SCH/KM

7 December 2016

ALL MEMBERS OF ANGUS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

Dear Member

ANGUS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD MEETING

You are requested to attend a meeting of the Angus Health and Social Care Integration Joint Board to be held in the Town and County Hall, Forfar on **Wednesday 14 December 2016 at 2.00pm**.

The agenda and papers are enclosed.

If you have any queries, please contact Karen Maillie on (01307) 476265 or e-mail MaillieK@angus.gov.uk

Yours sincerely

SHEONA C HUNTER

Head of Legal and Democratic Services

DISTRIBUTION:

Members of the Integration Joint Board

Voting Members of Angus Health and Social Care Integration Joint Board

Angus Council
Councillor Glennis Middleton
Councillor Jim Houston
Councillor David May

NHS Tayside
Hugh Robertson, Non Exec Board Member - Chair
Judith Golden, Non Executive Board Member
Alison Rogers, Non Executive Board Member

Named Proxy Members for Angus Council (for information)
Councillor Colin Brown
Councillor Lynne Devine
Councillor Sheila Hands

Named Proxy Members for NHS Tayside (for information) - tbc

Non Voting Members of Angus Health and Social Care Integration Joint Board

Vicky Irons, Chief Officer
Kathryn Lindsay, Chief Social Work Officer
Peter Burke – Carers Representative
Mavis Leask, Staff Representative
Independent Sector Representative - tbc
David Barrowman, Service User Representative
Alison Clement, Clinical Director
Alexander Berry, Chief Finance Officer
Douglas Lowdon,Consultant Acute & Elderly Medicine
GP Representative - tbc
Neil Prentice – Third Sector Representative
Barbara Tucker - Staff Representative
Jim Foulis, Associate Nurse Director

Operational Advisers

George Bowie, Head of Community Health and Care Services – South
Gail Smith, Head of Community Health and Care Services - North
David Coulson, Associate Director of Pharmacy, NHS Tayside
Bill Troup, Head of Integrated Mental Health Services
David Thompson, Principal Solicitor, Angus Council
Michelle Watts, Associate Medical Director, NHS Tayside
Drew Walker, Director of Public Health, NHS Tayside

ANGUS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

**TO BE HELD IN THE TOWN AND COUNTY HALL, FORFAR
ON WEDNESDAY 14 DECEMBER 2016 AT 2.00PM**

AGENDA

1. APOLOGIES

2. DECLARATIONS OF INTEREST

Members are reminded that, in terms of the Code of Conduct of Members of Devolved Public Bodies, it is their responsibility to make decisions whether to declare an interest in any item on this agenda and whether to take part in consideration of that matter.

3. MINUTE OF PREVIOUS MEETING INCLUDING ACTION LOG

PAGE NO.

(a) Previous Meeting

Submit, for approval, as a correct record, the minute of meeting of the Angus Health and Social Care Integration Joint Board of 26 October 2016. (1 - 6)

(b) Action Log

Submit Action Log of 26 October 2016. (7 - 8)

4. AUDIT COMMITTEE - MEMBERSHIP UPDATE

With reference to Article 5 of the minute of meeting of this Board of 26 October 2016, the Board were advised of the resignation of the Carers representative from both the Integration Joint Board and Audit Committee. The Board are asked to note that Jim Foulis, Associate Nurse Director expressed an interest in becoming a member of the Audit Committee.

5. ANGUS ADULT PROTECTION COMMITTEE UPDATE

With reference to Article 9 of the minute of meeting of this Board of 31 August 2016, Ewen West, Chair, Angus Adult Protection Committee will provide a verbal update.

6. ENHANCED COMMUNITY SUPPORT

Short video to be shown.
Submit Report IJB 85/16 by Vicky Irons, Chief Officer (9 - 12)

7. FINANCE MONITORING REPORT

Submit Report IJB 86/16 by Alexander Berry, Chief Finance Officer. (13 - 22)

8. PARTNERSHIP FUNDS

Submit report IJB 87/16 by Alexander Berry, Chief Finance Officer (23 - 28)

9. BUDGET AGREEMENTS WITH PARTNERS AND FINANCIAL PLANNING FRAMEWORK

Submit Report IJB 88/16 by Alexander Berry, Chief Finance Officer. (29 - 36)

10. PRESCRIBING MANAGEMENT

Submit Report IJB 89/16 by Vicky Irons, Chief Officer. (37 68)

11. COMMUNICATION, PARTICIPATION & ENGAGEMENT STRATEGY 2016-19

Submit Report IJB 90/16 by Vicky Irons Chief Officer. (69 – 84)

12. PERFORMANCE REPORT

Submit Report IJB 91/16 by Vicky Irons, Chief Officer. (85 - 126)

13. EQUALITY MONITORING AND IMPACT ASSESSMENT

Submit Report No IJB 92/16 by Vicky Irons, Chief Officer. (127 - 140)

14. RISK MANAGEMENT REGISTER

Submit Report IJB 93/16 by Vicky Irons, Chief Officer. (141 - 148)

15. DATE OF NEXT MEETING

The next meeting of the Angus Health and Social Care Integration Joint Board will be held on Wednesday 22 February 2017 at 2.00pm in the Town and County Hall, Forfar.

16. EXCLUSION OF PUBLIC AND PRESS

The Angus Health and Social Care Integration Joint Board will be asked to consider, in terms of paragraphs 2, 3 and 4 of Part 1 of Schedule 7A to the Local Government (Scotland) Act 1973, whether the public and press should be excluded during consideration of the following items, so as to avoid the disclosure of exempt information.

17. ANGUS HUMANITARIAN AID – INFORMATION REPORT

Submit Report IJB 94/16 by Vicky Irons, Chief Officer (149 - 152)

18. BUDGET SETTLEMENT WITH ANGUS COUNCIL 2017-18

Submit Report IJB 95/16 by Alexander Berry, Chief Finance Officer (To Follow)

MINUTE of MEETING of the **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held in the Town and County Hall, Forfar on Wednesday 26 October 2016 at 2.00pm.

Present: **Voting Members of Integration Joint Board**

HUGH ROBERTSON, Non-Executive Board Member, NHS Tayside – Chair
Councillor GLENNIS MIDDLETON, Angus Council
Councillor JIM HOUSTON, Angus Council
ALISON ROGERS, Non-Executive Board Member, NHS Tayside

Non Voting Members of Integration Joint Board

TIM ARMSTRONG, Chief Social Work Officer, Angus Council
DAVID BARROWMAN, Service User
SANDY BERRY, Chief Finance Officer
PETER BURKE, Carers Representative (from Item 5 only)
ALISON CLEMENT, Clinical Director, Angus IJB
VICKY IRONS, Chief Officer
MAVIS LEASK, Staff Representative, Angus Council
DOUGLAS LOWDON, Consultant Acute and Elderly Medicine, NHS Tayside
SUE MACKIE, Associate Nurse Director (Development)
NEIL PRENTICE, Third Sector Representative

Advisory Officers

GEORGE BOWIE, Head of Community Health and Care Services - South, AHSCP
DAVID COULSON, Associate Director of Pharmacy, NHS Tayside
GAIL SMITH, Head of Community Health and Care Services - North, AHSCP
DAVID THOMPSON, Principal Solicitor – Resources, Angus Council
BILL TROUP, Head of Integrated Mental Health Services (AHSCP)
MICHELLE WATTS, Associate Medical Director, NHS Tayside

HUGH ROBERTSON, in the Chair.

1. APOLOGIES

Apologies for absence were intimated on behalf of Councillor David May, Angus Council; Judith Golden, Non-Executive Board Member and Drew Walker, Director of Public Health, NHS Tayside.

2. DECLARATIONS OF INTEREST

The Integration Joint Board noted that there were no declarations of interest made.

3. MINUTE OF PREVIOUS MEETING INCLUDING ACTION LOG

(a) ANGUS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

The minute of meeting of the Angus Health and Social Care Integration Joint Board of 31 August 2016 was submitted and approved as a correct record.

(b) ACTION LOG

The action log of the Health and Social Care Integration Joint Board of 31 August 2016 was submitted and noted.

(c) ANGUS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE

The minute of meeting of the Angus Health and Social Care Integration Joint Board Audit Committee of 31 August 2016 was submitted and noted.

4. TIMETABLE OF MEETINGS 2017

The Board agreed to note the timetable of meeting dates for 2017.

5. THE APPOINTMENT OF MANDATORY NON VOTING MEMBER

With reference to Article 4 of the minute of meeting of this Board of 31 August 2016, there was submitted Report No IJB 76/16 by the Chief Officer considering the appointment of a mandatory non voting member of the Integration Joint Board as required by the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

The Report indicated that the Integration Joint Board was legally obliged to appoint members in respect of each of a number of distinct groups. The recommendations contained in the report would enable the Integration Joint Board to partially discharge the legal obligations incumbent upon it.

The Chief Officer advised that this was the last meeting for Sue Mackie and that Jim Foulis had been appointed as the replacement Associate Nurse Director.

The Integration Joint Board agreed:-

(i) to note the resignation of Ms Alison Myles as a non voting member of the Integration Joint Board representative of persons providing unpaid care in the area of the local authority; and

(ii) to approve the appointment of Mr Peter Burke as a non voting member of the Integration Joint Board representative of persons providing unpaid care in the area of the local authority.

Hugh Robertson, Chair, welcomed Mr Peter Burke to the meeting. Mr Burke confirmed that he had no declaration of interest to be made.

The Chair, on behalf of the Board, thanked Sue Mackie and Alison Myles for their valued contributions and wished them well for the future.

6. FINANCE MONITORING REPORT

With reference to Article 10 of the minute of meeting of this Board of 31 August 2016, there was submitted Report No IJB 77/16 by the Chief Finance Officer presenting an update to the Board regarding the financial performance of Angus Integration Joint Board (IJB).

The Report indicated that this was the second Finance Monitoring Report since the IJB had inherited formal responsibility for the management of devolved services. The Angus Integration Joint Board Integration Scheme set out that for 2016/17 and 2017/18, should the IJB overspend then that overspend would be attributed back to the Partner organisation in which the overspend had been incurred.

The Chief Finance Officer provided a brief overview in relation to the prescribing position.

Alison Rogers, Non-Executive Board member raised concerns in relation to a number of points arising from the GP prescribing position.

Thereafter, Alison Clement, Clinical Director, Angus IJB provided an update in relation to GP prescribing.

The Integration Joint Board agreed:-

(i) to note the contents of the Report including the risks documented in the Financial Risk Assessment;

(ii) to note that a Report regarding Partnership Funds would be brought to the next meeting of the Board;

(iii) that Finance Monitoring reports would be provided to future Integration Joint Board meetings; and

(iv) to request an update report be brought to a future meeting of the IJB in respect of the prescribing issues and to include reference to possible steps to achieve costs reduction.

7. BUDGET AGREEMENT WITH NHS TAYSIDE 2016/2017 AND FINANCIAL PLANNING FRAMEWORK FOR ANGUS IJB'S NHS SERVICES

With reference to Article 11 of the minute of meeting of this Board of 31 August 2016, there was submitted Report No IJB 78/16 by the Chief Finance Officer updating the Board regarding the status of the Budget Settlement between Angus Integration Joint Board and NHS Tayside for 2016/2017 and the financial planning framework for Angus IJB's NHS Services.

The Report indicated that since the August Board meeting, Angus IJB had confirmed its position regarding the budget with NHS Tayside but, as at the start of October, had not received any confirmation from NHS Tayside regarding the conditions set out in the letter. Whilst Angus IJB could still fully function, formally the budget still remained unconfirmed.

Budget discussions had now been agreed with NHS Tayside on a monthly basis involving the Chief Finance Officers from all Tayside IJB's.

The Chief Finance Officer provided an overview of the main pressures within Angus IJB's NHS Services, the savings measures and work programmes previously agreed by Angus IJB and the further measures that were being taken forward by the Executive Management Team.

The Chief Officer also highlighted that there would tough and challenging times ahead and that the Integration Joint Board would require to make wise and difficult decisions.

The Integration Joint Board agreed:-

(i) to note the status of the IJB's devolved budget, to note that NHS Tayside had yet to respond to the Angus IJB position regarding the budget; to note that renewed managerial effort would be put into resolving residual issues; and to note that at the start of October 2016, the IJB had not received any confirmation from NHS Tayside regarding the conditions set out in the letter issued to them previously;

(ii) to note the scale of the financial pressures facing Angus IJB's NHS Services;

(iii) to note that savings measures previously agreed by the IJB Board in June 2016 had all now been fully implemented;

(iv) to note the progress with the work-streams previously agreed by the IJB Board in June 2016 and to request that an update regarding these work-streams be provided to the Board in the report to the December 2016 Board meeting;

(v) to note the further work being considered by the Strategic Planning Group and to request an update regarding this work be provided to the Board in a Report to the December 2016 Board meeting;

(vi) to note the further work being progressed through the Executive Management Team and to request an update regarding this work be provided to the Board in a Report to the December 2016 Board meeting;

(vii) to request that the Strategic Planning Group and Executive Management Team bring forward a list of further options for consideration in the context of bringing the IJB's NHS Services towards financial balance to a future IJB Board meeting; and

(viii) to commend officers for their hard work in the implementation of the saving measures previously agreed by the IJB in June 2016.

8. CHIEF SOCIAL WORK OFFICER'S ANNUAL REPORT

There was submitted Report No IJB 79/16 by the Chief Social Work Officer advising Board members of the Chief Social Work Officer's Annual Report that had been considered by Angus Council on 8 September 2016.

The Chief Social Work Officer's Annual Report for 2015/2016 provided details as to how the Chief Social Work Officer for Angus Council discharged the specific statutory elements of the role and outlined the important contribution social work services made to the well-being and safety of the people of Angus. The Report also detailed key developments across the range of services and highlighted challenges for the year ahead, which were outlined in Section 4 of the Report.

Having heard from the Chief Social Work Officer and following questions from some members, the Integration Joint Board agreed to note the contents of the Angus Council Chief Social Work Officer's Annual Report for 2015/2016, attached as Appendix 1 to the Report.

Thereafter, the Chair commended Mr Tim Armstrong who was attending his last Angus Integration Joint Board as Chief Social Work Officer, and wished him well for the future.

9. SERVICES TO SHELTERED HOUSING TENANTS

With reference to Article 5 of the minute of meeting of this Board of 31 August 2016, there was submitted Report No. IJB 80/16 by the Chief Officer outlining the progress made towards the future plans for the deliver of support services in sheltered housing; the work undertaken by the transitions working group and the success of the new model.

The Report indicated that a working group had been established to manage the transition from the old model to the new model. The target date for the introduction of the new service was 1 July 2016. The working group had successfully introduced the new service on time.

Tenants were notified of the change to service provision in May 2016 and were offered the choice to opt in/opt out of the community alarm service. 80% of tenants opted to take up the service. Community Alarm was enhanced by additional Social Care Officers to manage the additional demand.

Care about Angus (CAA) visited all complexes to provide information regarding the services provided and tenants were offered the choice of two different support packages from CAA. Tenants were also advised that they could purchase the support required from alternative external providers or opt for no additional support.

The Integration Joint Board agreed:-

(i) to note the introduction of the revised service model of support to sheltered housing tenants; and

(ii) to note the continued monitoring of progress with the new delivery model through the transitions working group.

10. SELF DIRECTED SUPPORT

With reference to Article 5 of the minute of meeting of this Board of 26 October 2016, there was submitted Report No. IJB 81/16 by the Chief Officer advising members of the progress made in adhering to the Social Care (Self-Directed Support) (Scotland) Act 2013 within the Integration Partnership and to share information regarding the current Contributions Policy within Angus Council.

The Report indicated that Self-Directed Support (SDS) was a way of providing support that meant that people were given choice and control over what kind of support they received. It meant that people could choose and arrange some or all of their own support instead of it being solely determined by professionals.

Work was being undertaken to implement a Programme Governance approach to Self-Directed Support and the movement ultimately towards Self-Directed Support becoming "business as usual" so that it was embedded in practice and culture within the Partnership.

George Bowie, Head of Community Health and Care Services – South provided an update and confirmed that there had been considerable discussion at the development event with members of the SDS Programme Board in September 2016 and advised that Board members would be provided with a copy of the action plan once this had been finalised.

Discussion took place, where members' questions were answered. In respect of the contributions policy, the Board having noted the position as outlined in the Report, requested a copy of the contributions policy to be circulated to them.

The Integration Joint Board agreed:-

(i) to note the progress being made in relation to adhering to the legislation within the Integration Partnership;

(ii) to endorse the ongoing and future work being undertaken as detailed in the Report; and

(iii) that a copy of the contributions policy be circulated to Board members following the meeting.

11. NEW PRIMARY CARE GOVERNANCE ARRANGEMENTS

There was submitted Report No IJB 82/16 by the Chief Officer advising members of the arrangements for a new leadership framework for Primary Care Services in Tayside.

The Report indicated that the revised arrangements would be established in November 2016, as outlined in Appendix 1 to the Report.

The Integration Joint Board agreed to note the revised arrangements.

12. WINTER PLAN 2016/2017

There was submitted Report No IJB 83/16 by the Chief Officer advising members of the arrangements in place for Winter Planning across Tayside.

The Report indicated that the winter plan outlining winter planning arrangements required to be submitted to the Scottish Government by the end of October 2016. The plan was supported by a readiness assessment which had been completed in August 2016 and an unscheduled care improvement plan. The plan was also supported by standard business

continuity resilience plans produced annually by NHS Tayside in partnership with Health and Social Care Partnerships in Angus, Dundee and Perth and Kinross.

Gail Smith, Head of Community Health and Care – North provided an overview of the winter plan.

A number of members intimated that whilst the winter plan was a good plan, they raised concerns in relation to the lack of Angus detail in the plan. Douglas Lowdon, Consultant Acute and Elderly Medicine also outlined his concerns in relation to demand exceeding capacity at Ninewells that would then have a knock on effect on Angus facilities.

Having heard from Vicky Irons, Chief Officer, George Bowie, Head of Community Health and Care – South and also from the Chair, the Integration Joint Board agreed:-

(i) to note the plan in place, for the Board's interests;

(ii) to approve the draft plan as it related to Angus, for submission to the Scottish Government; and

(iii) to request further assurance that the winter plan adequately reflected the Angus position.

13. DATE OF NEXT MEETING

The Integration Joint Board noted that the next meeting would take place on Wednesday 14 December 2016 at 2.00pm in the Town and County Hall, Forfar.

14. EXCLUSION OF PUBLIC AND PRESS

The Joint Board agreed that the public and press be excluded from the meeting during consideration of the following item so as to avoid the possible disclosure of information which was exempt in terms of the Local Government (Scotland) Act 1973 Part 1, Schedule 7A, Paragraphs 8 and 9.

15. IMPLEMENTATION OF THE LIVING WAGE IN ADULT SOCIAL CARE

With reference to Article 13 of the minute of meeting of this Board of 29 June 2016, there was submitted Report No IJB No 84/16 by the Chief Finance Officer updating the Board regarding the status of the implementation of the Living Wage in Adult Social Care.

The Integration Joint Board agreed to approve the recommendations contained within the Report.

Prior to the conclusion of the meeting, the Chair took the opportunity to remind members and officers that, in terms of the Board's Standing Orders, reports printed on green papers were confidential and cannot be disclosed to, or discussed with, any other person.

He advised that appointments to the Board had been due to members involvement with other organisations and asked members to note that they could not disclose or discuss confidential Board matters with the organisations they were involved with. Board members had duties to the Board and must participate in Board business solely in the best interests of the Board.

Agenda Item 3 (b)

Action Points Update from Angus Health and Social Care Shadow Integration Joint Board

Complete	On Target	Overdue

Current Actions

MEETING	ACTION POINT	RESPONSIBILITY	PROGRESS	Timeline
28 October 2016	Update report on Partnership Funds	Sandy Berry	Paper to be considered by the IJB at meeting on 14 December 2016	For IJB meeting on 14 December 2016
	Prescribing Report to be compiled for consideration	David Coulson/ Alison Clement	Paper to be considered by the IJB at meeting on 14 December 2016	For IJB meeting on 14 December 2016
	Strategic Planning Group to consider efficiency plans in relation to in-patient services and MIIUs	Vicky Irons with Heads of Service	Paper to be considered by the IJB at meeting on 14 December 2016	For IJB meeting on 14 December 2016
	Update report on efficiency workstreams detailing further recommendations	Sandy Berry	Paper to be considered by the IJB at meeting on 14 December 2016	For IJB meeting on 14 December 2016
	Copy of the Contributions Policy to be circulated to IJB members	George Bowie	Complete	Complete
	Circulate evolving local operational Winter Plan to IJB members	Gail Smith George Bowie	In progress	To be circulated prior to 14 December 2016
31 August 2016	Update report on the outcome of changes to tenant support provision	George Bowie	Paper submitted to IJB meeting on 26 October 2016	Complete
	Progress report on Self-Directed Support	George Bowie	Paper submitted to IJB meeting on 26 October 2016	Complete

MEETING	ACTION POINT	RESPONSIBILITY	PROGRESS	Timeline
	Further report on Primary Care Services	Gail Smith	In progress	For IJB meeting in February 2017
	Six monthly Adult Protection Report	Vicky Irons	In progress	For IJB meeting in February 2017
	Update report on Scottish Living Wage	Sandy Berry	Paper submitted to IJB meeting on 26 October 2016	Complete
	Performance Report – schedule agreed quarterly	Gail Smith	In progress	For IJB meeting on 14 December 2016
	Corporate Risk Register report	Gail Smith	In progress	For IJB meeting on 14 December 2016
	Progress report on mental health services to future meeting	Bill Troup	Timetable for presenting paper has slipped in order to complete Learning Disability Workshops. Paper with preferred option will now come to February IJB.	For IJB meeting on 22 February 2017
18 May 2016	To provide half yearly updates by the Strategic Planning Group on the utilisation of Partnership funds as overseen by the Finance Monitoring Group	George Bowie	In progress	For IJB meeting on 14 December 2016
	To submit further progress reports on key improvement issues within the Angus Strategic Plan	George Bowie	Report submitted to IJB meeting on 31 August 2016	Next report to IJB meeting on 22 February 2017
	To present report on Clinical, Care & Professional Governance Framework on an annual basis and quarterly thereafter.	Sue Mackie/ Alison Clement	In progress. To be consolidated into overall Performance Report.	For IJB meeting on 14 December 2016
	To prepare an Annual Report on progress against the Equality outcomes as part of the annual Performance Report.	Vicky Irons	In progress	April 2017

AGENDA ITEM NO 6

REPORT NO IJB 85/16

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 14 DECEMBER 2016

ENHANCED COMMUNITY SUPPORT

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

This paper outlines the requirement to progress with our vision and the formal proposals set out in the Angus Health & Social Care Partnership (HSCP) Strategic Plan around the positive evaluation of the Enhanced Community Support (ECS) programme. This report is supported by a short video presentation based on the existing experiences of local staff, patients and carers.

1. RECOMMENDATION

It is recommended that the Integration Joint Board:-

i) Support investment in extending the service delivery of Enhanced Community Support across Angus.

ii) Endorse the consolidation of inpatient resources in line with current demand to support the shift in balance of care and to release the resource of non operational inpatient facilities to support the Enhanced Community Services model.

iii) Support the full implementation of Enhanced Community Support in advance of longer term proposals being established to consider the future configuration of inpatient facilities in Angus as set out in Angus HSCP Strategic Plan.

