJB on all financial matters and ensures the timely production and reporting of budget estimates, budget monitoring reports and annual accounts.

Governance Principle 7 – Implementing good practices in transparency, reporting and audit to deliver effective accountability

MIJB business is conducted through an established cycle of Board meetings which are held in public, and the agendas, reports and minutes are available for the public to inspect. There is a standard reporting format in place to ensure consistency of approach and consideration by Members to provide transparency in decision making.

Internal audit arrangements have evolved during the year with meetings held between the audit committee chairs, the chief officers and the chief internal auditors of the three IJBs in the Grampian Health Board Area. The purpose of these meetings was to understand the control framework applicable to the IJB's and the inter-dependencies between the parties with regard to audit assurances.

Principles have been established around audit arrangements such that audit work can be planned specifically in relation to topics or issues under the direct remit of the MIJB, with additional assurances available from audits completed by internal auditors of either council or The Grampian Health Board to the extent that these are of relevance to the MIJB.

In developing audit arrangements regard has been made to published guidance on 'The Role of the Head of Internal Audit in Public Organisations' (CIPFA) and to 'Public Sector Internal Audit Standards' (CIPFA). Internal audit terms of reference have been established, and the Chief Internal Auditor reports directly to the Audit and Risk sub-committee with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Audit and Risk sub-committee on any matter. The Audit and Risk sub-committee assumes the role of assurance and accountability for the MIJB. The 2015/16 annual accounts received an unqualified opinion from the external auditors. The annual accounts were minimal in nature given the establishment of the MIJB came into effect from 6 February 2016 and so covered a period of only eight weeks to 31 March 2016.

ANNUAL GOVERNANCE STATEMENT

Review of Adequacy and Effectiveness

The MIJB has a responsibility to review the effectiveness of its governance framework including the system of internal control and to produce an Annual Governance Statement. This work is pursued throughout the year by various means involving:

The MIJB and its Sub-Committees

The appointment of MIJB Members was carried out according to the requirements set out within the Health and Social Care Integration Scheme for Moray and the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014. Early in 2016/17, two sub -committees were established to assist with the planning and delivery of integrated services delegated to the MIJB. The Clinical and Care Governance sub-committee to ensure safe, effective and high quality care and to provide assurance to statutory post holders in relation to effective services and the Audit and Risk sub-committee to assist in ensuring a robust framework for risk management, governance and internal control and provide effective scrutiny of the MIJB's functions. The two sub-committees identified clear frameworks and membership and were established following formal MIJB approval. The effectiveness of the MIJB governance framework is enhanced through its membership and wide representation through the voting membership, non-voting membership, professional advisors and stakeholder members.

The Grampian Health Board and Moray Council

MIJB have placed reliance on the systems and procedures of its principal Partners, The Grampian Health Board and Moray Council. The Partners have maintained governance arrangements applicable to their respective organisations which are summarised annually and published in their Annual Governance Statements which form part of the annual accounts of each organisation. Moray Council has a duty under the Local Government in Scotland Act 2003 to make arrangements to secure continuous improvements in the way in which its functions are exercised. The Grampian Health Board is required to operate within the aspects of the Scottish Public Finance Manual (SPFM) issued by Scottish Ministers. The SPFM sets out the relevant statutory, parliamentary and administrative requirements, emphasises the need for efficiency, effectiveness and economy and promotes good practice and high standards of propriety.

For the 2016/17 review period, the Chief Executive of The Grampian Health Board has confirmed that he is not aware of any outstanding significant control weaknesses or other failures to achieve the standards set out in the guidance that applies to NHS Boards in relation to governance, risk management and internal control. Likewise the council in its annual review of its governance arrangements in line with the CIPFA code is satisfied that these remain fit for purpose, notwithstanding the challenges facing all public sector bodies in the period ahead.

ANNUAL GOVERNANCE STATEMENT

Internal Audit

Internal Auditing is defined in the Public Sector Internal Audit Standards (PSIAS) as an independent, objective, assurance and consultancy activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. Its mission, therefore, is to enhance and protect organisational value by providing risk based and objective assurance, advice and insight.

The Chief Internal Auditor to the MIJB was formally appointed in March 2016 for a period of two years. The Chief Internal Auditor has responsibility for MIJB's internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The requirement of the appointment is to report to the Audit and Risk sub-committee on the proposed annual audit plan, the ongoing delivery of the plan as well as reporting on the outcome of reviews undertaken and to submit an annual report.

In February 2017, the Internal Auditors for The Grampian Health Board, PricewaterhouseCoopers, carried out a review across all three Grampian integration joint boards in relation to two of the nine national health and wellbeing outcomes.

The review produced a low risk report with two medium risk findings around staff governance. MIJB acknowledges these findings and plans are in place as part of continuing and future development. Other risks identified during the review were in connection with aligning the strategic priorities of the MIJB with available budgets. MIJB has an existing awareness of the improvements required in relation to the outcome and work is planned to address this through further developing financial reporting formats and refreshing the Strategic Plan.

In summary, the review of the effectiveness of the MIJB's governance framework is informed by the work of the MIJB and its sub-committees, internal audit and the senior management teams.

External Agencies

In addition to the various internal review processes, there are aspects of the MIJB's governance arrangements that will be subject to consideration in various inspection reports by the external auditor and by service inspectorates. The foundations have been established for the MIJB to respond positively to the recommendations arising from inspection reports where these provide opportunities to strengthen governance arrangements.

The MIJB is subject to external scrutiny through external auditors appointed by the Accounts Commission to provide an opinion on the MIJB's annual accounts and conduct such other work that they may deem necessary or by request from the MIJB or its Audit and Risk sub-committee.

ANNUAL GOVERNANCE STATEMENT

Significant Governance Issues

Securing good governance continues to be a key focus of the MIJB, its sub-committees and senior management. This is a significant undertaking within a challenging financial climate and a commitment to deliver an ambitious Strategic Plan within a medium term time frame. In the prior year, the annual governance statement identified areas of challenge in relation to progressing the objectives and principles of integration whilst working closely with Partners, achieving financial balance and ensuring established performance reporting procedures. Whilst these issues have been successfully progressed, they reflect longer term objectives and so will continue to feature as significant governance issues in future periods.

The key governance challenges going forward will involve:

- Enabling the MIJB to move forward with a balanced budget that has addressed the challenges presented as a result of a difficult financial settlement from both The Grampian Health Board and Moray Council.

- Ensuring prompt attention is given to securing arrangements to fill the statutory role of Chief Financial Officer. Whilst progress has been made and Board approval secured for the independent appointment to this post, it is a priority to confirm that adequate interim arrangements are in place to ensure continuity of this statutory role in the event that the post is not filled prior to the departure of the current Chief Financial Officer.

- Early engagement with new MIJB Members following council elections to ensure they are appropriately inducted in order to participate appropriately in the business of MIJB.

- Working closely with all key stakeholders to progress and deliver the objectives as detailed in the Strategic Plan 2016-19.

ANNUAL GOVERNANCE STATEMENT

Further Developments

Following consideration of the review of adequacy and effectiveness, the following action plan has been established to ensure continual improvement of the MIJB's governance arrangements and progress against the implementation of these issues will be assessed as part of the next annual review.

	Area for Improvement and Outcome to be Achieved
1.	An assurance framework will be established. This will include the development of a Local Code of Corporate Governance to reflect the requirements of the CIPFA/SOLACE guidance of 2016 and the strengthening of the methodology for monitoring and reporting governance arrangements.
2.	MIJB financial reporting formats require modification to ensure clarity for Members, stakeholders and to further assist decision making. Improvements will assist in will assist in demonstrating alignment with the strategic priorities of the MIJB and ensure Directions are issued in line with legislation.
3.	Development of a Communications and Engagement Strategy assuring the MIJB's stakeholders understand and are engaged in its work. This work is to include the development of a designated website.
4.	Development work to be undertaken and co-ordinated across Grampian to ensure that the MIJB is embedded into the strategic planning processes surrounding the Set Aside budget.
5.	Implement agreed audit reporting arrangements to provide additional assurances to the Audit and risk sub-committee.
6.	Performance reporting to made a priority during 2017/18. Work to be progressed and developed through the board performance framework.
7.	Locality Planning will be a focussed programme during 2017/18 led by intensive engagement with communities.
8.	Review and refine our procurement approach and process in-line with statutory requirements and in support of the approach to strategic approach.

ANNUAL GOVERNANCE STATEMENT

Statement

In our respective roles as Chair and Chief Officer of the MIJB, we are committed to good governance and recognise the contribution it makes to securing delivery of service outcomes in an effective and efficient manner. This annual governance statement summarises the MIJB's current governance arrangements, and affirms our commitment to ensuring they are regularly reviewed and remain fit for purpose. Whilst recognising that improvements are required, as detailed above, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the MIJB's governance environment.

While pressure on financial settlements is likely to continue during the incoming period, we will continue to engage with our Partners and the wider community to agree plans and outcome targets that are both sustainable and achievable. Taking those forward will be challenging as we aim to fulfil the nine Health and Well-being national outcomes and the strategic priorities identified and detailed in our Strategic Plan. Good governance will remain essential in delivering services in a way that both meets the needs of communities and discharges statutory best value responsibilities.

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Pam Gowans

Chief Officer

Moray Integration Joint Board

……..

Christine Lester

Chair

Moray Integration Joint Board

29 June 2017

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

This statement shows the cost of providing services for the year ended 31 March 2017 according to generally accepted accounting practices.

2015/16 Net Expenditure £ 000		2016/17 Net Expenditure £ 000
	Community Hospitals	5,520
	Community Nursing	3,653
	Learning Disabilities	5,288
	Mental Health	7,405
	Addictions	823
	Adult Protection & Health Improvement	165
	Care Services Provided In-House	13,047
	Older People & Physical & Sensory Disability Services	16,267
	Intermediate Care and Occupational Therapy	1,629
	Care Services Provided by External Providers	9,945
	Other Community Services	7,169
22	Administration & Management	2,703
	Primary Care Prescribing	17,304
	Primary Care Services	14,890
	Hosted Services	3,681
	Out of Area Placements	525
	Improvement Grants	930
	Strategic Funds	877
	Set Aside	10,163
22	**Cost of Services**	**121,984**
22	Taxation and Non-Specific Grant Income (note 4)	(124,688)
0	**(Surplus) or Deficit on provision of Services**	**(2,704)**
0	**Total Comprehensive Income and Expenditure**	**(2,704)**

The Moray Integration Joint Board (MIJB) was established on 6 February 2016. MIJB became assumed responsibility for the delivery of health and social care services on 1 April 2017. Consequently, the 2016/17 financial year is the first fully operational financial year for the MIJB and the figures presented above reflect this.

There are no statutory or presentation adjustments which reflect the MIJB's application of the funding received from partners. The movement in the General Fund balance is therefore solely due to the transactions shown in the Comprehensive Income and Expenditure Statement. Consequently, an Expenditure and Funding Analysis is not provided in these annual accounts.

MOVEMENT IN RESERVES STATEMENT

This statement shows the movement in the year on the Moray Integration Joint Boards (MIJB) reserves. The movements which arise due to statutory adjustments which affect the General Fund balance are separately identified from the movement due to accounting practices.

Movement of Reserves During 2016/17	General Fund Balance	Unusable Reserves: Employee Statutory Adjustment Account	Total Reserves
	£000	£000	£000
Opening Balance at 1 April 2016	**0**	**0**	**0**
Total Comprehensive Income and Expenditure	(2,704)	0	(2,704)
Adjustments between accounting basis and funding basis Under regulations	0	0	0
Increase or Decrease in 2016/17	(2,704)	0	(2,704)
Closing Balance at 31 March 2017	**(2,704)**	**0**	**(2,704)**

BALANCE SHEET

The Balance Sheet shows the value of the Moray Integration Joint Board's (MIJB) assets and liabilities as at the balance sheet date. The net assets of the MIJB (assets less liabilities) are matched by the reserves held by the MIJB.

31 March 2016 £000		Notes	31 March 2017 £000
5	Short Term Debtors		2,704
	Current Assets		
5	Short Term Creditors		
	Current Liabilities		
0	Provisions		0
	Long Term Liabilities		
0	**Net Assets**		**2,704**
0	Usable Reserve: General Fund		2,704
0	Unusable Reserve:		
0	Employee Statutory Adjustment Account		
0	**Total Reserves**		**2,704**

The unaudited Annual Accounts were issued on 29 June 2017. The Annual Accounts present a true and fair view of the financial position of the MIJB as at 31 March 2017 and its income and expenditure for the year then ended.

Margaret Wilson CPFA
Chief Financial Officer
29 June 2017

NOTES TO THE FINANCIAL STATEMENTS

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Note 1 Significant Accounting Policies

General Principles

The Financial Statements summarises the Moray Integration Joint Board's (MIJB) transactions for the 2016/17 financial year and its position at the year-end of 31 March 2017.

The MIJB was established under the requirements of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Act 2014 and is a Section 106 body as defined in the Local Government (Scotland) Act 1973.

The Financial Statements are therefore prepared in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2016/17, supported by International Financial Reporting Standards (IFRS), unless legislation or statutory guidance requires different treatment.

The accounts are prepared on a going concern basis, which assumes that the MIJB will continue in operational existence for the foreseeable future. The historical cost convention has been adopted.

Accruals of Income and Expenditure

Activity is accounted for in the year that it takes place, not simply when settlement in cash occurs. In particular:

- Expenditure is recognised when goods or services are received and their benefits are used by the MIJB
- Income is recognised when the MIJB has a right to the income, for instance by meeting any terms and conditions required to earn the income, and receipt of the income is probable.
- Where income and expenditure have been recognised but settlement in cash has not taken place, a debtor or creditor is recorded in the Balance Sheet.
- Where debts may not be received, the balance of debtors is written down

Funding

The MIJB is primarily funded through funding contributions from the statutory funding partners, Moray Council and The Grampian Health Board. Expenditure is incurred as the MIJB commissions' specified health and social care services from the funding partners for the benefit of service recipients in Moray area.

Note 1 Significant Accounting Policies (cont'd)

Cash and Cash Equivalents

The MIJB does not operate a bank account or hold cash. Transactions are settled on behalf of the MIJB by the funding partners. Consequently the MIJB does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to or from each funding partner as at 31 March is represented as a debtor or creditor on the MIJB's Balance Sheet.

Employee Benefits

The MIJB does not directly employ staff. Staff are formally employed by the funding partners who retain the liability for pension benefits payable in the future. The MIJB therefore does not present a Pensions Liability on its Balance Sheet.

The MIJB has a legal responsibility to appoint a Chief Officer. More details on the arrangements are provided in the Remuneration Report. The charges from the employing partner are treated as employee costs. Where material the Chief Officer's absence entitlement as at 31 March is accrued, for example in relation to annual leave earned but not yet taken.

Charges from funding partners for other staff are treated as administration costs.

Provisions, Contingent Liabilities and Contingent Assets

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation as at 31 March due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in the MIJB's Balance Sheet, but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March, whose existence will only be confirmed by later events. A contingent asset is not recognised in the MIJB's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

Note 1 Significant Accounting Policies (cont'd)

Reserves

The MIJB's reserves are classified as either Usable or Unusable Reserves.

The MIJB's only Usable Reserve is the General Fund. The balance of the General Fund as at 31 March shows the extent of resources which the MIJB can use in later years to support service provision.

The MIJB's only Unusable Reserve is the Employee Statutory Adjustment Account. This is required by legislation. It defers the charge to the General Fund for the Chief Officer's absence entitlement as at 31 March, for example any annual leave earned but not yet taken. The General Fund is only charged for this when the leave is taken, normally during the next financial year.

Indemnity Insurance

The MIJB has indemnity insurance for costs relating primarily to potential claim liabilities regarding Board members. The Grampian Health Board and Moray Council have responsibility for claims in respect of the services that they are statutorily responsible for and that they provide.

Unlike NHS Boards, the MIJB does not have any 'shared risk' exposure from participation in the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). The MIJB participation in the CNORIS scheme is therefore analogous to normal insurance arrangements.

Known claims are assessed as to the value and probability of settlement. Where it is material the overall expected value of known claims taking probability of settlement into consideration is provided for in the MIJB's Balance Sheet.

The likelihood of receipt of an insurance settlement to cover any claims is separately assessed and, where material, presented as either a debtor or disclosed as a contingent asset.

NOTES TO THE FINANCIAL STATEMENTS

Note 2 Events After the Reporting Period

The Annual Accounts were authorised for issue by Margaret Wilson, Chief Financial Officer on 29 June 2017. Events taking place after this date are not reflected in the financial statements or notes. Where events taking place before this date provided information about conditions existing at 31 March 2017, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

Note 3 Expenditure and Income Analysis by Nature

2015/16		2016/17
£000		£000
	Services commissioned from Moray Council	49,344
	Services commissioned from The Grampian Health Board	72,508
17	Employee Benefits Expenditure	115
5	Auditor Fee: External Audit Work	17
22	**Total Expenditure**	**121,984**
22	Partners Funding Contributions and Non-Specific Grant Income	(124,688)
	(Surplus) or Deficit on the Provision of Services	**(2,704)**

Note 4 Taxation and Non-Specific Grant Income

2015/16		2016/17
£000		£000
11	Funding Contribution from Moray Council	41,252
11	Funding Contribution from The Grampian Health Board	83,436
22	**Taxation and Non-specific Grant Income**	**124,688**

The funding contribution from The Grampian Health Board shown above includes £10.163m in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by The Grampian Health Board who retains responsibility for managing the costs of providing the services. The MIJB however has responsibility for the consumption of, and level of demand placed on, these resources.

Note 5 Debtors

31 March 2016		31 March 2017
£000		£000
2.5	The Grampian Health Board	1,403
2.5	Moray Council	1,301
	Debtors	**2,704**

Amounts owed by the funding partners are stated on a net basis. Creditor balances relating to expenditure obligations incurred by the funding partners but not yet settled in cash terms are offset against the funds they are holding on behalf of the MIJB.

Note 6 Usable Reserve: General Fund

The MIJB holds a balance on the General Fund for two main purposes:

- To earmark, or build up, funds which are to be used for specific purposes in the future, such as known or predicted future expenditure needs. This supports strategic financial management.
- To provide a contingency fund to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the MIJB's risk management framework.

The table below shows the movements on the General Fund balance. 1 April 2016 is the date that the MIJB assumed operational responsibility for the functions delegated to it. Accordingly, there was no transfer of reserves during 2015/16. The £2.704m transfer in to reserves relating to the 2016/17 financial year is as a result of slippage on strategic funds during the year.

2015/16					2016/17		
Balance at 1 April 2015	Transfers Out 2015/16	Transfers In 2015/16	Balance at 31 March 2016		Transfers Out 2016/17	Transfers In 2016/17	Balance at 31 March 2017
£000	£000	£000	£000		£000	£000	£000
0	0	(0)	(0)	Strategic Funds		(2,704)	(2,704)
0	**(0)**	**(0)**	**(0)**	**General Fund**	**(0)**	**(2,704)**	**(2,704)**

Note 7 Agency Income and Expenditure

On behalf of all IJB's within The Grampian Health Board, the MIJB acts as the lead manager for Grampian Medical Emergency Department (GMED) and Primary Care Contracts. It commissions services on behalf of the other IJBs and reclaims the costs involved. The payments that are made on behalf of the other IJBs, and the consequential reimbursement, are not included in the Comprehensive Income and Expenditure Statement (CIES) since the MIJB is not acting as principal in these transactions.

There is a zero balance for the 2015/16 financial year due to the MIJB not becoming operational until 1 April 2016.

The amount of expenditure and income relating to the agency arrangement is shown below.

2015/16		2016/17
£000		£000
0	Expenditure on Agency Services	8,067
0	Reimbursement for Agency Services	8,067
0	**Net Agency Expenditure excluded from the CIES**	**0**

Note 8 Related Party Transactions

The MIJB has related party relationships with The Grampian Health Board and Moray Council. In particular the nature of the partnership means that the MIJB may influence, and be influenced by, its partners. The following transactions and balances included in the MIJB's accounts are presented to provide additional information on the relationships.

Note 8 Related Party Transactions (cont'd)

Transactions with The Grampian Health Board

2015/16		2016/17
£000		£000
0	Funding Contributions received from the NHS Board	(83,436)
0	Expenditure on Services Provided by the NHS Board	72,508
	Key Management Personnel: Non-Voting Board Members	55
0	**Net Transactions with The Grampian Health Board**	**(10,873)**

Key Management Personnel: The Chief Officer, being a non -voting Board member is employed by The Grampian Health Board and recharged to the MIJB. Details of the remuneration of the Chief Officer are provided in the Remuneration Report.

Balances with The Grampian Health Board

31 March 2016		31 March 2017
£000		£000
3	Debtor balances: Amounts due from The Grampian Health Board	(1,403)
3	Creditor balances: Amounts due to The Grampian Health Board	0
0	**Net Balance due from The Grampian Health Board**	**(1,403)**

Note 8 Related Party Transactions (cont'd)

Transactions with Moray Council

2015/16		2016/17
£000		£000
0	Funding Contributions received from the Council	(41,252)
0	Expenditure on Services Provided by the Council	49,361
	Key Management Personnel: Non-Voting Board Members	60
0	**Net Transactions with Moray Council**	**8,169**

Balances with Moray Council

31 March 2016		31 March 2017
£000		£000
2	Debtor balances: Amounts due from Moray Council	(1,301)
2	Creditor balances: Amounts due to Moray Council	0
0	**Net Balance due from Moray Council**	**(1,301)**

The Chief Financial Officer to the MIJB is provided by Moray Council on the basis of these services being free of charge and as such there is no recharge to the MIJB

Note 9 VAT

The MIJB is not registered for VAT and as such the VAT is settled or recovered by the partners. The VAT treatment of expenditure in the MIJB accounts depends on which of the partners is providing the services as each of these partners are treated differently for VAT purposes.

VAT payable is included as an expense only to the extent that it is not recoverable from Her Majesty's Revenue and Customs. VAT receivable is excluded from income.

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2017

SUBJECT: SELF- DIRECTED SUPPORT RESIDENTIAL CARE PROJECT EVALUATION REPORT

BY: MICHELLE FLEMING, SDS OFFICER

1. REASON FOR REPORT

1. To inform the Board of the report to be submitted to the Scottish Government in relation to the Self-Directed Support (SDS) Residential Care Project.

2. RECOMMENDATION

2.1. It is recommended that the Moray Integration Joint Board note the evaluation made regarding the Self-Directed Support (SDS) Residential Care Project.

3. BACKGROUND

3.1 The Social Care (Self Directed Support)(Scotland) Act 2013 introduced the principles of Self Directed Support (SDS) into mainstream delivery of Community Care. This is underpinned by a national SDS strategy, which CoSLA and the Scottish Government expect will take 10 years to fully implement.

3.2 The SDS legislation directly related to individuals living in the community. The Scottish Government invited Local Authorities to put forward their interest to test all of the principles and options within The Social Care (Self-Directed Support) (Scotland) Act 2013 with those living in residential care.

3.3 Moray Council was successful in its bid to the Scottish Government to conduct the project looking at the ethos of SDS within residential care home settings. The choice and control that comes with SDS was tested with individuals who opted to take part in the pilot to determine if their outcomes could be met in a more personalised way. This in turn would hopefully allow for an increase in an individual's quality of life. To test out the ethos and processes of SDS, work was done alongside two older people's residential care homes and one Learning Disability care home.

3.4 Moray Council currently has an exception within the Self-Directed Support (Direct Payments) (Scotland) Regulations 2014, which permits the use of Direct Payments in residential care. The project was to determine if offering the full suite of options in residential care provided better outcomes for residents, and if this was financially viable for care homes.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Since June 2015, Moray Council has been exploring the use of all of the four options of SDS in residential care settings. The four options of SDS are:

Option 1 : A cash payment made to the individual to allow them to secure the care and support services required to meet their agreed outcomes
Option 2: The individual selects the care and support required and the Local Authority or third party make the necessary arrangements on the individual's behalf.
Option 3: The local authority selects and arranges the care and support services required to meet the individual's outcomes.
Option 4: A mix of two or more of the above options, selected by the individual to meet their agreed outcomes.

A dedicated project team was formed to deliver on the outcomes of the project.

4.2 The project initially focused on reviewing individuals in a residential setting with the current SDS paperwork which was used in the community. This was to determine if the paperwork was suitable for use with individuals in residential care. This testing allowed for a robust set of assessment materials to be developed tailor made for individuals in residential care still using a Resource Allocation System (RAS). The RAS is a tool which through a supported self-assessment questionnaire an indicative budget can be identified.

4.3 The paperwork was redesigned, informed by the findings, which included the introduction of a base line survey. The base line survey enabled the Social Worker to build positive relationships with the individuals and allowed them to explore who they were prior to entering residential care. It also enabled individuals to identify outcomes important and personal to them and to score their satisfaction out of 10 with the identified outcomes.

4.4 Care homes were identified through the project team's attendance at care home owners and manger's meetings, with interest registered from the individual care homes. Individuals within the participating care homes were identified in conjunction with the care homes, the allocated social worker, the individual and their families.

4.5 In total, twelve individuals were assessed using the revised paperwork across two older people's care homes and one learning disability care home. Of the twelve individuals, one decided that they were content with the care and support provided by the care home. Five individuals chose to take a direct payment through option 1 of SDS, all of whom resided in older peoples care homes. The remaining six individuals chose option 2 of SDS. Out of the twelve individuals, four resided in a learning disability care home. Two individuals residing in older people's residential care opted to explore receiving their care home fees through SDS as opposed to Moray Council funding the care home directly. The aim was to determine if they had a greater sense of choice and control by managing their care home fees.

4.6 One aspect of living in a care home was their surrounding community, and it was important to recognise that there is the community within the care home, and that of the wider community. As a result of this, three of the individuals who opted for a direct payment chose to employ Personal Assistants to reconnect them with the wider community. One individual through option 2 chose to re-attend the Moray Resource Centre which they had done prior to entering residential care.

4.7 Towards the end of the project, individuals revisited their outcomes and rescored their satisfaction. Of all of the participants who had fully implemented their support plan, all reported a significant increase in their score. One family member reported the project as “excellent”, stating, “I have nothing but praise for the care carried out and would hope that many people can benefit from this project. I know many people who are in care homes and never get outside again. This has been brilliant for my mother as she was taken out by a carer to visit her sister and this worked out so well for her and her family was delighted”. It is evident that the project delivered increased personalised outcomes with two individuals wishing to fund the support privately once the project comes to an end due to the positive impact that this has made on their lives.

4.8 Through building a close relationship with the care homes involved the project team was able to explore the impact of SDS in residential care homes. This included care homes looking at a minimum opt in that individuals needed to purchase when choosing to move into the care home. It became apparent that the make-up of the current national care home contract did not lend itself to offering true choice and control and within the current climate could destabilise the market. It is clear that a ‘one size does not fit all’ when funding individuals in residential care and does not afford itself to complete choice and control and does not lend itself to the principles of SDS which identifies personalised budgets. The full report is included at **appendix 1**.

5. SUMMARY OF IMPLICATIONS

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

Moray has made a commitment to the development of SDS as a means of promoting independent living and equalities. The independent living and equalities agenda cuts across all areas. In line with the Integration Joint Board strategic plan there is a commitment to respect individual needs and values, demonstrating compassion, continuity, clear communication and shared decision making.

(b) Policy and Legal

The Council has a legal duty under the Social Care (Self Directed Support) (Scotland) Act 2013 to promote direct payments, which in terms of the Health and Social Care Integration Scheme for Moray has been

delegated to the Integration Joint Board. The Self Directed Support legislation requires the values and principles which underpin the SDS strategy and legislation to be promoted. The values highlighted are Respect, Fairness, Independence, Freedom and Safety. The underpinning principles are, Collaboration, Dignity, Informed Choice, Innovation, Involvement, Participation, Responsibility and Risk Enablement. The SDS Residential Care Project was to explore if the values and principles of SDS, in particular Direct Payments increased an individual's choice and control. The findings from both Moray Council and East Renfrewshire Council projects will inform policy decision at the Scottish Government whether to amend SDS legislation to permit the use of Direct Payments in residential care.

(c) Financial implications

The testing of Self- Directed Support within residential care carried no finical implications as the project was fully funded through the Scottish Government.

(d) Risk Implications and Mitigation

There are no risks identified.

(e) Staffing Implications

There are no staffing implications as the project is fully funded by the Scottish Government. This enabled a dedicated project team to be recruited to for the duration of the project.

(f) Property

There are no implications.

(g) Equalities

An equality impact assessment was carried out as part of the development of the policy, strategy and activity. No negative impact has been identified. The recommendations are expected to promote equality of opportunity for the following groups; age, disability.

(h) Consultations

Consultations have taken place
with Pam Gowans, Chief Officer
Jane Mackie, Joint Operational Manager
Roddy Huggan, Service Manager, Commissioning and
Performance Pauline Knox, Senior Commissioning Officer
Any comments received have been considered in writing the report.

6. CONCLUSION

6.1. This report to the Integration Joint Board informs of the evaluation report to be submitted to the Scottish Government.

Author of Report: Michelle Fleming
Background Papers: SDS Residential Care Project Evaluation document
Ref:

Signature: Date: 15 June 2017

Designation: Chief Officer Name: Pam Gowans

HEALTH & SOCIAL CARE MORAY

D-01998

moray Self Directed Support

30th June 2017

SDS Residential Care Project

Moray Council Self-Directed Support

SDS Residential Care Project Officer Michelle Fleming

Equality Statement

If you need information from the Moray Council in a different format, such as Braille, audio tape or large print, please contact:

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Jei pageidaujate tarnybos Moray tarybos teikiamą informaciją gauti kitokiu formatu, pvz., Brailio raštu, garso įrašu ar stambiu šriftu, kreipkitės:

Jeśli potrzebują Państwo informacji od Rady Okręgu Moray w innym formacie, takim jak alfabet Braille'a, kasety audio lub druk dużą czcionką, prosimy o kontakt:

Se necessitar de receber informações por parte do Concelho de Moray num formato diferente, como Braille, cassete áudio ou letras grandes, contacte:

Если вам нужна информация от «Морей Каунсл» в другом формате, например шрифтом Брайля, в виде аудиозаписи или крупно напечатанная, обращайтесь:

Si necesita información del consejo de Moray en un formato diferente, como Braille, cinta de sonido o en letra grande, póngase en contacto con:

You can get in touch by calling **01343 563999** Monday to Friday from 8.45am to 5pm.

Email: accesscareteam@moray.gov.uk.

In writing: Access Care Team, Community Care, Moray Council, 2-10 High Street, Elgin IV30 1BY.

Funding

The Scottish Government invited Local Authorities to submit bids in 2014 to be one of two test sites. The SDS Residential Care Project was a Scottish Government funded two year project to look at how the delivery of all four options of Self Directed Support can be delivered to those individuals in residential care.
Moray Council was informed the bid was successful in January 2015 and subsequently funding drawn down, with the project running from June 2015 to June 2017.

Acknowledgements

The project team would like to thank Andersons Care Home, Elgin; Parklands Group, Buckie and Parkholme, Cornerstone, Lossiemouth; the Residential Care Homes taking part in the project. We would also like to thank Enable for working alongside us, to explore the use of SDS Option 2 in Residential Care Homes. We would like to express our sincere gratitude to the individuals and their families who took part in the project and the Personal Assistants and Support Workers who supported them through the work of the project. In addition we would like to thank Mr. Sam Newman; critical friend for his support and advice throughout the life of the project. Without their help, support and cooperation, this project would not have been possible.

Contents

Summary

The Social Care (Self Directed Support) (Scotland) Act 2013 currently does not permit the use of Option 1 (Direct Payments) for those living in residential care. The project aim was to explore the full suite of options encompassed in the Self Directed Support (SDS) legislation to determine if this led to better outcomes for individuals in residential care. The project was to examine if offering option 1 of SDS increases an individual's choice and control, leading to better outcomes and in turn an increased quality of life. In addition, would residential care settings be able to offer complete choice and control. If so, would this be financially viable for them or is there a risk that this would destabilise the market. The project explored to what extent did SDS provide new opportunities to achieve better outcomes including accessing more diversity in personalised support. Moray Council has an exception within the legislation to allow for the full exploration of all of the impacts of offering and delivering all of the options encompassed within the legislation.

The project initially focussed on reviewing individuals currently in residential care using the community based Supported Self-Assessment Questionnaire (SSAQ). The SSAQ uses a Resource Allocation Method (RAS) to determine an indicative budget. In total, 32 individuals were reviewed with the aim of producing robust and fit for purpose paperwork for people in a residential setting. Once the redesign process was complete, individuals within the care homes were assessed using this paperwork. In total, twelve individuals were reviewed with the new SDS paperwork, of which one family decided that they were content with the provision that was currently received. A further five individuals opted for an Individual Service Fund through option two, with one individual also receiving the national care home rate through this route. One individual chose for the local authority to hold their budget through option two. Five individuals chose to have their budget through a direct payment, with one individual opting to receive all of their care home costs via the direct payment. Four of the individuals who took part in the project resided in a learning disability care home, with all four residents opting to use an Individual Service Fund through option two.

The most common group for the uptake of a direct payment was for individuals who were over 75, and in the 'older' category. All of the individuals were already residing in the care home prior to their involvement in the pilot project. Of the individuals who opted for a direct payment, only one individual manged the direct payment themselves. The remaining four individuals had their direct payment managed by their Power of Attorney (POA), three of whom were family members, and one who was a solicitor.

Of the five in receipt of a direct payment, three had opted to use their budget for activities out with the care home, which involved the employment of Personal Assistants to enable this. Two of the individuals chose a direct payment for use within the care home to purchase items to enhance their experience within the care home.

The individual, who took their budget through option two held by the Local Authority, chose to use their budget to return to the day centre previously attended. Of the 5

individuals who opted for an Individual Service Fund, four opted to undertake activities out with the care home, with one individual opting for a piece of equipment to utilise within the care home setting.

Individuals identified their individual outcomes and scored their satisfaction with them prior to commencement of the project. Towards the end of the project, individuals revisited their outcomes and rescored their satisfaction. Of all of the participants who had fully implemented their support plan, all reported a significant increase in their score. One family member reported the project as “excellent”, stating, “I have nothing but praise for the care carried out and would hope that many people can benefit from this project. I know many people who are in care homes and never get outside again. This has been brilliant for my mother as she was taken out by a carer to visit her sister and this worked out so well for her and her family was delighted”. It is evident that the project delivered increased personalised outcomes with two individuals wishing to self-fund the additional support once the project came to an end.

Through building a close relationship with the care homes involved, the project team was able to explore the impact of SDS on residential care homes. This included care homes looking at a minimum opt in that individuals needed to purchase when choosing to move into the care home. It became apparent that the make-up of the current national care home contract payment rates did not lend itself to offering true choice and control and within the current climate. It was apparent that removing any elements of the charges in order to pay them to another provider or use them differently could destabilise the market. It is clear that a ‘one size does not fit all’ when funding individuals in residential care, and does not afford itself to complete choice and control. It is also evident that the funding structure does not lend itself to the principles of SDS which identifies personalised budgets based on individual’s level of need.

Findings from the interviews with the care home owners showed that they were receptive to the project, with the benefits for both the care home and their residents clearly visible. There were welcomed benefits with the introduction of Personal Assistants; however, there were also concerns which would need to be addressed for a successful introduction to the wider market-place.

Introduction

Self-Directed Support (SDS) is the way in which long term supported is delivered through community care. It recognises that individuals are the experts in their own lives and puts them in the driving seat. It aims to offer choice, control and flexibility over the support individuals need to lead the life they want, and meet their outcomes in a personalised approach. In order to achieve this, the Scottish Government introduced The Social Care (Self-Directed Support) (Scotland) Act 2013. The Act came into force on 1st April 2014, and from this date all local authorities have a duty to offer individuals the range of options within the Act. The Authority must give "*the supported person the opportunity to choose one of the options for self-directed support unless the authority considers that the supported person is ineligible to receive direct payments*" (The Social Care (Self-Directed Support)(Scotland) Act 2013).

As laid down in 2013 Act, the four options of Self Directed Support are:

Option 1	The making of a direct pay ment by the local authority to the supported person f or the prov ision of support.
Option 2	The selection of support by the supported person, the making of arrangements f or the prov ision of it by the local authority o n behalf of the supported person and, where it is prov ided by someone other than the authority , the pay ment by the local authority of the relev ant amount in respect of the cost of that prov ision.
Option 3	The selection of support f or the supported person by the local authority , the making of arrangements f or the prov ision of it by the authority and, where it is prov ided by someone other than the authority , the pay ment by the authority of the relev ant amount in respect of the cost of that prov ision.
Option 4	The selection by the supported person of Option 1, 2 or 3 f or each ty pe of support and, where it is prov ided by someone other than the authority , the pay ment by the local authority of the relev ant amount in respect of the cost of the support.

Source: Social Care (Self -Directed Support) (Scotland) Act 2013

SDS aims to increase the individual's choice, control and flexibility for people that require support in the community. Local authorities have been striving to offer SDS in its entirety to individuals requiring long term support, by promoting the options of SDS through its duties and powers as laid down in the legislation.

The Direct Payment Act (1996) shaped and informed policies and procedures for SDS and is now encompassed with the Social Care (Self-Directed Support) (Scotland) Act 2013. Individuals can opt for a direct payment when assessed as being eligible for support through SDS. Direct payments are cash payments made directly to the individual, or the person supporting them, to enable them to purchase the support that will meet their outcomes.

The current SDS legislation does not permit the use of Option 1 within a residential care setting. Moray Council along with its counterpart in East Renfrewshire has exceptions within the regulations. . This allows for the full exploration and testing as to what impact the delivery of Option 1 would have in relation to individuals living in a residential care setting.

In October 2014 the Scottish Government presented an opportunity for local authorities to apply to be a two year testing site to explore the use of SDS in residential care homes. Moray Council submitted interest to become one of the two test sites, laying out its proposal to explore the use of SDS options within residential care. This was to have a strong emphasis on option 1, direct payments. The SDS Residential Care Project in Moray focused primarily on older people and adults with a learning disability. The overarching aim was to explore the potential benefits that could be introduced within residential care within an SDS framework.

The Care Home Census for Adults in Scotland shows that between 2006 and 2016 the number of care home places decreased by 4% in line with the number of adults in care homes also decreasing by 3% to a figure of 36,621 individuals residing in a care home in 2016. The research highlighted however, that the number of residents with dementia increased by 30%, from 15,303 to 19,905 during this ten year period. The figures show there has been a significant increase of those individuals with dementia in a residential setting. New treatments and a shift in the emphasis to care in the community are not going to prevent the increasing prevalence of dementia. As a result of this, it is likely that there is always going to be a requirement for residential care. Therefore, it is important that we can ensure Scotland's care home population have the same rights, choice and control as those individuals living in their own homes. This could be best achieved through a person centred approach offering the full suite of options embedded in the SDS legislation.

Scotland are not the first to explore the use of SDS in a residential setting, in 2012 the Department of Health in England invited councils to express interest in becoming a pilot site for the testing of direct payments in a residential setting. Twenty test sites were selected to take this forward. Individuals utilised a direct payment to participate in activities both within and out with the care home. *"Among the service users who declined direct payment and the relatives of people declining, the most common reason was that they were already resident in the care home and happy with the current arrangement".* (Source Evaluation of Direct Payments on Residential Care Trailblazers pg. 2)

The findings from the trailblazers in England showed that there were concerns in relation the financial viability of direct payments in care homes, and whether it actually increased flexibility within existing budgets. Providers argued that person centred planning should be embedded in everyday practice within the care home setting, and not through the use of a direct payment.

The government has since delayed the implementation of direct payments for long term residential care in England until 2020. Twenty local authorities part of the trailblazer sites have had the option to continue offering direct payments to those already in receipt of this option. They were also able to offer direct payments to new

residents who would wish to choose this option. As a result of this, sixteen authorities have continued to deliver direct payments in residential care.

Moray Council commenced the project in June 2015, with the project proposal identifying whether there are any aspects of this process that are either positive or challenging in terms of impacts relating to outcomes. It also looked at the cost for any stakeholders including the residential care homes but primarily for residents and their family.

With the involvement of all relevant stakeholders the project produced the necessary tools, guidance and processes to inform and support the use of Self Directed Support. The aim being to afford the maximum choice, control and flexibility for individuals, using the service in relation to residential care.

Moray Council looked at the wider impacts including providers, commissioners, Health and Social Care Moray along with service users and their carers for national policy and local practice.

A Resource Allocation System (RAS) underpins SDS in Moray, but it is clear from Moray Council's Supported Self-Assessment Questionnaire (SSAQ) and RAS, it must be relevant for the people it aims to support. In its current form, some areas may not be applicable for a residential setting and others areas offer only a partial picture. The learning from the project will be crucial for Moray Council and will inform legislation that could impact other Local Authorities. The project would also assist the providers of accommodation and care to deliver greater person-centered outcomes.

Project Aims

The project aimed to explore all of the options afforded within the Social Care (Self-Directed Support) (Scotland) Act 2013 to determine whether, offering direct payments in particular, increased an individual's feelings of choice and control. In turn, would the use of direct payments lead to better delivery of outcomes for individuals in residential care? The project had specific aims that it wanted to achieve during the life of the project, with the initial task being to review and redesign the existing Supported Self-Assessment Questionnaire and Resource Allocation System. The aim was to develop a robust and fit for purpose tool to be used with individuals in residential care.

It became evident in the early stages of the project that there needed to be time invested by the practitioner to build a relationship with the individuals. This enabled the practitioner to gain an insight into who the individual is and what interests they had. This was to be done through the introduction of a base line survey, which also supported the individual to identify outcomes important to them. These outcomes were to be scored at the start of the project and revisited again at the end. Through the scoring of personal outcomes, the project would be able to determine if, the supports put in place had a positive impact upon their satisfaction.

The project aimed to identify individuals who were willing to test the purchase of residential care using the SDS options, in particular through option 1. This allowed for the exploration of the impact that this may have to an individual in terms of their choice and control.

The project was to work in partnership with residential care homes for both older people and those with a learning disability, to explore both the positive and negative impact around the use of SDS in a residential setting. This included supporting the care homes to identify a breakdown of costs and decide on a minimum opt in that those wishing to live in their home must purchase. This explored the flexibility for both provider and individual in terms of what is purchased and what impact this has in greater person-centred planning within the residential setting.

A desk top exercise was to be conducted for individuals previously using a direct payment in the community who are moving into residential care in order to compare costs. This would support in identifying how truly person centred costs are for those in residential care.

It was anticipated that the project would explore the use of pool budgets to secure desired and appropriate accommodation, in addition to the staffing and living costs. The pooling of budgets was to be explored in the wider context with those individuals already in residential care or accommodation for the achievement of greater social provision. Unfortunately this was not possible in the time scales of the project due to the focus of this particular element of the project being on those in a learning disability care home. Due to the provision of support already in place for this client group and the satisfaction reported with their identified outcomes, none of the individuals were open to looking into this concept.

Detailed Overview of the Project

Phase 1, Year 1

The project commenced in June 2015 with a dedicated project team being recruited and an action plan developed with a timeline of the proposed project being put in place. An Information Handout (see appendix 1) was developed to allow for the project team to discuss the project with potential stakeholders ensuring the full expectations of the test site were clear. The project officers attended Moray Council's Care Home Owners and Care Home Managers meeting to put the proposed plan forward. This allowed for the care homes to discuss the project, with a clear understanding of the expectations from them should they wish to become involved.

From attendance at the meeting, two care homes expressed their interest in taking part in the project. As the project also wanted to focus on learning disability care homes, the team contacted the sole care home in Moray which provided this support. As a result of this, the care homes that worked alongside the project team were, Andersons Care Home in Elgin providing residential care and Parklands Group, Head Office based in Buckie, consisting of a group of Residential Care Homes, providing both residential and nursing care and Cornerstone; Parkholme care home providing support to individuals with severe and profound learning disabilities. Once the partner providers were identified a Partnership Approach document (appendix 2) was developed with the care homes, giving clear expectations of all parties involved.

Care Homes in the Project

Andersons Care Home, Elgin

Anderson's Care home, Elgin, is a registered charity and is run by a Board of Trustees / Governors, as specified in the terms of the bequest of Major General Andrew Anderson, dated 1815. The Board operates under the terms of a Statutory Instrument, revised in 1982, setting out the composition of the Board and its duties and responsibilities.

The Statutory Instrument / Constitution recommend that the Board is drawn from the ranks of the Sheriffdom, the Presbytery of the Church of Scotland, the Parish Church and the Town Council. These bodies have largely delegated responsibility for the selection of Board Members to the Board itself which now consists predominantly of co-opted members selected, from the local community, for their skills and experience.

The Board, which meets bi-monthly, is accountable to the Scottish Charities Commission for its stewardship of the sizeable budget required to conduct the business of maintaining and running a modern residential care home for the elderly, within the confines of two Victorian Buildings on a single site. The Board is empowered to appoint a manager who is responsible, to the board, for the day to day

running and management of the home. The manager is supported by a small administrative team, jointly accountable to the manager and to the Board, and who support the various domestic and care teams who deliver the service to the residents.

The Chairman of the Board of Governors, with effect from 1st January 2015 is Dr. David Evans and the current manager, appointed on 1st August, 2015, is Mrs. Kathy McGrath-Gunn.
Source: Dr. David Evans, Chairman of Board of Governors, Andersons Care Home, Elgin, Moray

Andersons have approximately 105 staff members, 87 of whom are contracted and report there are no vacant positions at present. There are 5 core units within Andersons where everyone is integrated. Andersons is registered to care for 54 residents, however they comfortably run with 52.

Mrs. Kathy McGrath- Gunn advised that Andersons currently have individuals on work experience from Barnardo's, in addition they have strong links within the community such as VIP childcare, the local primary school and Moray College. They also make regular use of social media in particular a dedicated Facebook page to share the daily life of Anderson's. Anderson's value public opinion and distributes surveys to obtain feedback in addition to holding meetings for relatives to attend. Andersons have a quality assurance policy in place and as a charitable organisation, need to ensure they are spending their money in the right way.

Parklands Group, Head Office Buckie, Moray

Parklands Care Home Group was founded in 1993, and is one of the largest independent care home operators in Moray and Highland, with a total of 250 care placements and employing around 475 staff (February 2016). Most homes are operating waiting lists, with almost all at capacity. They provide a range of nursing, personal and palliative care as well as breaks, respite and convalescence after hospital. A number of homes offer day services for non-residents.

Parklands Group is pioneering new approaches to dementia care, working with specialists and academics to develop new methods of care. Last year, for example, Parklands was shortlisted for a Scottish Dementia Award along with partners Robert Gordon University and NHS Highland for their work with people living with dementia. Urray House, a newly opened Parklands care home in Muir of Ord became the first care home in the UK to support a student dietitian on placement who worked with care home residents with various stages of dementia to explore food memories. The project called, 'Rabbit Stew Anyone?' used a 1940's themed menu and encouraged residents to recall memories from their childhood and during the war.

Parklands Group is a plc and operates its own Quality Management System, audited by senior managers and discussed at monthly meetings. The Group is governed by a 3 member Board of Directors.

Founder and Managing Director, Mr. Ron Taylor, says the rationale for taking part in the SDS project is about finding new initiatives for the market. 'The market is moving forward and with the advent of people living longer in their own homes, we need to find new initiatives and new markets.'

The Group in Moray consists of:

Speyside Care Home, Aberlour 36 room capacity
4 assisted living suites
Provides both nursing and residential care

Netherha Care Home, Buckie 33 room capacity
Day service also available

Parklands, Buckie
27 room capacity

Burnbank, Buckie
18 room capacity
4 assisted living suites

Glenisla Care Home, Keith
42 room capacity
Provides both nursing and residential care
Day service also available

Source: Founder and Managing Director, Mr. Ron Taylor, Parklands Group, Buckie, Moray .

Cornerstone Parkholme, Lossiemouth, Moray

Parkholme is home to six residents. Their experienced, well trained staff team provides 24 hour care and support to people with complex learning and physical disabilities (PMLD). There is a good working relationship with external agencies such as the Community Learning Disability Team and the Moray Coast medical practice to further enhance skills and knowledge.

Parkholme was purpose built approximately 13 years ago for resettlement of people from long stay hospitals (Ladysbridge). It comprises of two rooms with en-suite bathrooms for people who are relatively ambulant, but are fitted with handrails and pull cords. The other bedrooms share a bathroom between two rooms and are serviced by tracking hoists and rise and fall baths. Each person's room is decorated and furnished to their own taste.

As far as possible, the residents are involved in the choice of décor and furnishings in the communal areas. There is a homely, friendly atmosphere in Parkholme with relatives and friends visiting as and when they choose. The residents enjoy utilising the sensory room and the activities' room.

There is a lovely garden with some sensory equipment. One of the resident's families tends to the garden and involves the people in Parkholme in planting and watering fruit, vegetables and flowers. Each person received a framed, personalised certificate from the family for successfully growing sunflowers.

The residents are well known in the local community visiting the church, the weekly coffee morning, the shops, the hairdresser and restaurants. Mrs. Williams Briggs stated 'It's lovely to hear our folks being hailed by the locals when out for a walk',

The service manager has pre-arranged meetings monthly with the families who live near at hand and is in contact by e-mail and phone with those at a distance. However, families can meet and contact the manager at any time.

Parkholme promotes Cornerstone's Aims and Values and operates a personalised approach. They identify and implement Cornerstone's and Moray Council 'Outcomes' processes. All staff are registered with the Scottish Social Services Council. Last year's Care Inspectorate report awarded a grading of 5's and 6's.

Parkholme takes a holistic approach in the care of their residents and includes families, professionals and volunteers in working together to enable the people they support to enjoy a valued life.

Mrs. Dawn Williams- Briggs, Operational Manager at Cornerstone said, "Our reasoning for wishing to participate in the project is that we see the potential benefits that an SDS package would have for the people in the service. They all have very different needs, varying support needs and interests so being a part of this pilot will help us to look at providing a more personalised service. It will give us an opportunity for learning as to how SDS could fit or replace block funding for services like care homes. It is an exciting opportunity for Cornerstone to be involved in live testing the SDS residential pilot and work in partnership with families/guardians and our local authority partners".

Source: Mrs. Daw n Williams- Briggs, Operational Manager, Cornerstone, Moray.

The Project

The first year of the project focused on developing relationships with the care homes and supporting them to identify their breakdown of costings. This involved looking at 'hotel costs' and what this meant for each individual care home, and included management costs, meals, insurances, training, equipment, depreciation and utilities. Care and support hours and activity costs were identified separately. For the life of the project the care homes were guaranteed that their current funding levels received from Moray Council would not change and any additional care and support identified through the project would be funded in addition to this through the project.

The project worked in partnership with the care homes, Moray Council social work teams and families to identify individuals who would benefit from taking part in the project. The project officers developed an information leaflet to explain the purpose of the project to individuals and their families. This would support them to make a decision as to whether they wished to take part.

To ensure correct checks and balances were put in place, and to advise the project team on developments of the test site, a critical friend was commissioned to support the service. Mr. Sam Newman, Partners for Change, has been a critical friend to Moray Council for a number of years in a specific SDS capacity. Therefore, it was decided the project would commission a separate service from Mr. Newman to

provide an advisory service to the team. A critical friend remit was developed and agreed between the parties (appendix 3).

An SDS Residential Care Project Steering Group was formed which consisted of the project team, project lead, service managers, commissioning, audit, social work team managers and community care finance. The purpose of the group was to use them as further critical friends, to discuss ideas and to use their expertise when progressing with the project. A role and remit for the group was developed (appendix 4). In addition to this, a short term stakeholder group was set up to bring together service users or their representatives, our partner care homes and other external interested parties.

It was envisaged that in year one, a ten percent sample of individuals residing in all care homes throughout Moray would be assessed using the community SDS paperwork, to allow for robust testing of the community Supported Self-Assessment Questionnaire (SSAQ) and Resource Allocation System (RAS). This would entail reviewing a number of residents who were due for their annual review and to incorporate into this, the SSAQ to assist in determining its suitability. However, this was more time consuming than first thought and a sample of thirty five residents was undertaken. This allowed for a revised SSAQ for residential care to be developed and consulted on by the SDS Residential Care Steering Group and the Stakeholder Group alongside our partner care homes.

A revised RAS was originally going to be developed, however through consultation with relevant parties and our critical friend it was decided that the focus of the project should be about looking at individual outcomes and having positive conversations with individuals. Upon further investigation and consultation, we did not want to create a further two tiered assessment process, with different monetary values between those in the community and those in residential care. Individuals, when assessed and allocated an indicative budget in the community are done so based solely on their care and support needs and does not take into consideration basic living costs such as rent, utilities and food. It was decided that this would be reflected in residential care, and through the provision of individualised costings from each of the care homes, this was possible.

A desk top exercise was undertaken looking at individuals who had been in receipt of a direct payment in the community who had recently moved into residential care. This allowed for a comparison of the level of the direct payment when in the community to the cost of their care home placement.

Towards the end of year one the individuals who were taking part in the project were reviewed through the use of base line surveys which allowed for the practitioner to get an insight into the individual. They were able to build a relationship with them, get to know who they were, what their hobbies were and what was important to them. All too often we can lose sight of this when an individual enters residential care, and too great a focus can be centered around a functional assessment based on their care and support needs. Such needs can be easy to meet for the care home; however, meeting an individual’s social and emotional needs can be far more complex if you do not know the individual.

Through the use of the base line surveys, individuals and their families found it easier to think about the things that were important to them, and to identify outcomes. These outcomes were scored out of 10 in terms of how happy they were that their outcomes were being met at the present time, these would then be revisited at the end of the project.

Towards the end of year one a report was produced as to the progress of the project and the plans entering into the second phase. This was targeted at our care home managers in Moray to allow all of the care homes to be involved in giving feedback and to keep them updated with progress. To take account of our partner's busy schedules this took the form of a progress report and a drop in session organised for the target audience to attend should they wish for further information.

Phase 2, Year 2

Year two of the project focused on the live testing of the paperwork, consisting of the base line surveys (see appendix 5), the revised SSAQ, and the standard support plan. The base line surveys allowed for the practitioner to get an in-depth insight to the individuals taking part in the project. It also assisted individuals and their families when identifying what was important to them, and when identifying focused outcomes for the project.

Once the SSAQ was completed an indicative budget was identified. Through the breakdown of costs, the care home's identified minimum opt in was excluded with only the care and support costs being addressed via the indicative budget. Through the use of a staffing needs analysis for each individual taking part in the project, it was evident the level of support required on a daily basis and this was factored into the SDS budget.

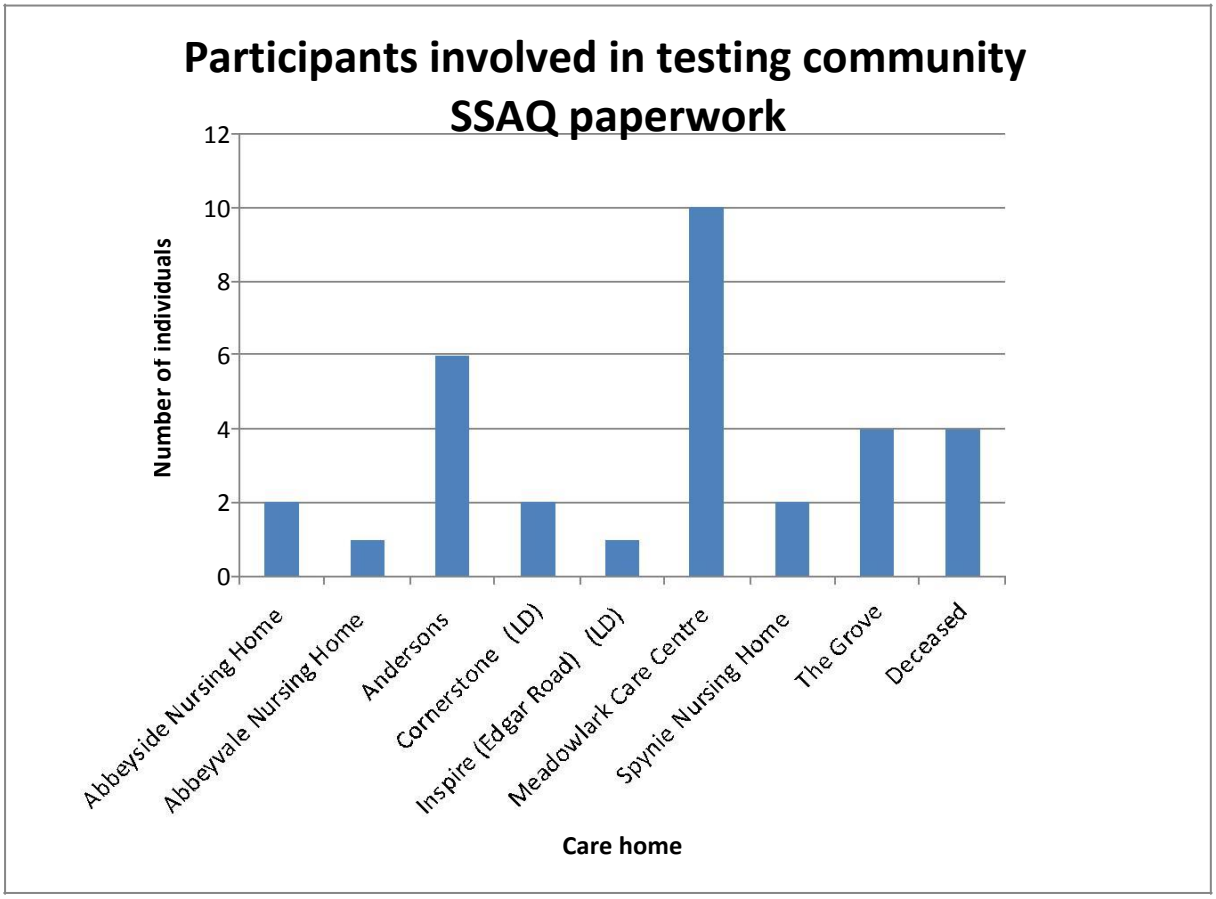
Of the five individuals who opted to meet their outcomes through the use of a direct payment, three had opted to use their budget to employ a personal assistant. This involved separate conversations with the care home owners and managers as to the feasibility of this and any foreseen implications of Personal Assistants entering the care home. Care homes needed to look at their own insurances and practices to determine if this was going to cause problems. One care home did not perceive any issues with this after consulting with the board of directors and their insurance providers. However, one care home did have reservations and questions posed from their insurance company which then put the use of a direct payment for employing a Personal Assistant into doubt. A considerable amount of work and liaison was undertaken to try and resolve this issue to move forward with the project, however no solution was found quickly. As the individual in this care home wanted to use a Personal Assistant for social activities out with the care home, discussions took place to determine if this would affect the decision. It was in October 2016 before these issues could be resolved and the individual could proceed with employing a Personal Assistant, with the main resolution coming due to the fact that the Personal Assistant would not be undertaking any work within the care home.

Outcomes Achieved

Staff

Testing the Community SDS Paperwork

The current SDS paperwork used in the community was reviewed including the SSAQ and RAS. This was used with individuals who were due for an annual review across all of the care homes in Moray, not solely focusing on those who were resident in the partner care homes.



The revised SSAQ was developed based on the findings from the use of the community based SSAQ. Several of the questions remained under the same overarching headings, but with the multiple choice phrases reworded to be more specific to the environment of a residential care setting.

Question Number	Community SSAQ	Residential SSAQ
1	Personal Care Needs	Personal Care Needs
2	Keeping Safe	Keeping Safe
3	Eating and Drinking	Eating and Drinking
4	Practical Aspects of Daily Living	Practical Aspects of Daily Living
5	Physical and Mental Wellbeing	Physical and Mental Wellbeing
6	Relationships and Social Inclusion	Relationships and Social Inclusion
7	Making Decisions	Making Decisions
8	Managing Money	Managing Money
9	Communication	Communication
10	Parenting and Caring Responsibilities	Care Home Environment
11	Family/ Carer Support	Maintaining Relationships
1	Unpaid Carer Impact	Unpaid Carer Impact

Through using the community SSAQ with individuals in residential care, it became apparent that some of the questions were relevant, but that the responses needed to be tailor made to the environment in which they are living. It was evident very early on, that the question in relation to parenting and caring responsibilities was not applicable to individuals in a residential care setting. It was clear from the conversations with the allocated social worker, the individual, their family and key worker at the care home, there needed to be a further question surrounding the care home environment. Question 11 (see table above), was also highlighted during the review process as one which was not fit for purpose. Despite the unpaid carer still needing to be recognised as an integral part of the individual's life, the caring responsibilities took a shift in balance to the care home. The replacement question wanted to focus on maintaining valued relationships with unpaid carers and family members once they went into residential care. A full list of the SSAQ responses can be seen in appendix 6.

Oleson and Shadick (1993) developed guidelines to assist staff in supporting the transition from home to residential care which included assisting the individual to maintain and sustain relationships with family and friends.

As a result of this scrutiny of the community SSAQ, it was felt that a robust SSAQ for those in residential care was developed, allowing for what should be a suitable and robust indicative budget to be identified.

What was evident from the revised SSAQ for residential care was the acknowledgement of an unpaid carer, and them identifying themselves as an unpaid carer. It is often felt that once a loved one moves into residential care, then any impact of supporting this individual when they lived in the community, is either diminished or no longer there to the unpaid carer. However, as is evident from the questionnaire responses, many individuals have either a Power of Attorney (POA), or a Guardianship in place to support them and ensuring that their best interests are being supported. This does have an impact on the POA or Guardian and therefore their responsibilities are still very evident. It is accepted that the practical support of personal care has moved to the staff in the residential setting, but support in making

decisions, managing finances and, equally important, emotional support is still being given by the unpaid carer. This recognition is a change in mind set that we locally need to address and give higher recognition to unpaid carers supporting individuals in a residential setting.

As previously mentioned in this report, the decision was made to use the same RAS and scoring as that which is used in the community. This allowed for greater time to be spent on having meaningful conversations with individuals taking part in the project, and looking at meeting their outcomes in a more person centered way.

The revised documentation was used with all participants in the live testing phase of the project to identify robust indicative budgets.

The use of the base line surveys assisted individuals in identifying their outcomes. It allowed their allocated social worker to get an in-depth insight into the person's life, about their hobbies, interests, family, who they were before they went into residential care. It has become apparent that the base line surveys have been extremely useful to the individual and their family in particular around the new conversations practitioners have in relation to SDS. It can be more difficult for care homes to meet an individual's emotional support needs when they do not have an in depth insight into that individual. This is especially evident when an individual has dementia. This is a specific issue with figures from the Care Home Census showing that there has been an increase in residents of care homes with dementia of 30% over the period 2006-2016. Due to individuals remaining in their own home for longer, when individuals enter into residential care, their needs are generally higher and when presenting with dementia, this is often more progressed As a result of this, it is imperative for care homes to get to know the individual and a synopsis of their life history; this gives a solid starting block for conversations and reminiscence to put them at ease.

The base line survey further allows for the individual's allocated social worker to build a relationship with them; for them to get to know the person that they are supporting from a social and emotional aspect. This can be seen as a significant addition to the present, more functional assessment currently used for the individual.

The use of the base line surveys has been particularly beneficial to support the identification of outcomes for the individual, especially when taking on board that all of the individuals whom were taking part in the project were already living in residential care. Due to this, from initial conversations, those taking part in the project were stating that they were content with their lives within the care home and found it quite complex to think about things that were important to them. The base line survey has enabled a focus on having meaningful conversations with individuals in a residential setting. The use of the base line surveys has in turn made Moray reflect on its own practice for those living in residential care and the conversations that take place with residents. Counsel and Care highlights the importance of getting to know an individual and suggests important things that a care home should know about its residents is information like, what they prefer to be called, what drinks they like and how they liked them to be served, the names of

relatives and friends and those who both visit and are visible in photographs and information about their lives. They do stress however, that it is important to remember that individuals do change their minds over time.

Desk Top Exercise of Individuals Moving Into Residential Care

A desk top exercise was undertaken to compare the current cost of budgets for those in receipt of a direct payment in the community, to that of the cost of moving into residential care.

Service User	Community Budget	Care Home Rate (as of March 2016)	a) Weekly Client Payment 2015/16	b) Weekly Council Payment 2015/16	c) Gross Weekly Care Fees 2015/16	d) Comments
A	£155.90	£524.67	£143.38	£381.29	£524.67	
B	£111.29	£609.31	£126.15	£483.16	£609.31	
C	£136.08	£524.67	Unknown	£249	Unknown	SU eligible for FPC funding only
D	£151.04	£524.67	£130.28	£394.39	£524.67	

The desk top exercise looked at the cost of the individual's total SDS budget in the community at the time they entered long term residential care, in comparison to the cost of either the residential or nursing rate under the National Care Home Contract.

For the period that the desk top exercise was undertaken, a total of four individuals who were in receipt of a direct payment in the community, moved into long term residential care. The exercise showed that the cost significantly increased when moving into a residential care home. However, if the hotel costs were to be removed from an individual's budget, the increase to their actual care and support needs would possibly not be as significant. From the four individuals who were part of the desk top exercise, it was evident that the reason for them moving into long term residential care was not as a result of requiring increased physical personal care needs, but around their personal safety if they remained living independently at home.