2. BACKGROUND

Enhanced Community Support services in Angus are rooted in the principles of anticipatory care, and targeted at improving access to care for people in Angus.

The Board will know that from 2014/15 Angus Community Health Partnership (CHP) started to invest in ECS in South Angus. The funding to support this was initially from Scottish Government short term funding sources, but from 2015/16 the funding was mainstreamed through reinvestment of part of the resources released from Little Cairnie Hospital Inpatient Services.

Noting the positive evaluation of the initial ECS programmes, during 2015/16 and 2016/17 in South Angus localities, Angus CHP and Angus HSCP had set out plans to fund the next steps of a programmed roll out of ECS across the rest of Angus. This enables the planned strategic shifts in care and a move away from assessment and care being provided in institutions to developing services in localities, enabling more people to access the care they need in their own homes as set out in our Strategic Plan.

3. CURRENT POSITION

There are two key elements to delivering ECS. The move to working in this new model involves alignment of Medicine for the Elderly (MFE) and Old Age Psychiatry Consultants with their corresponding teams to localities. Associated with this the multi-disciplinary/ multi-agency teams are also designated to specific localities, including Community Nursing, Pharmacy, Allied Health Professionals, Voluntary Sector, Social Care and General Practice.

Alignment of services in this way is recognised as being crucial to managing current and future increases in the proportion of older people living with long-term conditions and is dictated by national policy (National Audit Office 2013 and Scottish Government 2011).

In South Angus, ECS is managing our delays in timely discharge and increasing levels of personal care have contributed to a significant (61%) reduction in bed days lost to delayed discharges for people aged over 75 years. This reduction has continued into 2016/17 with a 37% reduction in bed days lost to delayed discharge in the first 6 months of the year. The ECS approach is showing a significant decrease on the use of inpatient services in a Community Hospital setting. Furthermore, there has been a 12% reduction in emergency bed day use by over 75 year olds from South Angus.

4. PROPOSALS

Initial plans relied on further Scottish Government funding on a short term basis. This revised plan now sets out a proposal to fund a comprehensive roll out of ECS across the whole of Angus on a permanent and sustainable basis. Generally for programmes such as this, a planning timeline would be set out that addressed issues such as bridging or transitional costs. While there will be a transitional phase, the element of transitional/ bridging/double running costs is limited in this model as most of the funding relied on is accessible at the point of implementation. The transitional phase will therefore be described, through the HSCP's Management Teams, in more detail once timelines are known and implementation plans agreed.

Resources to Support Service Delivery

Table 1 below sets out the resources required to support service delivery of ECS across the whole of Angus. Planned resources are described by locality and by type of resource.

TABLE 1

Locality	**South**	**North East (Brechin and Edzell)**	**North East (Montrose)**	**North West**	**Angus**	**Total**
Resources	**£**	**£**	**£**	**£**	**£**	**£**
Pharmacy	43	10	10	25	0	89
Nursing	226	50	50	118	0	445
Occupational Therapy	42	10	10	25	0	87
Physiotherapy	67	17	17	33	0	133
Medical (GP)	209	10	64	119	0	402
Medical (Medicine for the Elderly)	0	41	6	12	0	59
Supplies	12	5	5	11	0	33
Voluntary Sector	0	0	0	0	50	50
Future Growth	0	0	0	0	80	80
Total	**598**	**143**	**163**	**344**	**130**	**1,378**

While the resources shown above reflect the planned service model, some additional financial planning comments are noted here:-

1) The model for South Angus has been in place since 2014/15, albeit subject to ongoing review. In particular the GP components of ECS would require to be reviewed should there be amendments to the GMS contract that overlap with the work commissioned by Angus HSCP in this proposal.

2) This model utilises the current cost per patient for GP/Medical input. This input would need further evaluation before it was utilised in the roll out of services. Included in the evaluation would be a review of the linking of funding to over 65 patient numbers – noting that other indices of need may be more relevant.

3) Costs associated with a roll out of ECS to Friockheim are included here and can be managed within available resource from Little Cairnie. Non-medical resources will be redeployed across the whole of South Angus (including whole of Friockheim population) while medical resources will be provided through GP input.

4) Generally the model provides Pharmacy, Nursing, Allied Health Profession and Medical (MfE) resources to all Localities and GP Medical (or equivalent) resources at Practice level. Resources are roughly aligned to over 65 population size but exact deployment of resource will be allocated on a pragmatic basis (e.g. to ensure ability to recruit to posts). Resources will also have to be set aside to manage a future increase in over 65 population and this is allowed for at a rate of 6% (to cover annual growth in Demand of c3% for the next 2 years).

5) An addition an Angus-wide investment in the Voluntary Sector to support their role in localities (e.g. Volunteer Driving) is also included here. This would be an important mainstreaming of the Voluntary Sector's contribution to ECS work in Angus.

6) This service model describes investment in community services. Unlike investment in hospital services, community resources can be remodelled incrementally if required. This means that should the HSCP need to further refine its ECS model, alongside other HSCP resources, in future then this will be more practical that re-modelling investments in Inpatients Services.

7) The implementation will be overseen by the Angus HSCP Executive Management Team.

5. FINANCIAL IMPLICATIONS

Funding To Support Investment

In this paper Angus HSCP is seeking to describe how a pan-Angus roll out of ECS can be supported financially. The funding model is now set out in table 2 below:-

	TABLE 2
Funding Source	**£**
Remodelling of Little Cairnie	582
Remodelling of Non Operational Services (In Patients)	426
Delayed Discharge	344
Remodel GP Input to Community Hospitals	16
Remodel Other GP Resources	10
Total	**1,378**

The following points should be noted:-

1) As noted previously the funding of service in the South Locality has been sourced from the release of resources in Little Cairnie Hospital.

2) In June 2016, the IJB Board agreed to release resources (£800k) from temporarily non-operational services (including In Patient Services in the North East Locality) to support the IJB's overall financial position for 2016/17 only. While the IJB's overall financial position still requires the delivery of significant levels of recurring savings (see IJB Board paper 78/16), the HSCP's Strategic Plan also gave a commitment to work towards shifting the balance of care by investing in community services and reducing dependency on hospital beds. This funding model for ECS does support the investment

in Community Services and also needs to rely on the release of In Patient resources to support that investment. This means some of the resources from temporarily non-operational services (£426k) that in 2016/17 were used to support the IJB's overall financial plan will now be reinvested on a permanent basis in Enhanced Community Support and Community Services (including the Voluntary Sector).

3) Noting the overall financial position of NHS Tayside and Angus HSCP, the costs for medical input to Edzell (shown within Brechin and Edzell in Table 1) will be supported by a realignment of a small element of existing GP resource dedicated to Edzell.

4) This model also relies on funding from Delayed Discharge sources. That is a Scottish Government funding stream that has been devolved to HSCP's on a permanent basis. That funding stream does have ear-marks within it to support the roll out of ECS. While those ear-marks are time limited, approval by the Angus HSCP Strategic Planning Groups of this roll out on a permanent basis can be accommodate with the existing ECS ear-marks and longer term unallocated resources within the delayed discharge funding stream.

Looking beyond the direct financial model for ECS, three further issues need to be noted as follows:-

1) The ECS model above does rely on resource being released from non-operational Inpatient Services in Angus. The balance of funding that is released from non-operational Inpatient services will be c£860k. Of that £860k, c£426k is required to support the roll out of the ECS proposals described above. This will mean that approximately 50% of the resources released from non-operational services will be reinvested in ECS and the Voluntary Sector and the balance (£434k) can be utilised to support the IJB contribute towards delivering efficient savings targets devolved to it as part of the overall budget settlement with NHS Tayside.

2) Alongside the ECS project, an additional piece of work is required to consider the future configuration of inpatient facilities as part of the model in Angus. This will be fully developed in a collaborative manner with the localities with the aim of a strategic plan for the future estate and service configuration to be developed and presented in 2017.

3) Post-implementation reviews of this investment in ECS should also be undertaken to assess the impact on the Angus HSCP Inpatient services. If any review indicated that further redesign and further resource release was practical then this will help support the IJB address other financial planning issues - including mainstreaming commitments funded through short term Scottish Government funding and addressing efficiency saving targets devolved by NHS Tayside. These matters are of importance as the IJB needs to ensure that the financial planning risks associated with making significant investment in Community Services such as ECS are offset by an increased ability to release resources from other services in the future.

6. EQUALITIES

A full Equalities Impact Assessment (EIA) has been completed. ECS is particularly targeted at members of the population who are over 65 years, as this is the specific section of the population who are at greatest need of support. The model is based on evidence of need and in the main that need exists within those members of the population who are over 65 years. Should a younger member of the community also be identified as being frail, then they would be considered for inclusion in ECS. The EIA will be reviewed annually along with the publication of the annual report which includes review of progress with the delivery of the strategic plan.

REPORT AUTHOR: **Gail Smith, Head of Community Health and Care Services (North Angus)**
Dr Alison Clement, Clinical Director, Angus HSCP
Dr Douglas Lowdon, Consultant, Acute & Elderly Medicine
Dr Marc Jacobs, GP/Chair North East Angus Locality Improvement Group

EMAIL DETAILS: gailsmith@nhs.net, aclement@nhs.net, douglas.lowdon@nhs.net, marc.jacobs@nhs.net

REPORT NO IJB 86/16

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 14 DECEMBER 2016

FINANCE MONITORING REPORT

REPORT BY ALEXANDER BERRY, CHIEF FINANCE OFFICER

ABSTRACT

This report provides an update to the Angus Integration Joint Board (Angus IJB) regarding the financial performance of Angus IJB. Generally the Board will be asked to note the content of these reports, note or approve the need for further updates to future Board meeting or be asked to make specific decisions relating to the financial resources of the IJB or the financial performance of the IJB.

1. RECOMMENDATION(S)

It is recommended that the Integration Joint Board:-

(i) note the content of the report including the risks documented in the Financial Risk Assessment,

(ii) to note and support the work being undertaken to work towards a revised set of Adult Services financial reporting headings,

(iii) approve the revised delegation of authority until the end of the current financial year to the Chief Financial Officer to approve, in consultation with the Chief Officer, virements without further reference to the Board. Any virements made above £500,000 will be reported back to the Board in future Finance papers, and

(iv) note that Finance Monitoring Reports will be presented to future IJB Board meetings.

2. BACKGROUND

During the financial year 2015/16 Angus IJB received periodic reports regarding the financial performance of local Community Health and Adult Care services – generally those services that were to be formally devolved to the IJB from 1st April 2016.

This report is the third Finance Monitoring report since the IJB inherited formal responsibility for the management of devolved services.

This report is structured in the following way:-

a) Update re budget setting.
b) NHS devolved budgets.
c) Angus Council devolved budgets.
d) Partnership Funds
e) Financial Risk Assessment.

The Board will recall that the Angus IJB Integration Scheme set out that for 2016/17 and 2017/18, should the IJB overspend then that overspend would be attributed back to the Partner organisation in which the overspend was incurred.

The IJB's detailed forecast financial position for 2016/17 is set out in appendix 1.

3. CURRENT POSITION

3.1 UPDATE RE BUDGET SETTING

The IJB Board continues to receive reports providing updates regarding the budget settlements with NHS Tayside and Angus Council. There remain a small number of issues still to be resolved between NHS Tayside and Angus HSCP regarding the detail of devolved budgets but progress continues to be made in addressing these issues.

3.2 NHS DEVOLVED BUDGETS

Budgets devolved from NHS Tayside are described in a series of components as follows:-

- Local Hospital and Community Services
- Service Hosted in Angus on behalf of Tayside IJBs
- Services Hosted Elsewhere on Behalf of Angus IJB
- GP Prescribing
- General Medical Services and Family Health Services
- Large Hospital Services.

Local Hospital and Community Health Services

Previously a range of in year and recurring savings proposals have been approved by the IJB. These together with a series of other non-recurring under spends mean these budgets will under spend this year. Some comments, many similar to those listed in the last update, regarding the main variances are noted below:-

- Psychiatry of Old Age – Short term under spends in advance of implementing service redesign. Some of these short term under spends are likely to be offset by one-off costs of agency medical staffing.
- Minor Injuries – Under spends due to staffing levels reflecting revised opening hours.
- Community Nursing – Long term overspends due to underlying activity levels; service subject to review including review of Medicines Administration.
- General Adult Psychiatry – Short term under spends in advance of implementation of Home Treatment Service.

While these budgets will collectively under spend this year by c£0.9m, there is still a shortfall on recurring savings of £623k as per paper (78/16). This is considered in a separate paper to the December Board meeting.

Service Hosted in Angus on Behalf of Tayside IJBs

Previously a series of in year savings proposals for these services have been approved by the IJB. These measures, together with a series of non-recurring under spends, mean some services will under spend or breakeven after delivering savings. However unmet savings and cost pressures mean overall these services are forecast to overspend this year by c£200k. Some comments regarding the main variances are noted below:-

- Tayside Out of Hours Services – Short term under spends due to some GP Out of Hours shifts being unfilled and some medium term nursing under spends that reflect current service configuration.
- Tayside Forensic Medical Services – Medical staffing risks continue as noted in Due Diligence process. The service continues to actively manage the issues.
- There is a level of unmet savings apportioned to these budgets but this apportionment has to be flexible to reflect the requirement of the IJB to deliver savings across a range of services.

The issue of addressing the residual shortfalls is considered in a separate paper to the December Board meeting.

Services Hosted Elsewhere on Behalf of Angus IJB

As the Board will be aware a number of devolved services are managed by other IJBs on behalf of Angus IJB. Previously it has been noted that there had been some progress towards identifying savings associated with these services but that there were significant underlying risks of overspends and the forecast is currently for an overspend of £599 Further information regarding this is set out in appendix 2. Issues such as outcomes of reviews of Mental Health Services would be reflected in this set of information.

GP Prescribing

Previous reports have highlighted the risks regarding GP Prescribing budgets and the fact that Angus IJB is an outlier with in Tayside and Scotland. Work is being taken forward at a Tayside level via the Prescribing Management Group and locally to address Prescribing overspends. This is described in detail in a separate report to the Board.

The current position remains that the Partnership is forecast to overspend by c£2.5m. This results from a combination of underlying volume growth being in excess of expectations, drug pricing being in excess of expectations and an under delivery of savings targets. It is also important to note that forecast cost reductions for 2016/17 are largely assumed to happen in the second half of the financial year, therefore any risk of under-delivery of those cost reductions has yet to materialise.

The Committee are reminded that Prescribing information is only available 2 months after the month end to which it refers. Therefore in compiling financial reports to October, this has to be based on actual costs to August and estimates for September and October. .

General Medical Services and Family Health Services

At this stage in the year, and noting the Scottish Government funding allocations received in July, along with the receipt of cost pressure funding from NHS Tayside in the budget settlement, these budgets are forecast to under spend this year (£58k). This includes allowing for a share of costs associated with the current arrangements at Brechin Health Centre. The provision of cost pressure funding allows recent growth in Enhanced Serves and Premises costs to be contained but longer term risks re further growth in these costs, the general uncertainties re General Practitioner recruitment and the introduction of a new GP contract from 2017 remain.

Budgets associated with other Family Health Services (FHS) are also forecast to slightly under spend this year (£32k).

Large Hospital Services

This is reflected for the first time in the IJB's financial report. The Board will recall this is a budget that is devolved to the Partnership for Strategic Planning purposes but is operationally managed by the Acute Sector of NHS Tayside. The budget is presented as breaking even in advance of further development of associated financial reporting and reflecting the risk sharing agreement for 2016/17.

Overall Position Regarding NHS Devolved Resources

The overall position is that NHS Services are expected to overspend this year by c£2.3m. The offsetting variances, including large overspends re Prescribing, are described above. The IJB Executive Management Team and Senior Leadership team continue to look for opportunities to make both in year savings and for efficiencies to contribute to the longer term financial sustainability of the IJB. The progress with this is reflected in separate papers to the Board.

3.3 ANGUS COUNCIL DEVOLVED BUDGETS (Adult Services)

The projected financial position for Angus Council's devolved budgets based on the October 2016 monitoring position shows a year end overspend of £389k. The breakdown of this overspend, by service area, can be seen at Appendix.1. It should be noted that work continues to reconfigure the sub headings appearing in each service area to improve the quality of the report and therefore, to avoid inconsistency with future reporting.

Part of the forecast overspend is due to an underlying increase in demand for services. This often materialises through payments to Third Party Providers. Other factors such as delays in, and under delivery of, 2016/17 savings are also reflected. The overall position is supported by some one- off benefits (e.g. those relating to part year implementation of Living Wage).

The ongoing strategic approach to delivering sustainable savings includes working with the Council's partner, Ernst & Young. This includes the Help to Live at Home project which continues to look at Care at Home with a view to changing the delivery model to achieve tangible savings in 2016/17. These savings targets were reflected in the 2016/17 budget settlement between Angus Integration Joint Board and Angus Council. Beyond the strategic approach, the IJB Executive Management Team and Senior Leadership team continue to look for opportunities to make both in year savings and for efficiencies to contribute to the longer term financial sustainability of the Partnership.

3.4 PARTNERSHIP FUNDS

Partnership Funds are described in more detail in a separate report to December's Board meeting. To the extent that funding has been formally agreed, this is reflected in the assessment of financial performance.

3.5 FINANCIAL RISK ASSESSMENT

Appendix 3 sets out ongoing or emerging financial risks for the IJB Board. Many of these are IJB-wide risks including examples such as future funding levels and the risks regarding delivery of savings. This risk register includes more detail than is held at a corporate level for Angus IJB's financial risks but does form part of the formal overall assessment of financial risks.

4. PROPOSALS

On behalf of the HSCP, Angus Council Finance team are continuing to work towards a revised set of financial reporting headings designed to better reflect the configuration of services provided. The Board are asked to note and support the progressing of that work.

Reflecting the above issue, a number of Adult Services budgets need realigned as we seek to refresh the budget management system. A number of the changes being undertaken will involve the reallocation of budgets to reflect financial reporting changes rather than service delivery changes.

Under the Financial Regulations of the IJB, budget virements (moving budgets from one areas to another) requires is delegated to the Chief Officer as follows:-

"The IJB CO, in consultation with the IJB CFO, can undertake budget virement of up to and including £500,000 under delegated authority subject to this virement not impacting upon current IJB, Council or NHS policies. Budget virement in excess of this sum requires approval of the IJB."

Due to the scale and urgency of some of the budget realignments required, it is noted that some of required virements will exceed the virement limit as set out in the financial regulations. The Committee is therefore asked to delegate authority until the end of the current financial year to the Chief Financial Officer, in consultation with the Chief Officer, to approve virements without further reference to committee to allow these necessary budget adjustments to be processed timeously, noting any changes progressed will not effect underlying service delivery. Any virements made above £500.000 will be reported back to the Board in future Finance papers.

5. FINANCIAL IMPLICATIONS

The main financial implications of this report are set out in the body of the report at section 3. The collective financial position of the IJB will have a material impact on the way Angus IJB provides services in future. By making ongoing progress with delivery of efficiencies and cost reduction programmes alongside service redesign and modernisation, the IJB will be most able to deliver the services it requires to deliver to the local population on a sustainable basis.

REPORT AUTHOR: ALEXANDER BERRY
EMAIL DETAILS: hsciangus.tayside@nhs.net

5 December 2016

List of Appendices:
Appendix 1: Angus Health and Social Care Partnership Financial Monitoring Report 2016/17
Appendix 2: Hosted Services
Appendix 3: Angus Health and Social Care Partnership Financial Risk Register

Appendix 1 - Angus Health & Social Care Partnership - Financial Monitoring Report 2016-17

	Adult Services		Angus NHS		Partnership Accounting	
	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over/Under
	£,000	£,000	£,000	£,000	£,000	£,000
Older Peoples Services						
Psychiatry Of Old Age			4,868	(284)	4,868	(284)
Medicine For The Elderly			3,449	(58)	3,449	(58)
Community Hospitals			3,382	(146)	3,382	(146)
Minor Injuries / O.O.H			2,047	(209)	2,047	(209)
Joint Community Loan Store			90	(3)	90	(3)
Community Nursing			3,608	171	3,608	171
Enhanced Community Support			601	(47)	601	(47)
Older Peoples Service	28,861	1,625	18,045	(576)	46,906	1,049
Mental Health	1,412	(6)	2,258	(80)	3,670	(86)
Learning Disabilities	10,527	349	486	(40)	11,014	309
Physical Disabilities	2,821	(11)	0	0	2,821	(11)
Substance Misuse	422	140	861	(51)	1,283	89
Community Services						
Physiotherapy			1,365	(36)	1,365	(36)
Occupational Therapy			677	(38)	677	(38)
Anti-Coagulation			306	(28)	306	(28)
Primary Care			760	(31)	760	(31)
Health Improvement			89	1	89	1
Carers Strategy			118	0	118	0
Complex Care			26	0	26	0
Homelessness	833	(71)			833	(71)
Community Services	833	(71)	3,341	(132)	4,174	(203)
Planning / Management Support						
Centrally Managed Budget	1,536	(1,446)	502	95	2,038	(1,351)
Grants Voluntary Bodies Angus			69	0	69	0
Management / Strategy / Support Services (inc central recharges)	1,362	(191)	708	(88)	2,070	(279)
Planning / Management Support	2,898	(1,637)	1,279	7	4,177	(1,630)
Local Hospital and Community Health Services			26,270	(872)		
Services Hosted in Angus on Behalf of Tayside IJBs						
Forensic Service			741	705	741	705
Out of Hours			6,778	(270)	6,778	(270)
Speech Therapy (Tayside)			993	(12)	993	(12)
Tayside Continence Service			1,470	30	1,470	30
Hosted Services Recharges to Other IJBs			(7,031)	(576)	(7,031)	(576)
Unresolved Savings Associated with Hosted Services			(338)	338	(338)	338
Services Hosted in Angus on Behalf of Tayside IJBs	0	0	2,613	215	2,613	215
Services Hosted Elsewhere on Behalf of Angus IJB			12,723	599	12,723	599
GP Prescribing			20,841	2,459	20,841	2,459
General Medical Services			16,419	(58)	16,419	(58)
Family Health Services			11,461	(32)	11,461	(32)
Large Hospital Set Aside			11,759	0	11,759	0
Grand Total	**47,775**	**389**	**102,086**	**2,310**	**149,861**	**2,699**

SERVICES HOSTED IN ANGUS IJB ON BEHALF OF TAYSIDE IJBs			
	Annual Budget	Projected Over/Under Spend	
	£	£	
ANGUS HOSTED SERVICES	9643430	790500	
HOSTED SERVICES ATTRIBUTABLE TO DUNDEE & PERTH IJBS	7030060	576275	72.9%
SERVICES HOSTED IN DUNDEE & PERTH IJBs ON BEHALF OF ANGUS IJB			
	Annual Budget	Projected Over/Under Spend	
	£	£	
ANGUS SHARE OF SERVICES HOSTED IN DUNDEE	4740000	32000	
ANGUS SHARE OF SERVICES HOSTED IN PERTH	7983000	567000	
HOSTED SERVICES ATTRIBUTABLE TO ANGUS	12723000	599000	

APPENDIX 3 – ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP FINANCIAL RISK REGISTER

Risks – Revenue	Risk Assessment		Risk Management/Comment
	Likelihood	Impact (£k)	
Savings Targets			
Progress to identify and deliver balance of 2016/17 recurring NHS savings target, additional 2017/18 NHS targets and to release funding to support overspends elsewhere.	Medium High	c£600k (2016/17) TBC (2017/18)	IJB pursuing:- actions as per IJB Report to December meeting.
Progress to deliver 2016/17 GP Prescribing Savings	High	c£2500k	Progress being taken forward through combination of local working and the NHST-wide Prescribing Management Group. See report to December meeting.
Progress to deliver 2016/17 agreed Adult Services savings and additional 2017/18 requirements in context of overall financial position of Angus Council.	Medium High	c£400k (2016/17) TBC (2017/18)	The IJB Senior Leadership Team continue to monitor delivery of 2016/17 planned savings and seek alternative measure were savings have not been delivered. The IJB continues to review its progress with Transforming Angus programmes and is considering other options to deliver further financial benefits in future years. This is rated high due to scale of financial challenge faced by Angus Council.
Cost Pressures			
Review of Nurse Staffing Levels by NHST Nursing Directorate may recommend increased staffing with consequent exposure to increased costs on basis of existing service configuration.	Low	Not known	No recent update from Nursing Directorate
IJB is still exposed to ongoing NHS overspends regarding Community Nursing and Forensic Medical Services.	High	c£900k	Both services are continuing to review service delivery models.
For 2016/17 IJB's Large Hospital Resources will be reported at breakeven. In the longer term this will be an increasing financial risk for the IJB.	Low Increasing	Nil (2016/17) From 2017/18	Existing Risk Sharing arrangements accommodate Large Hospital resources for 2016/17. Potential risks from 2017/18 or 2018/19 pending further discussion.
The IJB's Adult Services budgets are forecast to overspend in 2016/17. This is mainly as a result of demographic pressures and unmet savings.	Low High	c£300k (2016/17) c£700k (Recurring)	The IJB will improve its Adult Services budgetary framework and will look to non-recurring solutions to offset in year overspends. The IJB continues to explore permanent resolution to underlying overspends.
The IJB has a number of significant impending (2017/18) cost pressures that will feature as part of budget settlement discussions with Angus Council.	High	c£2.5m	Rated high due to scale of financial challenge faced by Angus Council and the impact that position will have on the budget settlement discussions.
Other (including Funding)			
Impact of NHS Tayside overall financial position.	High	Not known	The overall financial picture for NHS Tayside may influence budget settlement discussions between NHST and the IJB.
Impact of Angus Council overall financial position.	High	Not known	Angus Council has documented the scale of the financial challenge it faces. This will affect the 2017/18 budget settlement discussions between Angus IJB and Angus Council.
Resolution of Devolved Budgets to the IJB (current or emerging issues)	Low Medium	Low 16/17 Not known (from 2017/18 only)	Some issues remain unresolved. NHS Tayside may consider the devolution of NHS funding to support Complex Care to IJBs. Angus currently consumes a high proportion of the Tayside funding for Complex Care.
Integrated Care Fund	High	£2.13m from 2018/19	Scottish Government funding of £2.13m only confirmed to March 2018. It is proposed to set aside short term bridging funds to assist manage sustainability planning – see papers for December meeting.
Finance Support Structure	Medium	N/A	Support in both Angus Council and NHS Tayside continues to evolve and is subject to issues such as staff turnover. CFO continues to work with both Angus Council and NHS Tayside to ensure required support in place but currently there are areas of risk (including ability to improve Locality Finance reporting).