Service Providers

Breakdown of Costings

The partner care homes were all tasked with looking at their breakdown of costs, allowing them to determine what their minimum opt in would be for individuals wishing to move into their care home. From the two older people's care homes, their costings were reflective of each other. Both care homes gave the project team a figure of between £700 and £750 as the true cost of an individual living in residential care. The Care Home Census 2016 (Source of Funding) shows the average weekly gross rates for long stay residents in care homes for old people in Scotland.

Source of funding	Value	% change from 2015-2016
Publically funded without nursing care	£525	3%
Publically funded with nursing care	£609	3%
Self-funded without nursing care	£755	7%
Self-funded with nursing care	£814	5%

Source Information Services Division Publication Report, Care Home Census for Adults in Scotland, Figures for 31 March 2006-2016, Publication date 25 October 2016

The figures show a greater percentage increase in the self-funded rates compared to the publically funded rates. It highlights the difference between the public and self-funded rates; this can be a difference of nearly £200 for the same category of care. By looking for a middle ground on the published rates, it gives support to the average cost of care per resident being somewhere in the region of £700 and £750.

It took longer than anticipated, to identify their costings due to the complexities of looking at all of the overheads associated with running and maintaining a care home. On reflection, it was somewhat unrealistic for the project team to expect that such a complex piece of work could be completed in the timescales identified in the action plan. It needs to be highlighted that the care homes, despite given the support of the project team to break down the costs, were not given any financial support to undertake this task. As a result, the priorities of running a care home had to be their priority which contributed to the time taken to produce the figures. There was an apprehension surrounding the provision of the figures to the project team and what they would be used for. Guarantees were given to all of the care homes that their figures would not be shared out with the project.

SDS Training Delivered to Care Homes

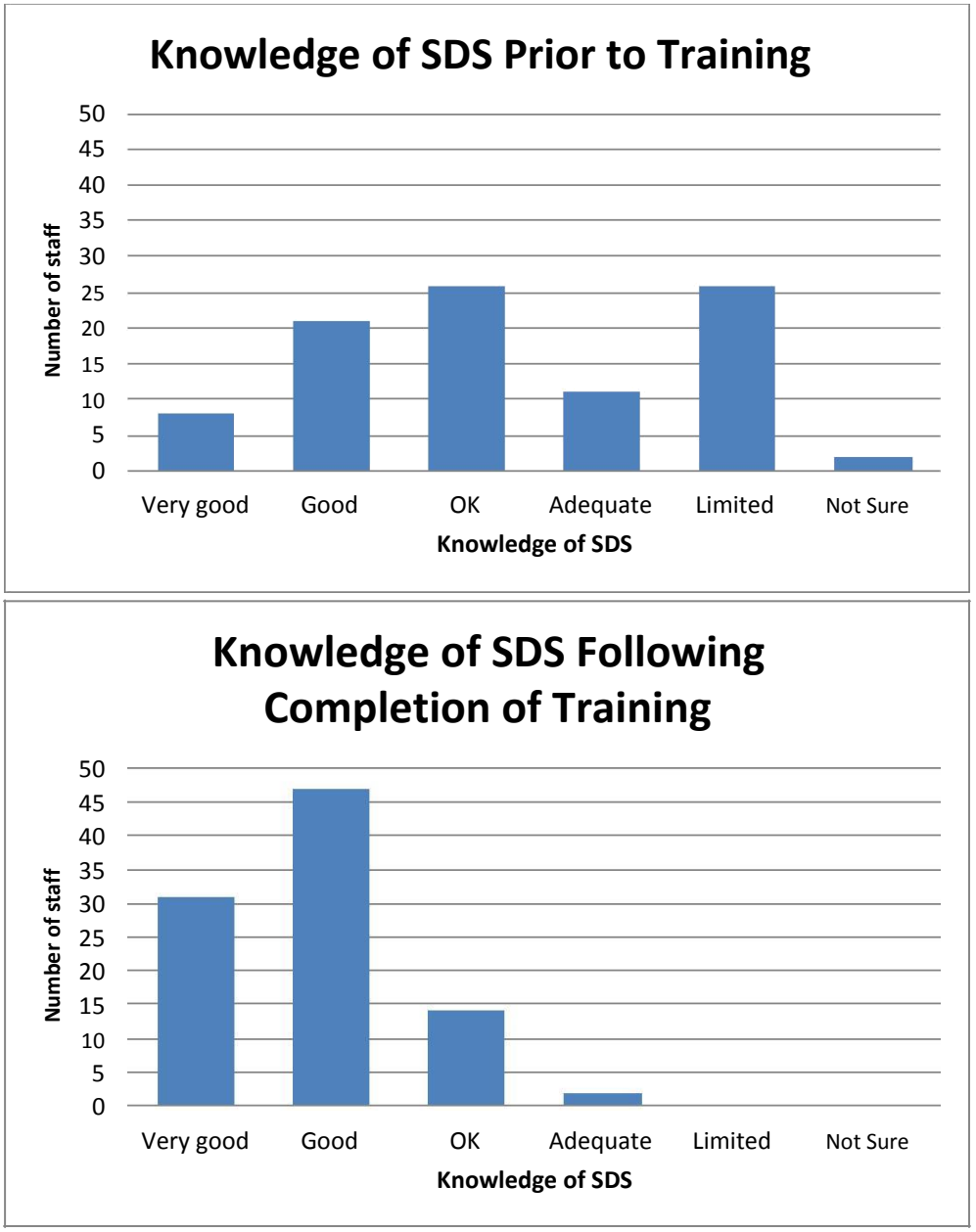
From early conversations which had taken place with the staff in the residential care homes, it was apparent that the knowledge and understanding was limited in relation to SDS. Care home owners and managers agreed that the project team deliver SDS Awareness Training to all staffs who work with the residential care homes. Consultation took place with the care homes to establish the most appropriate way in which the training could be delivered, without interrupting the work rotas already in place. It was agreed that the most unobtrusive way was to deliver online training to all staff and follow this up with face to face information sessions if required or requested.

Following a scoping exercise undertaken by the project team, the most appropriate training was that which was on offer through Moray Council's e-Learning. This required all staff to gain access to Moray Council's Learn Pro system to allow for the training to be undertaken and recorded appropriately.

It was agreed that the training would take place within the care home either before or after the staff members allocated shift. The project funded the extra hours claimed by the staff to undertake the training through the payment of an invoice from the care home.

The care home staffs were asked for their opinions of how they felt SDS would increase an individual's choice, control and flexibility within a residential care setting prior to the delivery of the training. Staff felt they could not offer a valid opinion due to their overall minimal awareness surrounding SDS. Some staff did feel however, that SDS would benefit individuals in a Residential Care Home. There were feelings that as individuals are now going into residential care frailer and possibly for palliative care, SDS may not make a significant difference to these individuals.

The training was delivered and subsequently evaluated by all staff that completed the e learning, with a total of 94 staff from Andersons and Parkholme undertaking the training. Of the 94 individuals who undertook the training, 31 staff rated their knowledge of SDS following the training as very good and a further 47 staff rating it as good. This is in comparison to pre training when their responses consisted of only 8 staff rating their knowledge as very good and 21 staff feeling that they had a good knowledge. Prior to the training a total of 26 staff felt that they had ok knowledge, 11 with adequate knowledge, a further 26 with limited knowledge and 2 who were not sure.



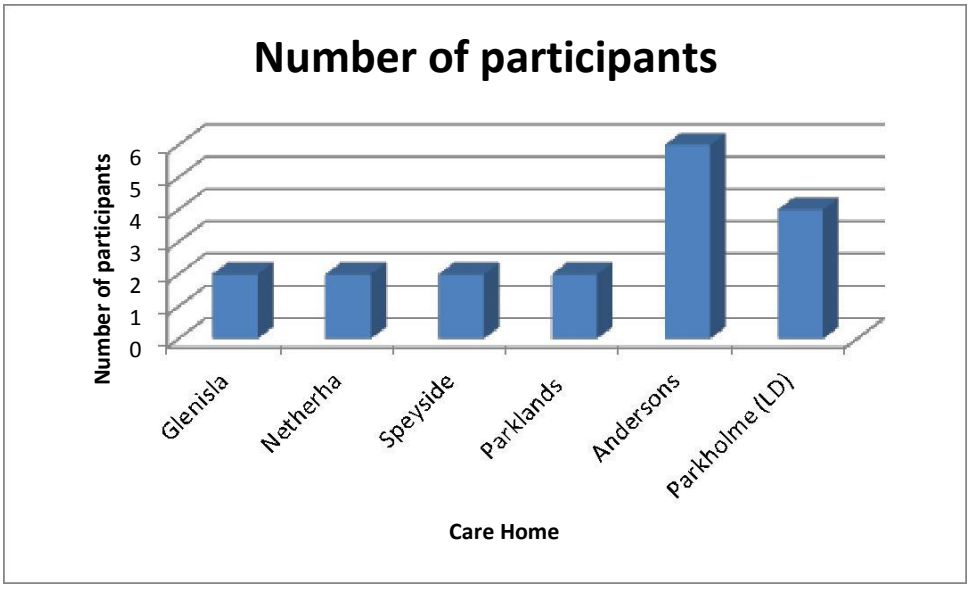
As a result of the training, care home staffs reported that they are more aware of individual resident's needs and wants, and gives a greater understanding about what is going on around them in their working environment. When asked what they would do differently as a result of the training, it was reported that they feel able to raise awareness and the ability to provide information and assistance. This would support residents to make real decisions about how much choice an individual wants through the range of different options. In addition, some staff reported that the training allowed them to improve their skills and update their knowledge on how best to support individuals in a residential setting. Staff also reported that they felt more empowered to offer information in relation to SDS to residents, their families and their colleagues.

As an evaluation to the training, should this take place again, it was suggested that this could have been better delivered via face to face training. However the logistics of this would need to be discussed with the care home managers as to the impact that this may have on their shift patterns. There is also the question of how feasible this would be due to the number of sessions this would then entail per care home. It was also suggested that reading material or information could be given to allow for staff to read at their own pace in their own time.

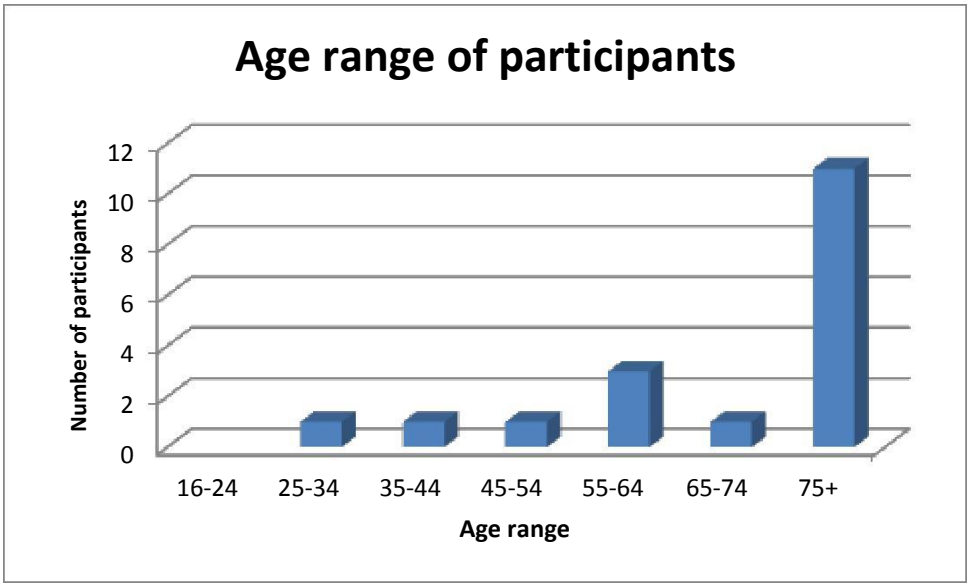
Service Users

Participants Identified

Participants were identified and put forward to take part in the project. From the partner care homes, a total of 18 individuals were put forward to participate in the project.



The age range of identified participants can be seen in the table below.

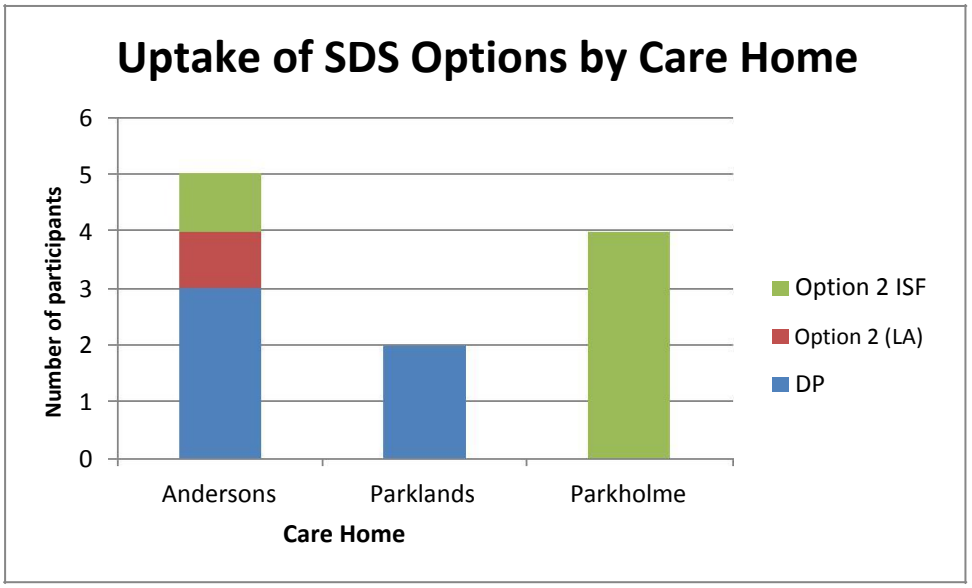


Due to the nature of working with older people, one participant from Andersons passed away, which reduced the participant numbers to five.

Of the participants identified from the Parklands Group (Glenisla,Netherha, Speyside, Parklands) one passed away reducing the participant numbers to seven. However, due to the time constraints and the issues surrounding insurances, the start of the live testing was significantly delayed. As a result the project team was unable to work with most of the participants identified. The team was able to continue working with one participant from Parklands and a further participant from Netherha due to the progress already made with the individuals and their families.

Uptake of SDS Options

The table below indicates the options chosen by individuals participating in the project by residential care home.



The individuals who participated in the project were reviewed with the revised paperwork, and indicative budgets were identified. As the care home providers were guaranteed their funding levels would not be reduced for the life of the pilot, the additional costs were met out of the project's budget. Individuals had an indicative budget identified that did not incorporate the standard opt in costs as identified by each care home provider. These costs encompassed the 'hotel' costs that would be standard for any resident within the care home regardless of their level of support required. This allowed for the budgets identified to solely reflect the care and support needs that would be assessed within the community. This would ensure continuity, fairness and transparency.

Participant	Indicative budget	Actual cost	Cost over residential rate given to Individual	Option
A	393.60	581.82	44.03	Option 1
B	369.60	637.52	12.98 (One off payment)	Option 1
C	196.80	573.71	35.92	Option 1
D	278.40	587.79	50.00	Option 2 (LA)
E	326.50	634.39	96.60	Option 2 (ISF)
F	259.20	550.60	12.81	Option 1
G	326.40	584.31	46.52	Option 1
H	456.00	1809.44	-NA LD Res	Option 2 (ISF)
I	456.00	2569.10	-NA LD Res	Option 2 (ISF)
J	412.80	1988.77	-NA LD Res	Option 2 (ISF)
K	441.60	1719.19	-NA LD Res	Option 2 (ISF)

The above table shows the indicative budget, actual budget and the options individuals chose through the assessment process.

Of the individuals taking part in the project, one individual unfortunately passed away before the direct payment could be put in place (Participant B). One individual who had opted for an Individual Service Fund had to stop working with the project due to the time constraints. This was in relation to the live testing time scales along with the families own time constraints to get things put in place (Participant J). The family decided that they were content with the support in place through the block funded contract. In total, four direct payments commenced, with one stopping before the end of the project due to the family's choice as the individual's health was failing quickly and has since passed away (Participant G).

What became evident from the use of an indicative budget and subsequently allocating a robust budget to meet outcomes was that, large budgets were not required to enable social and emotional needs to be met in a more personalised way.

Case Studies

Participant A – Option 1: Participant A has a diagnosis of dementia, and is lacking in capacity to make welfare and financial decisions about her life. Participant A's daughters have joint power of attorney which allows them to act upon their mothers best interests. When exploring the options, Participant A's daughter felt option 1 would be best to meet identified outcomes.

The outcomes identified for Participant A were mental and social stimulation, of which both scored 3/10 in the baseline interview.

Participant A is very fatigued and lacks mental stimulation, her Power of Attorneys feel that she would benefit from community based activities in order to meet her outcomes. The direct payment was for a total of £44.03 in addition to the cost of the care home fees. The support consisted of two hours support per week to enjoy a variety of meaningful activities within the community. The direct payment will also pay for a wheelchair taxi twice per month, to allow Participant A to visit her hometown and reminisce.

At the end of the project, on reflection, Participant A and her family reported that they believed the project was a good social initiative. They reported that their mother was happy and bright when out, and greatly benefitted from taking part in the project. It was noted that there was a good rapport with the Personal Assistant and Participant A felt that that there was a significant degree of personalisation through to the one to one support afforded with the project. Improvements for the project could be made through having greater communication between the PA and the care home, possibly through the use of a log book.

When the outcome scores were revisited, they reported a score of 6/10 for mental and social stimulation in comparison to the earlier score of 3/10.

Participant B - Option 1: Participant B likes to spend time in his room and would not like to spend time out in the wider community. Participant B opted for a direct payment to meet their outcomes in a personalised way.

The outcomes identified were mental, which he scored as 4/10 in the baseline interview, and having meaningful things to do which he scored as 4/10 in the baseline interview.

Participant B spends most of his day in his room because he does not particularly enjoy the activities that are put on within the care home. He used to enjoy playing darts in the local pub, but due to mobility difficulties, this is no longer possible. In order to meet his outcomes, Participant B wanted to purchase a dart board and sky sports to watch his favorite teams play.

Unfortunately before the direct payment could be put in place, Participant B passed away. As a result, the project team could not put in place the support identified and subsequently revisit the base line survey.

Participant C - Option 1: Participant C has capacity to make decisions about his life and decided to take up Option 1 and be the employer himself.

The outcomes identified with Participant C were socialisation and reconnecting with the community which he scored both as 3/10 in the baseline interview. Participant C feels there is a lack of activities that he enjoys within the care home. He decided to employ a PA for 2.5 hours per week to visit the biblical gardens and other meaningful activities out in the community. Participant C selected an individual to be his PA who works within the care home whom he already knows. From speaking with Participant C and his daughter they agreed to receive the care homes fees through the direct payment, instead of this being paid directly to the care home from Moray Council. The direct payment for the PA was £35.92, which included payroll costs and employers liability insurance.

When the project revisited the base line survey with Participant C and his daughter, both reported that they felt informed and were notified of everything stating there was good communication between the project team and themselves. Participant C reported that they felt settled with the activities put in place and enjoyed getting out to the different places with the PA. Negative aspects in relation to the project centre on the PA, with the initial PA having to withdraw from the work due to ill health, and the second PA stopped turning up for their shifts. This led to apprehension when a new PA was recruited; however, they have successfully established a good relationship. When asked what difference the project has made, participant C reported that he now has something to look forward to and he laughs again. Improvements could come through greater communication and closer working between the PA and care home. When the outcome scores were revisited, he was now reporting scores of 8/10 for both social inclusion and reconnecting with community compared to 3/10 prior to the project. Due to the positive outcomes from the project, participant C wishes to explore ways of continuing to fund the additional support, even if this is through a self-funded route.

Participant D – Option 2: Participant D knew what service she would like to attend, and only stopped attending this service, a local resource centre, when she moved into residential care. Participant D benefitted from this service socially and mentally. She has short term memory difficulties and did not feel able to take on the role of option one. Her mother, who has power of attorney, is an elderly lady and did not feel able to be in control of the budget either.

The outcomes identified were social inclusion which scored 2/10 in the baseline interview, and mental stimulation, also scoring 2/10 in the baseline interview. The outcomes were met through re-starting the resource centre, which they used to attend before moving into Andersons. Participant D found it difficult adjusting to life within the care home as she is a younger lady and the levels of cognition within the care home vary, making it very difficult for her to settle.

When the base line survey was revisited, participant D reported that she felt fully involved in the project. Through attending the local resource centre she reported positive outcomes, including having company and people to talk to, but also gave her something to look forward to. One slight negative was that the routine was the same each week. However this could have been addressed had the project been

continued. Participation in the project, and having her outcomes met in a personalised way gave Participant D a feeling of fitting in, an elevated mood and allowed them to build their confidence. The additional cost to attend the resource centre was £50 per week. When the outcomes were rescored, they were reported as 8/10 for social inclusion and 10/10 for mental stimulation. The positive impact that the project has made for participant D, has led them to explore the possibility of continuing to attend the centre after the project draws to a close.

Participant E – Option 2 (ISF): Participant E is a very sociable man, he is very well known within Elgin and the surrounding areas. When he moved into residential care due to having a stroke, he was unable to go out and about himself. This has left him with feelings of isolation. The outcomes were identified as socialisation, scored as 3/10 and having meaningful activities to do scored as 2/10.

In order to meet the identified outcomes, he stated that he would have preferred to use option 1. However, as Participant E lacks the capacity to manage his own care, he felt that he would be unable to manage this option. He does not have any family that could act on his behalf and there are no local authority powers in place. Option 2 was then explored using an ISF, where the flexibility and choice of Option 1 is offered. The ISF provider developed the support plan with the individual to meet their identified outcomes, made all the necessary arrangements and managed the budget on behalf of the individual. Participant E is a very sociable individual and feels somewhat restricted at Anderson's as he can no longer freely mobilise to town like he used to. He requires full support with mobilising and understands that staffing levels means he cannot always get out, causing him upset. A dedicated support worker was employed by the ISF provider (Enable) to take Participant E to the football and to reconnect with the community. Participant E is taking their entire budget, including the fees to the care home through the National Care Home Contract via an Individual Service Fund. The additional monies given to the ISF provider was £96.60 above the care home fees.

When the base line survey was revisited at the end of the project, it was reported that his mood has improved. A further positive for participant E was when his longtime friend moved into Andersons care home and he was then able to accompany him when going out with the support worker. When the outcomes were rescored, the outcome relating to social inclusion was scored at 8/10 in comparison to the pre project of score of 3/10. The score relating to meaningful activities was rescored at 8/10 in comparison to the previous score of 2/10. Participant E's case study can be seen in depth in the accompanying video clip.

Participant F – Option 1: When discussing the options with Participant F and her solicitor who has Power of Attorney, they felt that they would like to take up Option 1. The outcomes identified for Participant F were stimulation which was scored 3/10 in the baseline interview and meaningful things to do which also scored 3/10 in the baseline interview.

Participant F did not wish to use a direct payment to go out of the care home to meet her outcomes. She is very content within her room and enjoys her own company; she does however love sport and enjoys watching a variety of sport in the comfort of her own room. Participant F enjoys football but is unable to get to football games

and therefore requested a sky sports package to be put in place in her room to meet her outcomes. The direct payment was for an additional cost of £12.81 per week. When the scoring was revisited at the end of the project, participant F noted that there was no change in her pre project score. Following discussions, it became apparent that the sky sports package had been in place prior to the commencement of the project resulting in no change in the outcome scores. Participant F was fully aware that the funding for the project would stop and is therefore happy to return to funding the cost of the package privately.

Participant G - Option 1: Participant G would be unable to manage an option 1 independently but her son who has power of attorney was willing to manage the package on her behalf. The flexibility and choice within this option attracted them both.

The outcomes identified were seeing other people which she scored as 4/10 in the baseline interview and having meaningful things to do which was scored as 3/10 in the baseline interview. In order to meet these outcomes, Participant G wished to employ a PA to take her to visit a family member in Cullen as they have agoraphobia and can no longer visit the care home; it means a lot to Participant G to be able to see this family member. The PA would also accompany her out for walks and coffee.

The support for participant G was successfully put into place with the PA visiting on a weekly basis to take her out and, in particular to visit her sister whom she had not seen for a considerable time. The additional cost through the direct payment was £46.52 per week. Unfortunately participant G's health deteriorated and she was no longer able to safely get out of the home, as a result of this, the PA continued to visit her on a weekly basis to sit with her and give the lady dedicated 1:1 time. This was possible due to the flexibility that is afforded to option 1, and continued until the Participant G was too frail and was subsequently cared for in bed. Participant G passed away, however, for the relatively short time that the support was in place, her outcomes were significantly improved and the family was happy in the knowledge that she was able to visit her sister. Prior to Participant G passing away, the base line survey was revisited with the family and reported nothing but praise for the project, stating that it had "been excellent". It was stated that the project worked well due to the fact that Participant G was able to have a carer visit her in the home and also out to see her sister. Her son stated that they were delighted with the service, with no negative aspects being reported, but hoping that many others could benefit from such a project. The POA is quoted as saying, "it made me and the rest of the family happy in the knowledge that whilst we were not always available to visit, that an outside carer was tending to my mother, taking her out of the home and away from the routine of the care home". When revisiting the outcomes, following the project, her outcome of seeing other people was rescored at 10/10 in comparison to the pre project score of 4/10. Likewise the outcome of having meaningful things to do was rescored at 10/10, in comparison to the pre project score of 3/10.

Participant H (LD), Option 2 ISF- Their identified outcomes related to emotional well-being and relaxation along with maintaining contact with her sister. The scoring as to her satisfaction with her identified outcomes, took place in conjunction with the support planning. When conversations took place regarding the identified outcomes,

participant H reported that they were content with the outcomes and how they were already being met. It was reported that they would like to look at different ways in which the outcomes could be met, but was not through dissatisfaction with how they were being met currently. Participant H did not have the ability to take onboard the management surrounding option 1 and did not have close family who were able to do this on her behalf. An ISF through option 2 was chosen. Due to the time constraints of the project and as a result in the unforeseen delay and complications in obtaining the service's break down of costings, it was not possible to successfully put in place Participant H's chosen outcomes fully within the scope of the project. As the project was entering the final stages when the chosen ISF package was ready to be undertaken, there were reservations as to putting short term support in place which could be withdrawn at the end of the project. It was therefore agreed that the focus should be surrounding one off items or activities and as a result, Participant H chose to meet her outcomes by taking a short break, to get respite from her home environment. This consisted of a Spa weekend away with support from carers as personal appearance and pampering are important to Participant H.

Participant I (LD)- Option 2 ISF, had identified outcomes of having more 1 to 1 time, and to have greater stimulation. Scoring of the outcomes did not take place as Participant I did not report dissatisfaction with the current outcomes, but wanted to look at exploring how they could be met in a different way. It was originally thought that this could have been achieved through the employment of Personal Assistants. After further consideration the named guardians for Participant I decided that the Option 1 route was not suitable and that they did not want to take on the responsibility of becoming an employer. As the goals were to have a small team of support staff around Participant I, it was decided that they would turn to an ISF to deliver a person centered plan, with dedicated staff without having to manage the budget. At the time of writing, the package was still not fully in place due to the time taken for decisions to be made in choosing an ISF provider and recruiting a dedicated staff team. However meet and greets have now taken place between the recruited staff and the individual and their family. Staff training is currently being undertaken and a familiarisation with the care home is taking place. There have been initial questions around the ISF staff supporting care home staff in moving and handling, however these issues have been resolved. As the extra funding used for the ISF was already in place prior to the project, the ISF will remain in place after the project has ended.

Participant J (LD), Option 2 ISF has expressed that they are satisfied with the outcomes identified in previous plans of continuing to live their life the way they want to, but to explore different ways of staffing the support he receives. As a result the project was unable to accurately score their outcomes. Participant J did not wish to take on the responsibility of a direct payment and had no support to deal with the administration of this and therefore an ISF through option 2 was chosen. Due to the time constraints of the project and as a result in the unforeseen delay and complications in obtaining the service's break down of costings, it was not possible to successfully put in place Participant J's chosen outcomes within the scope of the project. As the project was entering the final stages when the chosen ISF package was ready to be undertaken, there were reservations as to putting short term support in place which could be withdrawn at the end of the project. It was therefore agreed that the focus should be surrounding one off items or activities. As a result,

Participant J identified that a new custom vibrating bean bag would be beneficial to allow them to continue to enjoy their love of music in comfort and safely within the residential setting. The bean bag was an additional one of payment of £375. The purchase has allowed participant J to be comfortable in his new bean bag whilst relaxing in the snoozelen, with Parkholme stating that enjoying his music will make such a difference to his well-being.

Participant K (LD). Their identified outcomes included mental stimulation, physical activities and to look at how this support can be staffed in a more personalised manner. The scoring as to their satisfaction with her identified outcomes was due to take place in conjunction with the support planning. Unfortunately due to delays in obtaining the settings break down of costings, and difficulty in arranging meetings with the family due to prior commitments, the project team had to withdraw from working with Participant K. This was largely due to the fact that a support plan was still not developed once the project was a considerable time into the live testing phase.

Feedback From The Project

Service Users and their families

Base line surveys were revisited towards the end of the project, with the individuals and their families asked to re-score their outcomes. This allowed for the project to determine if the supports put in place had an impact as to their satisfaction with the identified outcomes.

Participant	Outcomes identified	Pre project score	Post project score
A	Mental and social stimulation	3/10	6/10
B	Mental stimulation Meaningful things to do	4/10 4/10	Not applicable
C	Socialisation Reconnecting with the community	3/10 3/10	8/10 8/10
D	Social inclusion Mental stimulation	2/10 2/10	8/10 10/10
E	Socialisation Meaningful activities	3/10 2/10	8/10 8/10
F	Stimulation Meaningful things to do	3/10 3/10	3/10 3/10
G	Seeing other people Meaningful things to do	4/10 3/10	10/10 10/10
H	Emotional well being Relaxation	Not scored	Not scored
I	Increased 1:1 time Greater stimulation	Not scored	Not scored
J	To continue to live my life the way I want to	Not scored	Not scored
K	Mental stimulation Increased physical activities	Not scored	Not scored

On evaluating their participation within the project, service users and their families reported overall that their experience had been one which was positive. This can be evidenced through three of the service users wishing to continue the supports put in place once the project ends. This is to be funded privately to ensure that, until any future decisions have been made on a national level, Moray was not creating inequity for individuals in residential care.

Families and individuals reported that the impact the project has had on their emotional and social well-being has been significant. One individual reported that their overall mood was elevated and had built their confidence again by being able to reconnect with the local resource centre. The feeling of familiarity and being able to meet new people added to their feeling of increased confidence.

Another individual reported that he was able to get out and about and ‘have a laugh’ with his Personal Assistant. The PA was able to give him something to look forward to, and was able to visit places centred on his personal choices. A further individual who stated that they were extremely sociable and a well-known figure in the community, reported that the support worker gave him something to look forward to. More importantly, the individual’s friend had recently moved into the same care home, and through the flexibility and personalisation that is afforded to the ISF, his friend was able to accompany him on his outings. This is in turn has also had a positive impact on the individual’s experience within the care home.

One family member reported that the project has been excellent and hoped that many others could benefit. It was stated that the family were delighted, and it made him and his family happy in the knowledge that whilst they were not always available to visit, an outside carer was tending to their mother. In particular taking her out of the home and away from the routine that comes with this.

Interestingly, of the two individuals who opted to test out taking their care home fees directly and pay these to the care home, one via a direct payment and one through an ISF, neither reported a benefit in doing so. The individual who took the fees via a direct payment reported that it did not work for them and felt it was a huge responsibility, saying that they preferred the way it was before.

The overall feedback has been positive, with valuable feedback relating to the effective use of Personal Assistants to support the enhancement of an individual’s social and emotional well-being. Service users and their families identified increased communication between the care home and Personal Assistant to ensure effective working partnerships for the benefit of the resident.

Feedback from the residential care homes

Andersons Care Home

Ms. McGrath-Gunn admitted that initially she was very skeptical about the project and that this would never work. However she was open minded and thought about how she could make it work within a care home. Ms. McGrath-Gunn advised that her motto is “don’t knock it till you try it” and confirmed that she agreed to take part in the project later that day, highlighting that she felt if there were to be any change, she would like to be involved in it from the beginning. It was advised that she had to get the board of governors to agree with her decision before committing to the project.

Ms. McGrath-Gunn advised that she feels it is one of the best projects she has had the opportunity to be part of and feels it has been an extremely positive experience. She commented that the project generated vast amounts of interest and opened up Andersons in other ways that they never imagined which overall raised their profile.

Initially, when the project required a breakdown of costs, looking at how care could be funded, it was time demanding and had not been anticipated as being so lengthy. At the time this was deemed as a down side, however, as the project progressed and ever increasing cost pressures on care homes came to the forefront, in particular relating to the living wage, breakdown of costs became useful as the project progressed. Looking at the true cost of care had been an extremely enlightening task in the current climate for residential care.

As an overall evaluation, it was felt that with some changes the project would have provided more positive outcomes, but welcomed the support Personal Assistants can give to their residents.

(Further feedback from Ms. Kathy McGrath-Gunn can be seen in the accompanying video)

Parklands Group

Mr. Ron Taylor advised that he had read about the SDS residential project and was immediately keen to get involved to increase both the level of care within the residential homes and within the community. Mr. Taylor noted that he felt that there were areas which would benefit from the pilot, such as introducing a Frailty Unit and advised that he would be keen to see how this would work within a care home setting.

Mr. Taylor advised that he felt that the idea of the Personal Assistant coming into the care home was a limitation. It was highlighted that care homes are heavily regulated by the Care Inspectorate and therefore, those in charge of residential care settings are often risk averse. Inquiries by Parklands with the Care Inspectorate showed that they are not supportive of a PA coming into the home if they are not necessarily PVG cleared and have had the relevant training, insurances and so forth put in place. Mr. Taylor felt if the PA's work was more regulated, it would be easier to get around this situation. Mr. Taylor confirmed that the uptake of SDS was through the use of a direct payment to employ PA's for activities taking place out with the care home. Parklands felt that offering a PA was the most valuable thing that the project could offer as it has made a difference to the residents, and was able to offer something that the care home could not offer in the current climate.

The potential for such individualised support would mean that the individual would not have to go off the premises to receive this person centred provision; it could be as simple as the PA sitting and talking to them within the care home environment. Mr. Taylor advised that whilst it can be difficult to evaluate, there was a benefit to those taking part, reporting there was an overall better mood; it goes back to the idea of having something to look forward to which can make all the difference. He stated that this is a positive which has come out of the project, the evidence was clear for Parkland's that PA's could supplement the care and support which an individual currently receives. Mr. Taylor stated however that, for this to be successful, PA's need to be just as regulated as other staff. It was acknowledged that there is an element of risk in anything you do, however this just goes back to choice.

When asked about the effectiveness of the base line surveys used during the project, it was acknowledged that these forms were, and could be, extremely useful. Mr. Taylor confirmed that he did not feel that they were always provided with enough personal information when an individual first enters the care home.

The project wanted to ascertain if taking part in the project had resulted in a change in practice for Parklands. The team was advised that Parklands used to run group activities; however they have since changed this as "one size does not fit all". The number of activities has now been increased to ensure that all individuals are considered to be "stimulated and not just entertained". As a result there has been the introduction of a pool table, a men's room showing football and other sporting activities and a film night.

The team was advised that it could have looked at how the ethos could be more successfully integrated dependent on the goal, if the project were replicated. When posed with the question as to the overall success of the project from a series of four statements, the response was that with some changes, the project would have provided more positive outcomes.

(Further feedback from Mr. Ron Taylor can be seen in the accompanying video footage)

Cornerstone, Parkholme

The project team arranged a meeting with the care home manager following conversations with the Operational Manager, to discuss the aims of the project. Mrs. Linda Smith noted that she saw the project as an opportunity, however noted that she did have her initial concerns. Mrs. Smith acknowledged that she feels that Parkholme could have been more proactive during the course of the project and, through not having a single person nominated to attend meetings could have resulted in a misunderstanding of the project. This was due to them relying on each other for updates and passing on relevant information. On reflection, Mrs. Smith stated it should have either been consistently one, or both of them.

When asked if there were any foreseen limitations, Mrs. Smith advised that this would have depended on what option was chosen, as there would have been different drawbacks based on each choice.

It was reported that for the service itself, there was a feeling that the project had stalled somewhat in the earlier stages, however it was noted that this was a result of the complexity in breaking down the costs of the service. To further highlight the issue surrounding not having a single point of contact, the service initially thought it was just care and support costings, and did not take into consideration indirect staffing costs and how time consuming such an activity would be.

The project did highlight some disparities, for example one resident has dementia and cannot walk, and is totally dependent, however doesn't present as difficult and is content with their own company. Parkholme noted that they need to ensure that she is receiving her fair share of care, and that her social needs are being met in comparison to some more demanding residents. Mrs. Smith stated that this could be used as an example to bring to the attention of staff, and gave Parkholme the evidence to pin point towards better care.

The organisation found it difficult to evaluate the project as they have not been able to develop the project fully. It was noted that Parkholme didn't feel it worked whilst the project was ongoing, however it did have positive outcomes and could have been beneficial if they had been given more time. The time was a result of difficulties and time constraints with some of the families, and the project did not foresee these delays once the processes were put in place to deliver the full suite of SDS options.

Views of other professionals involved

Enable

Enable is a registered charity; it has been a non-profitable organisation since 1954 with their “backbone” being in Learning Disability. They provide various different types of support noting that the social care landscape has changed a lot, highlighting that Enable is moving with the change. In terms of staffing, Enable employ 28 staff members Moray and have recruited an additional four members of staff that are currently going through the vetting process. The majority of staffs are employed to support one person. They have, in some cases done bespoke recruitment, which they feel is beneficial. Enable scored highly with the Care Inspectorate this year receiving both 5’s and 4’s. The Care Inspectorate commented that they were extremely impressed with the work that Enable is doing.

Discussions took place regarding the traditional role of the support worker and how people like the support worker (James) are now able to take on the role similar to that of a PA. James and his team are now doing rotas, and work in self-managing teams to give them more ownership of the work they undertake.

Enable were part of the local ISF delivery project, where they have been looking at holding the budget and using it in a unique way, encouraging individuals to make their own choices. The residential care project was introduced to Enable by the project assistant, as an individual at Andersons had requested an ISF to support and manage their budget. Mrs. Joanna Grieve explained the process as a bit “frantic” at first. It was a case of support was required and was Enable in a position to provide it. Mrs. Grieve spoke about how quickly they responded, explaining how they were asked on the Friday and were taking Participant E, out on the Saturday. James did a lot of research before taking Participant E out and the arrangement slotted in very well. The support was gradually built up and became a regular occurrence. Enable were able to transfer their skills and experience that they had in other areas in relation to transitions to support Participant E. They had to ensure that he was prepared before he went out and as a result, they liaised closely with Andersons.

It was not felt that there were any disadvantages or missed opportunities from the project but saw it as an opportunity and took it. From an individual level, they saw new chances to support Participant E and got these up and running.

At the point of potentially moving forward, it was highlighted that problems could arise when working with other providers seen as their “competition”. However, admitted that in this specific case it has worked extremely well. There is potential, however, for issues with other services in relation to insurance, access to data, different ways of working and not having a “shared practice”.

Enable reflected on the project and believe that it has provided good value in terms of outcomes, and from a more personalised approach, for Participant E, the project has really changed his life. James (support worker) commented that he found it enjoyable taking Participant E out. Participant E's main outcome was socialisation; he became more outgoing, chatty, engaging and overall grateful as a result of the experiences

James described Andersons as very receptive, noting that they have worked very well alongside him to support Participant E. James spoke of the benefits, explaining that it is rewarding to feel that they are making a real difference in someone's lives.

(Further information from Enable can be seen in the accompanying video in relation to Participant E's story).

Personal Assistant

Vanda has been supporting one individual for the previous few months enabling them to get out into the local community. They have been visiting the local library and having coffee in the café. Once their relationship develops, then they aim to explore other options available to them. Unfortunately, the individuals initial Personal Assistant let them down and stopped turning up for work. As a result, when Vanda turned up for her first shift, the individual "wasn't ready, because he thought that I wasn't going to turn up, but now he's ready and waiting and I feel that this is a positive impact". The individual is building up trust with the PA, and when out and about share many a laugh together.

Feedback From Critical Friend

Mr. Sam Newman, Partners for Change

Tackling issues of choice and control, autonomy, and a personalised life, within a residential setting, is a challenging activity and fraught with complexity. It is really important that pieces of work such as this programme, are undertaken to counteract the risk that people entering residential and nursing care are forgotten, become isolated, become 'maintained' rather than supported as individuals. As someone once said we all need to thrive, not just to survive.

The project team in Moray have done a great job in my opinion, not least in avoiding the bear traps of being bogged down in process, forms, and bureaucracy and focusing instead on people as individuals and what it means to help people in institutions lead as much of their chosen life as possible. I was particularly impressed with the use of the baseline interview which really focused on people as individuals, what mattered to them, and what would have the most impact, and also that the most crucial evidence of the project was not numbers, or costings, but the stories of individuals that participated in the project.

The project has created some really important learning and the key messages for me include the following:

- Small amounts of money can make big changes – it is not necessarily about finding large amounts of additional funds. This project showed that if you can find relatively small amounts of money, that crucially, are available in a flexible way – it can make a big difference.
- People entering residential care are at risk of their connections and relationships breaking – the system assumes that they are no longer required. One care home manager told me a number of stories where, as an individual entered their home, all the other connections and supports were 'shut down' immediately without any discussion.
- It's not about paperwork, processes or forms. It's about ensuring that we have conversations that are about people, not about services – and then ensuring that there is someone who will do something about it – not least because the system is not congenial always to making the changes that will impact positively on people's lives.
- Baseline interview scores helped the project focus on people not services, and target areas that would have the greatest impact on peoples well-being and quality of life
- People chose to reconnect with people and places and activities that they used to be connected to, to do things they used to do before being a resident, sometimes to meet family that otherwise they would be unable to meet. As with most SDS projects, fears that people would want to do outlandish or extreme things were unfounded. People want to do the basics – connect with people that matter and who love them, and spend some time doing things that make them feel valued and alive.
- Meaningful relationships in the home matter – it is interesting that the project identified one individual who chose a trusted member of staff to be his PA

- It was great to see the council opening up its e-learning systems to residential care staff. It is crucial that if we are collectively going to get it 'more right' for people living in residential care that all the responsible parties are prepared to work and act collaboratively. The first steps in this co-working needs to be taken, as they were in this project, by the council (the money holder) moving beyond a pure commissioning and/or procurement function and being prepared to truly work in partnership with care homes, but also with individuals, their families and other community based organisations. Then, of course, all other parties need to respond positively, and be prepared to find solutions – not just get defeated by the first structural challenge – e.g. the issue of PAs entering care home premises.

In terms of going forward the potential next steps include the following. None of these things are easy, but all have value.

- Where additional funding has been provided to improve the quality of somebody's life it would be useful to identify the 'return on investment' and the potential for this to have a benefit somewhere else in the health and social care system. i.e. can we show by using the baseline interview scores that someone's mental and or physical health has improved, and that this could/should have a positive impact and prevent the potential additional demand on social and health care resources.

- This programme, as with all programmes looking at residential care, bumped into the issue of cross subsidisation – i.e. uniform fee levels hiding the reality that some people's needs and requirements mean that others paying the same get less. One solution may be to look at three elements of care home fees not two – hotel costs, fixed staff costs, and an individual support amount that could be really individualised. Everybody would have to pay the first two elements. The third could be really tailored to each individual. This of course would conflict with the notion of a national care home rate – but the very concept of a national rate conflicts with what we have always known, and what this project has powerfully reminded us of – that people are individuals with individual needs and requirements, and this doesn't magically disappear when someone enters a care home.

- There are many important practice lessons to take forward as a result of this work. Not least is the significance of the moment, the point of entry as someone moves from the community to a home. Often this becomes a transactional piece of work as the social care system switches from a community package, to someone becoming resident. This project shows how crucial it is that professionals do not regard it in this way. They must regard it as a huge point of risk for each individual and work hard to ensure that people's connections to people that matter to them (often family), places and activities are maintained.

My visit to one of the homes in the project confirmed to me that the biggest impact on the quality of life of people in homes is almost certainly the commitment and leadership of the person in charge, and the culture of each home – how much it is

dedicated to seeing individuals as individuals, people as people with lives that need to be maintained beyond the confines of the home. I was hugely impressed with the dedication of the whole staff team to the individuals they were supporting – despite all the structural limitations they experienced including fee levels, the 'switching off' of all other supports as someone entered the home, and the complexity of supporting a relatively large number of people with widely differing needs. Well done!!

Views of the SDS Residential Care Team

Pauline Knox, Project Lead

When the opportunity initially arose to submit a proposal to the Scottish Government for this project I immediately saw the potential for us locally, as well as the benefits anticipated at a national level. We are a small local authority area, and unlike many areas, we have no national 'chain' care homes. This, I believe has been to our benefit when it has come down to making decisions about cost breakdowns and things that may have been much more challenging if it meant getting a national board of directors to agree to elements of the project.

Key to the success of the project has included the following in my opinion:

- The recruitment of the right project team. The Project Officer post was recruited as a job share with two individuals that had very different skill sets that added significantly to the project. One has years of experience working within an operational SDS Team and the other has years of experience in managing external residential care services.
- The transparency and honesty with all stakeholders and partners. Having open and honest conversations with all parties has helped to build trust and strengthen the relationships between all involved.
- Doing 'with' all stakeholders and partners and not doing 'to' them. Collaboratively generating options and solutions to the challenges where possible and recognising that there was not one overall expert in the work that we were doing.
- Above all, the willingness of the individuals and their families for getting on board and opening up their lives to trying something different with us.

I believe that the overall result from this project has been very positive, but I don't think that is largely directly relating to the opportunity to use a direct payment in a residential setting, although this has also proved to have a positive impact. However, as is evident in the baseline surveys and the feedback, having choice and control is often about 'feeling' that you have them rather than anything more tangible, and what gave most people that feeling was the different conversations that took place around the baseline surveys, and not that they could use any particular SDS option.

Michelle Fleming, Project Officer

Building a close working relationship with the residential care homes was a pivotal point in the success of the project, allowing both the project team and the care homes to be open and honest. To fully explore an individual's outcomes, the project team needed to get to know the residents whom we were working with, to gain their trust and understand who they are. The base line interviews were instrumental, allowing individuals to share their history and who they were, prior to moving into residential care. It assisted individuals to think about their outcomes, especially as some had become institutionalised within the care homes. The initial conversations with individuals centered on their satisfaction within the home and

many reported no desire to change. By getting them to think about their life and the things that were important to them in a ‘safe space’, the conversations took a different path.

On reflection, the project did not anticipate the length of time it would take to obtain a breakdown of costings, this impacted upon the ‘live testing’ phase of the project. At times, different stakeholders in the project felt as though it had become static. This was due to the amount of work required to establish a bespoke costing for individual care homes and their minimum opt in. As an exercise this has been extremely beneficial to the care homes, and was certainly worth the time taken; however more time should have been factored in for this.

Despite incorporating both older people’s residential care homes and learning disability care homes, I feel that the greatest success has come from working with older people. The disparity between the two client groups was substantial in relation to the activities that were undertaken on a weekly basis, in line with their support plans. Therefore the costs attached to each individual were far greater for learning disability clients than those allocated to older people, reflecting the increased social and emotional support afforded to learning disability clients. Potentially this could have affected the outcomes identified with learning disability clients, and their uptake of the project. The learning disability service users and their families often reported that they were happy with their identified outcomes. This was a factor when the project chose to stop working with the participant, coupled with the family’s personal apprehension. I believe as a project the greatest improvement can be made for those individuals in older people’s residential care. This is achievable without the requirements for large amounts of money. It has been evident from the project, that small amounts of money can be significant for individuals and enhance their lives. “Things don’t stop being important to you when you go into Residential Care” Michelle Fleming, Moray Council, Scottish Care SDS @SelfDirectedSup Twitter (15/03/2017). We need to strive to deliver greater person centred planning for those residing in residential care. Direct payments are an effective vehicle to deliver this. One hindrance within this however, is the national care home contract and the rate where one size fits all. In order to be truly person centred, I strongly believe that monies allocated to residents, should be individualised to reflect their needs. We need to have a stronger focus on an individual’s social and emotional needs to ensure a truly person centred delivery, without detracting from the physical supports required. As Maslow (1943, 1954) highlighted, to reach true self – actualisation, the lower needs must be satisfied, and we should strive to support residents to climb the hierarchy. We should not simply strive to meet an individual’s basic biological and physiological needs, but also consider their individual transcendence needs and support residents on their journey to self-actualisation.

I feel that there have been some large successes within the project. The evidence shows that some service users want to continue the supports put in place. This is due to the positive impact the support has made to both the individuals and their families.

Aimee Borzoni, Project Officer

As Job Share Project Officer I had a large role in shaping the direction and priorities of the Residential Care Project. At the start of the two years we had large expectations and a set action plan to get us to the end of the project. The action plan was pivotal in keeping us on track and realising our progress, as well as ensuring that we could communicate effectively with our stakeholders at all times. In undertaking this project, one of the largest benefits was job sharing the project officer post. In practical terms it ensured that the pressure and responsibility was shared and in a personal respect, each project officer had an area of expertise. I have no doubt that this has contributed to the success of the project.

The most difficult part of the project was supporting Care Homes to breakdown their costs. They were all willing to undertake this task, but found it very difficult to decide on an 'opt in' policy and to provide the level of detail required for the success of the project. This caused a very long delay within the whole timeline and in turn meant that the live testing phase was considerably shorter than planned for some individuals.

The main success within this project has been in terms of meeting people's outcomes, whether they were expected outcomes or not. Seeing people in a care home get more opportunities has been the most rewarding part of this project. Realising that in order to achieve these outcomes, frontline workers mostly just need to have better conversations with individuals as there is no need for large amounts of money to be attached to this. Going forwards, it is important that we support our frontline workers to have different, more outcome focused conversations and reviews with people living in a care home so that they can enjoy a more personal experience.

Yasmin Humphries, Project Assistant

I felt that the SDS project gave the participants opportunity to have more choice and control over their lives within the care home. This was shown through the adapted Supported Self-Assessment Questionnaire and identifying an individual budget based on their needs. Once this had been established, the budget was used to meet their outcomes. The use of the base line surveys allowed for an in-depth insight to the individuals back ground and life history to be obtained. Using the ISF project within the residential project was beneficial as some of the participants were unable to manage a direct payment independently and benefitted from the ISF provider managing their budget.

The difficulties that were found throughout the project were establishing Personal Assistants within the limited time the project had and how information was communicated relating to the provision of the Personal Assistant. Despite the project being undertaken over a two year project, it is felt that there were still some time

constraints and that without these time constraints more participants could have benefitted from the project and would have provided richer data for analysis.

As a way forward for the project, the communication needs to be improved between Personal Assistants and care homes; this could possibly be achieved through a log book to aid communication.
I believe for the project to work successfully in the future, the care homes would require a dedicated named social worker to support with planning and a dedicated Direct Payment Coordinator.

Julie Cameron, Clerical Assistant

Being part of the SDS Residential Pilot Project has been an interesting and amazing journey with lots of positivity and minimal setbacks. A substantial impact on people's lives has been made through the project and this was to be celebrated recently when we arranged regular visits with one lady from the Care Home to her sister, who she had not seen in years. .

The project has raised awareness of SDS by incorporating SDS E-Learning for all workers in a residential care setting and highlighting the choice and control which is available to all people through SDS. The support and dedication from both Andersons and Parkholme management ensuring all SDS E-Learning was undertaken positively.

The recent film footage gave us substantial feedback from individuals participating in the project, Support Workers, Care Home Owners and our project assistant. The support, kindness and availability of the people who agreed to be interviewed was amazing and has certainly contributed to the overall success of the project.

Independent Evaluation

Executive Summary

The Self Directed Support (SDS) Residential Care Project in Moray is an ambitious two year pilot managed by a dedicated project steering group, and funded by the Scottish Government into the possibility of extending self-directed support using Options 1 (direct payments) to Option 4 (a combination of Options 1-3) to support service-users living in residential care to have greater choice and control over the services provided to meet their assessed outcomes. Extending self-directed support into residential care settings supports the aims of the *2020 Vision for Health and Social Care*; and *The Health Quality Strategy for NHS Scotland (2010)* that the provision of health and social care services be person-centred; integrated; and encourage innovation in, and the creative planning and provision of health and social care services in partnership with care service-providers, those who work within the care sector, and communities.

The pilot sample set is older people and people with learning disabilities living in residential care homes, in partnership with them, their social care providers, and health and social care workers the project team under took a wide ranging set of tasks to facilitate testing the potential for SDS to be extended for use into residential settings including: a review of the Resource Allocation System (RAS) used in community settings to obtain an indicative budget (required for SDS), the review and redesign of the Supported Self-Assessment Questionnaire (SSAQ), the development of Baseline Surveys to assist in facilitating a conversation with service-users, enabling them to talk about their lives, choices, and what mattered to them. This work evidenced the current flaws, weaknesses and limitations of the RAS, and how we engage with service-users and their families for the purposes of assessment, support planning and review, once the service-user moves into a residential care setting.

To assist in the engagement of residential care providers and their staff the project strove to develop effective tools, multimedia information resources; to gain access for residential care home staff to learning on SDS; and to find new ways of working with care providers to develop an understanding of the potential SDS opens up for service-users living in residential care and their families.

The pilot highlighted how funding processes such as the block funding of residential care placements creates barriers when assessing the true cost of care for the individual and are the antithesis of the aim that care services be person-centred. The work of the project team in this area with their partners in the pilot: evidenced that small amounts of funding can have a significantly positive affect on the mental and physical wellbeing of service-users.

One of the unexpected findings from the pilot is that there are inequalities between service-user care groups; and within service-user care groups i.e. in relation to whether you live in your own home or whether you live in a residential care home; and that social care professionals and communities have a perception of residential care that serves to undermine the innovative work that could be done to ensure that living in residential care is a positive and life enhancing experience.

The pilot has delivered some good outcomes; show cased good practice, produced valuable learning, and has met some of the original objectives set for the pilot. However the pilot would have benefited from having a more disciplined approach to project management.

The test site has been successful in delivering a series of findings:

- The legislation which regulates SDS requires to be changed/adapted to allow service-users living in residential care to have access to Option 1
- The tool kit for SDS: RAS and SSAQ needs to be reassessed and upgraded in the light of the findings from the pilot and the changes made to the SSAQ were necessary to reflect that when people move into residential care they are still part of their community and that service-users' families still provide caring support to their relative abet potentially in a different way
- The learning from the analysis of costs arising from the pilot demonstrates that continuing to block fund residential care placements to cover all costs regardless of their nature does not fit with the aims of the 2020 vision for health and social care, and the ethos of care being person-centred
- The assessment, monitoring and review of support planning for service-users requires to be reviewed and updated to take better account of service-users' life experience, values, choices and to afford service-users greater control over the services they receive to meet their outcomes
- Financial planning has to be realistic i.e. reflect the true costs of residential care, and those costs have to be transparent to service-users and the families/people who care for them
- The government should consider the development of processes and where needed financial assistance, to ensure that service-users plan for their older age when they may not have the capacity to make decisions on where they live, their care and how it is delivered, by promoting the value of having a power of attorney and/or guardian in place to represent and safeguard their interests
- The pilot found that communities should be informed of and recognise the value of having a range of care services available including residential care; and recognise that residential care is a valuable resource meeting needs that cannot be met if the service-user were to remain living in their own home
- The pilot found that there are challenges to joint working and pooling resources with external service-providers, but that it is worth meeting those challenges as the positive outcomes of doing so for service-users, their families, and people who work in the care sector were clearly evidenced

- The pilot found that having the discussion of SDS as part of the package of options available for service delivery to service-users to meet their outcomes while living in residential care assists in promoting a cultural shift opening up possibilities of residential care not being seen as the “end of the line” when it is no longer sustainable for a service-user to live in their own home, but is a new and positive chapter in the service-user’s life which can be socially rewarding, and enable the service-user to still play an active part in the local community.

The pilot vision asks the questions: “Would having access to SDS provide service-users living in residential care with greater choice and control over the services they receive to meet their outcomes? AND, “Would having greater choice and control afford service-users, living in residential care, greater opportunity to be a valuable part of their community?” The review found that the most positive outcome out of the pilot has been illuminating the amount of work and change required before a positive answer to those questions becomes a reality for service-users living in residential care.

Jacqueline D Goldthorp

The full report can be seen in appendix 7.

Recommendations From The Project

It is evident from the findings of the project that it has successfully managed to implement positive change into the lives of some of its care home residents. Both the individuals who participated in the project and the care homes reported that the project was successfully able to deliver on providing improved outcomes relating to social and emotional well-being. It is evident that meeting an individual's physical needs is far easier to meet for residents in care homes compared to emotional and social factors. It must be noted that this is not due to a lack of willingness from the care homes trying to address this, but larger factors affect this, in particular staffing and budgetary constraints. As a result of such constraints their focus has to be around meeting physical needs, and recognising that whilst they offer social and emotional support, there is still a more personalised approach which can be taken. Therefore, the introduction of Personal Assistants via a direct payment and dedicated staff through an ISF has been a welcomed addition from individuals, their families and the care homes themselves recognising the support that they can offer. Whilst it is acknowledged that this is a beneficial addition, there is also the acknowledgement that for any successful introduction in the long term, there is a desire for the work of Personal Assistants to be regulated. This not only provides reassurance to families, but also to the care homes themselves when having other workforces enter their residencies.

There has been a significant benefit to all parties when looking at increased personalisation and the positive impact that individualised support can have. Through building a close relationship with the care homes involved, the project team was able to explore the impact of SDS to residential care homes. This included care homes looking at a minimum opt in that individuals needed to purchase when choosing to move into the care home. It became apparent that the make-up of the current national care home contract did not lend itself to offering true choice and control and within the current climate breaking down costs to offer more flexibility could destabilise the market. It is clear that a 'one size does not fit all' when funding individuals in residential care and does not afford itself to complete choice and control and does not lend itself to the principles of SDS which identifies personalised budgets. Trying to follow the principles of SDS and the personalisation that is aligned to this, can be complex and freeing up the funds for alternative supports complex under the current funding arrangements.

Staffs within the care homes found the SDS training informative and useful, particularly regarding outcomes and personalisation. This in turn highlights individual outcomes and how this can be addressed in a more person centred away. Increasing knowledge about SDS to all care home staff can only benefit the way in which care and support is delivered in care homes and in delivering better outcomes. Due to the success of the training, this is something that is going to be delivered throughout Moray in the future.

Establishing close working relationships with individuals and their families and gaining an in-depth insight into their lives has been a significant shift in the way in which practitioners conduct their assessment. All too often individuals can start to lose their identity in residential care, and who they were prior to living in care homes

can be forgotten. Whilst it is recognised that their likes and dislikes can change, it is vital that they do not lose sight of who they are. The introduction of the base line survey has supported in this and allowed for a close working relationship to be built and has also supported individuals and their families to identify outcomes based on what is important to them. The care homes reported that these were a welcome addition as the personal information detailed within the base line survey would support them to build a relationship with the individual whom they are supporting. By sharing the base line surveys with the residential care homes, it would allow their staff to get to know the individual and build a relationship quicker and support them to reminisce. Moray have taken the decision to look at the way their assessments are conducted with all residents, whether on moving into residential care or for those who already reside in care homes to ensure a greater outcomes focused assessment in line with building a close working relationship with the individual.

In summation, the project has been able to successfully deliver increased outcomes to individuals in residential care, which was supported through the use of direct payments. However this would require further work to ensure that this could operate smoothly and efficiently. It is vital that the individual remains at the heart of any assessment process and this can be achieved through the use of Self-Directed Support and effective support planning centred around the principles within the Social Care (Self-Directed Support)(Scotland) Act 2013. The introduction of personalised budgets can serve to achieve a truly person centred delivery of support in residential care, however, this is complex under the current funding model.

Glossary

Self -Directed Support (SDS)
SDS allows individuals to choose how their support is provided, giving them as much control as they wish over their individual budget through the use of one of the four options.

Direct Payments (DP)
A cash payment paid to an individual to enable them to purchase services in order to meet their assessed needs.

Supported Self- Assessment Questionnaire (SSAQ)
An assessment tool used to identify an indicative budget usually based on multiple choice answers to a series of questions.

Resource Allocation System (RAS)
A set of rules that allows a fair budget allocation to be made based on the responses in the Supported Self-Assessment Questionnaire.

Personal Budget
The agreed budget required to meet an individual's outcomes.

Personal Assistant (PA)
An individual employed directly employed by an individual or the person acting on their behalf to provide support to the individual.

Individual Service Fund (ISF)
A different way to purchase care and support through option 2 of SDS. The individual retains the choice and control over their support with the ISF provider managing the budget.

References

Ettelt, S. Wittenberg, R. Williams, L. Perkin, M. Lombard, D. Damant, J. Mays, N. (February 2015) *Evaluation of Direct Payments in Residential Care Trailblazers,* Policy and Innovation Research Unit.

Moss, C & Reed J (2007), Managing the Transition into a Care Home. My Home Life Research accessed at http://myhomelife.org.uk/wp-content/uploads/2014/11/MHL-Research-Briefing-1-Managing-Transitions.pdf

Information Services Division Publication Report, Care Home Census for Adults in Scotland, Figures for 31 March 2006-2016, Publication date 25 October 2016 accessed at http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2016-10-25-CHCensus-Report.pdf?954283092

Social Care (Self-Directed Support) (Scotland) Act 2013, accessed at http://www.scotland.gov.uk/Publications/2013/06/1341

https://m.simplypsychology.org/maslow.html

http://www.sdsscotlnad.org.uk/

Appendices

Appendix 1 SDS Residential Care Project Information Hand Out

The SDS Residential Care Project focuses primarily on older people and people with learning disabilities and the aim is to explore the potential benefits that could be introduced within residential care and residential accommodation by using the flexibility of the options available through Self Directed Support (SDS).

The project will identify if there are any aspects of this process that is challenging in terms of negative impact relating to outcomes or cost for any stakeholders but primarily for those who use the service and their family.

With the involvement of all relevant stakeholders the project will produce the necessary tools, guidance and processes to inform and support the use of Self Directed Support to afford the maximum choice, control and flexibility for those using the service in relation to residential care and residential accommodation.

It will do this via:

- Review and/or redesign our existing Resource Allocation System (RAS) in relation to residential care/accommodation.
- Work in partnership with residential accommodation and extra care housing providers to explore the impact (both positive and negative) around the use of SDS for individuals wishing to purchase accommodation only with different choices explored around the provision of housing support and personal care.
- Working in partnership with care homes to test the use of a 'unit costing toolkit' to support care homes to identify their costs for hotel, residential and nursing care, as separate items to explore the flexibility possible for both provider and user in terms of what is purchased and what impact this has on the ability to improve person-centred planning within the residential setting.
- Conduct a desk top research exercise with individuals previously using a Direct Payment for care at home who need, or wish to move, into residential care/accommodation in order to understand the possibilities and implications of using Direct Payments in this way.
- Identify individuals who will work with us to test the purchase of residential care using the SDS options.
- Use the redeveloped RAS to work in partnership with care homes in considering the dependency needs of those individuals that do not need nursing care but have needs that cannot be sufficiently met under the current National Care Home rate of funding for residential care.
- Identify individuals who wish to explore the use of pooled budgets. This will be explored in terms of pooling the budget to secure desired and appropriate accommodation, in addition to the staffing and living costs. In addition, the pooling of budgets will be explored in the wider context with those individuals already in residential care/accommodation for the achievement of greater social provision.
- Live test the four options of SDS.
- The final stages of the project will be to collate the ongoing evaluation from all partners, including service users and their families to support the final independent evaluation of the project outcomes and achievements.

Appendix 2 SDS Residential Care Project; A Partnership Approach

The SDS Residential Care Project focuses primarily on older people and people with learning disabilities; its aim is to explore the potential benefits Self Directed Support (SDS) can offer people living in residential care or residential accommodation and its impact on people, providers and processes.

This is a two year project that will work with a small group of individuals (20-24) in this care setting, identifying the challenges and impact on personal outcomes as well as any negative impact for service providers.

This project is one of two test pilots in Scotland, and will be used to inform both local and national learning. Partnership working across all stakeholders will be crucial and your involvement is vital.

From this partnership approach, the project will then develop, and in some instances, re-design the necessary tools, guidance and processes to inform and support the use of Self Directed Support to afford the maximum choice, control and flexibility for those living in residential care or residential accommodation.

Benefits:

- Accessible support to a dedicated SDS team
- Opportunity to identify gaps in service provision; optimise resources/capacity
- Inform wider SDS policy
- A broader and informed perspective for residential care staff.

Your Role:

- To assist in providing an accurate and detailed breakdown of costs, including "hotel costs". It may also be necessary to provide an hourly staffing analysis (template will be provided) of residents involved in the project.
- To consider what the minimum 'opt in' provision would be for a resident in your service. (Please note the minimum 'opt in' cannot be full provision of services. However, your initial proposal is not fixed.)
- In order to allow live testing of all of the SDS options, consider the impact on your service and administration. For example, invoicing procedure for Direct Payments or residents using pooled budgets.

Our Commitment:

- Open, clear communication, respecting confidentiality at all times.
- Bring together stakeholders in timely and appropriate meetings.
- Working in partnership to develop a unit costing toolkit to support care homes.