AGENDA ITEM NO 8

REPORT NO IJB 87/16

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 14 DECEMBER 2016

PARTNERSHIP FUNDS

REPORT BY ALEXANDER BERRY, CHIEF FINANCE OFFICER

ABSTRACT

The purpose of this report is to update the Board regarding the status of a series of Partnership Funds that are routinely overseen by the Partnership's Strategic Planning Group (SPG) with routine management and review through the Partnership's Finance Monitoring Group (FMG).

1. RECOMMENDATIONS

It is recommended that the Board:-

(i) Notes the background information regarding Partnership Funds including the status of the funds described.

(ii) Reviews and supports the funding plans for utilisation of Social Care Funding as set out in the report (section 2.3).

(iii) Reviews and supports the funding plans for utilisation of Integrated Care Fund (ICF) funding as set out in the report (section 2.4) including the proposals regarding the utilisation of Social Care Funding.

(iv) Reviews and supports the funding plans for utilisation of Delayed Discharge funding as set out in this report (section 2.5) including noting that these plans may, in due course, be subject to material revision and noting the proposal to support system wide capacity issues in 2016/17 only.

(v) Requests that half yearly Partnership Funds reports continue to be submitted to the IJB Board on behalf of the Strategic Planning Group. Should there be material changes in funding assumptions, then updates will require to be brought back earlier than otherwise scheduled.

2. PARTNERSHIP FUNDS - BACKGROUND

2.1 In May 2016 (IJB paper IJB/46) it was agreed that the Angus HSCP Finance Monitoring Group (FMG) would continue to have the role of overseeing Partnership Funds on behalf of the Angus HSCP's Strategic Planning Group. It was agreed that the FMG would provide reports to the SPG regarding Partnership Funds and that, in turn, the SPG would provide a half-yearly report to the IJB Board regarding those funds. This report is the most recent half yearly report to the IJB Board on behalf of the SPG.

2.2 Ongoing Partnerships Funds have been previously listed as

- Social Care Funding (from 2016/17)
- Integrated Care Fund (from 2015/16)
- Delayed Discharge Funding (from 2015/16)
- Technology Enabled Funding (from 2015/16).

Of these funds, Social Care Funding and Delayed Discharge are now confirmed as being permanent allocations, the Integrated Care Fund is confirmed to March 2018 only and the Technology Enabled Funding is time limited.

These funds are now described in the sections below with future funding proposals set out for review and approval. Once funding streams are deemed to have become mainstream, then they will be monitored alongside core Angus HSCP resources and no longer subject to specific monitoring by the Finance Monitoring Group or Strategic Planning Group.

2.3 SOCIAL CARE FUNDING (Share of Scotland £250m, AHSCP - £5.376m; permanent funding)

As noted in previous papers to the IJB Board much of the Angus share of this Scottish Government funding stream was allocated in line with Scottish Government guidance to cover commitments including 1) addressing charging issues and supporting the costs of additional Social Care capacity and 2) the introduction of the Living Wage and forecast cost burdens within Local Authorities (Adult Social Care). Previous papers provided to the Angus IJB Board (70/16) described these two groups of commitments as Tranche 1 and Tranche 2 – again reflecting Scottish Government guidance.

Tranche 2 of this funding was revisited in October's Angus IJB Board meeting (paper 84/16). It was noted that there will be an impact of c£608k to Angus Council's financial planning arrangements as a result of the Living Wage implementation. This is now reflected in Angus Council's financial considerations for 2017/18.

Tranche 1 of the funding has previously been allocated as follows:-
Table 1

Description	£k	Comment
Demographic Growth (Older Peoples Services)	700	Now embedded in Adult Services Budgets
Demographic Growth (Mental Health)	230	Now embedded in Adult Services Budgets
Demographic Growth (Learning Disability)	497	Now embedded in Adult Services Budgets
Amendment to Charging Thresholds	130	To be embedded in Adult Services budgets
Sub-total	1557	Now mainstreamed
Further consideration	1113	See below
Total	2670	

It is now noted that the sub-total of £1557k noted in table 1 is mainstreamed alongside overall Adult Services resources and will be monitored alongside overall Adult Services resources. These resources therefore no longer need to be considered by FMG, SPG or the IJB Board as discrete funding.

However the balance of £1.113m has been considered by the Finance Monitoring Group, and shared with the SPG, and a proposal for its allocation is set out in this paper (see section 2.4). In considering the options available, the FMG had to take into account the overall financial position of the HSCP including the status of other funding streams that support commitments within the HSCP and other issues that will be have an imminent impact on the IJBs ability to deliver services within overall resources.

After recommendations in section 2.4 of this paper there remains a balance of c£0.5m available to allocate from this Social Care Funding stream. For 2016/17 only, it is recommended that these resources are used to support the overall pressures within Angus HSCP Social Care with this position being reviewed further later in 2016/17.

2.4 INTEGRATED CARE FUND (£2.13m; to March 2018)

In 2015/16, Angus Partnership received £2.13m of Integrated Care Fund (ICF) funding from the Scottish Government. This funding stream was initially in place for a 3 year period (i.e. to March 2018). To date funding has been allocated in line with Scottish Government guidance and local priorities consistent with the Angus HSCP Strategic Plan. From the outset there has been uncertainty regarding the longer term status of this funding stream, though this may be resolved in the near future. This issue has previously been noted as a major risk for the Angus HSCP with significant service commitments dependant on this funding stream.

Due to the impending March 2018 end date for this funding stream, the FMG has increasingly being focussed on the sustainability issues associated with this funding stream. This has included considering if some of the commitments could now be mainstreamed through other funding sources and looking at options to assist with managing the transition to sustainable solutions over a period beyond March 2018.

After receiving reports from the FMG, the SPG are now recommending that some of the Social Care Funding stream noted in 2.3 is now used to support the mainstreaming of Social Care capacity that is delivered from within the Integrated Care Fund. As at 2016/17 this is expected to be c£600k per annum on an ongoing basis. This is consistent with the intention of the Social Care Funding stream to support additional capacity in Social Care. This also assists with managing the sustainability issues regarding this funding stream from March 2018 and reduces the burden on the ICF each year. Reducing the burden on the ICF to March 2018 allows the HSCP to create a fund that can be managed over an extended period to assist with the transition to sustainable solutions for the remaining commitments against the Integrated Care Fund.

At this stage, given the uncertainty regarding the Integrated Care Fund, to not address these risks would leave the Angus HSCP exposed to a higher level of unsustainable commitments against the ICF and leave little room for managing the transition to sustainability post-March 2018.

The proposed revised plan is now set out in the table below:-

Angus Integration Joint Board – Integrated Care Fund Summary (ICF)						**Table 2**
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	
	Actual	**Plan**	**Plan**	**Plan**	**Plan**	
Project/Workstream	**£k**	**£k**	**£k**	**£k**	**£k**	**Notes**
Enablement – Social Care Enablement Teams	195	0	0	0	0	To be funded from Social Care Funding
Enhanced Community Support	300	0	0	0	0	Mainstreamed from 2016/17
Physiotherapy & Generic Rehab & Falls	149	155	160	160	160	
Hospital Discharge Pathway	297	0	0	0	0	To be funded from Social Care Funding
Dementia	101	108	108	108	108	
Supported Housing	75	0	0	0	0	Concluded March 2016
Organisational Development Support	224	215	228	204	175	Including Independent Sector Support
Supporting Self Directed Support	1	91	71	0	0	Time Limited
Data Sharing System	0	0	100	0	0	Earmark only
Carers Support	258	245	256	256	256	
Working with Communities	296	191	135	135	135	
Working with Communities II	0	400	400	300	300	To be agreed with Voluntary Sector
Joint Store	0	200	0	0	0	One off only
Keep Well	13	48	73	73	73	
Locality Allocation	0	100	200	150	150	Formally 2 year agreement only
Glen Isla	62	60	60	0	0	
Other	89	99	52	52	52	
Movement Between Funds (ICF/Delayed Discharge)	0	0	511	0	0	
Total	**2060**	**1913**	**2354**	**1438**	**1409**	
Brought Forward from Previous Year	**1124**	**1194**	**1411**	**1187**	**0**	Carry forwards dependent on Social Care Funding
Scottish Government Funding (Confirmed)	**2130**	**2130**	**2130**	**0**	**0**	
Residual Shortfall	**0**	**0**	**0**	**251**	**1409**	Residual shortfall
Carried Forward to Next Year	**1194**	**1411**	**1187**	**0**	**0**	

Regarding table 2, it is important to note the following:-

- Individual projects will still be subject to approval through the FMG.
- Due to uncertainties regarding funding, projects funded via ICF currently have time limited approval to a maximum of March 2018.
- Some of the allocations shown from 2018/19 onwards are high-level ear marks and will not necessarily be approved – for example Locality Allocations will be displaced by increased locality involvement in overall HSCP resource management.

- The benefits of mainstreaming some Social Care costs against the Social Care Funding and then releasing ICF funds across an extended time frame can be seen in that it creates an improved timeframe for managing sustainability issues and can increase the planned funding duration for remaining projects.
- Table 1 would need to be re-worked should the Scottish Government clarify their position regarding permanence of the £2.13m funding stream.
- Currently this plan is reliant on the IJB being able to carry forward funds from one financial year to the next. This has happened at a similar scale as set in table 1 in previous years and in this proposal is assumed to be a flexibility that continues to be available to the IJB. However this will be reviewed on an ongoing basis. It is recommended that the timing of the utilisation of Social Care funding to support ICF costs, shown as from April 2016 in table above, is kept under review by the Finance Monitoring Group and managed flexibly.
- Information regarding ICF investments will be included in the Partnership's Annual Performance Report.

2.5 DELAYED DISCHARGE

In 2015/16, Angus Partnership received £639k Delayed Discharge funding from the Scottish Government. The utilisation of this funding stream in 2015/16 and plans for 2016/17 have been previously described (report IJB/40). The main intention of this permanent funding stream is to maximise opportunity for effective discharge planning and minimise number of unnecessary admissions.

Previous plans have included a significant level of investment allocated to Enhanced Community Support (ECS) and Developing Care Markets. Much of the 2016/17 funding had been intended to support the roll out of ECS in particular in advance of the development of sustainable funding solutions.

As things stand, there has been slippage on the implementation of ECS more widely across Angus in 2016/17. This may reflect the optimism of the original timeline but may also reflect the difficulties of rolling out services based on short term funding without a sustainable funding plan being in place. This paper does not seek to amend those high level plans but separate papers to the Board describe options regarding ECS that would, if approved, amend the planned utilisation of the Delayed Discharge funding.

While Angus HSCP is generally making progress with the management of Delayed Discharges, this remains an area of high priority for the Partnership. Issues are not restricted to Older Peoples Services. Once the position regarding ECS is clearer then this funding stream can be reviewed through the Delayed Discharge working groups and FMG. Reviews would take into account a range of client groups and also reflect the broader financial planning environment of Angus HSCP including the risks regarding ICF funding.

Angus Integration Joint Board – Delayed Discharge Summary						**Table 3**
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	
	Actual	**Plan**	**Plan**	**Plan**	**Plan**	
Project/Workstream	**£k**	**£k**	**£k**	**£k**	**£k**	**Notes**
Develop Home Care Market Contracts	0	50	150	150	0	Temporary Funding
Enhanced Community Support	4	116	860	40	0	May be revised by review of ECS
Working with Communities	114	38	25	0	0	Temporary Funding
Clinical Pathways	20	52	66	66	66	Including Acute Frailty Team
Developing Care Homes	0	16	0	0	0	
Other	26	73	49	49	49	
System Capacity (Tayside)	558	217	0	0	0	
System Capacity (Winter)	0	100	0	0	0	
Movement between Funds (ICF/Delayed Discharge)	0	0	-511	0	0	Reflected in ICF Plans
Unallocated	0	0	0	334	524	May be revised by review of ECS
Total	**722**	**663**	**639**	**639**	**639**	
Brought Forward from Previous Year	**107**	**24**	**0**	**0**	**0**	
Scottish Government Funding	**639**	**639**	**639**	**639**	**639**	
Carried Forward to Next Year	**24**	**0**	**0**	**0**	**0**	

In 2015/16, due to the pressures within the overall Tayside and Angus system regarding Delayed Discharge, it was agreed that part of the Angus HSCP's Delayed Discharge allocation would be utilised to support system capacity issues across Tayside - including those regarding Angus patients.

Members of the Board will be aware of the pressure (both service delivery and financial) that the whole NHS Tayside system is currently under. Noting the slippage on the implementation of ECS in 2016/17, and that Angus HSCP's overall financial position (forecast overspend of c£2.3m re Health Services) exacerbates the financial pressures on NHS Tayside, the SPG are suggesting a balance of c£200k-£250k of Delayed Discharge funding is used to assist meet overall NHS Tayside pressures regarding winter planning and Delayed Discharge – including pressures associated with Angus patients. This is reflected in the planned commitments in the table above table for 2016/17 only. This would not affect longer term planning for this funding stream.

2.6 TECHNOLOGY ENABLED FUNDING

While this funding is overseen by the Finance Monitoring Group, there is minimal local flexibility as to how the funding is applied as approved funding comes direct from the Scottish Government Technology Enabled Care Programme for specific developments. Angus has been awarded £155,000 payable over the financial years 2016/17 and 2017/18 to specifically enhance telecare. Angus has also been awarded £87,500 payable over the financial years 2016/17 and 2017/18 to host a Tayside wide telehealth initiative.

3. RESOURCE MANAGEMENT ISSUES

3.1 The points below cover various issues regarding management of resources.

3.2 DEVOLVING FUNDS TO THE THIRD SECTOR

Angus HSCP continues to devolve funding to the Third Sector (principally Voluntary Action Angus) in line with the Partnership's overall strategic objectives. From 2016/17, Voluntary Action Angus (VAA) has played an increasing role in the allocation process associated with Partnership Funds and is developing a monitoring role on behalf of the Partnership for funds committed to the Third Sector. It remains the intention that the HSCP will consider developing this role over time. This will be considered in stages and in the context of other financial developments (e.g. development of Localities) and other clarifications (e.g. re permanence of funding).

3.3 DEVOLVING FUNDS TO LOCALITIES

ICF plans include Locality Allocations. These are funds that have been made available in 2016/17 for individual localities to prioritise for investment in line with local plans and consistent with the HSCP's Strategic Plan. Progress with this has been slower than originally envisaged but it is anticipated that a number of commitments will be progressed in the near future. A framework for allocating this funding has been developed.

4. CONCLUSIONS

4.1 The Board should note the range of issues set out regarding Social Care Funding, Integrated Care Funding, Delayed Discharge Funding and Technology Enabled Funding. As the HSCP develops it is increasingly important for these resources to be seen in the context of the overall Partnership, the Partnership's longer term financial planning and in the context of the financial pressures facing Angus HSCP and both Angus Council and NHS Tayside.

The recommendations set out for the Committee reflect this position.

REPORT AUTHOR: ALEXANDER BERRY
EMAIL DETAILS: hsciangus.tayside@nhs.net

5 December 2016

AGENDA ITEM NO 9

REPORT NO IJB 88/16

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 14 DECEMBER 2016

BUDGET AGREEMENTS WITH PARTNERS AND FINANCIAL PLANNING FRAMEWORK

REPORT BY ALEXANDER BERRY, CHIEF FINANCE OFFICER

ABSTRACT

The purpose of this report is to update the Integration Joint Board regarding the status of the Budget Settlement between Angus IJB and NHS Tayside and Angus Council for 2016/17 and the financial planning framework for Angus IJB's Services.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:-

(i) Note the status of the delivery of 2016/17 Adult Services planned savings and the position that shortfalls in delivery of these savings will be reported within the overall Angus HSCP financial position for 2016/17 and then offset against additional recurring savings measures from 2017/18.

(ii) Note the investment submissions made to Angus Council for 2017/18 and support the Chief Officer and Chief Finance Officer in taking forward discussions with Angus Council regarding these submissions, noting all discussions will be in the context of the overall financial challenges facing Angus Council.

(iii) Note that Angus HSCP is committed to delivering cost reductions and efficiency savings for 2017/18 and that in turn proposals will be shared with Angus Council.

(iv) Approve both the savings proposals described in section 3.2 of the report and the further recommendations listed in table 2.

(v) Note that the Strategic Planning Group have endorsed proposals for the future planning of Minor Injury and Illness Services and approve the £170k of recurring savings supported by the Strategic Planning Group from April 2017.

(vi) Approve the savings of £274k (£50k conditional) identified by the Service Managers and described in appendix 1 and request further feedback to the Board regarding services listed at 3.5.

(vii) Approve the additional measures for assisting to delivering further efficiencies with the IJB's Health Services as described at section 3.6.

2. BUDGET AGREEMENT WITH ANGUS COUNCIL AND FINANCIAL PLANNING FRAMEWORK

2.1 This report covers a number of issues as follows:-

2.2 <u>2016/17 Savings Proposals</u>

Report 70/16 described the Adult Services savings the IJB had agreed with Angus Council for 2016/17 and on a recurring basis. That report suggested that while it was still forecast that the full recurring savings targets of £2.457m will be delivered there will be in year shortfalls.

Since that report was written there have been a number of reviews of actual savings delivered against this target and the current forecast is as follows:-

Table 1

Description	Planned Saving	Forecast Saving (Recurring)	Forecast Shortfall (Recurring)	Shortfall
	£K	£K	£K	
IJB Agreed Savings (Excluding Sheltered Housing)	1957	1794	163	Across a range of proposals
Sheltered Housing	500	270	230	As per Angus Council report 186/16
Total	2457	2064	393	

Of the shortfall of £433k, the first £163k was due to a range of factors including savings measures that could not be fully implemented, or failed to deliver the planned savings. In year this shortfall will be reported within Angus HSCP and will require to be offset through additional savings measures elsewhere on a permanent basis. This will reduce the ability to contribute additional 2017/18 savings to an equivalent extent.

There is also a forecast shortfall regarding Sheltered Housing. This was described in Angus Council report 186/16. The current situation is the IJB's financial settlement with Angus Council, agreed in February 2016 did not accommodate this shortfall (as set out in 186/16) and the IJB will seek to manage this through additional savings measures elsewhere on a permanent basis. This will reduce the ability to contribute additional 2017/18 savings to an equivalent extent.

2.3 2017/18 Investment Submissions

Angus HSCP has submitted a series of investment submissions to Angus Council for consideration as part of the 2017/18 budget setting process. The list included issues that could be viewed as corporate issues within Angus Council as follows:-

- Providing sufficient funds in to cover Third Party Provider inflation in 2017/18 reflecting increased costs such as the Apprenticeship Levy and further changes in the Living Wage.
- Addressing the existing Living Wage shortfall (see paper 84/16).

In addition to the above Angus HSCP has submitted investment bids including the following:-

- Learning Disability - Demographic growth (Children in Transition)
- Older Peoples Services - Demographic Growth
- Learning Disability – South West Angus (Changes in Family Support)
- Mental Health - Level 4 Accommodation Needs /Delayed Discharge
- Mental Health - Adults with Incapacity Act /Mental Health Officer Team
- Mental Health - Adults with Incapacity Act /Capacity Impact

There is a significant cost impact of the above reflecting ongoing demographic growth in services such as Older People and Learning Disability but also emerging issues regarding Learning Disability (Changes in Family Support) and Mental Health. The overall list of investment bids was submitted to Angus Council as part of the budget discussion for 2017/18 and will be subject of further discussion with Angus Council in due course. While it is requested that Board members support the Officers involved in those discussions with Angus Council, these budget discussions will be undertaken in the context of the overall financial challenges facing Angus Council.

2.5 2017/18 Savings Measures

As a partner with Angus Council, Angus IJB is committed to delivering further cost reductions and efficiency savings from 2017/18 and the IJB is already committed to increased levels of savings regarding the further implementation of Help to Live at Home. Whilst acknowledging the cumulative effect of previous years savings measures, the IJB's Senior Leadership team have been developing further savings and efficiency options. In advance of final discussions with Angus Council regarding additional 2017/18 savings, the IJB Board will have the opportunity to assess any new options in the context of their consistency with the Angus HSCP Strategic Plan and the statutory obligations of both Angus Council and Angus HSCP.

3 **BUDGET AGREEMENT WITH NHS TAYSIDE AND FINANCIAL PLANNING FRAMEWORK**

3.1 Report 78/16 set out the financial challenges faced by the IJB's Health Services. These were as follows:-

1. Unresolved local 2016/17 savings targets carried forward:- £0.623m (per 53/16).
2. Unresolved hosted (by Angus IJB) services 2016/17 savings targets carried forward:- £0.247m (from 53/16).
3. Potential 2017/18 additional recurring savings (excluding Prescribing):- estimate c£1.0m - subject to further discussion with NHS Tayside).
4. Funding required to offset existing cost pressures (e.g. GP Prescribing):- say £0.5m from 2017/18.

This creates a total savings burden of c£2.37m from April 2017 assuming Prescribing plans assist balance current Prescribing over commitments and partner IJBs are able to make progress with Hosted Services. While £2.37m is an initial estimate, it is proportionate to the challenge faced by NHS Tayside.

Report 78/16 described a series of measures that were being looked at to assist address the challenge. The status of that work is described below.

3.2 <u>Work Programmes Previously Agreed by Angus IJB Board</u>

In June 2016, the IJB agreed a series of work programmes with the intention that these be progressed to deliver recurring efficiencies that will assist with the IJB's overall financial position from April 2017. An update regarding these programmes was provided in October and the table below provides a further update and a series of recommendations.

The current status is noted in the table below.

Table 2

Programme	Provisional Saving Target (£K)	Current Proposed Savings Plans (£K)	Status	Recommendation
Travel & Transport	25	TBC	Work in Progress	Update report to be provided to Jan. 2017 Executive Management Team and summarised outcomes to be subsequently shared with IJB Board.
Non GP Prescribing	25	TBC	Work In Progress	Update report to be provided to Jan. 2017 Executive Management Team and summarised outcomes to be subsequently shared with IJB Board.
IJB Management Review	50	29	This represents a consolidation of AHP Management resources.	Saving be approved and revised management arrangements put in place within balance of funding.
IJB Administration & Clerical (A&C) Review	50	73	Savings identified by Exec. Management Team (see 3.5 below) to Dec'16.	Saving be approved and allocate Improvement Team resource to progress this further across partnership and alongside NHST Corporate Administration Review. Report to future Board meeting.
OT (Integration) Review	35	TBC	Work in Progress	Board to request formal report setting out plans for OT Integration to Feb.17 Board meeting, including identifying required financial and service efficiencies within that plan.
Community Nursing Review Community Nursing (Medication Administration)	130	0	Service currently overspend by c£150k-£200k pa. Redesign will be taken forward with new Service Manager to resolve overspend by April 2018.Report to future Board meeting.	
OOH Service Nursing Review (Note – This is a hosted service.)	TBC	56	Long term review still pending.	Saving be approved reflecting proposed consolidation of existing staff costs to release saving in advance of redesign.
Total	315	158		

It is recommended that both the £158k of savings from April 2017 described above and the further recommendations set out in the table are approved.

3.3 Further Work Being Considered via the Strategic Planning Group (SPG)

The IJB Board requested the SPG to consider two pieces of work in November 2016. These were regarding 1) Locality Community Services and In Patient Services and 2) Minor Injury and Illness Services. The IJB's Strategic Plan set out that these services would be reviewed in the context of contributing to the financial planning challenges facing the IJB and given the scale of the financial challenge it should be anticipated that reviews such as described here would make a contribution to the IJB's overall financial planning.

3.4 A separate paper "Enhanced Community Services Proposals" (IJB 85/16) describes the position regarding Locality Community Services and In Patient Services. Minor Injury and Illness Services were discussed at November 2017 Strategic Planning Group meeting. That meeting endorsed a planned review of these services from within the resources associated with the current service configuration. It was therefore agreed that £170k of recurring budgets could be released to offset the Partnership's savings targets reflecting current under spends against the historic budget.

3.5 Further Measures Being Taken Forward via the Executive Management Team

As noted in paper 78/16, the IJB's Executive Management Team has been reviewing the potential for all services to deliver 2% of additional recurring savings against the background of the level of non-recurring 2016/17 forecast under spends.

Managers have been responding to this request over recent weeks and the summarise position, is set out in appendix 1. Noting that a number of services had mitigating factors in terms of responding to this review (e.g. due to documented over-spends, recent redesigns, time limited funding etc.), paper 78/16 suggested that a target of £500k may be deliverable. After the first phase of this exercise, it is suggested that the £224k of recurring savings described in appendix 1 are approved by the IJB noting that this largely reflects a consolidation of existing service configurations and forecast under spends. It is also noted that a further £50k of savings can be approved conditionally pending clarification of other funding streams. (Total £274k). This process also generated the £73k of admin savings described in section 3.1.

Appendix 1 also notes a range of services where the Board should request further feedback from services at the next Board meeting including Occupational Therapy, General Adult Psychiatry, Grants Payable to Voluntary Bodies, Continence Service and Speech Therapy (Tayside). The opportunities for further savings from these services may be more limited.

3.6 Additional Measures for Consideration within Health Services

THE IJB Board asked the Angus HSCP Executive Management Team, Senior Leadership Team and Strategic Planning Team to consider high level options for the delivery of further savings. Feedback to date has suggested that, in addition to following up issues from 3.2 and 3.5 above, the following should be considered:-

1. In line with the Strategic Plan, ongoing review of the IJB's configuration of service delivery at the In Patient/ Community interface (including Psychiatry of Old Age).
2. Further and more detailed reviews of actions being progressed through NHS Tayside's Transformation Programme where they will be of material cost reducing benefit to Angus HSCP.
3. More generally further reviews of current and planned services in the context of the Strategic Plan and identifying and delivering operational efficiencies through existing or new forums.

3.7 Overall Summary

It is important to note that this paper does not address the improvement plans required for Prescribing, services hosted elsewhere on behalf of Angus HSCP or issues relating to Large Hospital Services. However, noting the scale of the financial challenge facing the HSCP, this paper does set out a range of proposals that help to address the financial challenges of the HSCP. The savings proposed to date are summarised below:-

Plans	Proposed Recurring Savings (£k)
Work Programmes Previously Agreed by Angus IJB Board (see 3.2)	158
Review of Community and In Patient Services (pending paper IJB 85/16)	430
Review of MIIUs (See 3.4)	170
Executive Team Review of Budgets (see 3.5)	274 (£50k –conditional)
Total	1032

This total of £1032k falls short of the requirement set out in section 3 of c£2.3m, but would allow the IJB to confirm that 100% of the devolved savings targets for local services had been met. Issues would remain regarding hosted services, 2017/18 savings targets and the challenges of addressing local cost pressures (e.g. Prescribing).

4. PROPOSALS

Noting the status of the IJB's financial planning for NHS Services, the recommendations of this paper reflect the content of sections 3.1 to 3.7.

The impact of the above proposals has been reviewed. The general assessment is that the impact is generally limited as many of the proposals now reflect current services delivery or service configuration. This suggests that much of the change associated with delivering these efficiencies has been contained within the system. The collective effect of identifying savings of c£1m is to limit the future scope for that funding to be invested or reinvested in services – though reinvestment is considered in paper IJB 85/16. The general level of savings required, and delivery of those savings as set out in this paper, is a reflection of the overall 2016/17 budget settlement – in this case with NHS Tayside.

5. FINANCIAL IMPLICATIONS

The main financial implications of this paper are set out in section 3. The collective financial position of the IJB will have a material impact on the way Angus IJB provides services in future. By making ongoing progress with delivery of efficiencies and cost reduction programmes alongside service redesign and transformation consistent with our strategic priorities as expressed in the Strategic Plan, the IJB will be best able to deliver the services it requires to deliver to the local population on a sustainable basis. In future it will increasingly be the case that the IJBs overall health and social care resources are considered collectively and addressing issues such as the identification of savings will happen more seamlessly across the Partnership.

REPORT AUTHOR: Alexander Berry, Chief Finance Officer
EMAIL DETAILS: hsciangus.tayside@nhs.net
December 2016

Appendices

Appendix 1 – Angus HSCP – Executive Management Team Submission

Appendix 1

AHSCP – Executive Management Team Submission

		Breakdown of Efficiencies					
	Annual Recurring Budget	General	Conditional	Admin	Total	Comment	Impact Assessment
	£K	£K	£K	£K	£K		
Psychiatry of Old Age	4,836	36	50	1	87	Reflects existing underspends	Nil/Low as reflects current service provision
Medicine for the Elderly	3,400	52	0	9	61	Reflects existing underspends	Nil/Low as reflects current service provision
Community Hospitals	4,203	39	0	49	88	Reflects existing underspends	Nil/Low as reflects current service provision
Community Medicine & Rehabilitation	**18,861**	**128**	**50**	**59**	**237**		
Physiotherapy	1,360	24	0	0	24	Service currently underspending	Planned vacancy from 2017/18
Occupational Therapy	715	0	0	0	0	Request further feedback	N/A
Allied Health Professions	**2,075**	**24**	**0**	**0**	**24**		
General Adult Psychiatry	2,258	24	0	3	27	Request further feedback	Nil/Low as reflects current service provision
Drug Problems Service	699	19	0	0	19	Service currently underspending	Note general impact of ADP funding shortfalls
Community Mental Health	**3,090**	**42**	**0**	**3**	**46**		
Learning Disability (Angus)	**486**	**10**	**0**	**0**	**10**	Reflects existing supplies underspends	Nil/Low as reflects current service provision
IJB (NHS) Management	564	0	0	0	0	See section 3.1 of report	N/A
Anti-Coagulation	306	6	0	0	6	Service currently underspending	Nil/Low as reflects current service provision
Primary Care	488	0	0	11	11	Service currently underspending	Nin/Low as Admin related
Grants Voluntary Bodies Angus	69	0	0	0	0	Request further feedback	N/A
Other Angus Services	**9,459**	**6**	**0**	**11**	**17**		
Out of Hours	6,748	0	0	0	0	See section 3.1 of report	N/A
Tayside Continence Service	1,428	14	0	0	14	Request further feedback	Nil/Low as reflects current service provision
Speech Therapy (Tayside)	972	0	0	0	0	Request further feedback	N/A
Hosted Services	**9,362**	**14**	**0**	**0**	**14**		
Centrally Managed Budget	-1,066	0	0	0	0	N/A	N/A
Total Hospital & Community Health Services	**42,268**	**224**	**50**	**73**	**348**		

AGENDA ITEM NO 10

REPORT NO IJB 89/16

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 14 DECEMBER 2016

PRESCRIBING MANAGEMENT

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

1. RECOMMENDATION(S)

It is recommended that the Integration Joint Board:-

(i) Note the current financial position and the actions being taken regionally and locally to ensure safe effective prescribing and delivery of the efficiency savings targets both in the short and longer term.

(ii) Request that a further update is provided to the April 2017 meeting of the Board describing a costed action plan, reflecting both actions taken regionally and locally, that returns Angus Health & Social Care Partnership's Prescribing budgets towards breakeven by the end of 2017/18.

2. BACKGROUND

NHS Tayside, and Angus prescribing spend is in excess of that in Scotland. This is in part due to higher than average prevalence of a variety of chronic diseases and the regional adoption of clinical pathways aimed at providing patients with the best possible care. There is evidence to support that investing in prescribing for some care pathways reduces mortality and morbidity and provide good examples of positive variation and reduced spend in other parts of the system. There are however a number of areas of unexplained variation which require further investigation and action.

A number of factors affect prescribing rates, including age, deprivation, clinical guidelines and rurality. The Quality and Outcomes Framework (QoF) within the GMS contract resulted in increased rates of prescribing; it is unclear what impact cessation of QoF will have on prescribing rates. There is a little evidence that the abolition of prescription charges has impacted on prescribing rates. It is estimated that drug wastage costs in Scotland are up to £20 million per year, with approximately 50% waste avoidable. Main causes of drug waste include repeat prescribing processes (including over ordering by patients) and prescribing in care homes. (Prescribing in general practice in Scotland: Audit Scotland, 2013).

3. CURRENT POSITION

Regionally the Tayside Prescribing Management Group, chaired by Dr Michelle Watts and Dr Gavin Main, are developing a 5 year strategic plan. Developed in collaboration with clinical teams across Tayside it aims to deliver the best possible healthcare, at the lowest possible cost, delivering the best experience for patients. Dr Alison Clement, Clinical Director and Mrs Rhona Guild, Primary Care Manager/Long Term Conditions Lead represent Angus on the Tayside Prescribing Management Group.

A detailed position statement outlining the current state with regards regional prescribing, and the proposed measures will be presented to NHST Board on 1 December and shared with the Public Audit Committee on 15 December **(Appendix 1).**

Within Angus a Prescribing Management Team is meeting monthly and leading the development of an Angus Prescribing Workplan incorporating both regionally prioritised actions and those identified locally through the Clinical Partnership Group and clusters. The current draft of the Angus Prescribing Workplan is to be presented for approval at the Clinical Partnership Group on 15 December.

4. PROPOSALS

Key actions 2016/17

(i) Development of Angus Prescribing Workplan

(ii) Delivery of quality prescribing visits and progression of actions agreed

Quality Prescribing Visits 2016/17:

These visits are voluntary with no contractual mechanism to mandate visits. Angus practices are to be commended for their engagement. Given the timescale of visits it is challenging to offer any definitive assurances re the delivery of savings from this programme. Learning from the visits will be shared with all Angus practices to support spread of good practice.

GP Practice	Quality Prescribing Visit Status as of 18th November 2016
A	Visit booked for 11 January 2017
B	Visit undertaken 27 September 2016 - Action plan produced post-visit and with practice for agreement then implementation
C	Visit undertaken 28 September 2016 - Action plan produced post-visit and with practice for agreement then implementation
D	Visit undertaken 9 November 2016 - Practice have agreed to produce their own action plan and have agreed to send proposal within 3 week timescale
E	Visit booked for 14 December 2016
F	Visit undertaken 17 November 2016 - Action plan produced post-visit and with practice for agreement then implementation
G	Visit booked for 28 November 2016

(i) Review use of rosuvastatin and ensure formulary compliance
(ii) Review use of lidocaine plasters
(iii) Review use of pregabalin
(iv) Progress tests of change within care homes to reduce waste
(v) Progress review of blood glucose meters

5. FINANCIAL IMPLICATIONS

The annual budget setting process for Tayside wide FHS prescribing reflected the following:-

i) a recurring budget uplift of £6.0 million (c£1.5m in Angus), and

ii) an efficiency savings target of £4.5 million (£1.175m in Angus), consistent with the 5.5% target applied across NHS Tayside, and noting Tayside's variance from Scottish average costs.

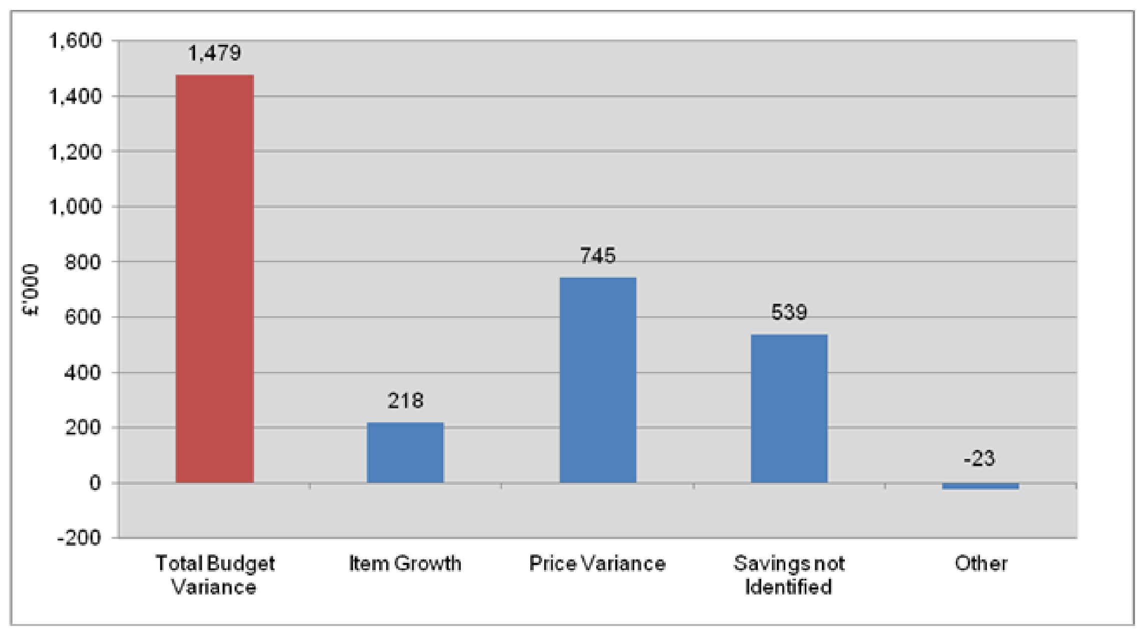
Although a formal savings target has been set, the level of cost reduction required to deliver a balanced budget in 2016/17 is also dependent on item growth and prices.

Angus - October 2016 Position

The FHS Prescribing position for the seven months to October 2016 is an overspend of £1.479 million, based on actual costs to August 2016 and accruals for September and October 2016.

The total budget variance and main component elements are presented below:-

FHS Prescribing - October 2016 - Budget Variance



Key Points

- Growth in items currently 1.7%, price increase 5%.
- 'Savings not Identified' represents the shortfall in delivery of the formal savings target of £1.175 million
- The 'Other' figure includes £54k from 2015/16, mainly resulting from a national pricing error
- Forecast outturn – based on current trajectory, of c£2.5m overspend.

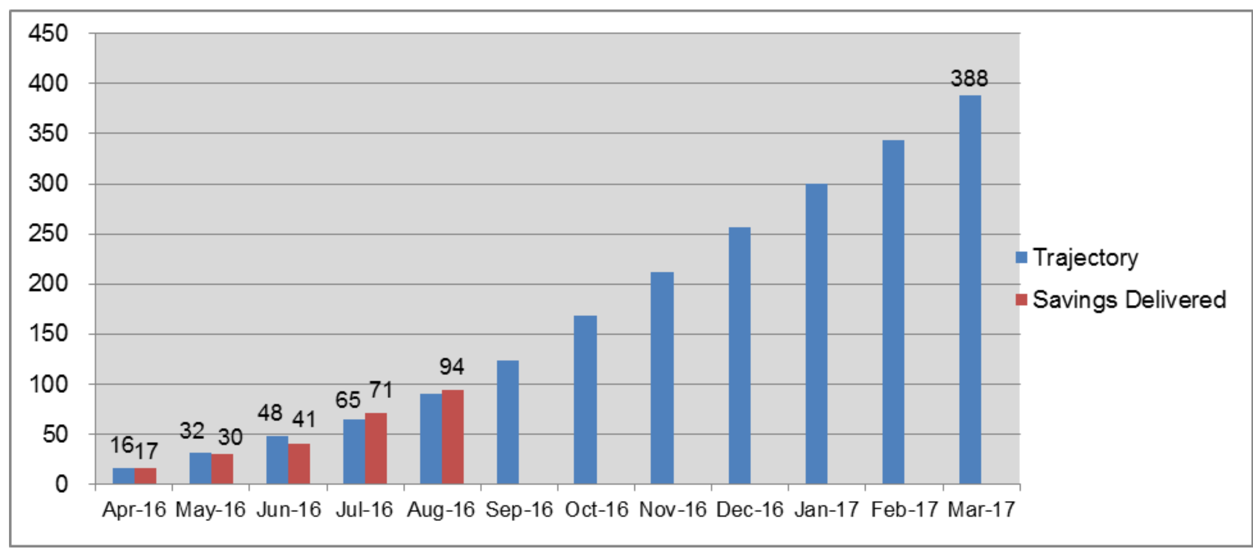
Efficiency Savings

The efficiency savings target is £1.175 million. £0.388 million efficiency savings have been identified to date against the target.

Progress to date with the £0.388 million savings, as identified through prescribing analysis, is noted below:-

	2016/17 Savings Identified	Trajectory to August	Delivered to August	Variance to August	Forecast Savings Achievement
	£'000	£'000	£'000	£'000	£'000
Practice Variation	49	0	0	0	49
Meds Price Rebates/ Generics	174	72	94	-22	174
ONS 25% reduction in spend	61	7	0	7	61
Quetiapine MR switch	13	3	0	3	13
Seretide to Fostair switch	17	7	0	7	17
SALT led protocol	5	0	0	0	5
Pregabalin pain pathway	4	0	0	0	4
Rosuvastatin 25% reduction	65	0	0	0	65
Total	**388**	**89**	**94**	**-5**	**388**

Progress with current year savings identified is depicted in the chart below:-



- £5k ahead of trajectory to date, but trajectory heavily weighted to second half of year. With consequent increased risks as year progresses.
- As set out in this paper work continues locally and across Tayside to identify further efficiency opportunities.

6. OTHER IMPLICATIONS

NHS Tayside has instructed that 70% of the locality pharmacy teams' time should be dedicated to delivery on the key initiatives. While assurances have been provided re impact on key programmes within Angus, such as Enhanced Community Support, we will continue to work with the regional management team and locality teams to minimise impact on key local developments of the processes outlined above.

The strategic risks associated with prescribing are detailed in the Angus IJB Strategic Risk Register.

REPORT AUTHOR: Rhona Guild, Primary Care Manager/LTC Lead
Dr Alison Clement, Clinical Director

EMAIL DETAILS: rhona.guild@nhs.net
aclement@nhs.net

List of Appendices:

Appendix 1: NHS Tayside Medicines Management Proposal

BOARD133 /2016
Tayside NHS Board
1 December 2016

NHS TAYSIDE MEDICINES MANAGEMENT PROPOSALS

1. PURPOSE OF THE REPORT

The purpose of the report is to inform the NHS Tayside Board on medicines management activities currently being delivered within Tayside and the plan over the remaining period of financial year 2016/17 and the evolving plans for the next three to five years. The report will consider outliers, unexplained prescribing variation, current activities and areas of good performance.

2. RECOMMENDATIONS

NHS Tayside Board are asked to approve the following recommendations;

1. Support the development of the Tayside Prescribing Management Group as a strategic means to support clinically led whole system quality oriented cost effective prescribing change.

2. Support the five focussed programmes to address the current financial gap in prescribing expenditure. These are five programmes are;

   - Deliver the quality prescribing visits scheduled across 15 practices with a view to releasing £100k by March 2017

   - Review the use of rosuvastatin within Tayside and ensure formulary compliance by December 2016 releasing £200k by March 2017

   - Review and reduce the use of lidocaine plasters within Tayside by December 2016 releasing £200k by March 2017.

   - Review and reduce the use of pregabalin Tayside and embed prescribing management guidance as part of a refreshed pain management pathway releasing £100k though implementation by March 2017.

   - Complete a review of our local formulary compliance by December 2017, with the implementation of a refreshed and combined NHS Tayside/Fife formulary releasing £1 million by March 2017.

   - Support the financial savings forecast of a of £5 million (FYE) through these and current initiatives, with £1.6 million to be delivered through the accelerated initiatives by March 2016/17

3. Review the 6 national therapeutic indicators where we are ranked lowest in Scotland and seek to address unwanted variation.

3. EXECUTIVE SUMMARY

The financial environment within Tayside's prescribing budgets remains a challenging one; however it is important that we do not lose sight of the clinical excellence delivered to our local populations.