Lead Contacts:

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September 2015

Appendix 3 Critical Friend Remit

SDS Residential Care Project

Critical Friend Remit

The Critical Friend will provide an independent supporting role to the Residential Care Project in Moray from a wider perspective. They will draw on knowledge and expertise of the wider Personalisation agenda and of SDS work from other areas throughout the UK. To give advice on the progression of the project to enable testing of all of the 4 options of SDS with a strong emphasis on option 1.

- To objectively challenge the progression of the project to ensure that the project remains focused to achieve the overarching aim.
- To give independent advice and feedback on processes and documentation developed throughout the project within agreed timescales.
- To hold 3 teleconferences per year throughout the project at regular intervals.
- To provide ongoing telephone and email support throughout the project.
- To be a platform to extend development ideas to, and gain feedback on this.

Appendix 4 Steering Group Role and Remit

Steering Group

ROLE AND REMIT

Title

SDS Residential Care Project Steering Group

Outcome

To provide the SDS Residential Care Project Team with partnership support in respect of testing Self Directed Support in Residential Accommodation/Care Homes.

Remit of the Steering Group

- To provide a forum for discussion between colleagues.
- To provide guidance to the project team.
- To provide a forum for the project team to discuss ideas.
- To provide a forum for colleagues to inform the project team of activities that may impact the project.

Operational Arrangements

- The Steering Group will aim to meet at least 6 times per year.
- Members should commit to the Steering Group for the duration of the pilot.
- SDS Residential Care Project Officers will chair meetings and are responsible for arranging agendas and minutes of meetings in the first instance.

Membership of the SDS Residential Care Steering Group

- SDS Residential Care Project Officer
- SDS Commissioning Officer (SDS Residential Care Project Lead)
- SDS Residential Care Reviewing Officer
- SDS Residential Care Project Clerical Assistant
- Commissioning and Performance Officer
- Social Work Team Manager
- Service Manager Assessment and Care

Reporting and Communication Mechanisms

- The SDS Residential Care Steering Group will feed information to the SDS Steering Group via the Project Officers.
- The SDS Residential Care Project Officers will ensure that the SDS Steering Groups views are discussed at the SDS Residential Care Steering Group.
- Reporting to Committee (where necessary) and The Scottish Government will be via the Project Officers.

Appendix 5 Baseline Survey

BASELINE INTERVIEW QUESTIONS

NAME _____ DATE OF BIRTH _____ RESIDENTIAL HOME _____

TELL ME ABOUT YOUR LIFE	
JOBS	
TRAVEL	
INTERESTS	
HOBBIES	
MUSIC	
ANIMALS/PETS	
FAMILY	
FRIENDS	

WHAT ACTIVITIES DO YOU ENJOY NOW THAT YOU LIVE HERE?	
IS THERE ANYTHING YOU DON'T LIKE TO DO?	
DO YOU DO ANY ACTIVITIES OUTSIDE THE HOME?	
DO YOU HAVE CLOSE FRIENDS HERE?	
CAN YOU TELL ME WHAT MAKES A GOOD DAY FOR YOU?	
CAN YOU TELL ME WHAT MAKES A BAD DAY FOR YOU?	
WHAT CHANGES WOULD YOU LIKE TO SEE AS A RESULT OF TAKING PART IN THIS PILOT?	
IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD?	

Appendix 6 Supported Self-Assessment Questionnaire Result Analysis

Review Questionnaire (Results Analysis)

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q1	Q2	Q3
A	1	0	1	0	1	26	0	33	9	2	0	12	17	0
B	3	2	8	1	3	0	7	1	7	-	0	2	17	16
C	0	0	13	0	9	3	5	0	1	-	20	0	3	1
D	0	31	11	32	20	3	21	0	20	-	13	3	0	0
E	3	0	3	0	0	3	0	0	0	-	0	0	0	0
F	20	0	0	0	0	0	0	0	0	1	0	0	0	0
N/A	-	-	-	-	-	-	-	-	-	30	-	16	16	17

Learning Disability

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q1	Q2	Q3
A	0	0	0	0	0	1	0	4	1	-	-	-	2	-
B	1	0	0	0	1	0	1	0	0	-	-	2	2	2
C	1	1	1	0	0	1	0	0	1	-	2	-	1	-
D	0	4	1	4	4	0	3	0	3	1	-	-	1	-
E	1	0	2	0	0	3	0	0	-	-	-	-	-	-
F	2	0	0	0	0	0	0	0	-	-	-	-	-	-
N/A	-	-	-	-	-	-	-	-	-	3	2	2	-	2

Participants (SDS Pilot Project) With Revised SSAQ

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q1	Q2	Q3
A	-	-	3	0	1	0	0	0	0	2	0	-	1	-
B	2	3	4	0	3	0	3	4	0	1	6	-	1	1
C	-	3	2	2	9	3	1	0	9	2	2	1	1	-
D	1	7	5	11	1	2	9	2	5	8	5	-	1	-
E	3	0	0	0	0	8	0	7	0	0	0	-	0	-
F	7	0	0	0	0	0	0	0	0	0	0	-	0	-
N/A	-	-	-	-	-	-	-	-	-	-	-	12	12	12

REPORT TO: **INTEGRATION JOINT BOARD ON 29 JUNE**

SUBJECT: **2017 STRATEGIC RISK REGISTER AS AT MAY**

BY: **2017 PAM GOWANS, CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To present the revised version of the Strategic Risk Register, updated as at May 2017.

2. RECOMMENDATION

2.1 The Integration Joint Board is asked to note the:

(i) revised version and update of the Strategic Risk Register approved at the Audit & Risk Committee on 25 May 2017; and

(ii) format of the Strategic Risk Register will be reviewed annually as agreed at the Committee on 23 February 2017 (para 9 of the minute refers).

3. BACKGROUND

3.1 At its meeting on 23 February 2017 (para 9 of the minute refers), the Audit and Risk Committee endorsed the revision of the current Strategic Risk Register to the new format, as attached in **APPENDIX 1.**

3.2 The existing Strategic Risk Register did not lend itself to clearly identifying risk appetite against each individual risk and allow easy tracking of risk movement. Research was undertaken to review alternative formats implemented successfully elsewhere and to that point, the revised Strategic Risk Register was amended to a preferred format which met the foregoing issues and was able to present risks in a more user-friendly format.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Chief Officer and the Senior Management Team agree what risks should be included in or removed from the Strategic Risk Register and submitted to the Audit and Risk Committee for review and approval.

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 IJB requires effective governance arrangements for those services and functions delegated to it. Such governance arrangements include systems for managing risks.

(b) Policy and Legal

As set out in the terms of reference, the Audit and Risk Committee has responsibility to provide assurance of the adequacy of the risk management framework.

There are no legal implications arising from this report.

(c) Financial implications

There are no direct financial implications arising from this report but the Board should note the failure to manage risks effectively could have a financial impact on the IJB.

(d) Risk Implications and Mitigation

The IJB governance arrangements include systems for managing risks such as the preparation and maintenance of strategic risk registers.

(e) Staffing Implications

Staffing implications associated with the identified strategic risks are addressed within the Risk Register.

(f) Property

There are no implications in terms of Council or NHS property directly arising from this report.

(g) Equalities

An Equality Impact Assessment has not been completed because there are no service, policy or organisational changes being proposed.

(h) Consultations

Consultations have been undertaken with the following who are in agreement with the content of this report as regards their areas of responsibility :-

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

6. CONCLUSION

6.1 This report recommends the MIJB note the revised and updated version of the Strategic Risk Register.

6.2 Note that to ensure risks are effectively reviewed, the format of the Strategic Risk Register will be reviewed annually.

Author of Report: Catherine Quinn, Executive Assistant
Background Papers: With Author
Ref: q:\ijb\june 17

Signature: Date : 20 June 2017

Designation: Chief Officer Name: Pam Gowans

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT MAY 2017

RISK SUMMARY

1. 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.
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 **HIGH**	**Rationale for Risk Rating:** 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 **NO CHANGE**	**Rationale for Risk Appetite:** The MIJB has zero appetite for failure to meet its legal and statutory requirements and functions.
Controls: - Integration Scheme. - Strategic Plan. - Governance arrangements formally documented and approved. - Agreed risk appetite statement. - Performance reporting mechanisms. - Business Management Team being developed.	**Mitigating Actions:** Management structure continues to be recruited to. SMT regular meetings and directing managers and teams to focus on priorities. System re-design and transformation.
Assurances:	**Gaps in assurance:** None known

• Audit and Risk Committee oversight and scrutiny. • Reporting to Board.	
Current performance: Meeting requirements. Increasing workload experienced – being managed by effectively recruiting to senior posts. No issues to highlight. Current milestones being met. Annual Performance Report to be presented to MIJB in June 2017.	**Comments:**

2	
Description of Risk: *Financial:* 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.	
Lead: Chief Officer/Chief Financial Officer	
Risk Rating: low/medium/high/very high **VERY HIGH**	**Rationale for Risk Rating:** 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). Impact of Living Wage on profitability depending on some provider models.
Risk Movement: increase/decrease/no change **NO CHANGE**	**Rationale for Risk Appetite:** The MIJB has a low risk appetite to financial failure and understands its requirement to achieve 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 will shortly be appointed and this role is important in ensuring sound financial information and supporting sound financial decision making, budget reporting and escalation. Draft recovery plan presented to MIJB in February for debate. Final recovery plan and forecast to be presented to June 2017 MIJB.	**Mitigating Actions:** Indicative budget for 16/17 was not approved 30 March 2017. Risk remains the MIJB can deliver transformation and efficiencies at the pace required. Indicative budgets for 17/18 and 18/19 forecast a significant deficit (6.5%). Financial information is reported regularly to both the Audit & Risk Committee, the MIJB and Senior Management Team. Heads of Service have held financial workshops with the Operational Management Team to scrutinise and risk assess budget savings and implications. Financial risk raised with Chief Executives of Moray Council and NHS Grampian following the December 2016 settlement, noting the immediate and forecast impact.

Assurances: Audit and Risk Committee oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.	**Gaps in assurance:** None known
Current performance: Indicative budget for 16/17 not approved on 30 March 2017. It was however accepted as a working budget and will go back for approval alongside the recovery plan to the June 2017 MIJB.	**Comments:** Regular and ongoing budget reporting and tight management controls 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 Plan developed and aligned to service priorities. Continued activity to address specific recruitment and retention issues. Management competencies being developed. Communication Strategy being developed. Incident reporting procedures in place. Council and NHS performance systems remain in place with single reporting in development.	**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.

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.	**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 IJB has a low risk appetite to failure.
Controls: Annual Governance statement produced as part of the Annual Accounts and signed off by External Audit. Communications Strategy being developed. Performance reporting mechanisms. Locality planning arrangements and communication engagement being reviewed.	**Mitigating Actions:** Annual Performance Report to be presented to MIJB in June 2017.
Assurances: Oversight and scrutiny by Clinical and Care Governance Sub-Committee and MIJB.	**Gaps in assurance:** None known
Current performance: Quality Assurance Framework to be developed.	**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 2017.
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 August 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 and will be presented to MIJB in 2017.	**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. 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. 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. Business Continuity Plans in place. A new model of care in Forres is being developed with five 2-bedroom flats for elderly and 7 dementia units being built to support people continuing to live independently. Jubilee Cottages in Elgin refurbished to provide short term high intensity rehab so people can leave hospital sooner, freeing up vitally needed NHS beds.	**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.

Assurances: Audit and Risk Committee oversight. Operationally managed by SMT.	**Gaps in assurance:** None known
Current performance: Communication Strategy being developed and will be presented to 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:** Management capacity to fully implement and oversee programme being still to be fully developed.
Risk Movement: increase/decrease/no change **DECREASE**	**Rationale for Risk Appetite:** Low tolerance in relation to not meeting requirements.
Controls: Chief Officer has regular meetings with partners. Infrastructure Programme Board set up. Chief Officer member of CMT.	**Mitigating Actions:** Infrastructure Programme Manager now in place to work with departments across the partnership and link the needs of services and future plans to workplans.
Assurances: Infrastructure Programme Board oversees activity and reports to Strategic Planning and Commissioning Group.	**Gaps in assurance:** Nil currently
Current performance: Lead Officer role for Infrastructure being developed.	**Comments:** This is a developing landscape where there is much learning to achieve and opportunity to engage with cross system.

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2017

SUBJECT: REVENUE BUDGET OUTTURN FOR 2016/2017

BY: CHIEF FINANCIAL OFFICER

1. REASON FOR REPORT

1.1 To inform the Moray Integration Joint Board (MIJB) of the financial outturn for 2016/17 for the IJB Core budgets and the impact this outturn will have on the 2017/18 budget.

2. RECOMMENDATIONS

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

i) unaudited revenue outturn position for the financial year 2016/17;

ii) the revisions to staffing arrangements dealt with under delegated powers for the period 1 Jan to 31 March 2017 as shown in Appendix 3; and

iii) impact of 2016/17 outturn on the 2017/18 revenue budget.

3. BACKGROUND

3.1 The overall position for the MIJB core services were overspent by £0.787m. The MIJB's unaudited financial position for financial year ending 31 March 2017 is shown at **APPENDIX 1.** This is summarised in the table below.

	Annual Budget £m	Actual Expenditure £m	Variance to date £m
MIJB Core Service	110.159	110.946	(0.787)
MIJB Strategic Funds	4.366	0.875	3.491
Total MIJB Expenditure	**114.525**	**111.821**	**2.704**

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

4 KEY MATTERS/SIGNIFICANT VARIANCES FOR 2016/17

4.1 Community Hospitals

4.1.1 The overspends within community hospitals, remain in each of the four localities Elgin, Buckie, Forres, Keith/Speyside totalling £0.219m to the year-end.

4.1.2 The long standing historic over spend continues to be realised for these services. The main overspend relates to community hospitals in Buckie (£0.129m), Speyside (£0.045m) and Forres (£0.065m) which is being reduced by under spends in admin (£0.015m) and medical staff (£0.005m), where the task of maintaining staffing cover alongside cumulative prior efficiency targets, continues to present a challenge. Non-financial objectives, including meeting waiting times, patient safety and delayed discharge targets still require to be maintained. A review is ongoing of staffing levels and structure. Nursing workforce tools used to assess the staffing levels against the bed base confirmed that in order to operate the bed base in existence the current staffing levels needed to be maintained. This requires to be addressed through redesign or re-prioritisation of local provision and the needs of the Moray population.

4.2 Community Nursing

4.2.1 Community nursing is overspent by £0.016m due to cumulative cost pressure of maintaining staffing cover throughout Moray.

4.3 Learning Disabilities

4.3.1 The Learning Disability service is underspent by £0.036m to the year-end. The underspend is primarily due to staffing (£ 0.155m) that has existed throughout this financial year, mainly relating to physiotherapy and psychology services. This is being reduced by overspends on the purchase of care for people with complex needs (£0.119m), including young people transferring from Integrated Children's services and people supported to leave hospital.

4.4 Mental Health

4.4.1 Mental Health services is overspent by £0.187m at the year end. This includes senior medical locum staff costs (£0.057m), nursing and other staff (£0.055m), supplies and equipment (£0.053m) and an efficiency target yet to be achieved (£0.075m). This is being reduced by underspends in the purchasing of care (£0.053m). Services have continued to be delivered where funding has been reduced or withdrawn and further costs are being incurred as a consequence of the regrading of two staff members.

4.5 Care Services Provided in-house

4.5.1 Care services provided in-house are underspent by £0.027m at the year-end. There are numerous variances within this budget heading, the most significant are primarily due to staffing and income recovery. Staffing includes underspends for care at home (£0.098m), independent living service (£0.012m) and an overspend for Taigh Farrais (£0.015m). There is an under recovery of income for care at home (£0.054m), community support workers (£0.022m), Taigh Farrais (£0.033m), Barlink (£0.020m), which is reduced by an increase of income from day services (£0.016m). Other underspends relate to transport (£0.021m), Maybank repairs budget (£0.015m) as this service will be moving to new facility in 2017/18 and other minor underspends (£0.009m). The Taigh Farrais respite unit is currently being reviewed and will be subject to a future report to this Board.

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

4.6.1 This budget is overspent by £0.235m at the end of the year. The year end position includes an over spend for domiciliary care in the area teams (£0.298m) and the year-end bad debts provision (£0.047m).This is reduced by an underspend in permanent care (£0.085m) and an over achievement of income within this area (£0.024m). The variances within this overall budget heading reflect the shift in the balance of care to enable people to remain in their homes for longer.

4.7 Intermediate Care & Occupational Therapy

4.7.1 This budget is overspent by £0.161m at the end of the year, this primarily relates to overspends on aids & adaptations (£0.096m), year-end stock adjustment (£0.030m), community alarm and telecare equipment (£0.020m) and other minor variances (£0.015m) to facilitate people remaining in their own home.

4.8 Care Services Provided by External Contractors

4.8.1 This budget is showing an under spend of £0.192m at the end of the financial year. This primarily relates to underspends on mental health contracts (£0.033m), a one off underspend where a provider has ceased trading (£0.058m), learning disability contracts (£0.087m) and an over achievement of income (£0.067m), which is being reduced by the over spend on Moray training (£0.053m).

4.9 Other Community Services

4.9.1 This budget is overspent by £0.048m at the year end. This is due to overspends in dental services (£0.027m), specialist nurses (£0.025m), allied health professionals (£0.024m) and pharmacy service (£0.011m), which is being reduced by an underspend in public health (£0.039m).

4.10 Administration & Management

4.10.1 There is an underspend of £0.117m at the end of the year. This predominantly relates to an underspend in the business support unit (£0.200m) including underspend on community pharmacist services. This is being reduced by overspends in admin & management (£0.035m), audit fee (£0.020m), service strategy (£0.013m), Chief officer costs (£0.010m) and other minor variances (£0.005m).

4.11 Primary Care Prescribing

4.11.1 The primary care prescribing budget is reporting an actual over spend of £0.416m for the twelve months to March 2017 after final adjustment following receipt of March's actual prescribing information at the end of May. The average unit cost per item prescribed varies and increased from £11.08 in March to £11.37 in October, this fell to £11.29 in November, rose again in December to £11.44 (expected seasonal impact) and then fell to £11.23 in January.

4.12 Hosted Services

4.12.1 For Moray recharges hosted services, the position overall is an over spend of £0.059m. There are a range of services within the overall recharge which includes overspends on Sexual health, Marie Curie, Police forensic and GMED, which is reduced by underspends in Intermediate care, Diabetes & Retinal screening and HMP Grampian.

4.13 Out of Area Placements

4.13.1 This budget is underspent by £0.144m at the end of the year following disaggregation, due to the nature of the service where services required have been lower than predicted.

4.14 Improvement Grants

4.14.1 This budget was underspent by £0.039m at the year end, this is due to the Improvement grants and the timing of works as the budget was fully committed for 2016/17. This balance will need to be included in ear marked reserves as the expenditure has already been committed.

5. STRATEGIC FUNDS

5.1 Strategic Funds are additional monies given by the Scottish Government via the NHS for the MIJB, they include:

- the total Integrated Care Fund (ICF)
- Delayed Discharge (DD) Funds and
- the unallocated balance of Pressures Funding and Innovation Funding received from the Scottish Government as part of the additional £250m, to help drive the shift towards prevention and further strengthen the approach to tackling inequalities

5.2 At the year end, the Strategic Funds have slippage of £3.491m and these funding streams have been utilised in part to fund the deficit in the short term. The use of £ 0.787m to offset the core service, year-end overspend, have reduced the resources available for 2017/18 and for dealing with any additional budget pressures to £2.704m.

6. CHANGES TO STAFFING ARRANGEMENTS

6.1 At the meeting of the Board on 31 March 2016, the Financial Regulations were approved (para 11 of the minute refers). The Chief Officer was granted delegated authority to establish appropriate staffing arrangements to deliver activities within the MIJB. All changes to staffing arrangements with financial implications and effects on establishment are to be advised to the Board.

6.2 Changes to staffing arrangements dealt with under delegated powers for the period 1 Jan to 31 March 2017 are detailed in **APPENDIX 3.**

7 IMPACT ON 2017/18 BUDGET

7.1 The actual out-turn for the 2016/17 Core Services budget year is an overspend of £0.787m. The variances against the budget have been reviewed and classified as one-off or likely to be recurring. The overall position is summarised below:

Area	Para Ref	Recurring	Non Recurring
		£m	£m
OVERSPEND			
Staff	8.2	(0.520)	(0.312)
Purchasing of Care	8.3	(0.440)	(0.040)
Income	8.4	(0.311)	(0.103)
Supplies & Services	8.5	(0.637)	(0.049)
Property costs		(0.015)	0
Client transport	8.6	(0.112)	0
Aids & Adaptations	8.7	(0.022)	(0.126)
Other		(0.064)	(0.063)
Sub-total		**(2.121)**	**(0.693)**
UNDERSPEND			
Staff	8.2	0.126	0.380
Purchasing of Care	8.3	0.153	0.230
Income	8.4	0.164	0.073
Supplies & Services	8.5	0.312	0.382
Property costs		0.009	0.022
Client transport	8.6	0.024	0.005
Aids & Adaptations	8.7	0	0.067
Other		0.006	0.074
Sub-total		**0.794**	**1.233**
TOTAL		**(1.327)**	**0.540**
Net Overspend			**(0.787)**

7.2 Staff turnover can incur both under and overspends. Underspends can be attributed by the process of recruitment, which adds a natural delay, with posts being filled by new staff at lower points on the pay scale and in some circumstances the nature of the positions have been challenging to recruit to. The Council has recognised this turnover and had set as part of the budget process a vacancy factor saving, which has been met for numerous years. Overspends can be due to the use of bank staff to provide required cover for vacancies/sickness and from the historic incremental drift and efficiency targets imposed. £0.100k of recurring staff underspend has been earmarked as a budget saving for 2017/18. Additional control measures for recruitment have been put in place for 2017/18 to ensure all vacancies are reviewed before being recruited to.

7.3 The purchasing of care overspend relates to the purchase of domiciliary care by the area teams and the underspend relates to care in a residential setting. The demographics show that Moray has an ageing population and the spend on external domiciliary care has seen growth of 18% in the number of care packages in 2016/17, this also reflects the shift in the balance of care to enable people to remain in their own homes for longer.

7.4 The under recovery of income budgets is apparent across a number of service headings, this is potentially due to the introduction of the contribution policy and the tier 2 entry into care. This will be fully investigated during 2017/18. It is very difficult to predict the level of income accurately. The recurring overspend also includes the historic income budget for Moray Training.

7.5 Supplies and services overspend relates mainly to prescribing drug costs. Further costs relate to purchases of medical supplies, medical equipment and maintenance cost of equipment.

7.6 Client transport costs are overspent in numerous service headings, which is due to increased costs for fuel and hire, which is expected to continue. Managers are continuing to monitor these budgets.

7.7 Aids and adaptations were overspent in 2016/17 but Service managers do not expect this to continue. Additional management interventions, controls and procedures have been put in place for 2017/18.

7.8 The financial results for 2016/17 show that underlying financial pressures on both the NHS and Council budgets remain, with the MIJB assuming responsibility for the budgets of the delegated functions and are expected to prioritise services within the budgets directed to it by Moray Council and NHS Grampian. The 2017/18 budget is subject to a more detailed report on this Board's agenda.

7.9 Facilitated discussion and brainstorming sessions have taken place to assist budget managers in exploring their areas of budget responsibility within the context of integration and potential service redesign. It is important at this stage to provide the enablers that will allow individuals to be innovative and creative in their thought processes in order to achieve the maximum potential from these sessions without restriction. From these discussions a structured approach will be taken to developing the issues and ideas that have been raised in order to address the budget challenges that are emerging**.**

8. SUMMARY OF IMPLICATIONS

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

This report is consistent with the objectives of the Moray 2026 and includes 2016/17 budget information for services included in IJB in 2016/17.

(b) Policy and Legal

There are no policy or legal implications in this report.

(c) Financial implications

The unaudited financial outturn for 2016/17 for the IJB core budgets is £0.787m overspend. The financial details are set out in sections 3-7 of this report and in **APPENDIX 1**.

The estimated recurring overspend of £1.327m, as detailed in para 8 will impact on the 2017/18 budget.

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

(d) Risk Implications and Mitigations

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

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

The year-end overspend is not unexpected but gives cause for concern going forward. The reserves of £ 2.704m will be required to help balance the budget for 2017/18, but this is a one off windfall. Savings will be required to be found in order for the MIJB to be able to sustain a stand still budget and cover the budget pressures from 2018/19 onwards.

(e) Staffing Implications

There are no direct implications in this report but Appendix 3 summarises staffing decisions that have been implemented through delegated authority to the Chief Officer.

(f) Property

There are no direct implications in this report.

(g) Equalities

There are no equality implications in this report

(h) Consultations

The Chief Officer, the Senior Management Team and the Finance Officers from the Community Health Partnership and Moray Council have been consulted and their comments have been incorporated in this report.

9. CONCLUSION

9.1 This report identifies Moray IJB's unaudited final out-turn position on the Core Budget of an overspend of £0.787m at 31 March 2017 and identifies major areas of variance between budget and actual for 2016/17.

9.2 The finance position to 31 March 2017 includes the changes to staffing under delegated authority, as detailed in APPENDIX 3.

9.3 The impact of the provisional outturn on the 2017/18 budget, of a recurring overspend of £1.327m is detailed in paragraph 8.

Author of Report: D O'Shea Principal Accountant (TMC) & B Sivewright Finance Manager (NHSG)
Background Papers: Papers held by respective Accountancy teams
Ref: DOS/LJC/213-2876/239-2023/239-2025 /239-2033

Signature: Date: 21 June 2017

Designation: Chief Financial Officer Name: Margaret Wilson

APPENDIX 1

MORAY INTEGRATED JOINT BOARD

JOINT FINANCE REPORT APRIL 2016 - MARCH 2017

		Para Ref	Indicative Annual Net Budget £000's	Annual Net Budget £000's 2016-17	Budget (Net) To Date £000's	Actual &Comm To Date £000's	Variance £000's	Most recent Forecast £000's	Variance To Budget £000's	Forecast Variance %
	Community Hospitals	4.1	7930	5,301	5,301	5,520	(219)	5,485	(184)	(3)
	Community Nursing	4.2		3,638	3,638	3,653	(16)	3,597	41	1
	Learning Disabilities	4.3	4693	5,325	5,325	5,288	36	5,414	(89)	(2)
	Mental Health	4.4	7130	7,218	7,218	7,405	(187)	7,418	(200)	(3)
	Addictions		1264	825	825	823	2	825	0	0
	Adult Protection & Health Improvement		190	174	174	165	9	172	2	1
	Care Services provided in-house	4.5	13834	13,074	13,074	13,047	27	13,239	(165)	(1)
	Older People & PSD Services	4.6	15901	16,032	16,032	16,267	(235)	16,288	(256)	(2)
	Intermediate Care & OT	4.7	15901	1,468	1,468	1,629	(161)	1,496	(28)	(2)
	Care Services provided by External	4.8	9351	10,137	10,137	9,945	192	10,072	65	1
	Other Community Services	4.9	7058	7,121	7,121	7,169	(48)	7,065	56	1
	Admin & Management	4.10	3710	2,821	2,821	2,703	117	2,780	40	1
	Primary Care Prescribing	4.11	16590	16,888	16,888	17,304	(416)	17,346	(458)	(3)
	Primary Care Services		13270	14,878	14,878	14,890	(12)	14,891	(13)	(0)
	Hosted Services	4.12	3891	3,623	3,623	3,681	(59)	3,678	(55)	(2)
	Out of Area	4.13		669	669	525	144	535	134	20
	Improvement Grants	4.14		969	969	930	39	969	0	0
	Total Moray IJB Core		103,548	110,159	110,159	110,946	(787)	111,269	(1,110)	8
	Strategic Funds	5.2	3570	4,366	4,366	874	3,491	2,321	2,045	47
	Total Moray IJB Including Strategic fund bala		**107,118**	**114,525**	**114,525**	**111,821**	**2,704**	**113,590**	**935**	**55**

APPENDIX 2

Description of MIJB Core Services

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

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

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

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

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

6. Adult Protection and Health Improvement

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX 2

Other definitions:

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

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

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

APPENDIX 3

HEALTH & SOCIAL CARE MORAY

DELEGATED AUTHORITY REPORTS - PERIOD JANUARY 2017 – MARCH 2017

Title of DAR	Summary of Proposal	Post(s)	Permanent/ Temporary	Duration (if Temporary)	Effective Dates	Funding
Shared Lives – Provider Services	Move service from Commissioning Services to Provider Services	1 x fte	Permanent	Permanent	January 17	N/A
LD Team Changes	Delete vacant 0.44 CCO post and transfer hours to increase SW post to 34 hrs	0.44 fte CCO,	Permanent	Permanent	January 17	No impact as hours from deleted post equate to increase to 34 hrs/pw
Public Involvement Officer	Post split 50/50 between MADP and Commissioning. Trf 50% from MADP to commissioning but budget to stay in MADP	1 x fte Grade 8	Permanent	Permanent	January 17	Funding on recurring basis from the Integrated Care Fund £15k

REPORT TO: **INTEGRATION JOINT BOARD ON 29 JUNE 2017**

SUBJECT: **PERFORMANCE REPORT – DELAYED DISCHARGES**

BY: **GARETH WILLIAMS, PERFORMANCE OFFICER**

1. REASON FOR REPORT

1.1 To present an update on delayed discharges and length of stay within Moray, in relation to figures recorded nationally and reporting due around the issues of Delayed Discharges.

2. RECOMMENDATION

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

i) scrutinise and note the population within localities outlined in this report in relation to the rates of delayed discharges and length of stay within Moray; and

ii) consider and note the localities as a whole within Grampian, accounting for distribution of delays within community hospital where the Moray Partnership requires action.

3. BACKGROUND

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

3.2 The Strategic Plan makes reference to the national suite of core indicators and a range of locally generated indicators with the intention of supporting a continuous improvement approach in relation to the delivery of health and social care services in Moray.

3.3 The purpose of this exception performance report is therefore to provide an overview of the level of performance for the Moray Health & Social Care Partnership for the period (starting Q3 2013 for Home Care) to 30 June 2016 where Data is available.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 This report will make reference to the performance data pertaining to the Suite of Core Indicators (**Appendix 1**).

4.2 The Board will note that data relating to these measures is not complete. The reasons for this are that some of the measures relate to data that will be

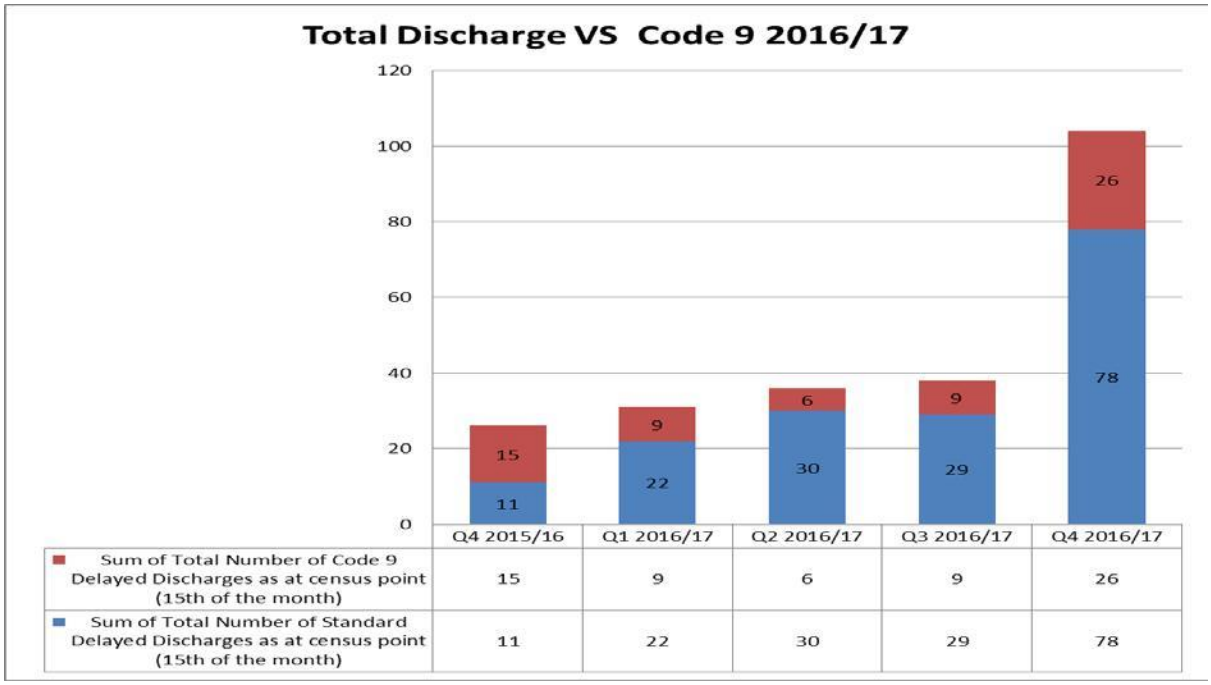
collected on an annual basis by the Scottish Information Services Division, while others are still in development.

4.3 Where appropriate and available, proxy data is however provided from Moray's own information management systems which will refer to a subset of a range of locally generated performance indicators where exceptions have been noted (**Appendix 2**). These indicators are the basis of the joint performance management reports submitted for consideration to the Operational Management Team.

4.4 The following section of this report will highlight areas of health and social care delivery that are highlighted as an exception and are identified for improvement.

4.5 **Exception – Delayed Discharge**

4.5.1 The number of people waiting to be discharged from hospital when they are ready (**Delayed Discharges**) peaked within Q4 2016/17. This is due to recording timeframes of 72 hours being implemented, and as a result the incidents appear to have increased.



4.5.2 Code 9 was introduced for very limited circumstances where NHS Chief Executives and local authority Directors of Social Work (or their nominated representatives) could explain why the discharge of patients was out with their control. These include patients delayed due to awaiting place availability in a high level needs' specialist facility where no facilities exist and where an interim option is not appropriate, patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation.

4.5.3 While addressing the increase in Code 9s it is worth noting that the increased complexity of conditions and guardianship cases have resulted in individuals

staying as a delayed discharges for longer. Moray is seeing an increase in code 9's rolling over to consecutive reporting periods and this is directly affecting the true number of monthly discharges.

4.5.4 The increase in Q4 2016/17 of Delayed Discharges has resulted in discussion and planning between the senior management team and has resulted in process planning for discharges.

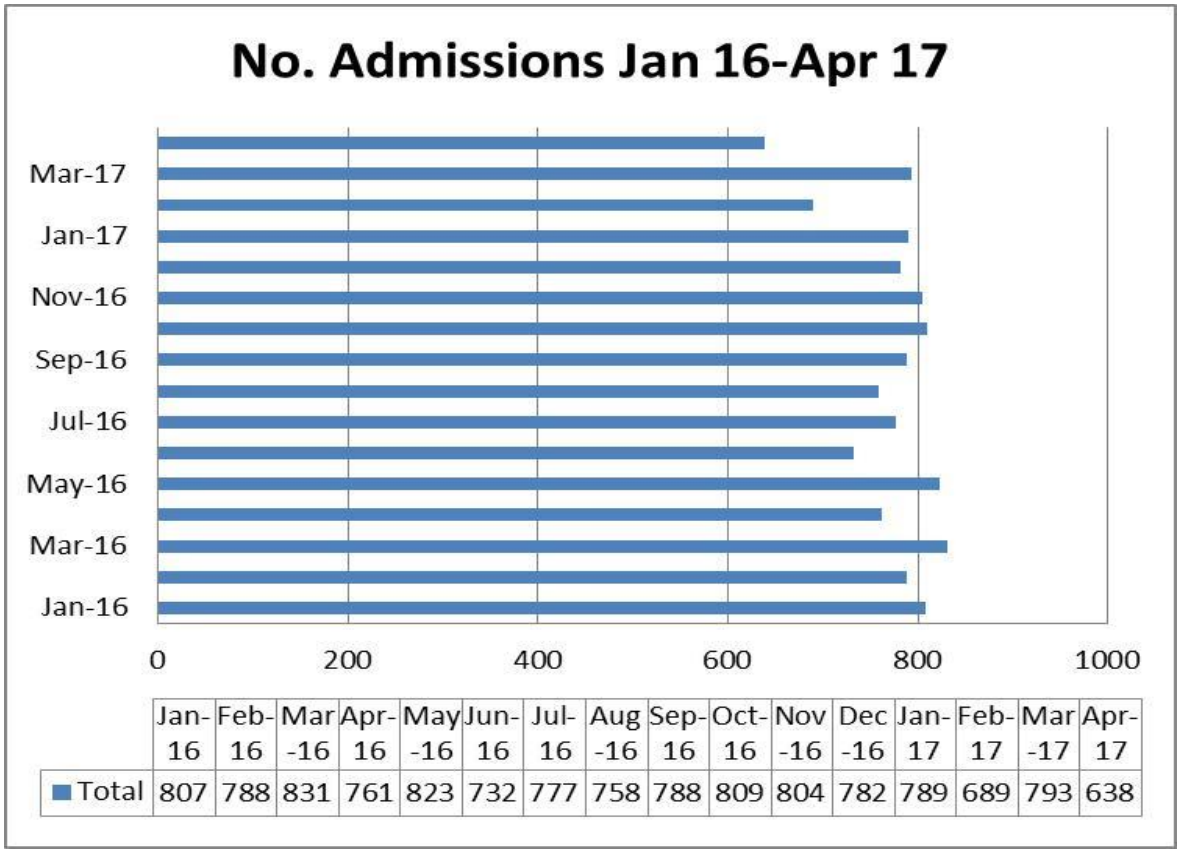
4.5.5 The Delayed Discharges commencing the week 5 June 2017 was recorded at 44, inclusive of 11 code 9's.

4.5.6 When further investigated the discharges recorded were not a true representation of the numbers and activity within Moray;

- 5 delays had already been discharged.
- 5 individuals were not in a position to be discharged and should not have been on the system.
- 8 individuals were awaiting care pathways already agreed.

4.5.7 Considering the findings of 4.5.5 and including the 11 code 9 individuals, the remaining number of discharges for the week of 5 June would be recorded at 15 standard delays.

4.5.8 Supportive action is being taken to ensure that individuals are discharged in a timely manner on the system as well as operationally; and a measure of consideration given to individuals that may be considered as not ready for discharge.



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Total	807	788	831	761	823	732	777	758	788	809	804	782	789	689	793	638

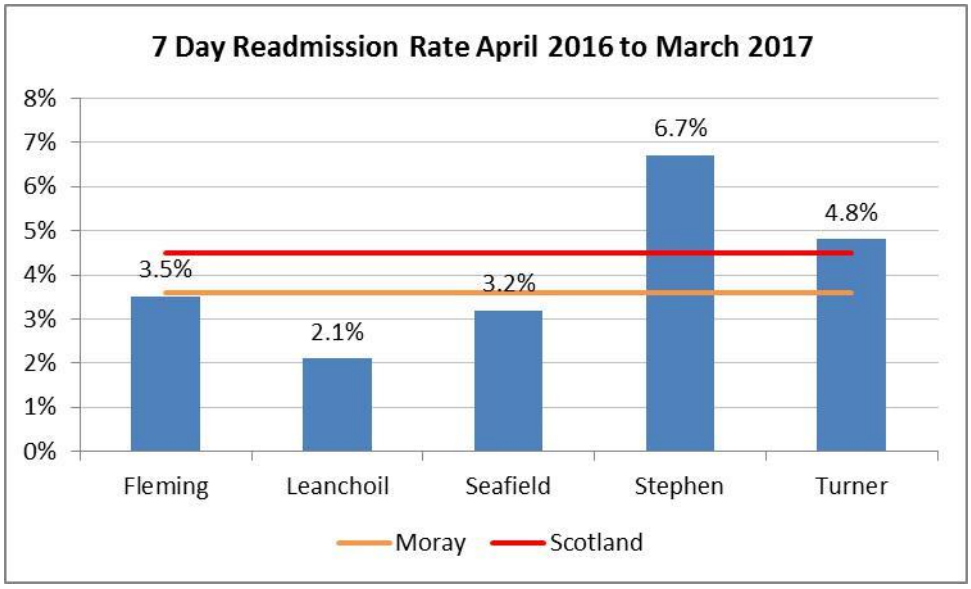
4.5.9 Homecare has been reported as well coordinated and delivered within Moray, scoring 77% over the national average of 75% within Scotland. There has been a major shift within the delivery of home care, staff are now working with increased flexibility and availability rather than working fixed packages.

4.5.10 The independent living service has moved away from home care as a separate focus and as a result there is more focus on home care with people being able to select their own delivery. This is all reflected positively despite the increasing amounts of double up delivery needed within the community, due to the increasing needs and complexity of individuals receiving care at home.

4.5.11 The number of admissions is currently lower than recorded over the last twelve months, evidences increased activity within the community setting and reflects positively in this manner.

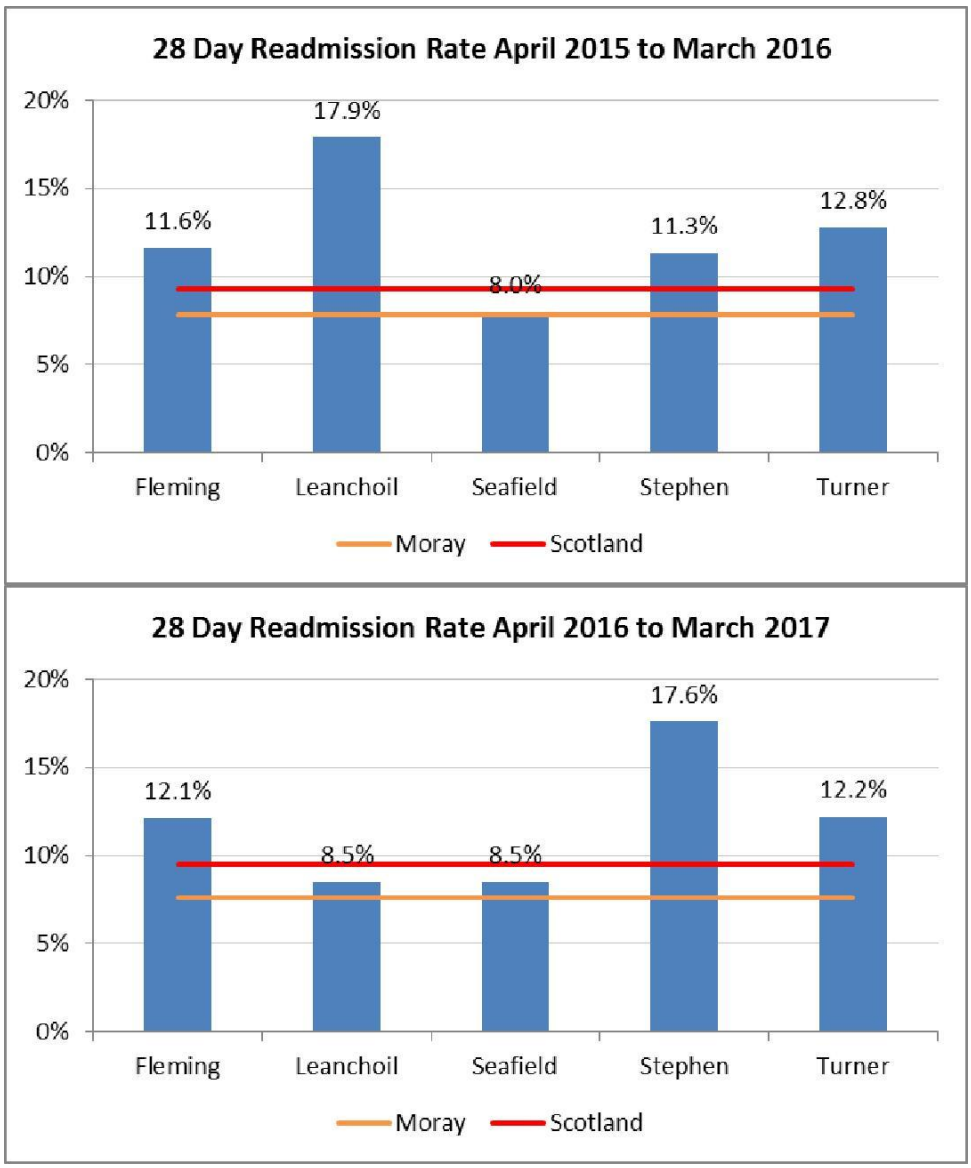
4.6 **Exception – Readmission Rate and Length of Stay**

4.6.1 The rate of readmission over 7days (**Appendix 2**) has decreased over the 12 month period from 15/16 – 16/17. With reference to 4.5.3 the decrease in readmission rates can be reflected by action taken within community care; delivery of previously reported planning and implementation.



4.6.2 The rate of readmission over 7 days within Community Hospitals has seen a reduction of most rates by almost 50%.

The only hospital to have remained static is Stephen hospital, previously recorded at 6.7% also for 2015/16. The greatest reduction over this twelve month period has been Leanchoil; the rate of 7 day readmission has reduced from 6% to 2.1%



4.6.3 In comparison the readmission rate for 7 day readmission is closer to the Scottish average, when compared to the 28 day readmission rate.

4.6.4 Included within this exception report is the data from 2015/16 and 2016/17. This is to draw comparison to the shift in 28 day readmission rates.

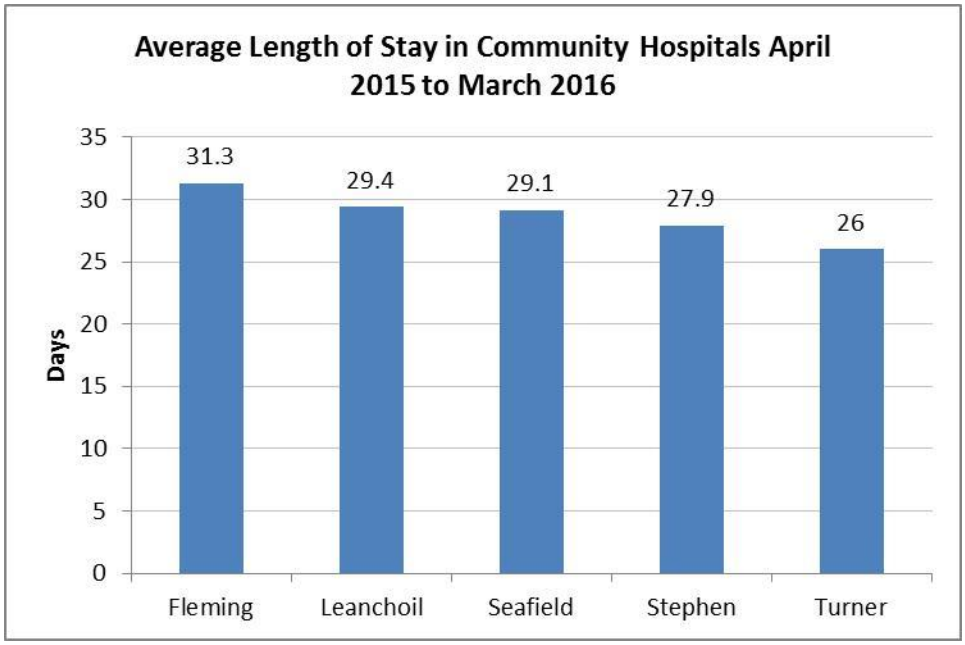
In 2015/16, Fleming and Leanchoil had the highest rate of 28 day readmissions within Moray.

As of 2016/17 there has been a reduction of 28 day readmissions within Fleming and Leanchoil, however the rates have now increased within Stephen and Turner.

4.6.5 In further analysis looking specifically to understand the shift in readmissions the data should be considered as presented in the following table:

28 Days	Fleming	Leanchoil	Seafield	Stephen	Turner
Q1 1617	4	1	7	6	5
Q2 1617	10	1	7	3	5
Q3 1617	4	2	6	9	7
Q4 1617	6	0	4	3	6

4.6.6 With reference to 4.6.5 and the above table of 28 day readmissions per quarter, the picture becomes clear that due to low numbers within Moray and presentations at individual hospitals, a slight increase can impact upon total percentages and cause concern due to inflation of data.



4.6.7 Current Length of Stay as an average for 2016 to 2017 highlights a 5 day difference between Leanchoil (40.6) and Stephen (30) as the highest and lowest rates.

Average Length of Stay (Days)					
	Fleming	Leanchoil	Seafield	Stephen	Turner
Mar-16	18.1	4.0	23.8	18.4	23.6
Apr-16	37.7	58.4	32.8	30.5	33.2
May-16	43.6	24.0	16.8	26.4	65.4
Jun-16	14.7	37.6	38.7	24.6	30.1
Jul-16	18.5	55.0	23.0	43.8	37.6
Aug-16	48.0	52.8	31.0	67.5	48.0
Sep-16	40.1	20.0	25.7	12.7	28.6

Oct-16	13.5	46.3	44.1	18.6	23.1
Nov-16	20.4	59.9	32.4	18.0	27.3
Dec-16	27.7	22.5	38.8	22.4	29.1
Jan-17	18.5	64.0	38.2	36.2	34.6
Feb-17	82.8	43.0	27.5	41.0	32.8
12 Month Average	32.0	40.6	31.1	30.0	34.5

4.6.8 With reference to readmissions and taking the 28 day rate as a comparison;

- Leanchoil has a higher number recorded for length of stay over this twelve month period
- The rate of 28 day readmission has decreased within Leanchoil over this same period.
- Stephen hospital has resulted in the lowest length of stay but has increased its rate of readmission over 28 days.

The process for stay and readmission is being considered using Leanchoil and Stephen as benchmarks for improvement.

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 makes reference to a range of the same indicators that inform the Moray 2026. A Plan for the Future priority area; 'adults living healthier, sustainable independent lives safeguarded from harm'. The indicators referred to in this report will also be used to inform the Moray Health and Social Care Partnership Annual Report 2016/17.

(b) Policy and Legal

The submission of this quarterly report complies with the requirements of the Moray Integration Scheme.

(c) Financial Implications

There are no financial implications directly arising from this report.

(d) Risk Implications and Mitigation

The improvement actions identified in section 4.7 of this report intend to mitigate against the risks to people accessing Moray health and social care services.

(e) Staffing Implications

There are no staffing implications directly arising from this report.

(f) Property

There are implications in terms of Council or NHS property directly arising from this report.

(g) Equalities

There are no equality issues directly arising from this report. Where appropriate, improvement actions, revised policy and procedures will be equality impact assessed.

6. CONCLUSION

6.1 This report is an exception report and therefore only notes areas that are highlighted as requiring attention.

6.2 Delayed Discharges had increased over Q4, primarily due to increased training in the system used to monitor them. Actions were undertaken to reduce this figure, which is now reflected within Q1 16/17 and performance in this area will continue to be scrutinised at a management and operational level.

Author of Report: Gareth Williams, Performance Officer, Moray Council.

Signature:  Date: 14/10/2016

Designation: Chief Officer Name: Pam Gowans

APPENDIX 1: National Indicator Data for Moray Partnership Performance Report

National Indicators 1 to 10		2011/12	2012/13	2013/14	2014/15	2015/16	Notes
NI - 1	Percentage of adults able to look after their health very well or quite well	**N/A**	**N/A**	**96%**	**N/A**	**96%**	**Source:** Scottish Health and Care Experience Survey done Biennially (Q52).
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**N/A**	**N/A**	**81%**	**N/A**	**78%**	**Source:** Scottish Health and Care Experience Survey done Biennially (Q36f).
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**N/A**	**N/A**	**73%**	**N/A**	**72%**	**Source:** Scottish Health and Care Experience Survey done Biennially (Q36b).
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**N/A**	**N/A**	**71%**	**N/A**	**77%**	**Source:** Scottish Health and Care Experience Survey done Biennially (Q36e).
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	**N/A**	**N/A**	**75%**	**N/A**	**78%**	**Source:** Scottish Health and Care Experience Survey done Biennially (Q37).
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	**N/A**	**N/A**	**85%**	**N/A**	**87%**	**Source:** Scottish Health and Care Experience Survey done Biennially (Q27).
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**N/A**	**N/A**	**73%**	**N/A**	**86%**	**Source:** Scottish Health and Care Experience Survey done Biennially (Q36h).
NI - 8	Total combined % carers who feel supported to continue in their caring role	**N/A**	**N/A**	**44%**	**N/A**	**43%**	**Source:** Scottish Health and Care Experience Survey done Biennially (Q45f).
NI - 9	Percentage of adults supported at home who agreed they felt safe	**N/A**	**N/A**	**73%**	**N/A**	**81%**	**Source:** Scottish Health and Care Experience Survey done Biennially (Q36g).

NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	**N/A**	**N/A**	**57% (NHS Grampian)**	**N/A**	**54% (Moray Council Community Care)**	**Source:** NHS Staff Survey National Report, Moray Council Employee Opinion Survey. The measures presented are not representative of the partnership as a whole and are placeholders for illustrative purposes. This PI is still in development due to various challenges in collecting the data for the whole of the Partnership. NHS data is not currently available at partnership level and work is underway to third and private sectors.
	National Indicators 11 to 23	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**Notes**
NI - 11	Premature mortality rate per 100,000 persons	**1142**	**1136.6**	**1040.7**	**1016.1**	**1121.9**	**Source:** Age-standardised Death Rates Calculated Using the European Standard Population (NR Scotland)
NI - 12	Emergency admission rate (per 100,000 population)	**7,796**	**7,443**	**7,659**	**7,830**	**7,654**	**Source:** Inpatient and Day Case Activity (ISD Scotland)
NI - 13	Emergency bed day rate (per 100,000 population)	**69,734**	**59,835**	**58,887**	**62,405**	**63,766**	**Source:** Inpatient and Day Case Activity (ISD Scotland)
NI - 14	Readmission to hospital within 28 days (per 1,000 population)	**Not Yet Available**	**Not Yet Available**	**Not Yet Available**	**Not Yet Available**	**76**	**LA Level data is not available yet. Related Local Indicator:** Multiple Emergency Admissions for over 65s. See LI5.
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	**92.9%**	**93.3%**	**93.0%**	**89%**	**90%**	**Source:** Quality Outcome Measure 10: Percentage of last 6 months of life spent at home or in a community setting (ISD Scotland)
NI - 16	Falls rate per 1,000 population aged 65+	**13**	**12**	**12**	**14**	**14**	**Still in development**
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	**Not Yet Available**	**Not Yet Available**	**Not Yet Available**	**Not Yet Available**	**78%**	**Still in development**

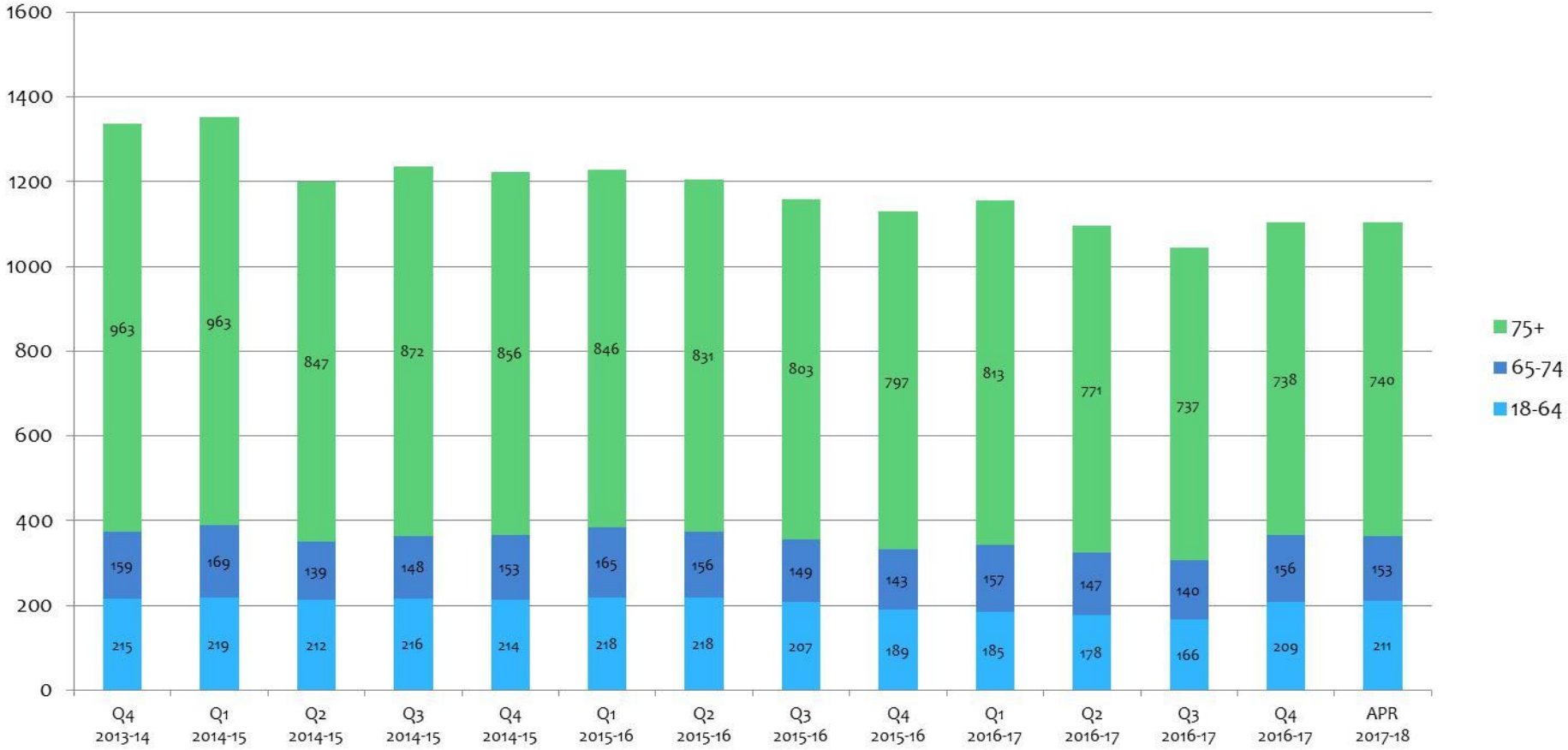
NI - 18	Percentage of adults with intensive care needs receiving care at home	**66%**	**67%**	**67%**	**66%**	**69%**	**Source:** Health and Social Care Datasets - Social Care Survey (www.gov.scot)
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**N/a**	**19**	**37**	**53**	**39**	**Source:** Delayed Discharges in NHSScotland - Occupied Bed Days (ISD Scotland)
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**19**	**19**	**19**	**20**	**20**	**Source:** ISD Scotland, awaiting signing of ISP with ISD to access Tableau.
NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	**Not Yet Available**	**Not Yet Available**	**Not Yet Available**	**Not Yet Available**	**Not Yet Available**	**Still in development**
NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	**Not Available**	**Not Available**	**Not Available**	**796 (75+ data only available)**	**764 (75+ data only available)**	**Source:** Delayed Discharges in NHSScotland - Occupied Bed Days (ISD Scotland) **Related Local Indicator:**
NI - 23	Expenditure on end of life care, cost in last 6 months per death	**Not Available**	**Not Available**	**Not Available**	**Not Available**	**Not Available**	**Source:** ISD Scotland, awaiting signing of ISP with ISD to access Tableau.