NHS Tayside has embarked on a clinically based, clinically focussed programme based on examining variation; polypharmacy; waste, safety and harm; and formulary compliance. This has been supported by central clinical guidance, a practice visiting programme and local Medicine Management Group (MMG) led initiatives within practices supported by local, Tayside and national prescribing information. Despite a limited degree of success in these programmes the prescribing budget remains significantly overspent.

Five key priorities have been identified to further address the efficiency opportunities within the FHS prescribing budget. These are: quality prescribing visits (initially targeting practices at greatest variance to prescribing spend); projects aimed at specific drugs, rosuvastatin, lidocaine plaster, pregabalin; reviewing the formulary.

In addition we recognise the importance to inform our local communities regarding their role and responsibility in the prevention of medicines waste and how we can manage expectations around ensuring adequate stocks of medicines during holiday periods.

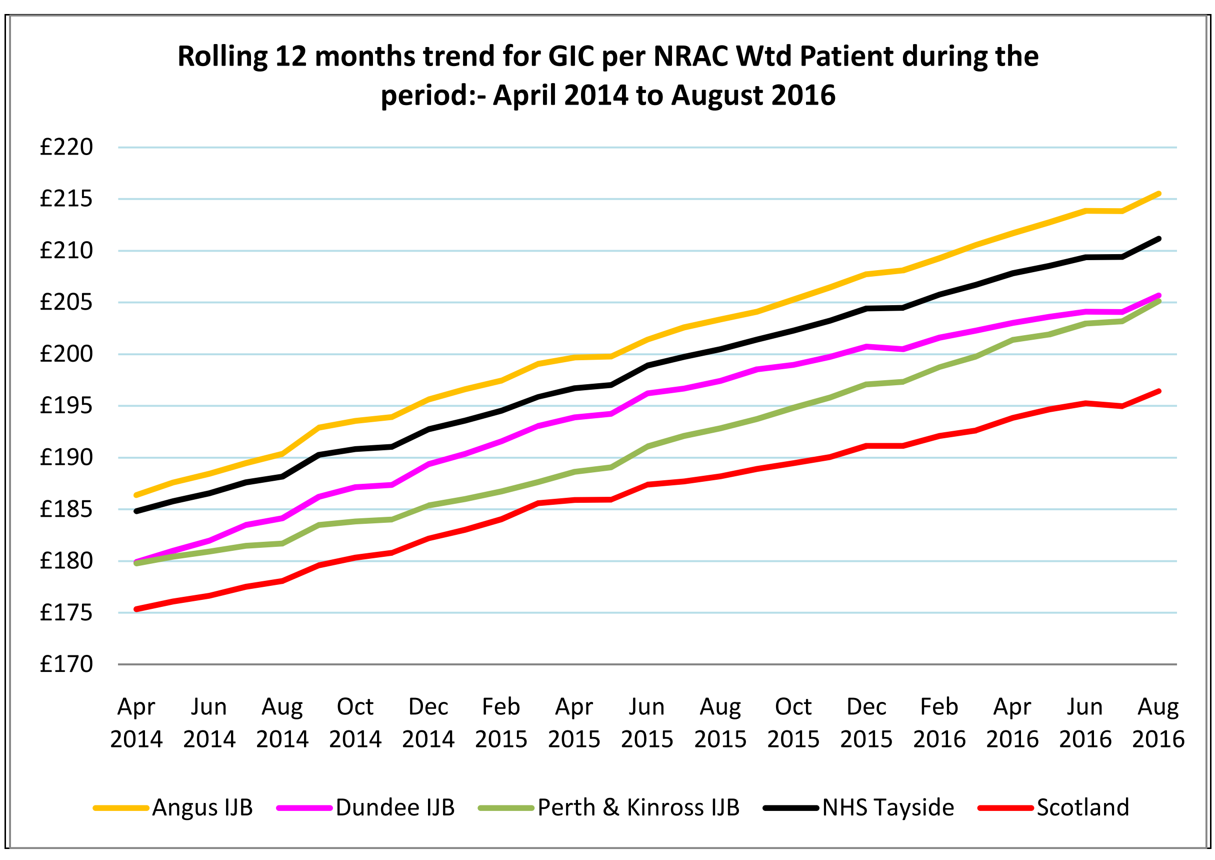
To deliver on this agenda weekly meetings will be held, chaired by Michelle Watts and Gavin Main to monitor progress and risk. However without a joint approach from all members of the multidisciplinary team, where all members contribute to the same aim of delivering the best possible healthcare, at the lowest possible cost, delivering the best experience for our patients we will fail to maximise opportunities. Teams must be aware of the need to comply with clinical pathways that have been developed within Tayside.

It is critical to accept that our costs in many areas are higher compared to other boards because we treat more patients, our clinical workforce are proactive and strive to deliver the best possible care for our communities. This is supported by NSS data that describes our cost per treated patient.

However it is also recognised that there are a number of areas of unexplained or unwanted variation which this accelerated programme will seek to address.

4. REPORT DETAIL

4.1 Current prescribing spend in Tayside remains in excess of that in Scotland.
The following graph demonstrates that this is in part due to higher than average prevalence of a variety of chronic illnesses, and in part because Tayside has established a series of clinical pathways that aim to provide our patients with the best possible care.



It has been accepted practice to use cost per NRAC weighted patient as a denominator when comparing prescribing metrics. This denominator was recognised as the most sophisticated one available within the previous prescribing data set. With the introduction of the Prescribing Information System access to patient level information is now possible. As the Community Health Index (CHI) capture rate has now increased we can begin to use the actual treated patient numbers as a denominator which provides a much more informed financial discussion regarding prescribing costs.

The correlation with prevalence is now much more evident. Cost per NRAC weighted patient used the entire Board population as a denominator, with weightings for age, sex and deprivation of the patient population while cost per treated patient reflects the prevalence of the condition being treated within the denominator allowing comparisons that better reflect the impact of treatment choices and doses/formulation used (both of which influence the cost of treatment) across Health Boards. Such information is just becoming available within NHS Scotland in November 2016 and initial review of this information begins to show that for several BNF chapters our prescribing choices are more cost effective than other Boards however more detailed work is required to fully understand the new datasets. We will ensure this is progressed in parallel with our established work streams.

Treatment pathways have been developed to make best use of our available resources, consider the whole system patient journey treatment and provide the best possible experience of care. They do not focus only on medicine costs, but consider whole system costs. Our clinicians have embraced national contractual arrangements, such as the Quality and Outcomes Framework in General Practice, and ensured our populations are screened for a range of clinical conditions. We have been successful at identifying patients at risk, and we have been successful in treating these identified patients.

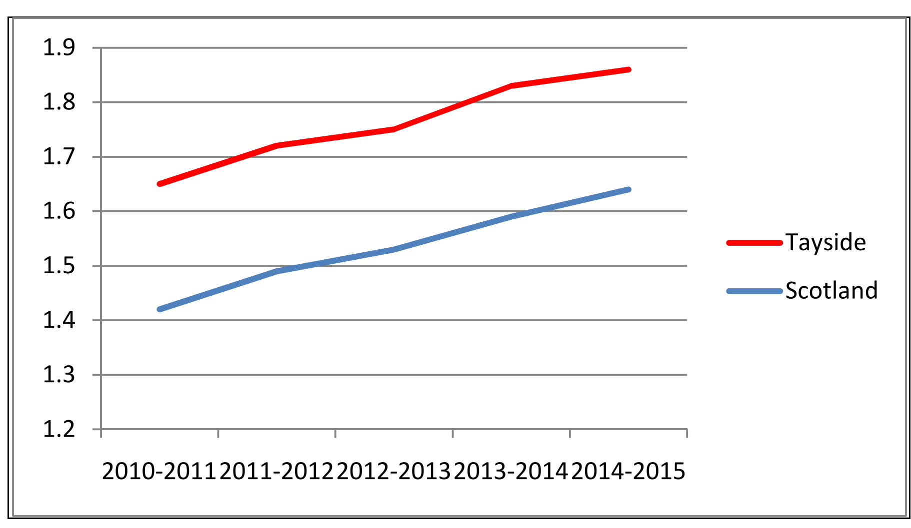
The identification of a greater proportion of our population as having significant treatable chronic illnesses that benefit from treatment; and the subsequent treatment of these illnesses to a greater degree with medications shown to have a positive effect on prolonging life and reducing harmful outcomes may be regarded as positive variation in prescribing.

4.2 **Examples of explained variation**

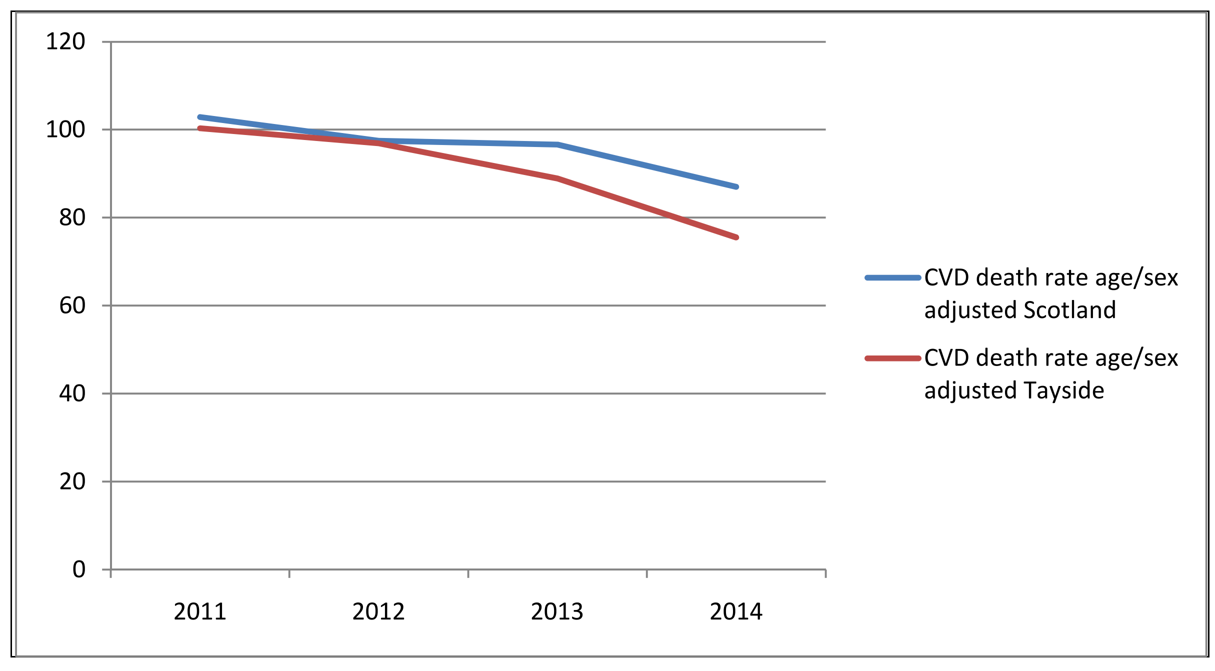
Cardiovascular

NHS Tayside has a higher prevalence rate of atrial fibrillation when compared with other Scottish boards. This is a result of more effective identification of this condition. In order to help manage these patients investment could have been made in to additional staffing to deliver ‘warfarin clinics’ where patients must attend to ensure their level of anticoagulation is within safe limits, or investment could be directed to new agents where the monitoring is not required. The clinical consequence of identifying and treating these patients can be observed in the death rate graph contained below.
The reduced mortality rate seen in Tayside as a result of its proactive approach to identification and treatment is a good example of positive variation.

QoF prevalence for AF(% of practice population)



CVD death rate age/sex adjusted from ISD Stroke report Jan 2016

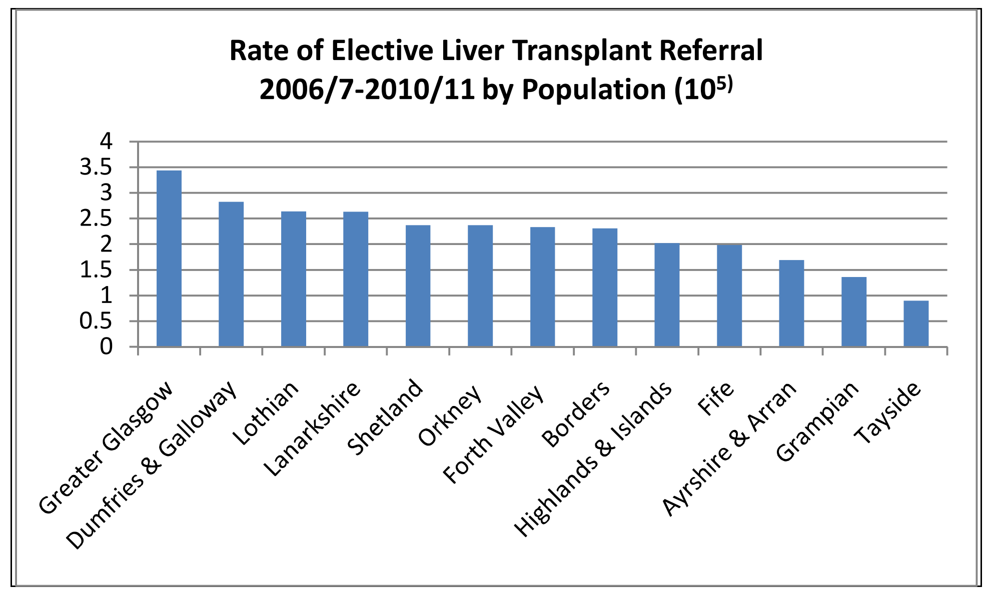


Chronic liver disease

Within Tayside we deliver a world class service for the identification and treatment of patients with Hepatitis C. Across Scotland around 50,000 people are estimated to have contracted this infection. Our clinical leaders were early adopters of new directly acting antiviral drugs (DAAs), in treating this communicable condition which can result in liver failure, liver cancer and early death for around 30% of these patients.

The DAAs have revolutionised the treatment of Hepatitis C from one of disease management to one of cure. The DAAs cure 95% of patients. This work is innovating around patient pathways, has led to a transfer of care from hospital based outpatient departments to treatment delivered through community pharmacies. This investment enables us to work towards eliminating Hepatitis C from our local populations within 5 years. Some of the benefits of this strategy are already being seen; with our Board having one of the lowest liver transplant rates for Hep C patients in Scotland. This work will release secondary care and the utilisation of healthcare resources from managing a chronic condition.

Rate of Elective Liver Transplant Referral by Population (10^{5})



The average rate of referral across Scotland is 2.22 patients per 10^{5} population, compared to Tayside’s rate of 0.90.

This work in innovating around patient pathways has led to a transfer of care from hospital-based outpatient departments to treatment delivered through community pharmacies.

4.3 **Greater Prevalence, better outcomes**

Out of 16 chronic diseases reported through the Quality and Outcomes Framework, Tayside has higher prevalence in 12, and at 99.5% reports higher levels of achievement than the 98.2% achieved in NHS Scotland:

Disease area prevalence	NHS Scotland	NHS Tayside	Percentage difference	Disease area	NHS Scotland	NHS Tayside	Percentage difference
Peripheral vascular disease	0.9	**1.0**	11.1%	**Cancer**	2.4	2.4	0%
Stroke	2.2	**2.5**	12.0%	**CKD**	3.2	3.1	-3.2%
AF	1.7	**2.0**	15%				
Heart Failure	0.8	**1.0**	25%	**Depression**	6.8	5.2	-23.53%
Hypertension	13.9	**14.9**	7.2%	**Mental Health**	0.9	**1.0**	11.1%
CHD	4.1	**4.2**	2.4%	**Dementia**	0.8	**1.0**	25%
Diabetes	5.0	**5.3**	6%				
Asthma	6.4	6.1	-4.7%				
COPD	2.3	2.5	8.8%				

This translates directly in to increased prescribing costs when comparing to other Boards, and when linked back to cost per actual patient, presents a very different argument: We have been compared unfavourably to NHS Lothian in terms of cost per weighted patient, however if we consider the QoF recorded prevalence for diabetes, NHS Lothian 4.18%, NHS Tayside 5.29% and the costs per actual patient being £221.04 and £208.23 respectively this demonstrates the effectiveness of our prescribing policy driven by our Diabetes MCN. Another example of good prescribing practice is demonstrated in our cost per actual patient receiving an inhaled corticosteroid. Within NHS Tayside our cost is £95.74 per patient whilst Lothian has a cost of £105.09; again we could argue that is a consequence of the clinical leadership demonstrated locally through our respiratory MCN.
These examples demonstrate effective management of chronic disease within community and primary care across a broad range of long term conditions. Although QoF is no longer part of the Scottish GP contractual framework, all practices in Tayside are committed to continuing to deliver holistic care for all patients living with chronic conditions, even without the contractual obligation. This approach is further supported by the growing development of multi- disciplinary teams, and the roll out of our enhanced care service, which has already shown significant reduction in hospital admissions, reduced bed days, and improvements in polypharmacy.

4.4 **Quality and safety in prescribing – antimicrobial stewardship**

The National Quality Indicator (NQI) for reduction of total antibiotic prescribing is a key HAI indicator. Antibiotic use, expressed in items/1000 patients / day, in at least 50% of practices in each NHS board will be at or below the 25th percentile of Scottish practices; or will have made an acceptable move towards that level. Antibiotic prescribing for each practice is measured in January – March and compared to the baseline prescribing measured in January – March 2013. This is to be updated for 2016-17 with a new baseline of January – March 2016. Figure 1 shows the data used to measure the antibiotic NQI in January – March 2016.

Figure 1: Practices in NHS Tayside January – March 2016.

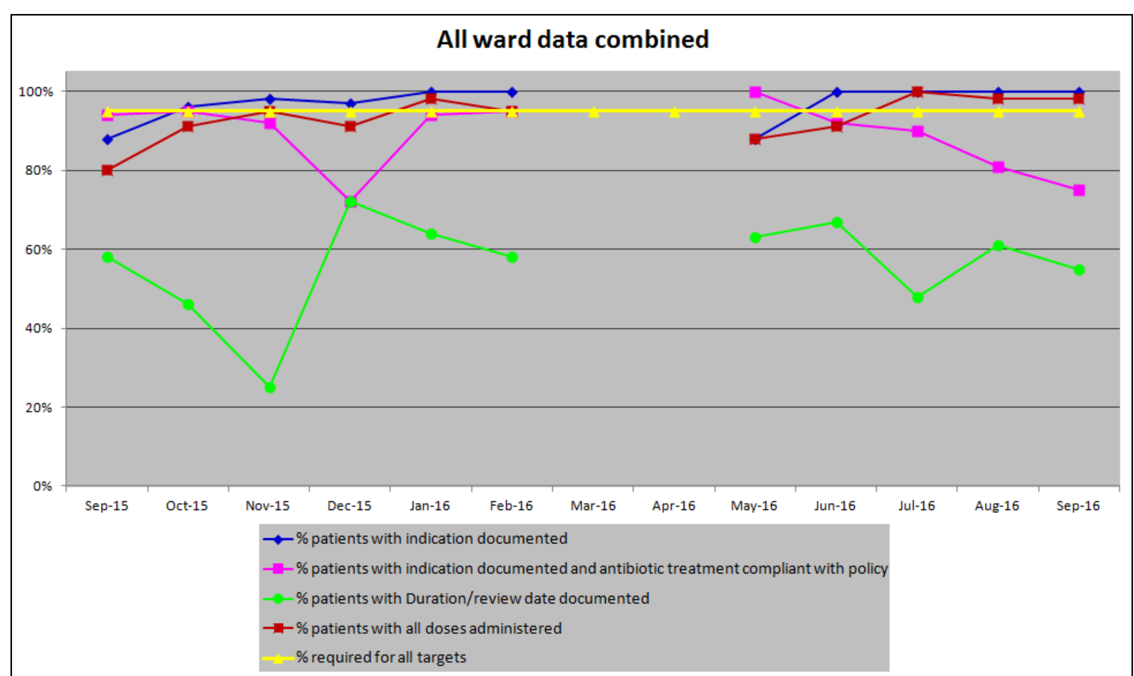
NHS Tayside comfortably exceeded the antibiotic NQI in 2015-16; with 41% of practices meeting the required target and 30% of practices making an acceptable move towards it. This total of 71% compliance compared to the required 50% shows the commitment from all members of the primary care team and Antimicrobial Management Group to meet a particularly challenging target.

Within secondary care for 2016/17 the Scottish Antimicrobial Prescribing Group (SAPG) national prescribing indicator requires the following information to be collected for two downstream wards on each site (Ninewells Wards 6 & 8 and PRI Wards1 & 6):

- missed doses of antibiotics
- duration/review date of antibiotic documented
- indication documented in notes
- antibiotic compliance with local guidance.

To ensure continuity and quality of monthly data for national and local submission, the data collection and reporting process has been updated. The Antimicrobial Pharmacist and Nurse collect monthly data and will continue to do so until all clinical teams can be engaged in this process.

The required target for each element detailed above is 95% compliance. Figure 1 shows the NHS Tayside data to September 2016.



Compliance with antibiotic guidance within NHS Tayside is reported quarterly to clinical teams in selected wards. The AMT continue to provide support and guidance around all aspects of antimicrobial prescribing within NHS Tayside. SAPG and the NHS Scotland HAI Standards require that AMTs are confident that the levels of antibiotic compliance are maintained.

4.5 **HIV Service**

Numbers of HIV positive patients continues to increase locally and nationally and treatment with antiretrovirals is now recommended for all patients regardless of CD4 count. Processes within outpatient clinics continue to be improved by the HIV pharmacy team to reduce wastage and patients' overstocking medicines. In 2014/15 this was calculated as £63k, 2015/16 it increased to £72k and for 2016/17 to date £67k.

5. Addressing the Challenge

Through the interpretation of both national and local data, conversations with clinical leaders the following initiatives have been identified to support the delivery of a further £5m FYE savings.

5.1 **Tayside Prescribing Management Group**

We have developed strong clinical leadership within the Prescribing Management Group (PMG). The PMG has been established to develop an evolving five year strategic medicine management plan, developed in collaboration with clinical teams across Tayside supported by horizon scanning data and local system intelligence.

A facilitated development session took place in mid October to start data generation to develop the plan. Data from the session is currently being synthesised with data from over 100 responses from a questionnaire to clinicians across Tayside. The medicine management plan will contain an annual focussed set of medicine management actions to promote clinically effective, cost effective and consistent management of prescribing.

The Prescribing Management Group (PMG) functions as a collaborative with delegated executive authority to allocate monitor and agree actions to make optimal use of the prescribing budget. They will hold to account the IJB and NHS Tayside prescribing forums for delivery of the identified medicine management plan. PMG will deliver a whole system approach to developing prescribing action plans, implementation of prescribing projects and monitoring, identification and management of financial risks within prescribing.

The IJB and NHS Tayside prescribing forums have a responsibility to ensure actions are delivered to make certain their local prescribing performance is safe, clinically effective and cost effective and the identified opportunities set by PMG are delivered.

Within the Health and Social Care Partnerships are local Medicines Management Groups (MMGs) supported by locality pharmacists and the Prescribing Support Unit (PSU). These MMGs generate and interrogate information regarding prescribing priority areas, financial targets, explore variation between practices, and examine prescribing processes between primary and secondary care; in patients requiring augmented social support such as those resident in nursing homes or who are otherwise less able to manage their medications; as well are reviewing areas of waste, safety, polypharmacy and potential harm.