Appendix 2

Moray IJB Performance – 10th November 2016

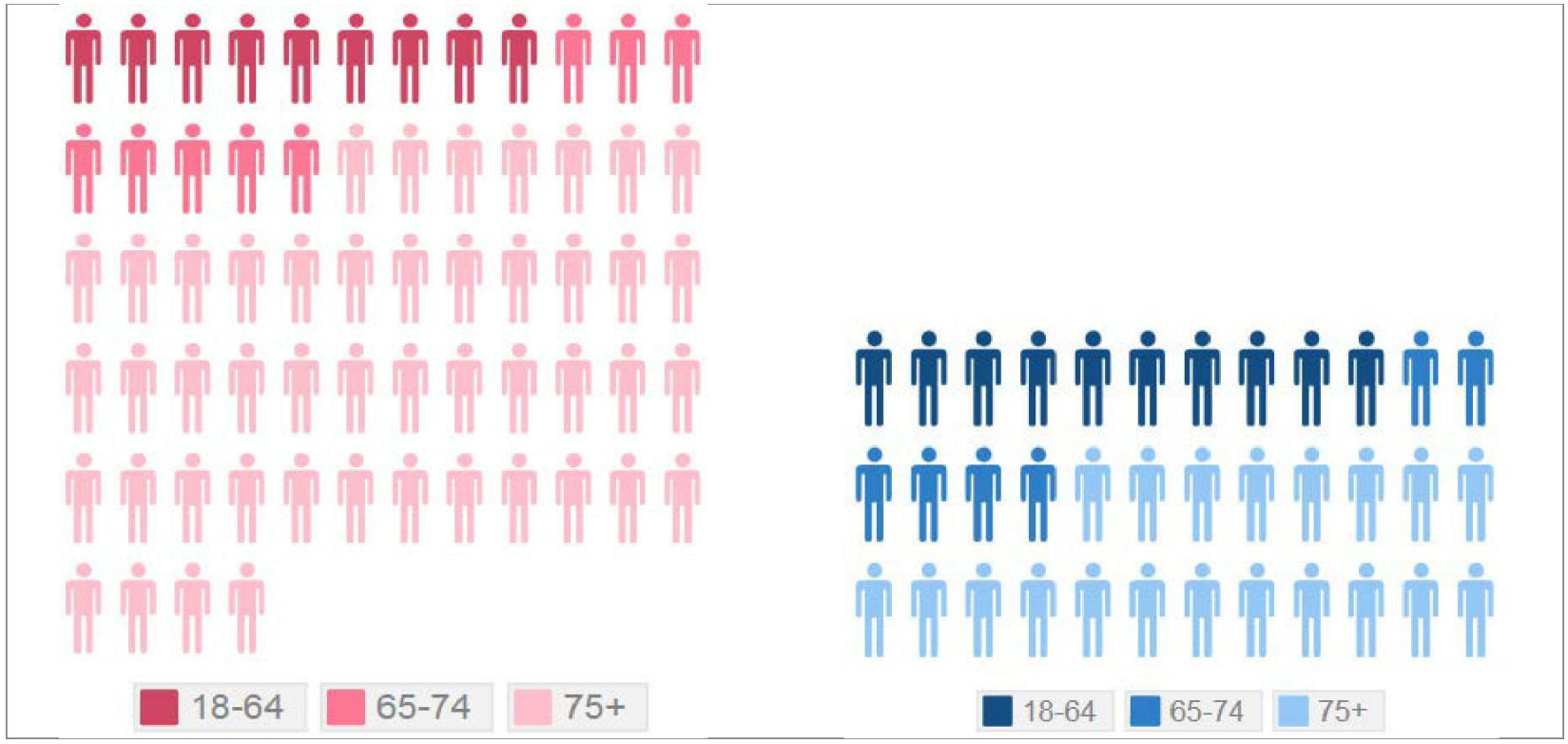
1. Home Care

1.1 All Home Care Service Users



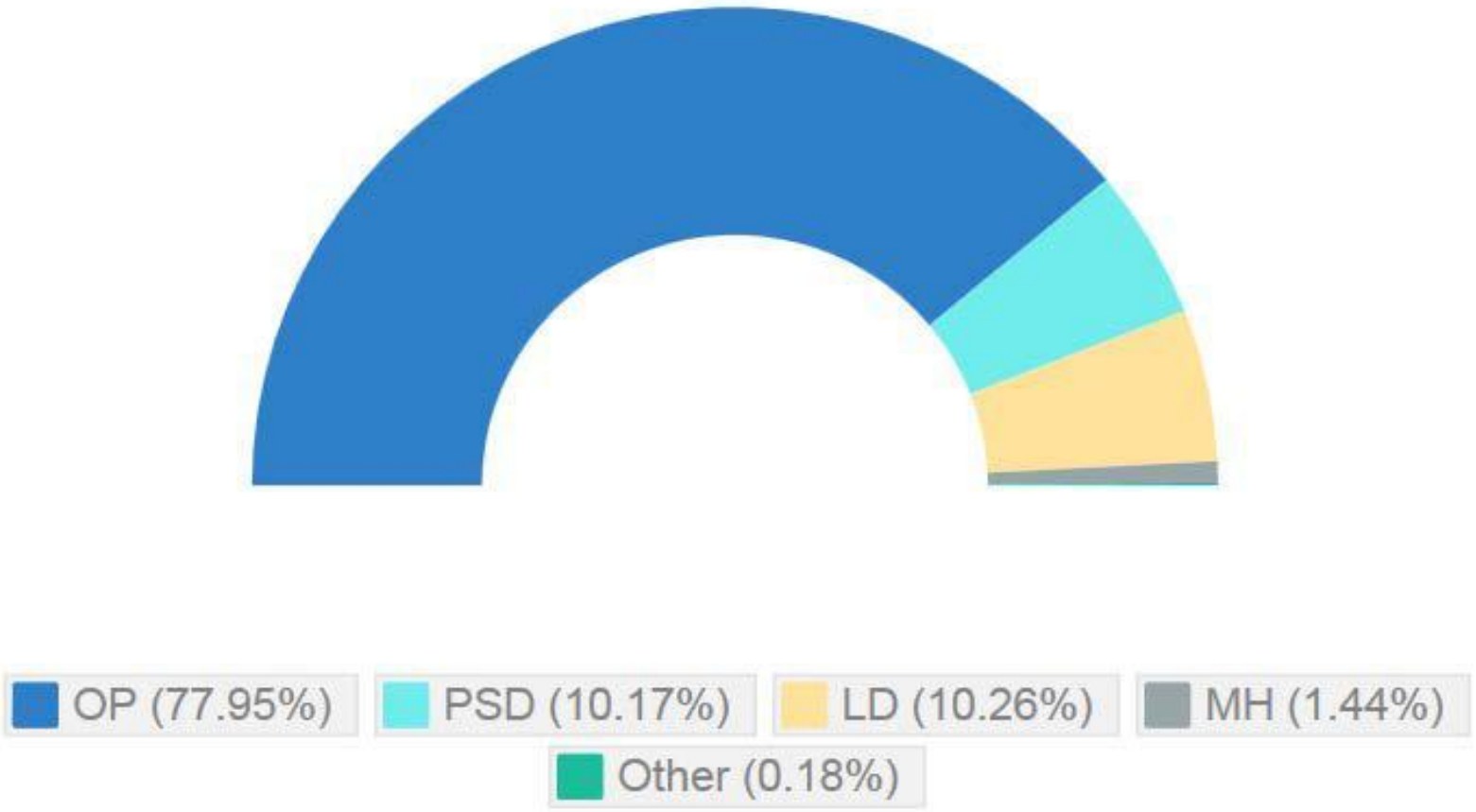
1. Home Care

1.2 All Home Care Packages by Gender (based on number of clients)



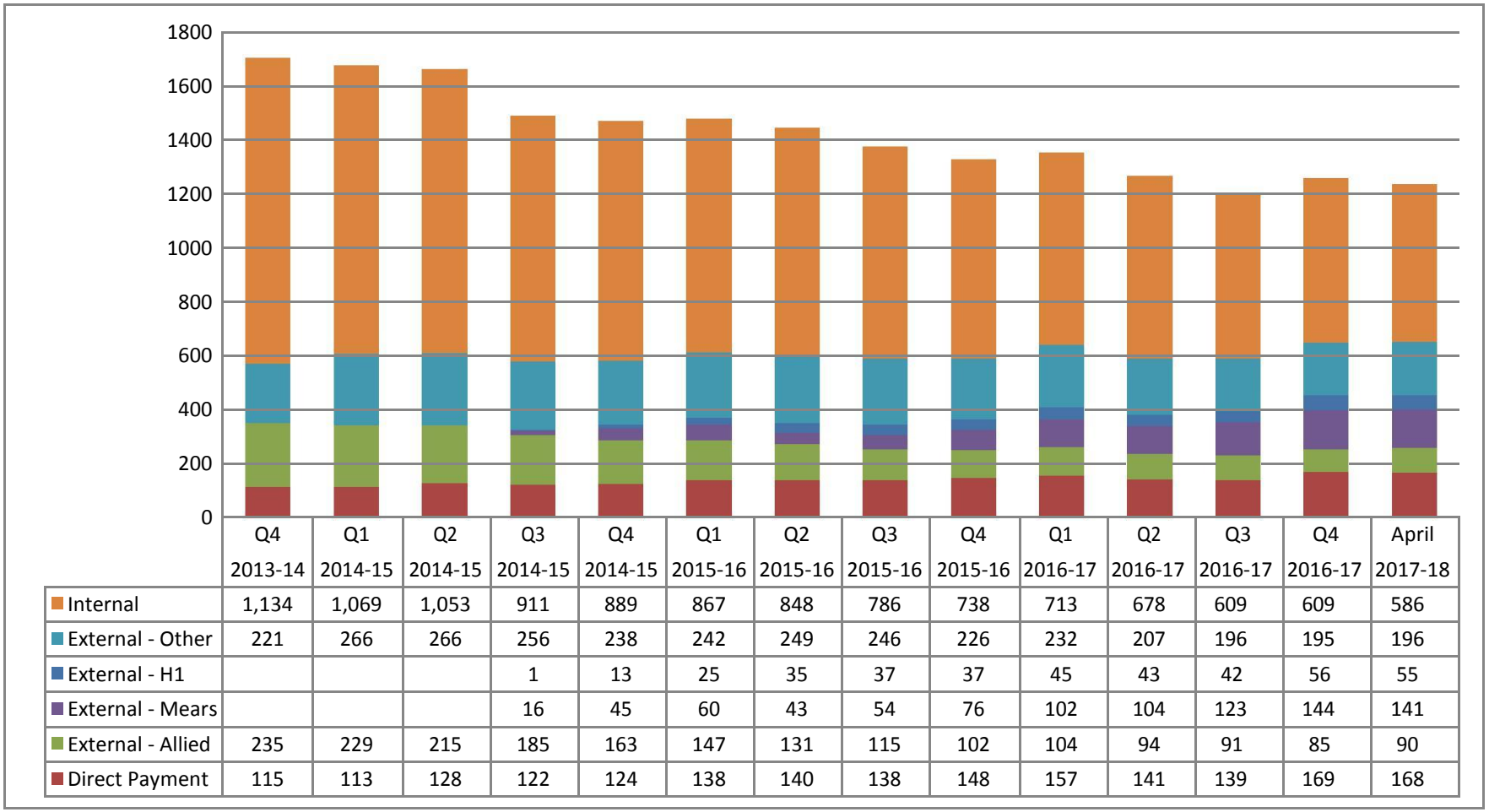
Home Care

All Home Care Client groups (Based on number of agreements)



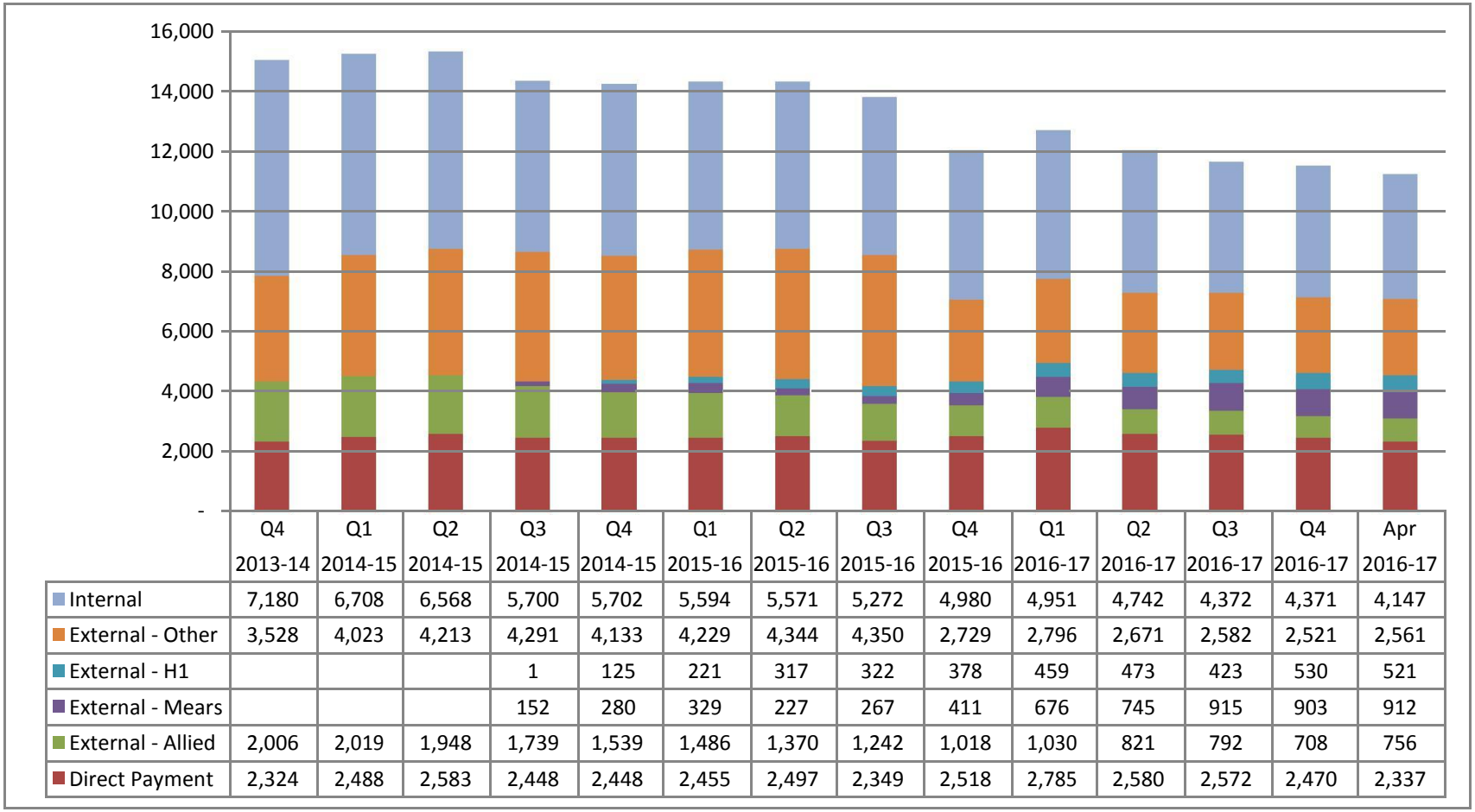
1.4 The reduction in Internal services continues.

Home Care: All Home Care Packages by Provider Type



	Q4 2013-14	Q1 2014-15	Q2 2014-15	Q3 2014-15	Q4 2014-15	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	April 2017-18
Internal	1,134	1,069	1,053	911	889	867	848	786	738	713	678	609	609	586
External - Other	221	266	266	256	238	242	249	246	226	232	207	196	195	196
External - H1				1	13	25	35	37	37	45	43	42	56	55
External - Mears				16	45	60	43	54	76	102	104	123	144	141
External - Allied	235	229	215	185	163	147	131	115	102	104	94	91	85	90
Direct Payment	115	113	128	122	124	138	140	138	148	157	141	139	169	168

Home Care: All Home Care hours by provider type

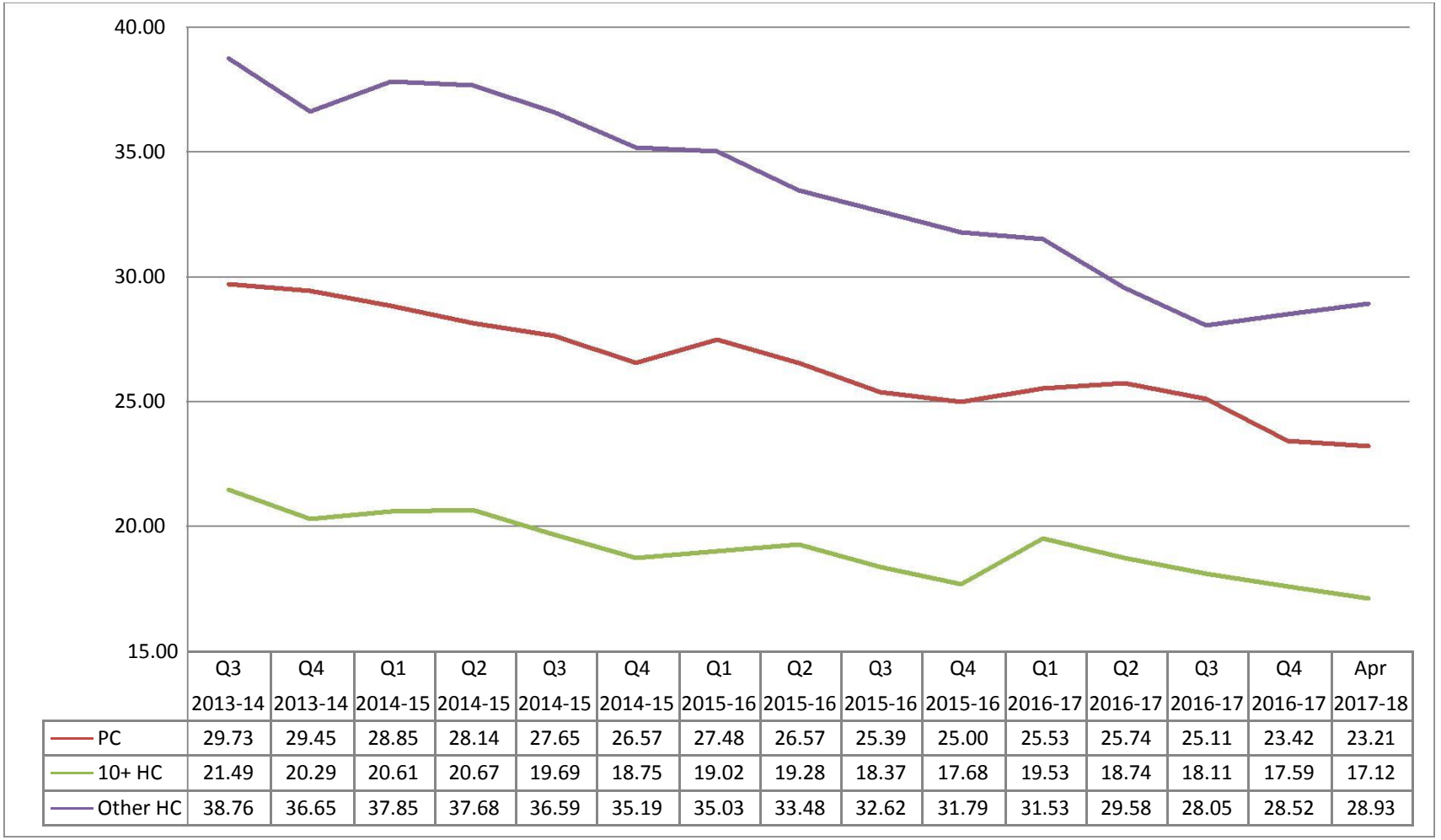


	Q4 2013-14	Q1 2014-15	Q2 2014-15	Q3 2014-15	Q4 2014-15	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Apr 2016-17
Internal	7,180	6,708	6,568	5,700	5,702	5,594	5,571	5,272	4,980	4,951	4,742	4,372	4,371	4,147
External - Other	3,528	4,023	4,213	4,291	4,133	4,229	4,344	4,350	2,729	2,796	2,671	2,582	2,521	2,561
External - H1				1	125	221	317	322	378	459	473	423	530	521
External - Mears				152	280	329	227	267	411	676	745	915	903	912
External - Allied	2,006	2,019	1,948	1,739	1,539	1,486	1,370	1,242	1,018	1,030	821	792	708	756
Direct Payment	2,324	2,488	2,583	2,448	2,448	2,455	2,497	2,349	2,518	2,785	2,580	2,572	2,470	2,337

Home Care: Service Users with 10+ Hour of All Home Care Services

	Q3 2013-14	Q4 2013-14	Q1 2014-15	Q2 2014-15	Q3 2014-15	Q4 2014-15	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	April 2017-18
75+	320	305	313	321	302	302	297	305	288	282	310	296	289	281	275
65-74	63	67	65	58	58	58	57	59	55	54	61	60	55	60	57
18-64	99	104	104	107	105	107	111	117	113	105	99	100	94	105	102

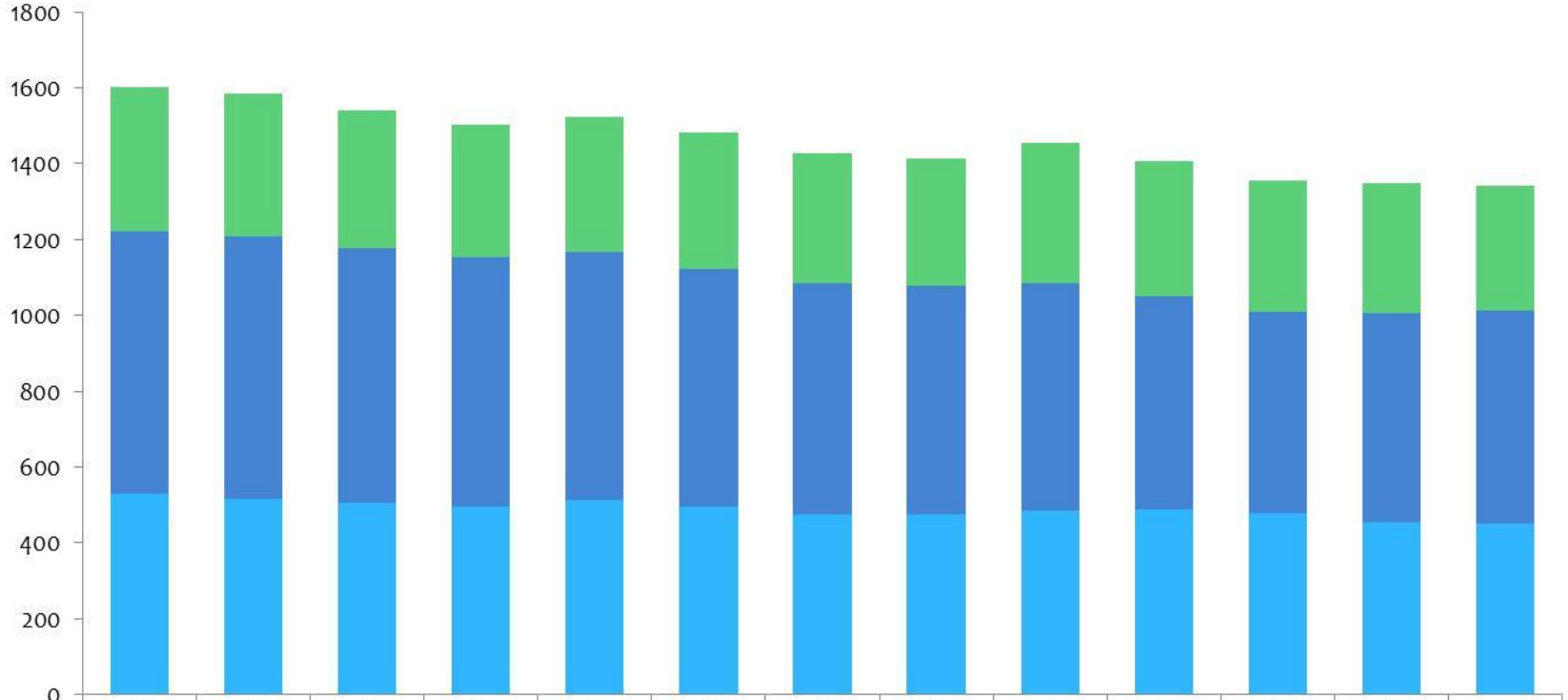
Permanent Care: 65+ Perm Care vs Home Care



	Q3 2013-14	Q4 2013-14	Q1 2014-15	Q2 2014-15	Q3 2014-15	Q4 2014-15	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Apr 2017-18
PC	29.73	29.45	28.85	28.14	27.65	26.57	27.48	26.57	25.39	25.00	25.53	25.74	25.11	23.42	23.21
10+ HC	21.49	20.29	20.61	20.67	19.69	18.75	19.02	19.28	18.37	17.68	19.53	18.74	18.11	17.59	17.12
Other HC	38.76	36.65	37.85	37.68	36.59	35.19	35.03	33.48	32.62	31.79	31.53	29.58	28.05	28.52	28.93

2.2 – Historically there is an increase in PC in Q1 but so far this trend is not evident with a low of 450.

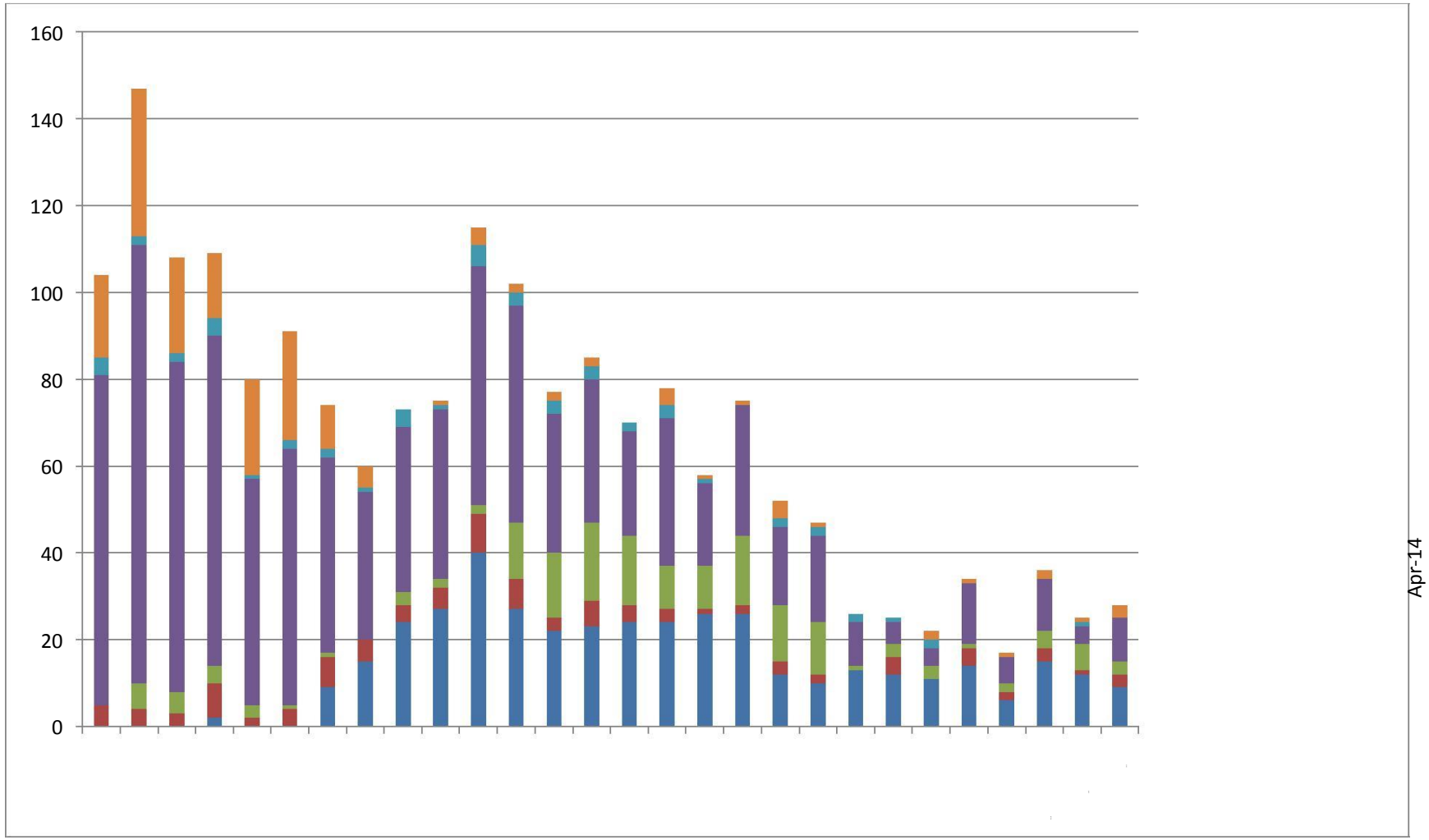
Permanent Care: 65+ Perm Care vs Home Care

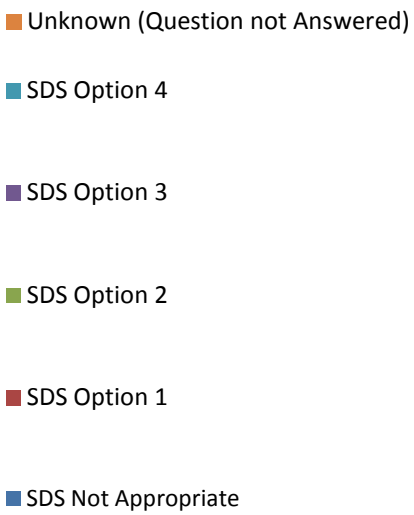


	Q1 2014-15	Q2 2014-15	Q3 2014-15	Q4 2014-15	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Apr 2017-18
10+ HC	378	379	361	350	355	360	343	336	371	356	344	341	332
Other HC	694	691	671	657	654	625	609	604	599	562	533	553	561
PC	529	516	507	496	513	496	474	475	485	489	477	454	450

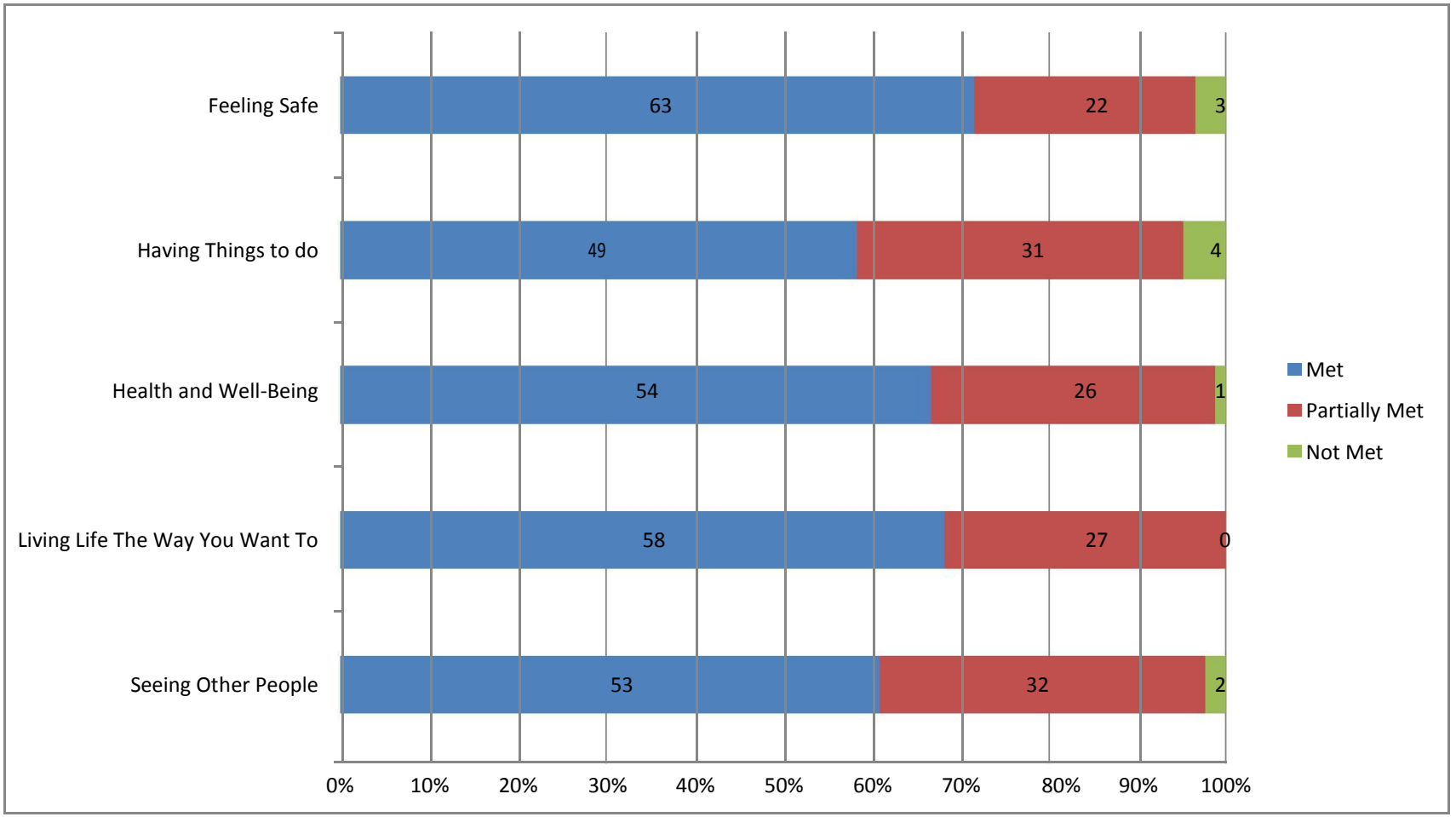
4.1 – Investigation into Tier 2 and SDS, for discussion.

Self Directed Support

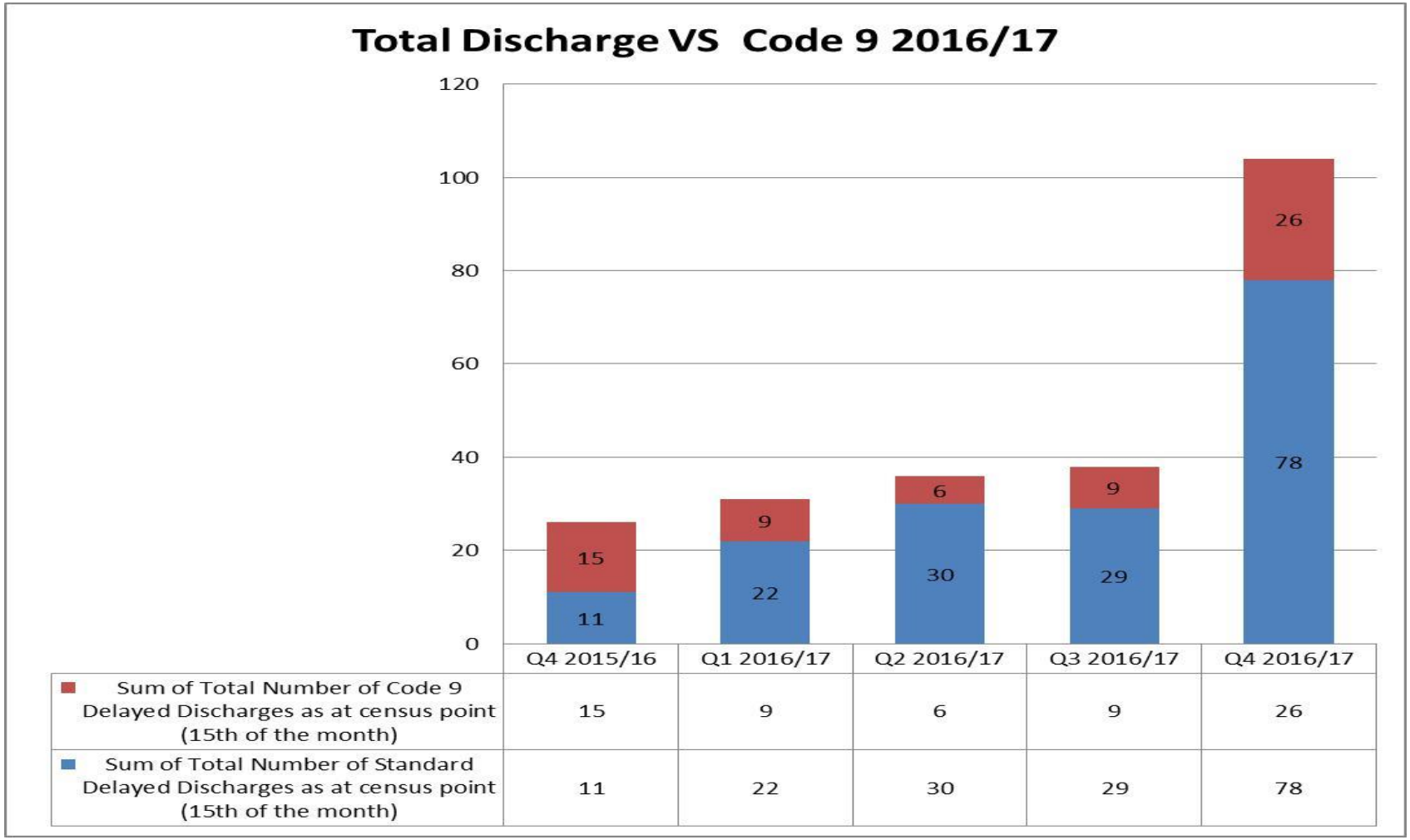



Unknown (Question not Answered)
SDS Option 4
SDS Option 3
SDS Option 2
SDS Option 1
SDS Not Appropriate