These groups are in the process of providing additional assistance to clusters of GP practices in developing a peer approach to support improvement in the prescribing metrics referred to above.

Critical to the successful delivery of these initiatives is the clinical leadership and clinical engagement required to deliver on the medicines management opportunities. NHS Tayside has an effective governance framework to support robust decision making, this can be viewed within **appendix 3**, links in to all key committees exist and are utilised.

An executive of this group will meet twice weekly to review progress against both the established and accelerated initiatives.

5.2 **National Therapeutic Indicator Summary**

National Therapeutic Indicators (NTIs) are measures that help to drive enhancements in quality and cost effective prescribing. They provide a national focus on issues within specific therapeutic areas that are common to all health boards. They were originally developed within the Scottish Government QUEST programme which sought to enhance quality and efficiencies in the NHS in several areas, including GP prescribing.

There are 41 NTIs currently being monitored across 14 Health Boards

Tayside ranked 1st, 2nd or 3rd	7 indicators	• Total 4C antibiotic script items per 1,000 patients per 100 days • Total 4C antibiotic script items per 1,000 patients per 100 days (weighted) • Antibiotics: number of women 16 years of age or older dispensed a 3 day course of acute UTI antibiotics (trimethoprim or nitrofurantoin) as a % of women 16 years of age or older dispensed acute UTI scripts • NSAIDs including Cox-2 inhibitors: DDDs/1,000patients/day • NSAIDs including Cox-2 inhibitors: DDDs/1,000patients/day (weighted) • NSAID prescribing to people aged ≥75 years without gastroprotection (EFIPPS) as a percentage of all people aged ≥75 years • Number of patients prescribed a NSAID and an oral anticoagulant without gastroprotection as a % of patients prescribed an oral anticoagulant
Tayside ranked 12th, 13th or	6	• Number of children under 12 years

14th		old of age prescribed high strength corticosteroid inhalers as a percentage of all children under 12 years of age prescribed inhaled corticosteroids Antipsychotics prescribed to people aged ≥75 years (EFIPPS #1) as proportion of all people aged ≥75 years registered with the practice • Gabapentanoids: pregabalin and gabapentin DDDs per 1,000 LS per day • Gabapentanoids: pregabalin and gabapentin DDDs per 1,000 weighted LS per day • Gabapentanoids: number of patients prescribed > 1 DDDs per day of gabapentanoid as a % of all patients prescribed a gabapentanoid • Black triangle medicines as a % of all medicines in BNF Chapters 1-7 and 9-13

Although Tayside is the lowest ranked board for use of “black triangle” medicines, it has the 4th lowest spend on non SMC recommended medicines across all Boards in the period April to June 2016, indicating that although Tayside is an early adopter of new medicines it does so largely within the criteria agreed by SMC

It is important to acknowledge that some of the variation is difficult to explain, our spend on pregabalin is greater than other boards; **appendix 4** describes this position in more detail. Our variation is also supported by the actual cost per patient information provided by NSS. Our treatment pathway for patients with chronic pain needs to be reviewed, and the clinical leadership to deliver put in place.

Five key initiatives have been identified to further improve our prescribing position within Tayside, these will be actioned as a whole system, maximising any identified opportunities.

In order to allow rapid delivery of the opportunities the locality pharmacy team will amend job plans to dedicate 70% of their time to delivering.

5.3 Quality Prescribing Visits

The PMG has embarked on a process of prescribing visits whereby a lead GP supported by a lead pharmacist attend with a practice that has been identified as being at a greater degree of financial variance than other practices within Tayside. This small team is supported with a variety of prescribing variation and safety reports. The ethos behind the visiting programme is that of discussing with the practice team the variation shown by the reports to see how much can be explained. Where unexplained variation exists, or where patient safety or cost-effective issues might be usefully addressed, the visiting team agrees specific funded projects with the practice team whereby this can occur. The team also has access to pharmacy technician and practice pharmacist resource to work on specific projects within identified practices.

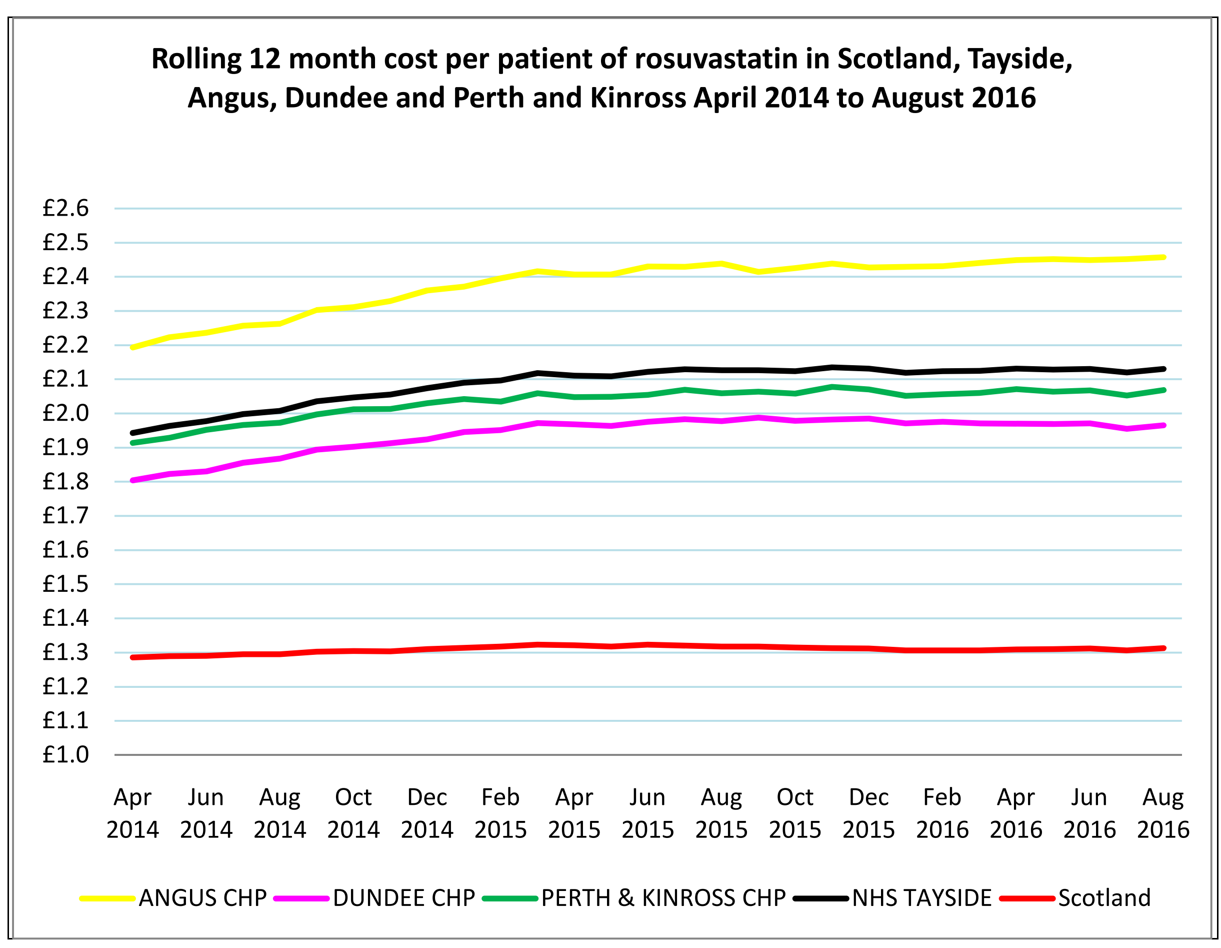
The programme is voluntary as there is no contractual mechanism to force practices to accept an unwanted visit. Most but not all of the identified practices have agreed to take part in this project. Where practices have declined visit additional contacts via local GP leads have been made to try to encourage co-operation, and where this has been unsuccessful, some additional

pharmacist resource has been invested into working within those practices in areas of unexplained variation. Within Dundee, this has been particularly successful, with a project within the one practice resulting in £40,000 savings.

GP Practice	Quality Visit Status as of 11th November 2016
Angus	
Practice 1	In discussion with practice around dates for January
Practice 2	Visit undertaken September 2016- Action plan with practice for implementation
Practice 3	Visit undertaken September 2016- Action plan with practice for implementation
Practice 4	Visit undertaken November 2016- Action plan with practice for implementation
Practice 5	Visit booked for December 2016
Practice 6	Visit booked for November 2016
Practice 7	Visit booked for November 2016
Dundee	
Practice 1	Visit refused- some enhanced work taking place by PSU pharmacy technician
Practice 2	Excluded at present
Practice 3	Visit refused- extensive pharmacy support in place working through a plan of cost-effective prescribing projects
Practice 4	Visit completed August 2016- Action plan with practice for implementation
Practice 5	Visit completed October 2016- Action plan with practice for implementation
Perth	
Practice 1	Excluded at present
Practice 2	In discussion with practice around dates for January
Practice 3	Visit booked for December 2016

5.4 **Rosuvastatin Review**

Work has already begun to address the formulary compliance issue we have identified. Stricter adherence to formulary first line choices has been proposed, with potential switching of patients not currently prescribed first line choices. Work is currently underway focusing on statins with atorvastatin being the first line choice in Tayside Area Formulary, but over 1200 patients in Tayside still prescribed rosuvastatin, which is restricted in the formulary to particular patient groups.



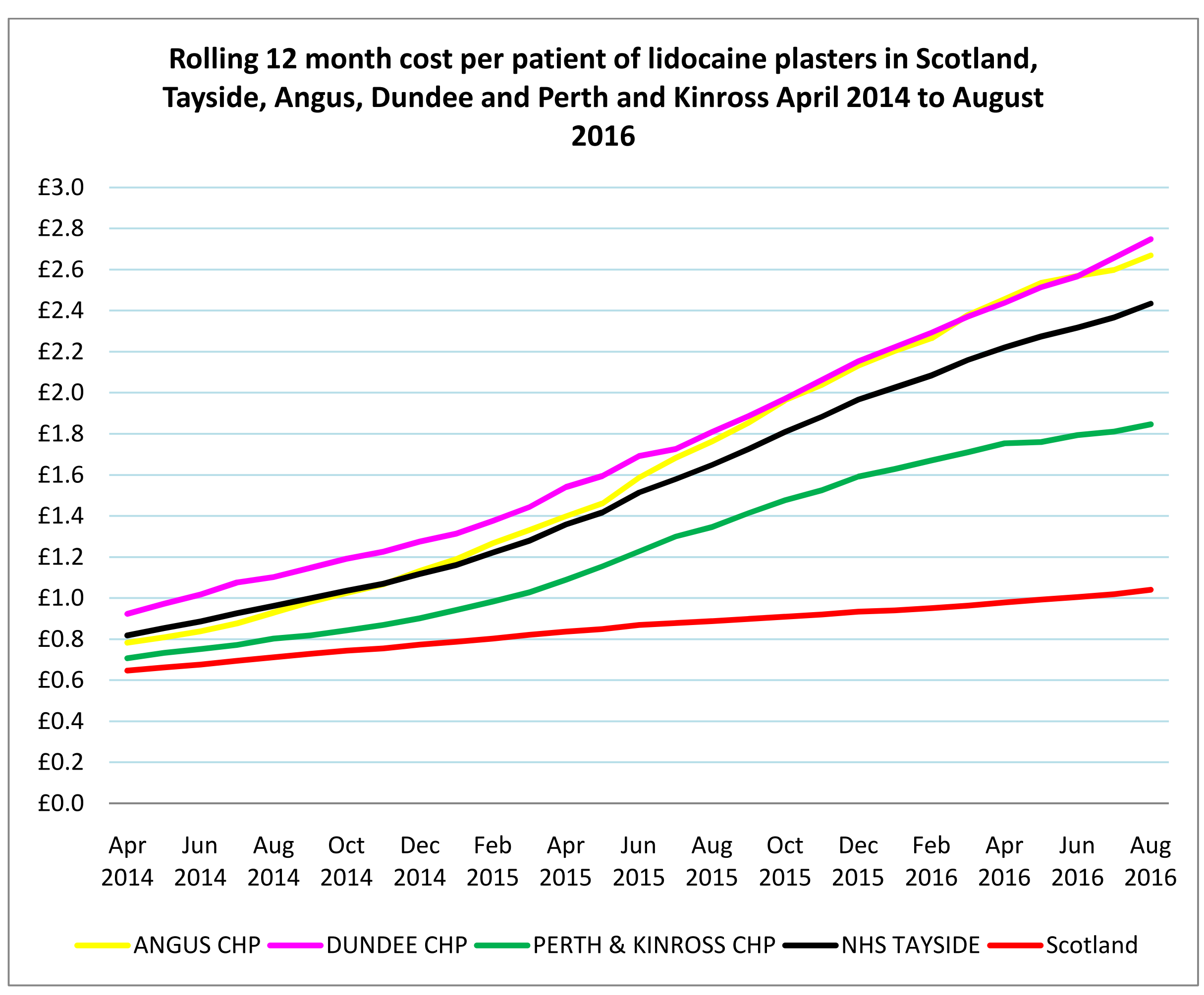
Reviews are being undertaken to ensure all remaining patients meet the restrictions; however several months' preparatory work and clinical engagement have been required before progressing with this. Considerable pharmacy staff time is being expended in reviewing the records of all patients on rosuvastatin and switching those not meeting the required criteria.

Early indications from the first two weeks of reviews are that the majority of patients reviewed so far actually **do meet the required criteria** for rosuvastatin prescribing and switching to atorvastatin to release resource will not happen on a large scale. If the principle of this approach is accepted, i.e. switching to first line formulary choice across a range of medicine groups/diseases there would need to be a major investment in capacity to deliver this, both in pharmacy and clinical time as not all medicines lend themselves to review and switch by pharmacists and would need GP and or consultant involvement. Consideration would need to be given to the principles underlining the Tayside Area Formulary, clinician engagement and public and political acceptance of large scale migration of patients to first line formulary choices.

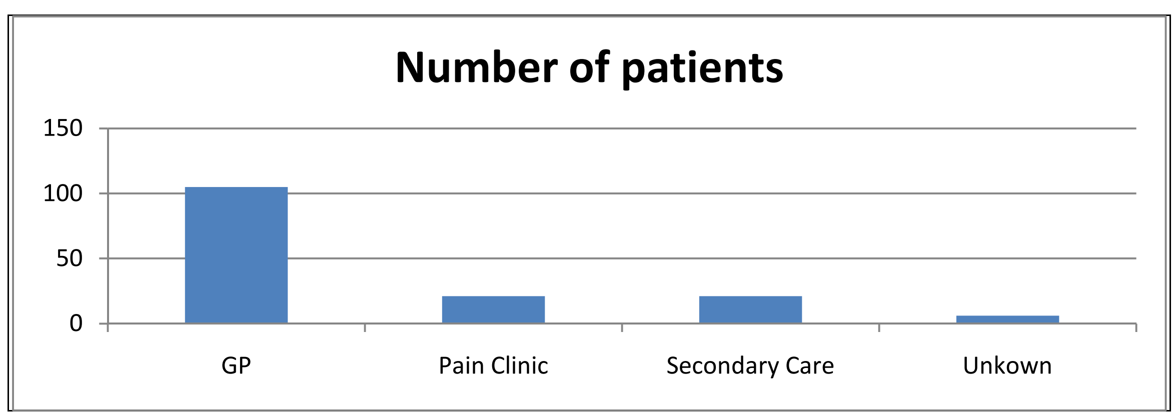
5.5 <u>Lidocaine Plasters</u>

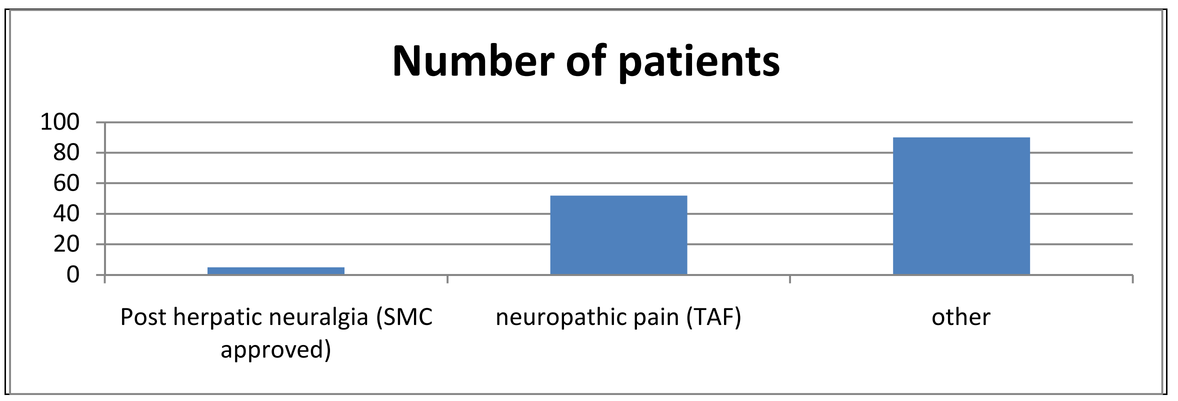
Lidocaine plasters have been identified as an area of prescribing growth contributing to the increasing variation in cost per weighted patient between NHS Tayside and NHS Scotland. SMC approved lidocaine plaster for use in NHS Scotland for 'neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia)' In addition the Tayside Area Formulary includes:-

- 4th line for peripheral neuropathic pain either alone or in combination with other medicinal products for pain.
- Restricted to patients who have not achieved adequate pain relief from, or have not tolerated, conventional first, second, and third line treatments.



The growth in lidocaine prescribing was initially following guidance from the Tayside pain clinic, but as with pregabalin, latterly the majority of growth has been seen in primary care. As with much chronic pain prescribing, there is a correlation between higher prescribing and higher deprivation rates. A recent review of patients prescribed lidocaine showed that most are started in GP practice. In addition most were for non SMC or non formulary indications.

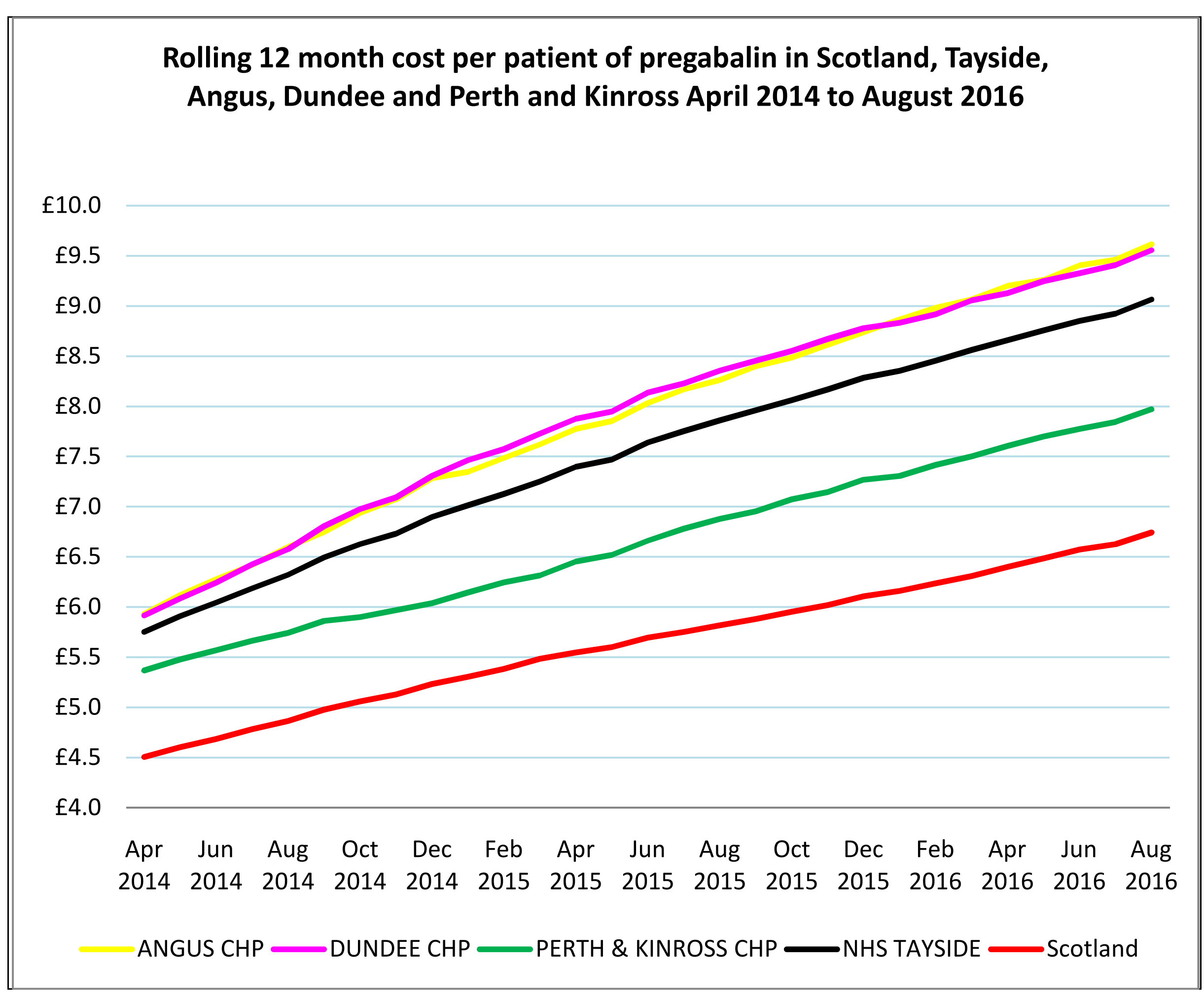




The Prescribing Management Group has discussed whether the current "green" formulary status, which allows general prescribing, should be changed to "amber" where a specialist recommendation is required before this medication is started in new patients. Clusters within Dundee have started to review lidocaine prescribing in concert with the practice pharmacy team to determine whether lidocaine is indicated in current patients. We are now rapidly progressing a whole system rapid improvement programme.

5.6 Pregabalin

NHS Tayside is an outlier against all other Boards in the use of pregabalin. Pregabalin is licensed for use as an anti epileptic (not on TAF as neurologists prefer other agents), for Generalised Anxiety Disorder (not recommended by SMC, also not on TAF) and neuropathic pain (on TAF). NHS Tayside treats more patients with pregabalin than other Boards areas, and NTIs show greater doses are used in Tayside then elsewhere. A detailed review of the use of pregabalin is included in **appendix 4**. Pregabalin is anticipated to become freely available for all indications as a generic in mid 2017, with a corresponding reduction in costs, Tayside will still be an outlier clinically.



The growth in pregabalin prescribing was initially following guidance from the Tayside pain clinic, but latterly the majority of growth has been seen in primary care. As with much chronic pain prescribing, there is a correlation between higher prescribing and higher deprivation rates. Pregabalin is also often sought by patients with opiate and other addiction problems as a means of managing their symptoms and affecting their drug experience.

The prescribing management group in conjunction with the pain clinic, the Tayside Substance Misuse Service and local GP clusters is working with practices on developing effective means of addressing variation in prescribing and encouraging appropriate pregabalin reviews in patients.

5.7 **Formulary review**

Review of the Tayside formulary, work will review chapters 1 (GI), 2 (cardiovascular), 3 (respiratory), 4 (CNS), 6 (endocrine) and chapter 10 (musculoskeletal) against the Lothian formulary has began using a methodology developed by NHS Fife. This is a major piece of work that required sufficient time and resources to initially identify areas where formulary compliance can be improved against either the Tayside Area Formulary or Lothian Formulary where appropriate. The subsequent steps will be to engage with the clinical community to progress as rapidly as possible any agreed areas for action.

In addition, and to address concerns regarding formulary compliance within secondary care, two additional pieces of work are being delivered. The first will be an audit of formulary compliance, delivered by the pharmacy team, this will be delivered on a single day and each pharmacist will be asked to identify 20 medicines commenced during an inpatient episode and assess for formulary compliance.

The second will be a review of outpatient communication forms sent via the clinical portal app, this audit will assess formulary compliance in relation to GP requests to prescribe.

5.8 **Social Media Campaign**

With the support of the Commications Team a social media campaign will be run over the winter months to rationalise the storage of medicines over the Christmas and New Year holiday period. It will also address issues of medicine waste.

6. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The initiatives contained in this paper will make a core contribution to delivery NHS Tayside's strategic aims.

7. MEASURES FOR IMPROVEMENT

Measures for improvement include decreasing the NHS Tayside cost per weighted patient to the Scottish average, whilst maintaining high quality clinical care within FHS prescribing and decreasing the medicines spend within secondary care.

Cost per treated patient will also be used as a measure for improvement.

8. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

In the development of this paper members of the Prescribing Management group have been consulted at the meeting of the 16 November 2016. Members of the PMG include;
AMD – Primary care
AMD – Access
Clinical Directors – Angus and Dundee
Senior management representatives from Angus and Dundee
Senior finance representatives from both health and the IJBs

NHS Tayside has launched a 'Let's Talk Medicines' campaign to encourage people to discuss any medicine related issue with their community pharmacist or other healthcare professional.

The plan has been discussed with colleagues from the therapeutics branch at Scottish Government.

The chair of the Scottish Prescribing Advisors Association has been engaged in conversation relating to the identified initiatives.

8. PATIENT EXPERIENCE

The initiatives described within the paper aim to improve patient experience, through improved clinical pathways of care, improved access to the appropriate medicine prescribed by the appropriate professional and through the delivery of Realistic Medicine as described in the CMO annual report. All initiatives described aim to ensure the most costs effective use of resources for the patients within Tayside.

9. RESOURCE IMPLICATIONS

Financial
Through a concentrated focus on these work stream initiatives we seek to drive efficiency savings forecast of £5 million. In order to support this some investment will be necessary. This may include:

- Backfill support to enable GP and cluster engagement
- Support for the production of educational and learning resources

Workforce
Comparison with other Health Boards suggests a robust programme management support is allocated to this significant improvement programme. The following resources should be allocated as a minimum standard:

- Strategic Leadership (Gavin Main, Frances Rooney, Michelle Watts)
- IJB Clinical Leadership-Clinical Directors
- An Acute Prescribing Lead
- 1 WTE Programme Manager
- 1 WTE Quality Improvement Lead

We believe this resource is currently available within NHS Tayside and much of this resource needs prioritised towards this programme.

10. RISK ASSESSMENT

RISK	LEVEL
Political consequences of denying/delaying/ capping treatment using medicines that have been accepted by SMC – particularly relevant to HIV, AMD, MS and oncology agents	HIGH (secondary care)
Higher than anticipated use of established/new medicines	MEDIUM (FHS/secondary care)
Delivery of £5.0m (FYE) prescribing efficiency saving	HIGH (FHS)
Sustained delivery of savings from previous cost-minimisation prescribing initiatives	MEDIUM (FHS)
FHS volume growth exceeding 1.5% and/or average cost/item exceeding £10.94	HIGH (FHS)
Risk of exposure as a result of Chemist Contactor negotiations with Scottish Government for 2016/17	LOW (FHS)
Impact of SMC new processes for the assessment of medicines for treatment at end of life and for very rare conditions – this could generate a cost pressure of £6m within oncology and haematology	HIGH
Continued expectation that the efficiencies will be delivered through locality pharmacy alone, and lack of support from the wider organisation	MEDIUM (FHS)
Lack of organisational support may result or delay delivery of the efficiencies	MEDIUM
Lack of ability to control the impact of medicines shortages and increased ingredient costs may hamper the ability to realise the required efficiencies	HIGH

11. LEGAL IMPLICATION

No legal implications identified

12. INFORMATION TECHNOLOGY IMPLICATIONS

No IT implications have been identified.

13. HEALTH & SAFETY IMPLICATIONS

No health and safety implications have been identified at this stage

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

No HAI implications identified, with the exception being the antimicrobial stewardship programmes.

15. DELEGATION LEVEL

Dr Andrew Russell – Medical Director
Ms Frances Rooney – Director of Pharmacy

16. TIMETABLE FOR IMPLEMENTATION

As described in the main body of the report various projects are underway and some are requiring the support of Directors and Chief Officers to identify resource to address the identified issues.

Performance of the agreed initiatives will be monitored by the Prescribing Management Group, who have the capacity to escalate concerns through the Transformation Programme governance framework.

17. REPORT SIGN OFF

Ms F Rooney, Director of Pharmacy
Dr M Watts Associate Medical Director Primary Care
Dr G Main Consultant Radiologist/Associate Medical Director

Ms L McLay
Chief Executive

November 2016

18. SUPPORTING DOCUMENTS

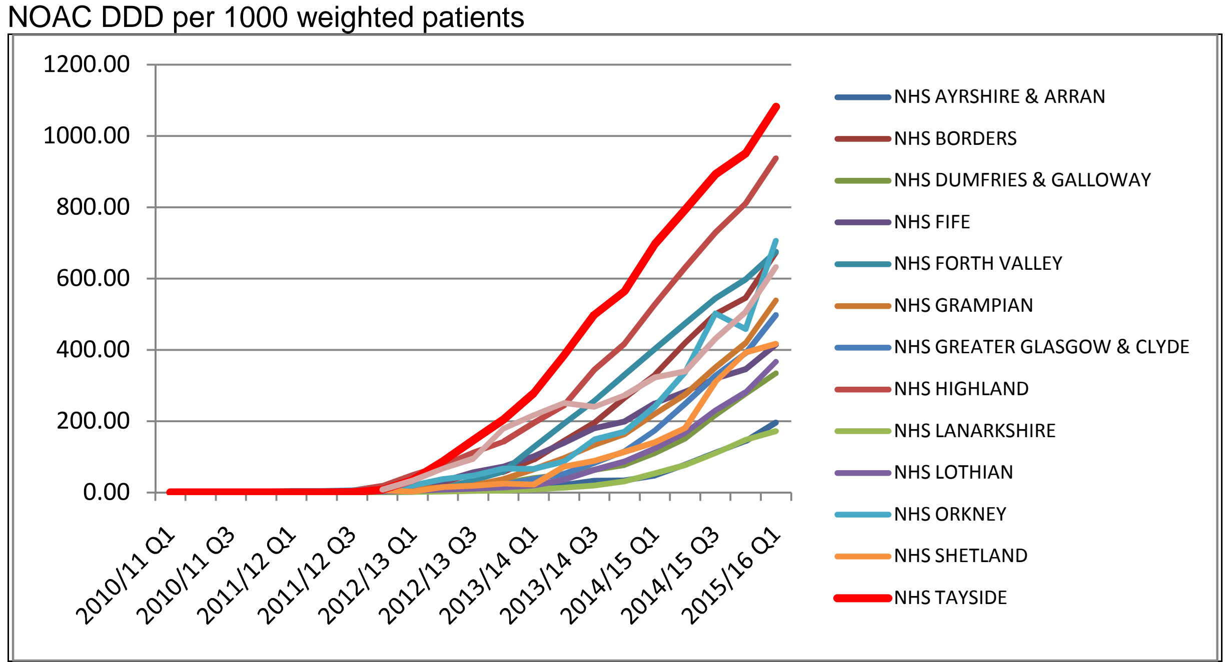
Appendix 1 – Rivaroxaban
Appendix 2 – NHS Tayside top 20 FHS medicines expenditure Q2 2015/16
Appendix 3 - Organisation committees supporting medicines management
Appendix 4 – Pregabalin data

Appendix 1
Review of NOAC Prescribing in NHS Tayside

Novel Oral Anti Coagulant Drugs (NOACs) are a group of drugs that act by inhibiting factor Xa which interrupts the intrinsic and extrinsic pathway of blood coagulation cascade, inhibiting thrombin formation and the development of thrombi. They are used as an alternative to warfarin for prevention and treatment of VTE and AF. The group of drugs includes apixaban, dabigatran, edoxaban and rivaroxaban. Within the NHS Tayside Formulary (TAF) warfarin is first choice for stroke prevention in AF with rivaroxaban as second choice and apixaban as third choice (as at January 2016). For DVT treatment and prevention rivaroxaban is first choice in TAF, followed by apixaban and warfarin. Edoxaban has recently been accepted by SMC for use in Scotland for both VTE and AF.

NHS Tayside uses comparatively more NOACs than other Boards in Scotland

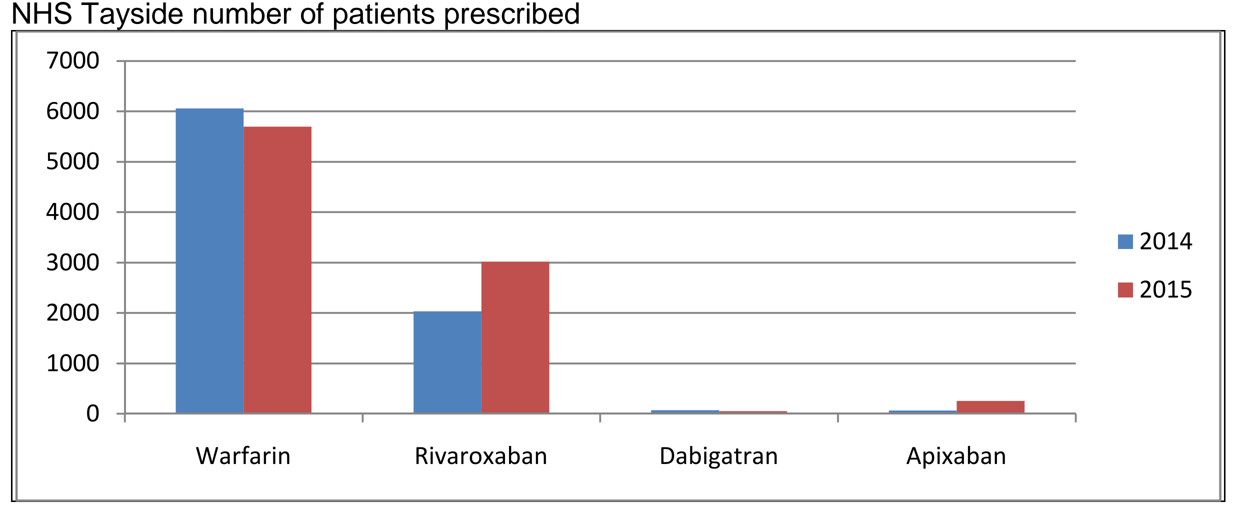
NOAC DDD per 1000 weighted patients



NHS Tayside also sits highest in comparative rankings across Scotland for total anticoagulant use (NOAC and warfarin)

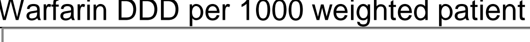
There has been a slight reduction in patients prescribed warfarin, with an increase in NOACs between March and August 2015 compared to the same period in 2014

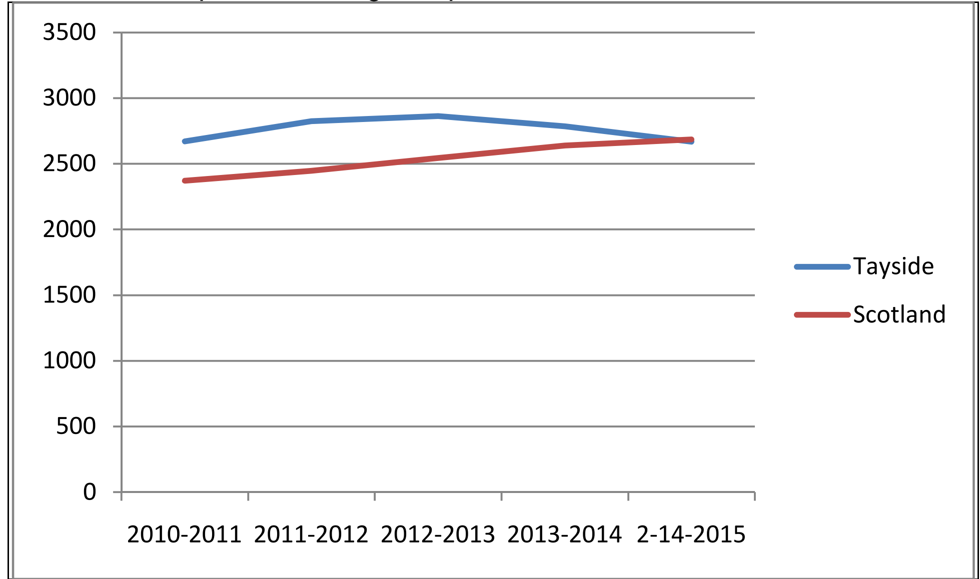
NHS Tayside number of patients prescribed



While the peak age for the number of patients being treated with oral anticoagulants is 70-79 years of age for male patients and 80-89 for female patients, with more males than females being treated in most age groups until the age of 80.

The reduction in warfarin use is not reflected in the rest of Scotland





Finally rivaroxaban has the third highest expenditure for quarter 2 (July to September) 2015 within NHS Tayside accounting for 2.19% of total medicines expenditure and equating to a full year expenditure of just under £2m, with a consistent year on year growth rate as shown in Chart 1 of 50%.

Appendix 2 NHS Tayside top 20 FHS medicines expenditure Q2 2015/16

Approved Name	GIC (Paid)	% total spend
PREGABALIN	881560.12	3.92
SALMETEROL WITH FLUTICASONE PROPIONATE	609455.2	2.71
RIVAROXABAN	**493033.8**	**2.19**
TIOTROPIUM	387527.95	1.72
LEVOTHYROXINE SODIUM	302692.96	1.35
CO-CODAMOL	276192.28	1.23
PARACETAMOL	250288.78	1.11
BECLOMETASONE DIPROPIONATE AND FORMOTEROL FUMARATE	236348.52	1.05
ROSUVASTATIN	222875.52	0.99
SOLIFENACIN	220565	0.98
LIDOCAINE	213972.41	0.95
ARIPIPRAZOLE	199335.98	0.89
METFORMIN HYDROCHLORIDE	194113.46	0.86
OMEPRAZOLE	190138.94	0.85
DULOXETINE	186332.82	0.83
BUDESONIDE WITH FORMOTEROL FUMARATE	175946.77	0.78
BECLOMETASONE DIPROPIONATE	171208.24	0.76
TRAMADOL HYDROCHLORIDE	170251.37	0.76
LIRAGLUTIDE	168732	0.75
OXYCODONE	166950.74	0.74
MESALAZINE	166658.2	0.74

Appendix 3 - Organisation committees supporting medicines management

NHS TAYSIDE

AREA DRUG AND THERAPEUTICS COMMITTEE (ADTC)

Prescribing Management Group

Executive Management Team (EMT)

Clinical Quality Forum (CQF) for reporting into Improvement & Quality Committee (I&QC)

Directors Group

Area & Local Medical Committees

Area Pharmaceutical Committee

Area Clinical Forum

Medication Safety Community

ADTC

Medical Gases

eHealth

Clinical Governance Committees

Undergraduate Prescribing Group

Medicines Advisory Group (MAG)

Medicines Policy Group (MPG)

Non-medical Prescribers Group (NMP)

Medicines Safety and Quality Subgroup (MSQ)

Antimicrobial Management Group (AMG)

Oncology and Haematology Medicines Management Group (OHMMG)

Patient & Public Reference Group (PPRG)

MCN Formulary Groups

Wound Management Group

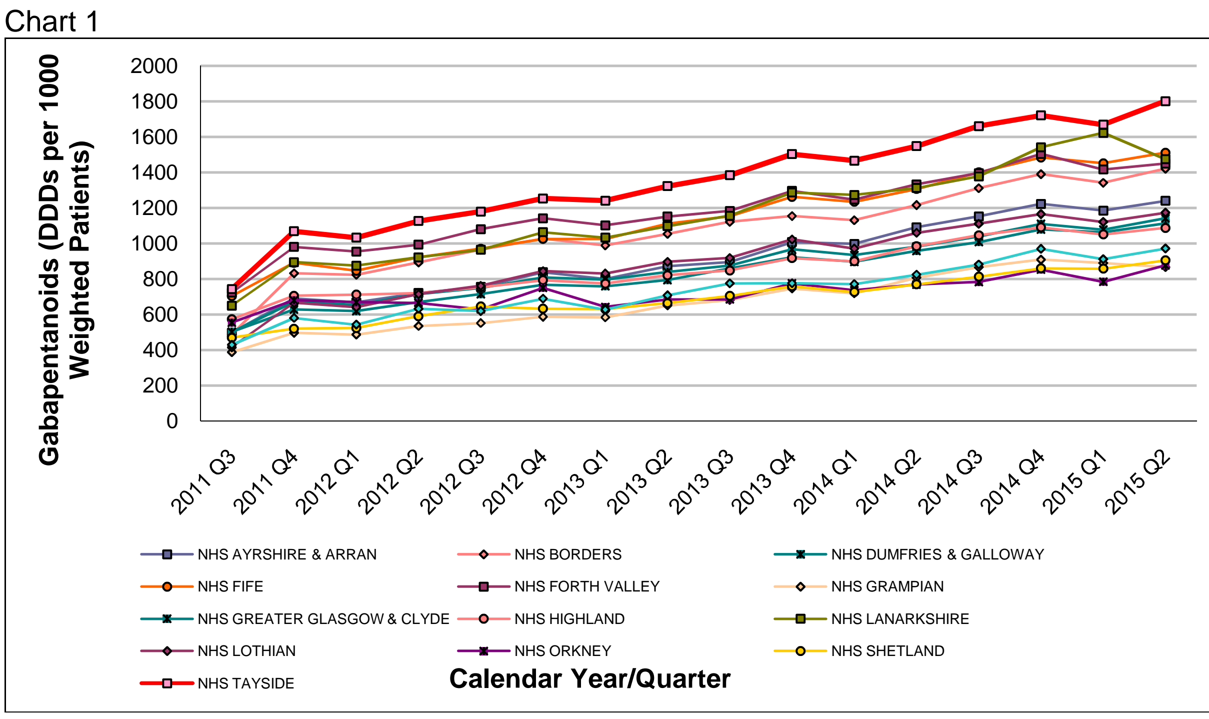
Patient Group Directions Group

Appendix 4

Pregabalin Growth and prescribing in NHS Tayside

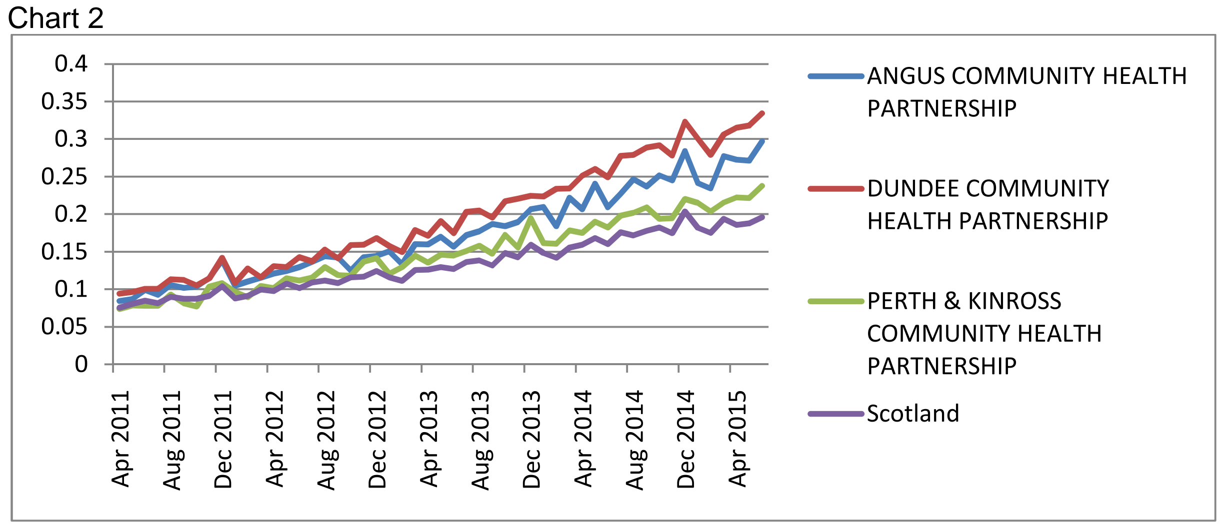
Between Q1 2014/15 and Q1 201516 Item volume growth for pregabalin was 22% across NHS Tayside, with costs up 21%. The use and rate of growth for pregabalin is greater in Tayside than for other Scottish Boards

Chart 1



The growth pattern across the three HCSPs against the Scottish average is shown below (DDD per patient)

Chart 2



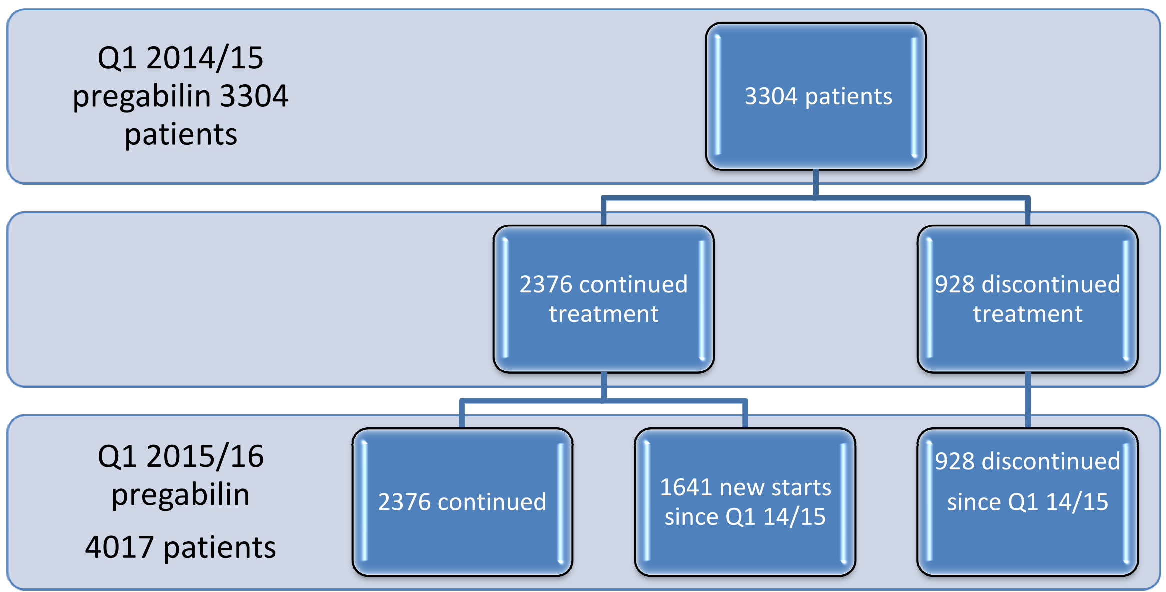
Pregabalin is the drug entity with the greatest expenditure in NHS Tayside for June-August 2015 accounting for nearly 4% of FHS expenditure

Table 1

Approved Name	GIC (Paid)	% total spend
PREGABALIN	881560.12	3.92

The item and cost growth is being driven by increasing numbers of patients being prescribed pregabalin, despite high rates of discontinuation.