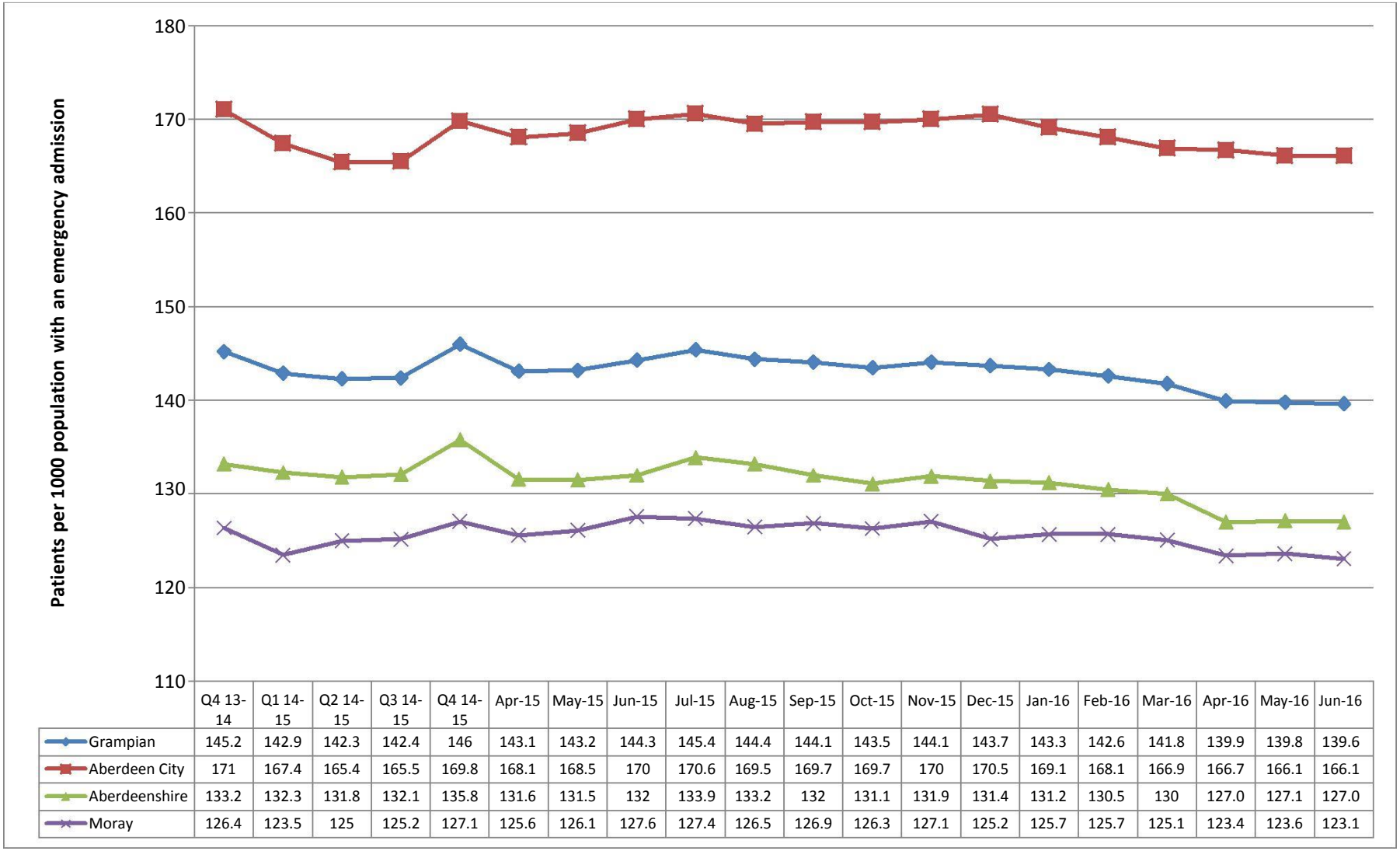
Personal Outcomes



10. Delayed Discharge

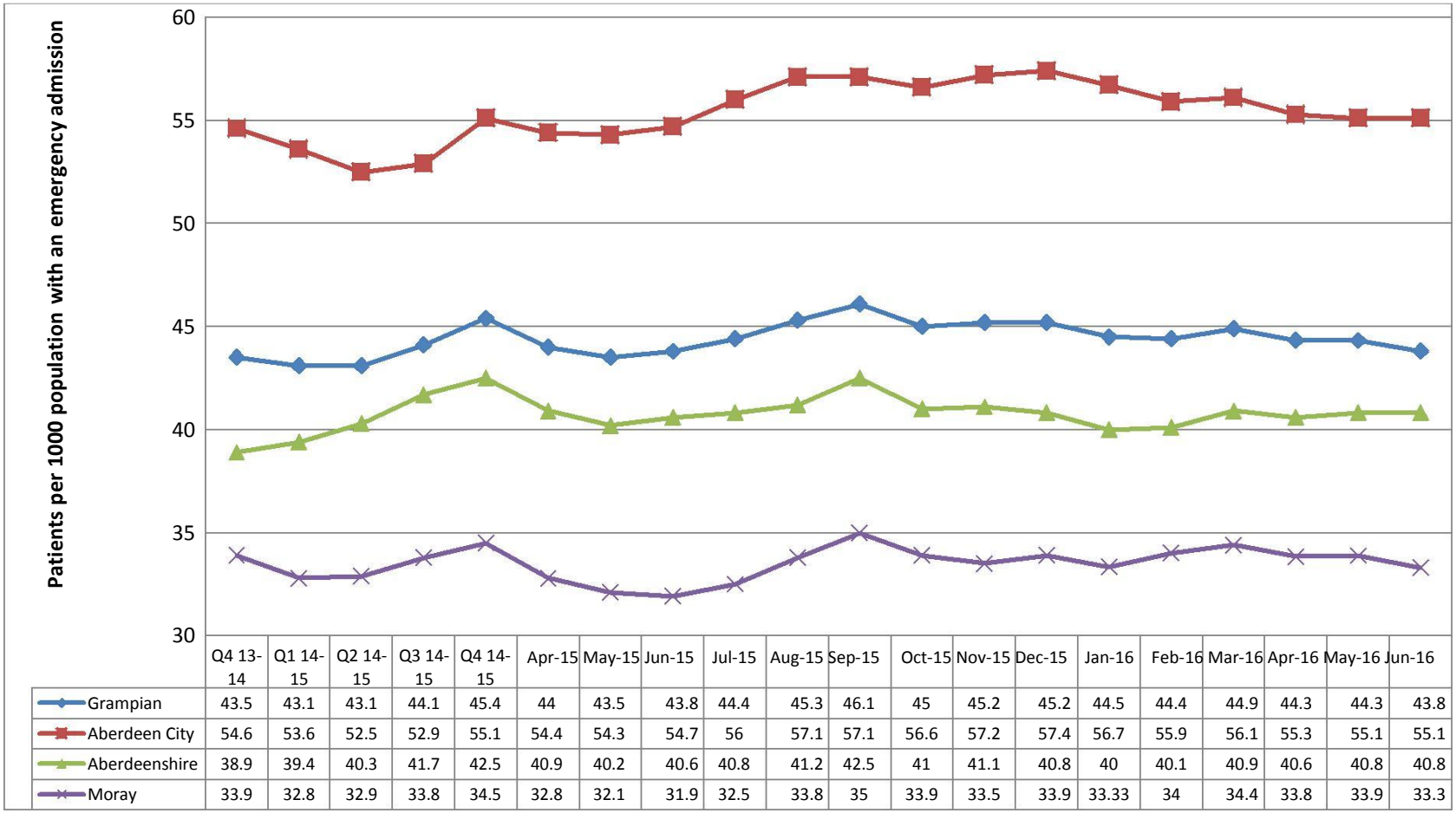


11. Emergency Admissions for over 65s in Grampian



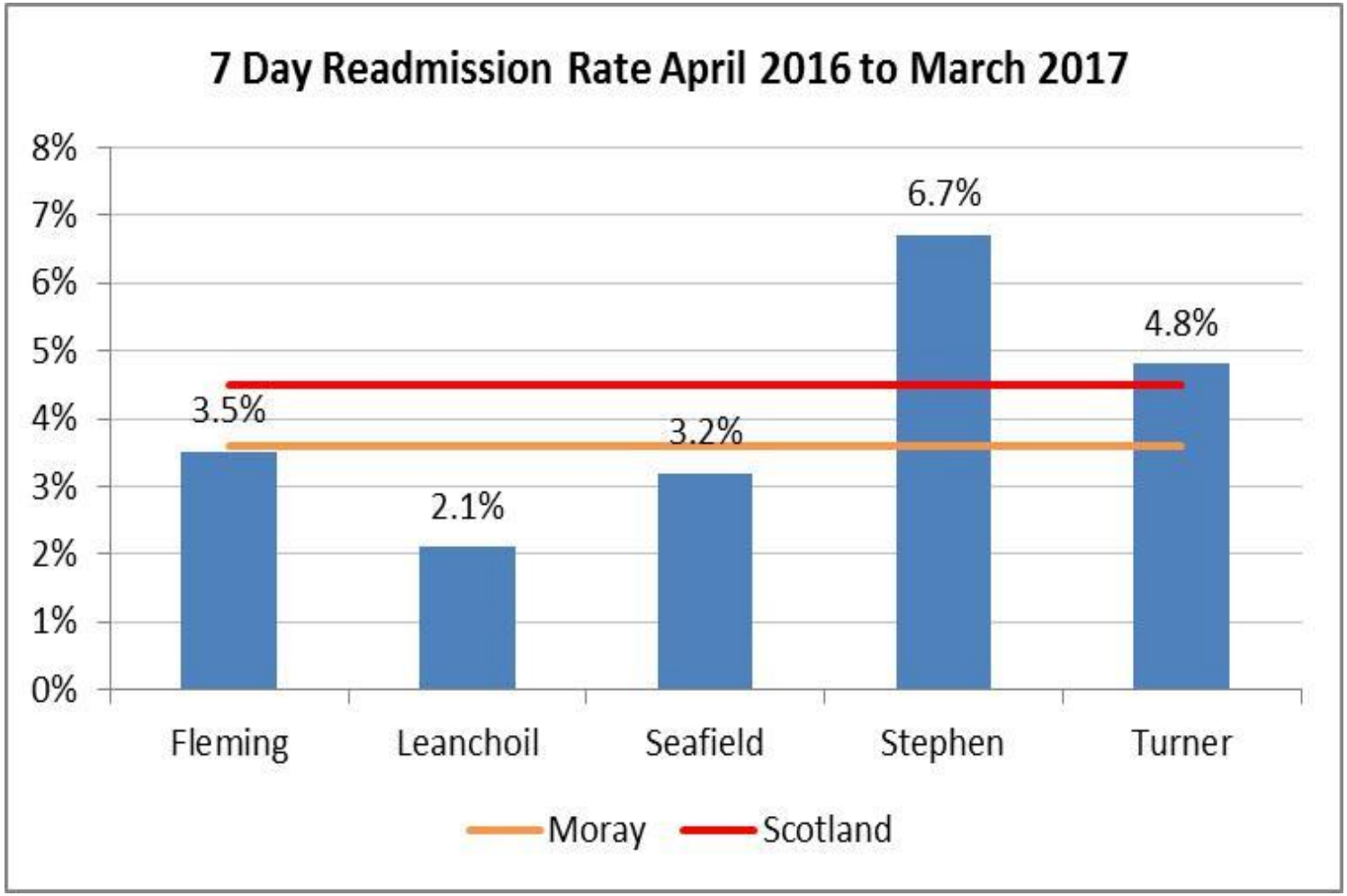
	Q4 13-14	Q1 14-15	Q2 14-15	Q3 14-15	Q4 14-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Grampian	145.2	142.9	142.3	142.4	146	143.1	143.2	144.3	145.4	144.4	144.1	143.5	144.1	143.7	143.3	142.6	141.8	139.9	139.8	139.6
Aberdeen City	171	167.4	165.4	165.5	169.8	168.1	168.5	170	170.6	169.5	169.7	169.7	170	170.5	169.1	168.1	166.9	166.7	166.1	166.1
Aberdeenshire	133.2	132.3	131.8	132.1	135.8	131.6	131.5	132	133.9	133.2	132	131.1	131.9	131.4	131.2	130.5	130	127.0	127.1	127.0
Moray	126.4	123.5	125	125.2	127.1	125.6	126.1	127.6	127.4	126.5	126.9	126.3	127.1	125.2	125.7	125.7	125.1	123.4	123.6	123.1

12. Multiple Emergency Admissions for Over 65s in Grampian

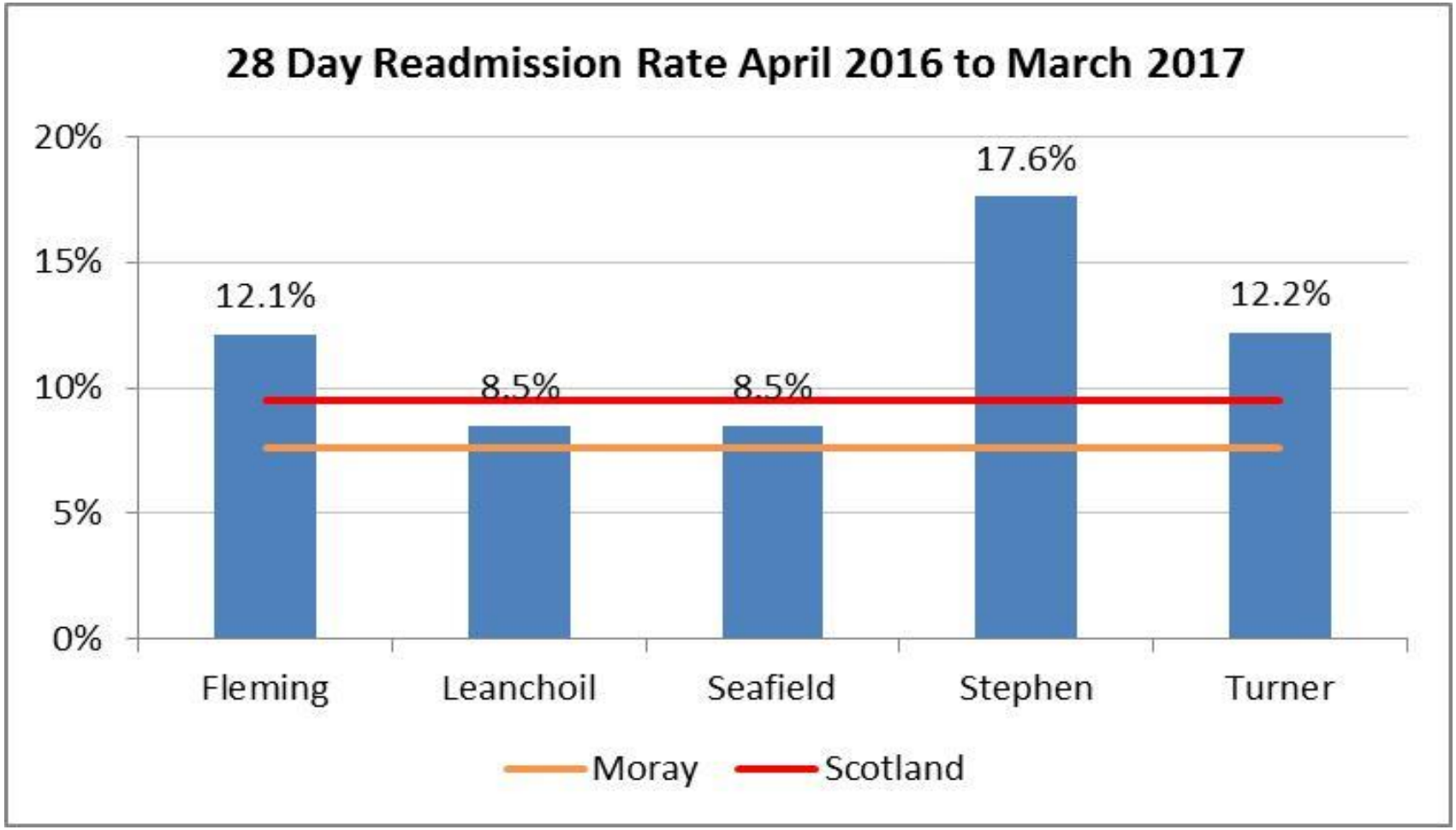


	Q4 13-14	Q1 14-15	Q2 14-15	Q3 14-15	Q4 14-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Grampian	43.5	43.1	43.1	44.1	45.4	44	43.5	43.8	44.4	45.3	46.1	45	45.2	45.2	44.5	44.4	44.9	44.3	44.3	43.8
Aberdeen City	54.6	53.6	52.5	52.9	55.1	54.4	54.3	54.7	56	57.1	57.1	56.6	57.2	57.4	56.7	55.9	56.1	55.3	55.1	55.1
Aberdeenshire	38.9	39.4	40.3	41.7	42.5	40.9	40.2	40.6	40.8	41.2	42.5	41	41.1	40.8	40	40.1	40.9	40.6	40.8	40.8
Moray	33.9	32.8	32.9	33.8	34.5	32.8	32.1	31.9	32.5	33.8	35	33.9	33.5	33.9	33.33	34	34.4	33.8	33.9	33.3

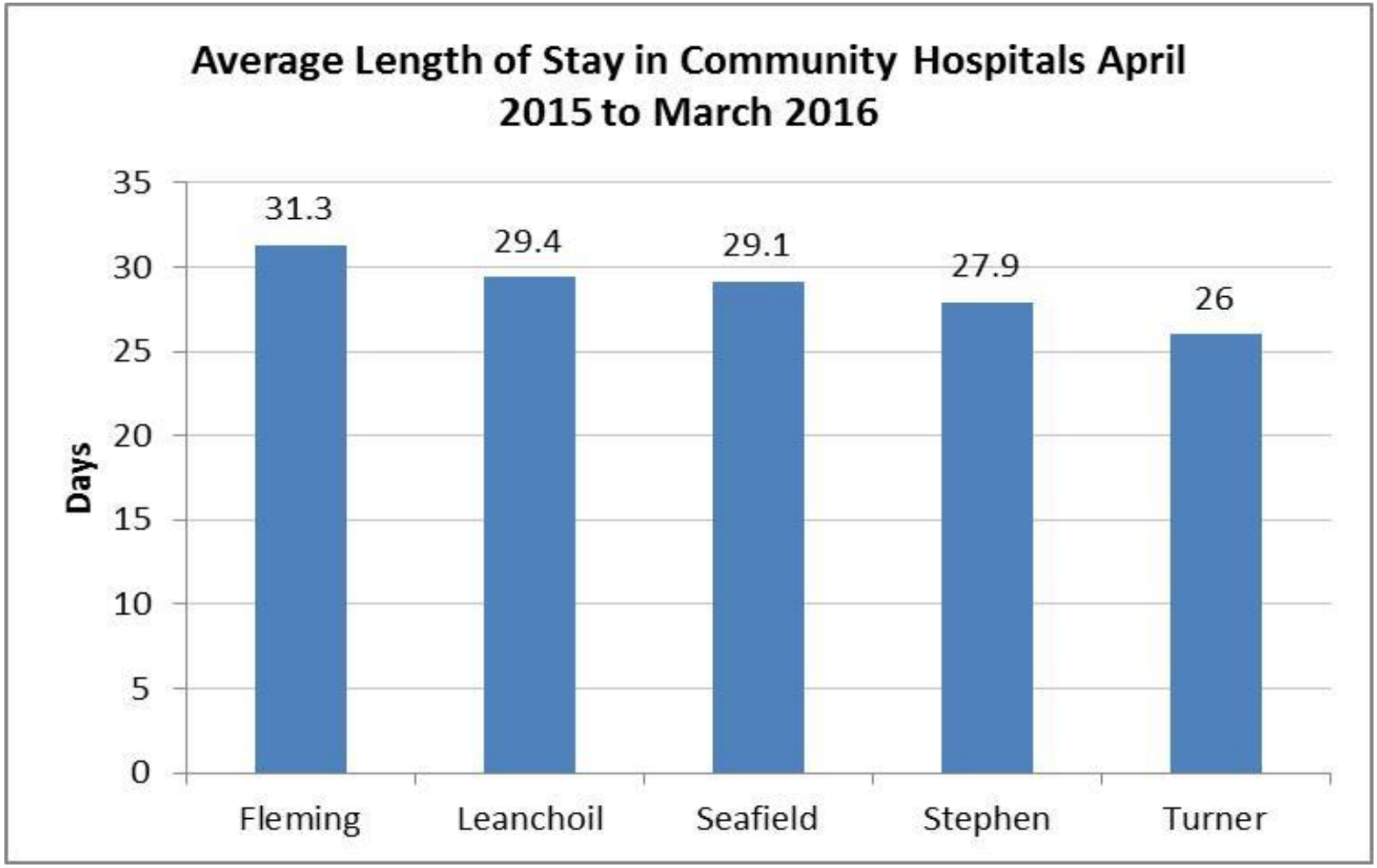
Readmission rate over 7 days.



Readmission rate over 28 days.



Average Length of Stay in Moray Community Hospitals.



REPORT TO: MORAY INTEGRATION JOINT BOARD ON 29 JUNE 2017

SUBJECT: REVENUE BUDGET 2017/18

BY: CHIEF FINANCIAL OFFICER

1. REASON FOR REPORT

1.1 To inform the Moray Integration Joint Board (MIJB) on the updated position in relation to achieving a balanced revenue budget for the 2017/18 financial year.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board :

i) approve the updated savings plan detailed at section 4.2;

ii) note the budget pressures highlighted at section 4.3 that will arise during the 2017/18 financial year and the forecast impact on the revenue budget;

iii) approve the level of reserves of £1.6m to be earmarked for the purposes specified at 4.4.3; and

iv) note the revised budget position for 2017/18 in relation to the paper presented to this Board on 30 March 2017.

3. BACKGROUND

3.1 On 15 December 2016 the Cabinet Secretary for Finance and the Constitution announced the draft Scottish Government budget. As a result of this announcement the provisional grant settlement figures were provided to both local government and health boards.

3.2 The Grant Settlement letter indicated that:

- the additional £250 million support for health and social care issued in 2016/17 would be base-lined from 2017/18. MIJB's share of this is £4.022m
- funding will be increased by a further £107 million to meet the full year costs of the joint aspiration to deliver the Living Wage. MIJB's share of this is £1.74m

To reflect this additional support, local authorities were granted permission to adjust their allocations to Integration Authorities in 2017-18 by up to their share of £80 million below the level of budget agreed with their Integration Authority for 2016-17. Moray Council at its meeting on 15 February 2017 (para 6 of the Minute refers) approved a budget which reflected the maximum share of the £80m which for the MIJB resulted in a £1.3m budget reduction and provided no additional funding for budget pressures arising in 2017/18.

Through NHS Grampian budget setting processes, acknowledgement was made to the £1.74m; however no additional funding for budget pressures was identified for 2017/18.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 2017/18 MIJB Funding

The MIJB has a responsibility under the Public Bodies (Joint Working) (Scotland) Act 2014 to set a balanced budget for the 2017/18 financial year. The funding of the MIJB revenue budget in support of the delivery of the Strategic Plan is delegated from NHS Grampian and Moray Council. The funds at the beginning of the financial year were as follows:

	£'000
NHS Grampian	63,279
NHS Grampian Notional Budget for Set Aside Services	10,163
Scottish Government Funding for Social Care	5,762
Strategic Funds – Integrated Care Fund & Delayed Discharge	2,067
Moray Council	39,089
Moray Council – Improvement Grants*	980
	121,340

* Improvement Grants includes £0.4m which requires to be ring-fenced as it relates to council tenants.

4.1.1 From the funding outlined above, £10.163m from NHS Grampian is the MIJB's notional share of the Set Aside budget for Grampian and which MIJB has a responsibility for the strategic planning of these services.

4.2 Savings Plan

Since the presentation of the revenue budget paper at the MIJB meeting of 30 March 2017 (para 2 of the Minute refers). Further work has been carried out by the Senior Management Team, Service Managers and the finance team to ensure a robust savings plan can be presented for approval. The Service Managers were asked to consider all options within their respective areas in order to produce efficiencies. The outcome of this initial work was summarised and presented as part of the budget paper on 30 March and identified £1.163m of potential savings that could be realised during the year. Following this initial exercise, two further sessions were held with the fore

mentioned teams to consider further the initial proposals and to gain clarity on what these proposals would mean on service delivery, the delivery of the Strategic Plan and more generally on the population of Moray.

4.2.1 The outcome of this work has produced a revised savings plan figure of £624k which has been summarised below.

Service Area	**Description of Saving**	**£'000**
Community Nursing	Staffing	100
Addictions	Staffing	54
Care Provided In-House	Efficiencies from Site Locations	125
Older People (Intermediate Care and Occupational Therapy)	Efficiency Target set by Service Manager	30
Older People (Assessment & Care)	Staffing and Care Requirements	75
Externally Commissioned Services	Ongoing Efficiency Review	140
Primary Care Prescribing	Local Enhanced Services (LES)	100
Total Proposed Savings		**624**

4.3 Budget Pressures

Budget pressures are a major consideration for the MIJB and are an intrinsic part of the budget setting process. The settlements from both NHS Grampian and Moray Council stated that there would be no additional funding available to meet these arising pressures.

4.3.1 Core principles need to be established and adhered to when determining the pressures that will present during the financial year. On this basis the budget pressures have been determined on the current level of service. Given the requirement to return to this Board with a revised budget position has provided the privilege of time and an assessment of the impact of the 2016/17 financial position as can be seen from the unaudited annual accounts report also being presented to the MIJB today.

4.3.2 There has been a review of the budget pressures presented to the meeting of the MIJB on 30 March 2017 by finance staff which have subsequently been agreed by the Senior Management Team. The revised budget pressures anticipated for the 2017/18 financial year are £1.8m and have been summarised below:

	£'000
Scottish Living Wage	490
Pay Awards	589
Apprenticeship Levy	223
Non Pay Uplifts	290
High Cost Complex Care Package	200
Internal Homecare Contract Changes	250
Prescribing	15

Rates Revaluation	31
Total Budget Pressures	**2,088**
Less New Allocations from Scottish Government *	(277)
Revised Budget Pressures	**1,811**

*New allocations are funding from Scottish Government routed through NHS Grampian and consist of £0.176m for Primary Care, £0.020m for 6 essential actions initiative and £0.81m in relation to the Carers Strategy.

4.4 Reserves

The 2016/17 budget outturn position returned a favourable variance after using the slippage on Strategic Funds, resulting in net assets of £2.704m which form the MIJB's general usable reserves to carry forward to 2017/18.

4.4.1 Also being reported to this Board are the unaudited annual accounts and the revenue budget outturn for 2016/17 which provide further detail to support this. The final outturn shows a much improved position on the forecast presented to Board in February 2017 where an adverse variance of £1.4m had been forecast to the end of the financial year on core services and a favourable position of £0.594m after consideration of strategic funds.

4.4.2 At a meeting of the MIJB on 31 March 2016 (para 12 of the Minute refers), a reserves policy was presented for approval. The policy outlined the circumstances in which reserves can be created and the governance surrounding these. The policy states that a prudent level of reserves for the MIJB would be 3% of net expenditure. The level and utilisation of reserves requires approval of the MIJB based on the advice of the Chief Financial Officer.

4.4.3 Of the £2.7m reserves achieved as part of the 2016/17 outturn, there are a number of areas that require funding during 2017/18 and approval is sought to earmark £1.6m from the general reserves to fund these commitments. The MIJB reserves policy details the circumstances supporting the balance of reserves. The particular point that relates to the request to earmark reserves is '*commitments made under delegated authority by the Chief Officer, which cannot be accrued at specific times (e.g. year-end) due to not being in receipt of the service or goods*'. The Senior Management Team have discussed the requirements detailed below and can support the proposal to earmark these funds for specific purposes.

	£'000
Scottish Living Wage (Full year effect)	682
Hanover Project (delay in starting)	500
Out of Hours Unscheduled Care	113
Primary Care Link Worker	107
Public Health	51
Mental Health Practitioner	53
Mental Health Access Funding	22
Carefirst Development	62

Mental Health & Wellness	33
Improvement Grants for Works Fully Committed	39
Total Required Earmarked Reserves	**1,662**

4.4.4 Reserves are generally held to cushion the impact of uneven cash flows, create a contingency or to build up funds to meet known or predicted liabilities. However, given the shortfall in funding for the 2017/18 budget it is considered necessary to utilise £0.8m of reserves to support a balanced budget position.

4.5 Revised 2017/18 Revenue Budget

4.5.1 Budget available to fund the 2017/18 revenue budget

	£'000
NHS Grampian (excluding Set Aside)	63,279
Moray Council	40,069
Scottish Government Funding for Social Care	5,762
Strategic Funds – Integrated Care Fund & Delayed Discharge	2,067
General Reserve	2,704
Total Available Funding	**113,881**

4.5.2 The budget required for 2017/18 is detailed in **APPENDIX 1** and summarised below:

	£'000
Core Services Rolled Budget	107,378
Commitments from Integrated Care Fund & Delayed Discharge	2,062
Budget Pressures	1,811
Commitments to be funded from Earmarked Reserves	1,662
Recurring Deficit on Core Services	1,327
Less Savings (If agreed)	(624)
Total Budget Required	**113,616**

Funding Surplus	**265**

4.6 Assumptions

4.6.1 In preparing the 2017/18 revenue budget as detailed in 4.5.2 above, the following assumptions have been made:

- The updated savings plan detailed at 4.2.2 is approved and is delivered in full during the year.
- The calculations for budget pressures highlighted at 4.3.2 are robust.
- The earmarked reserves identified at 4.4.3 as being required in year are approved.

- The balance of the £2.7m in the General Reserve, following approval of the earmarked element being £1.7m leaves £1m of which £0.8m is required to eliminate the identified funding gap.

- There will be no further slippage during 2017/18 on strategic funds.

- From the unused element of reserves there is £0.265m available to fund potential invest to save initiatives that may present during 2017/18. Any additional funding above this level required for investment will have to be met from de-commissioning services.

4.7 Future Years Budgets

4.7.1 Whilst MIJB is able to balance its budget for the 2017/18 financial year, it is essential to note that the £2.7m favourable net position achieved in 2016/17 is a one-off windfall that has made this possible.

4.7.2 It is critical to understand the impact of using reserves to achieve a balanced financial position. On the basis that the assumptions contained within 4.6 of this report transpire, the impact of utilising this reserve is that with no further identified savings, and no additional funding, MIJB will have an unfavourable budget position looking beyond 2017/18.

4.7.3 The most recent grant settlement provides the best indication of future levels of funding likely to be available to the MIJB. In order to stand still and cover estimated pay and non-pay inflation, along with the living wage uplift, the MIJB will have to deliver a minimum of £2.5 million savings per annum, unless additional funding is provided by the Scottish Government. Should there be further cash cuts in the MIJB partner organisations' funding then the level of savings required is likely to increase.

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

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

(c) Financial implications

The 2017/18 revenue budget for cores services as detailed in **APPENDIX 1** is **£107,378m**. After consideration of the revised savings plan, budget pressures, commitments and an acceptance of the recurring deficit, the total budget required for the 2017/18 financial year is **£113.616m**.

The funding available, which includes funding from both partners and the general reserve totals **£113.881m**.

The notional set aside budget of £10.163m should also be noted. The full funding of this budget is provided by NHS Grampian.

(d) Risk Implications and Mitigation

The risks and assumptions associated with the preparation of this revenue budget are discussed throughout the report.

(e) Staffing Implications

None arising directly from this report.

(f) Property

None arising directly from this report.

(g) Equalities

None arising directly from this report.

(h) Consultations

Consultations have taken place with the Senior Management Team, Service Managers and Finance staff of Moray Council and NHS Grampian who agree with the sections of the report relating to their areas of responsibility.

6. CONCLUSION

6.1 Legislation requires the MIJB to set a balanced budget. Given the work that has been progressed since the budget paper presented on 30 March 2017 and the favourable outturn position on the 2016/17 budget, the Chief Financial Officer to the Board recommends that the budget at APPENDIX 1 is approved, after noting the concerns in future years and the need to hold a level of reserves.

6.2 Through regular budget monitoring reporting, achievement against the savings target and observations of materialising budget pressures, this can be closely monitored.

Author of Report: Tracey Abdy, Senior Project Officer
Background Papers: with author Ref:

Signature: Date: 16 June 2017

Designation: Chief Financial Officer Name: Margaret Wilson

APPENDIX 1

MORAY INTEGRATION JOINT BOARD
REVENUE BUDGET 2017/18

		Annual Net Budget £000's 2017-18
Community Hospitals		4,919
Community Nursing		3,358
Learning Disabilities		5,505
Mental Health		7,151
Addictions		860
Adult Protection & Health Improvement		196
Care Services provided in-house		13,590
Older people & PSD - Assessment & Care		15,908
Intermediate Care & OT		1,536
Care Services provided by External Contractors		10,385
Other Community Services		
Allied Health Professionals		3,257
Dental		1,977
Public Health		390
Pharmacy		251
Specialist Nurses		847
Admin & Management		900
Primary Care Prescribing		16,949
Primary Care Moray		14,263
Hosted Services		3,891
Out of Area Placements		669
Improvement Grants		980
Provisions (including reduction of £1.3m from Moray Council)		(404)
Total Moray IJB Core		**107,378**
Identified Budget Pressures for 2017/18		1,811
Commitments from ICF & DD		2,062
Commitments from Earmarked Reserves		1,662
Recurring Deficit to Fund		1,327
Savings Identified		(624)
Total Budget Requirement for 2017/18		**113,616**
Budget Available for Core Services		
NHS Grampian		63,279
Moray Council		40,069
SG funding for Social Care		5,762
Integrated Care Fund & Delayed Discharge		2,067
Balance of Reserves		2,704
Total Available Budget for 2017/18		**113,881**