Diagram 1-Unique pregabalin patients comparing Q1 2014/15 to Q1 2015/16 for NHS Tayside



928 (27%) of the 3304 patients prescribed pregabalin in Q1 2014/15 had discontinued treatment by Q1 2015/16. This is towards the upper range in published evidence (SIGN 136 (Dec 2014) Management of Chronic pain) which reports 18-28% discontinuation due to adverse events

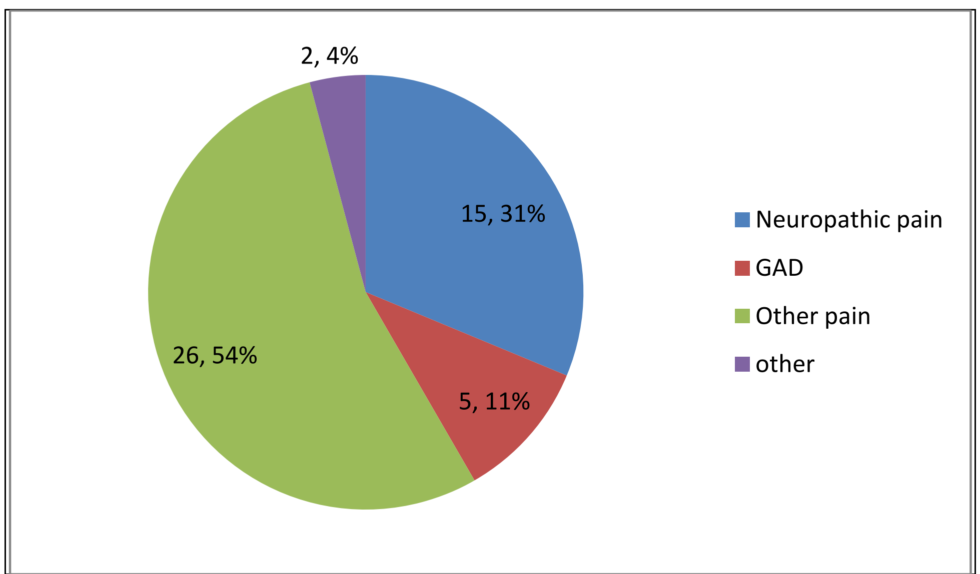
2376 (73%) of the 3304 patients prescribed pregabalin in Q1 2014/15 continued treatment at Q1 2015/16

An additional 1641 (49.6%) 3304 patients had commenced on treatment between Q2 2014/15 and Q1 15/16 and were still on treatment in Q1 15/16 giving a total of 4017 patients receiving pregabalin in Q1 15/16

A total of 4945 patients had pregabalin prescribed in the period reviewed (1.1% of registered practice population of Tayside as at July 2015)

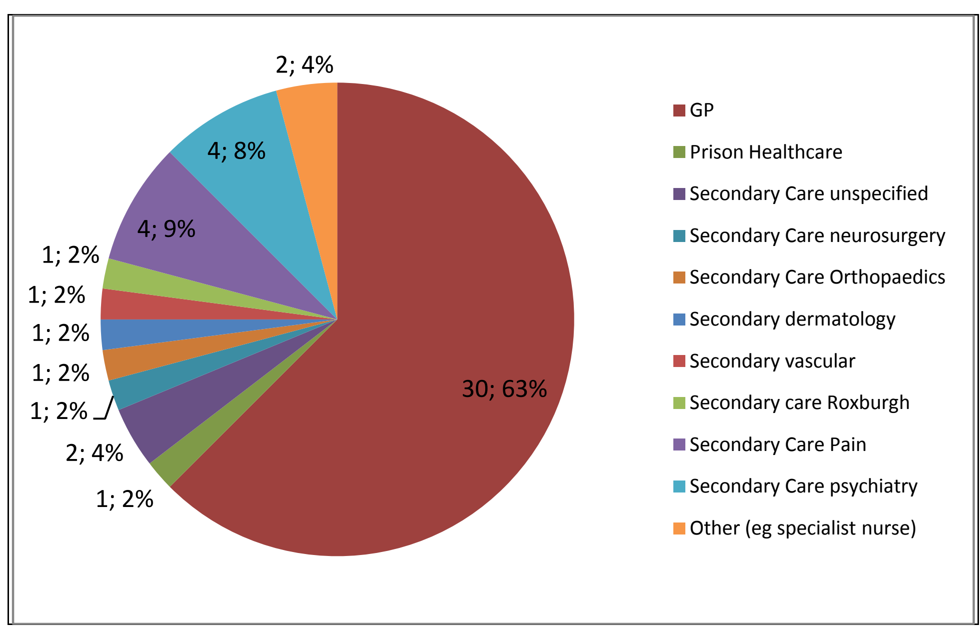
A review of recently initiated patients (one per practice, responses n=48) provided the following overview of prescribing

Chart 4- Indication recorded in notes



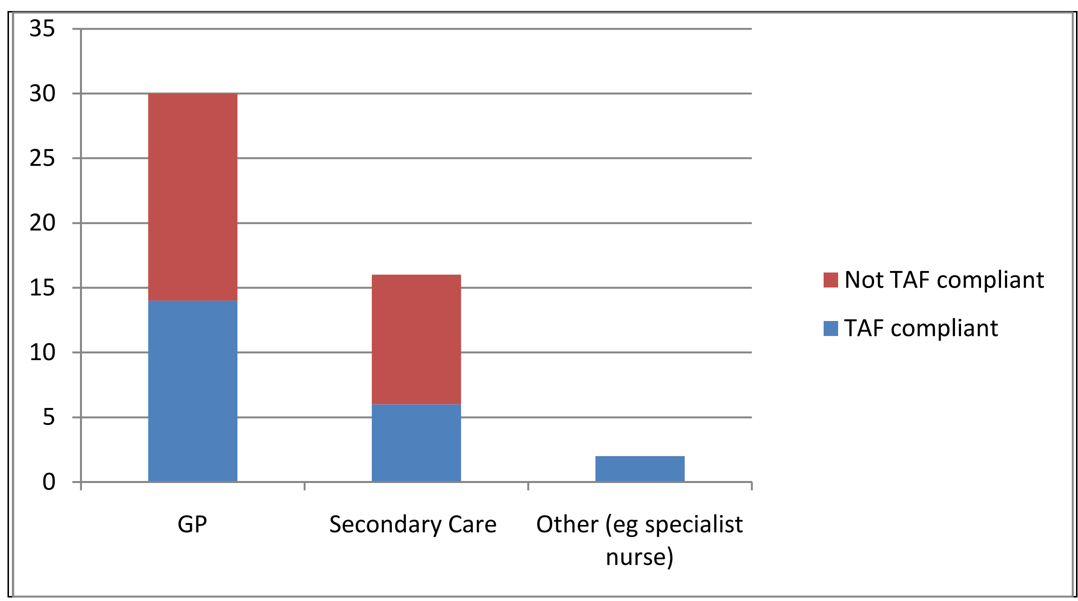
A minority of prescribing was for GAD or "other" indications, with 85% being for either neuropathic or other pain. In hearing the recent court case regarding secondary patents for neuropathic pain Mr Justice Arnold considered evidence from Pfizer and others and concluded that 70% of pregabalin prescribing nationally was for pain (http://www.bailii.org/ew/cases/EWHC/Patents/2015/2548.html paragraph 415), this would place NHS Tayside at variance with national prescribing patterns for pregabalin

Chart 5 –Clinician group or speciality initiating prescribing



63% of prescribing was initiated by GPs with a range of secondary care specialities initiating the remainder of patients

Chart 6 Compliance with TAF (third line after tricyclic and gabapentin for neuropathic pain, or IPTR for GAD)



The neuropathic pain guidance in TAF still indicates that prescribing of pregabalin for neuropathic pain should be initiated by a pain specialist, with transfer of prescribing to GPs following review after an 8 week trial, while there is also guidance for GP initiation as 3rd line treatment, so it could be argued that a large proportion of GP initiations fall outwith local guidance.

Following the recent court case Pfizer have appealed against the decision to lay aside the secondary patent. Until this appeal has been heard the previous advice on prescribing of pregabalin by brand name for neuropathic pain is assumed to continue within NHS Scotland

AGENDA ITEM NO 11

REPORT NO IJB 90/16

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 14 DECEMBER 2016

COMMUNICATION, PARTICIPATION AND ENGAGEMENT STRATEGY 2016-19

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

This report presents the Communication, Participation and Engagement Strategy 2016-19 to the Integration Joint Board for approval.

This strategy sets out the health and social care partnership's approach to communicating and involving a range of stakeholders including service users, carers, staff, volunteers and communities to achieve our vision for health and social care integration. The strategy seeks to involve local people and communities in the planning, design and delivery of services and supports in our localities. Furthermore it seeks to build new approaches which develops 'an Angus that actively cares'.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:

(i) approves the Communication, Participation and Engagement Strategy and notes that a public version of the document will be designed and made available internally and externally.

(ii) requests an update report on the strategy's implementation to a future meeting of the Integration Joint Board.

2. BACKGROUND

There is a strong legislative and policy context for communication, participation and engagement across health and social care.

In August 2013 the Health and Social Care Integration Oversight Group approved an Involvement and Engagement Plan which described proposals for communicating, involving and engaging with our stakeholders about health and social care integration.

The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014, clarify the Integration Authority's responsibility in relation to the influence that localities must have, and must be shown to have had, on the strategic commissioning plan and service delivery.

Locality Guidance, published by the Scottish Government in July 2015 details the requirements of IJBs to involve and consult at locality level.

3. CURRENT POSITION

Through a range of dialogue events across our localities we have engaged with a range of people who have provided valuable feedback on what matters to them in relation to health and social care provision. In addition to informing the Strategic Plan, this piece of work sets the

foundation for deeper dialogue and strengthening relationships with communities, ensuring people most affected by integration feel closer to influencing decisions.

We have 151 people on a virtual reference forum, all of whom wish to be kept informed and contribute to decision making processes.

4. PROPOSALS

Building on the work already undertaken, the Involvement and Engagement Group have refreshed the scope of the Involvement and Engagement Plan to ensure there is optimal consultation, participation and engagement around how we achieve our priorities for health and social care. The strategy seeks to support the Locality Improvement Groups with their communication, participation and engagement activities in order to identify specific locality based issues and drive improvement.

We aim to take a more participative approach recognising that local people, communities and co-contributors are central to shaping and improving the delivery of outcomes in Angus.

The strategy aims to make it easy for people contribute to shape the future of health and social care provision in Angus and where required, be supported to do so. In order to achieve this, the strategy recognises that we must challenge existing barriers to participation. We will ensure we use a shared language, develop clear messages and commit to open, honest and meaningful dialogue.

The strategy recognises that new behaviours and skills will be required and we are committed to cultural transformation, equal partnership and trans-disciplinary approaches towards joint working endeavours.

The strategy recognises that a commitment to building our engagement as part of the wider Community Planning agenda will be essential as we strive to develop locality influenced services which reflect the needs of our communities.

The Communication, Participation and Engagement Group will oversee the implementation and monitor the progress of this strategy within the four localities of Angus. It will also ensure links across the broader partnership in Angus are developed and sustained.

5. FINANCIAL IMPLICATIONS

£20K has been set aside from the Integrated Care Fund to cover expenses such as GP backfill, room hire, travel expenses etc.

6. OTHER IMPLICATIONS

(i) Risks

There is a legislative underpinning to communication, participation and engagement. The Integration Authority's annual performance report must include a description of the arrangements made in relation to consulting and engaging activities.

(ii) Equalities

An equality impact assessment will be undertaken before the final report is submitted.

REPORT AUTHORS: **Gary Malone, Chief Executive Officer, Voluntary Action Angus**
Sally Wilson, Locality Integration Improvement Manager

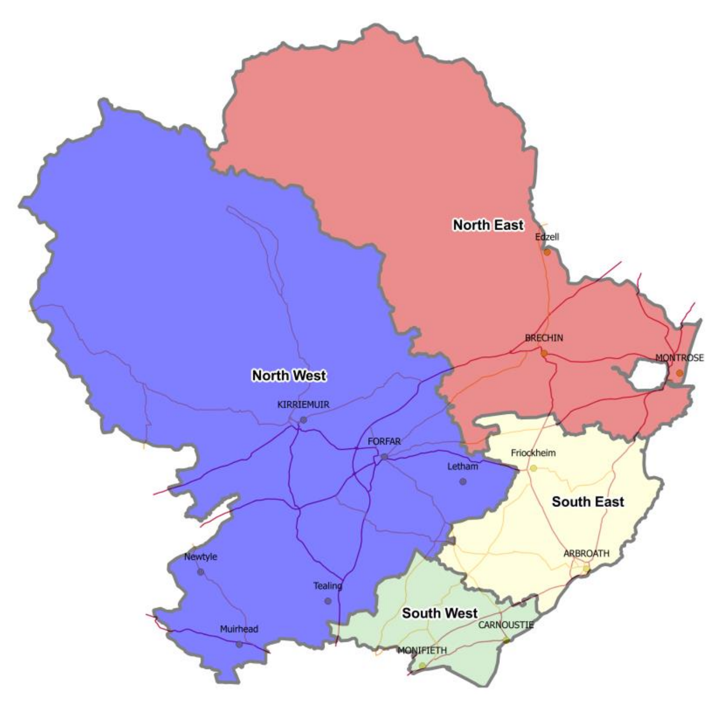
EMAIL DETAILS: hsciangus.tayside@nhs.net

22 November 2016

List of Appendices: Appendix 1 – Communication, Participation & Engagement Strategy 2016-19

APPENDIX 1

Communication, Participation & Engagement Strategy 2016-19



November 2016

1. Purpose of this strategy

This strategy sets out the Angus Health and Social Care Partnership's (HSCP) commitment to genuine approaches to work with all stakeholders impacted by health and social care integration. In particular it focuses on working with communities as evidence shows that the most effective services are those that are developed and designed in partnership with local communities. Furthermore this strategy seeks to build new approaches, which develops 'an Angus that actively cares'. The overarching aim of this strategy is to support the Angus HSCP to achieve its vision and meet the priorities for integrated health and social care services as outlined in the Angus Strategic Plan 2016 – 19. We will achieve this through being committed to cultural transformation, equal partnership and trans-disciplinary approaches towards our joint working endeavours.

"People are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting."

Angus Health and Social Care Partnership Vision for Health and Social Care

Successful implementation of this strategy will contribute to the Angus Partnership achieving the National Health and Wellbeing Outcomes. It will also contribute to the achievement of the Angus Community Planning Partnership priorities in particular the priority of 'caring and healthy' as outlined within the Angus Communities Directorate Improvement Plan 2016-19.

Now seems an ideal time to refresh our initial Involvement and Engagement Plan which was developed in 2013, to ensure there is optimal consultation, participation and engagement around how we achieve the priorities for Health and Social Care. Whilst recognising the statutory requirement to consult and engage outlined in the integration delivery principles within the Public Bodies (Joint Working) (Scotland) Act 2014, outlined in Appendix 1, We aspire to take forward this strategy based on a legacy of innovative approaches, research and a strong ethos of community development, which has built buoyant, integrated working in Angus for many years.

Our approaches to locality working will embed much of the above ensuring people most affected by integration feel closer to influencing the decisions being taken and the care movement built with communities. In essence, much of our communication and engagement philosophy is predicated on notions of civic health which takes account of the community as a living entity, is integrated, positive and comprehensive in its approach toward culture, resource and power shift. We believe that through such an approach we will achieve the overarching aims and vision as set within the priorities for integrated health and social care services as outlined in the Angus Strategic Plan 2016 – 19.

Local people, communities and co-contributors are central to the shaping and improving the delivery of outcomes in Angus. Such moves toward integration and service improvement will only become a reality if our activities are based on values of respect, asset based approaches and co-production. Genuine co-production also recognises co-consumption where we accept our position as service users as well as service providers. This helps build empathy and relationships necessary to achieving togetherness and care movements.

2. Developing an effective communication, participation and engagement strategy

The integration of health and social care is the Scottish Government's ambitious programme of reform to improve care and support for those who use health and social care services. The Angus Health and Social Care Partnership was established in April 2016. This partnership includes NHS Tayside, Angus Council, the Third sector and independent sector providers. Appendix 2 outlines both the strong legislative and policy context for communication, participation and engagement. This strategy also takes account of research and reflections on social care developments locally and nationally.

The (Public Bodies) (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014, clarify the Integration Authority's responsibility in relation to the influence that localities must have, and must be shown to have had, on the strategic commissioning plan and service delivery. Whilst it is important that the Integrated Joint Board has robust mechanisms in place to ensure effective communication, participation and engagement, this requires a new determination to build delivery through dialogues with communities.

Our vision for Health and Social Care in Angus is one where:

"People are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting."

3. Localities

In order to deliver for the future we will devolve local planning and delivery to the four localities within Angus. We want our health and social care partnership to have a positive impact on the lives of everyone it serves and we have a corporate responsibility to clear, consistent and transparent communication and engagement. As the Partnership spends public money we recognise our responsibility to help people understand, at locality level, more about our organisation, become more involved in how we make decisions and provide opportunities to share our progress.

In July 2015 The Scottish Government published Localities Guidance which sets out what localities are for, the principles upon which they should be established, and the ethos under which they should operate. The Guidance also details the requirements of the Integrated Joint Board to involve and consult, at locality level, with the following partners:

- General Practice
- Primary Care
- Secondary Care
- Housing
- Social Work and Social Care
- Third, voluntary and independent sector
- Communities

We want to build on our efforts to ensure that we value the impact and assets of local people, volunteers, families and neighbours to ensure that health and social care services are of high quality, good value for money and meet the needs of the people who live in Angus. It is essential that we empower people to better understand and inform how health and social care services can be delivered in

the context of increasing numbers of older people, fewer people of working age and growing financial pressures. In doing so, this will lead to better outcomes for our local population. We also want to create the conditions which empower people and communities to actively care, broadening the base of delivery.

Each locality is uniquely placed to consider local needs and communication, participation and engagement methods will need to vary across each area. Therefore we respect that our endeavours must bring people most affected by services closer to influencing decision making and also open up opportunities for voluntarism. It is vital that these groups understand their communities in terms of economy, people and place. Localities must be resourced and supported to build dialogues and engagement activities.

Commitment to building our engagement as part of the wider Community Planning agenda will be essential as we strive to develop locally-influenced services which reflect the needs of our communities. As a statutory member of the Community Planning Partnership the Integration Joint Board has a significant role to play within the Community Planning Process and is working with all partners and communities to create innovative approaches to working with communities to improve health and wellbeing.

4. Overarching standards and expectations

The Angus Health and Social Care Integration Joint Board will commit to:

- Placing individuals and communities at the heart of our service planning and delivery to ensure we can deliver person centred outcomes. In planning for the future we are committed to working together with people as assets and resources who have a greater responsibility to co-produce services that affect how they live their lives and meet their needs. This collaboration will help us to build a good understanding of what really matters to people. It will also help us to build community capacity by promoting health and wellbeing, reduce isolation, promote active ageing, improve our understanding of what works and support us to do more of it.
- Meaningful communication, dialogue, participation and engagement which is embedded into our Partnership's culture. This will enable all stakeholders to become fully informed and involved in taking an active role in effective and meaningful communication and engagement. We will reciprocate by ensuring people have the ability to influence service planning and decision making process of the Angus Health & Social Care Partnership.
- A genuine commitment to equality of esteem where all partners are involved in all aspects of leadership and strategy.
- Understanding the needs of the different people who live in our localities. We are committed to reducing inequalities which arise as a result of socio-economic status. In doing so we must take account of individual and collective characteristics, in particular the protected characteristics, as described within the Equalities Act 2010, of:
    - Age
    - Disability status
    - Ethnicity
    - Gender/sex
    - Religion/belief

- Sexual orientation, and
- Transgender identity.

In addition we choose to take account of poverty and social deprivation.

- Develop a common and agreed language, which is shared across agencies and professions who work with people who use services and community-based care and support.
- Encourage a learning from experience approach, sharing information and feeding back the results of our participation and engagement activities, demonstrating how people's views have been considered and impacted upon change. We will encourage channels for a two way free flow of information, both listening and informing, which will provide clarity about what we can do and importantly what we sometimes cannot do and why.
- Where service change is proposed that will have an impact on the community, we will involve and consult appropriate representatives of that locality and will support reasonable costs to enable those representatives to give their view.
- Develop collective media relations to promote a positive public image that builds and maintains public confidence in Angus community health and care services.
- Comply with legislation and guidance relating to informing, engaging, involving and consulting people.

5. Communication

5.1 Principles

- Communications and engagement activity must follow a consistent approach and standard to help us to fully reflect the values of the Angus Health and Social Care Partnership. In turn this will influence the actions of the organisation and the behaviours of our staff and members.
- When planning communications and engagement we need to commit to communication which reflects the audience it involves .
- Ensure open, honest, meaningful and appropriate communication using appropriate methods which are accessible. We aim to overcome barriers to involvement. This will include support to be able to engage with us through, for example, supporting reasonable costs, assisting with travel, child care accessibility etc.
- Develop a shared and compelling explanation for local health systems about how integration will improve outcomes for people in the future, building upon the knowledge, skills and confidence of all who take part. This will be clear, easy-to-understand and consistent information that takes account of the needs of people with physical and learning disabilities, sensory impairment, individuals with literacy problems, people from minority ethnic communities and individuals from hard to reach/vulnerable groups. In addition this will improve the information and communication across health and social care services creating a knowledgeable and well-informed workforce.
- We will work in partnership with other organisations to make sure that when communicating and engaging with the general public of Angus we do so in the most appropriate, co-ordinated and effective way possible.

- Information will be in plain English, without jargon and with minimal use of acronyms, which are explained. Readability and disability guidance will be used to analyse our external communications and documents to help us to recognise the potential limitations of our communication i.e. reading difficulties, dyslexia, blindness and colour blindness, and English not a first language.
- Published material will be developed with the public, patients, staff, partner organisations, carers, volunteers, Third and Independent sector organisations. Written messages will be clear and concise, using short sentences and avoiding management language.
- The right messages will reach the right people, in the right format, at the right time.
- Credibility is earned by responsible, honest and timely communication.

5.2 Our Key Messages

Key messages will be used to convey our vision, values and qualities of the Angus Health and Social Care partnership. It is important that we reflect these key messages in all our communications with our key stakeholders to ensure a consistent approach. These are:

- We are committed to placing people at the heart of our organisation and building a culture of Angus being a partnership that 'actively cares'.
- We are proud of the achievements we have made and confident that we will continue to make Angus a great place to live and work.
- We will develop innovative ways of engaging with our stakeholders.
- We are committed to working with people to design and commission high quality, safe accessible local services which meet the needs of the communities within our localities.
- We are committed to developing effective partnership working to help to improve the health and well-being of local people.
- We will work with people to prevent them from becoming ill, support them to detect conditions early, manage their conditions, make life style changes and access the right service, in the right place at the right time.
- We will support people to live independently in their own homes and community for as long as possible.
- We are committed to research and innovation leading to continual improvement for the people of Angus.
- We are committed to raising standards of care and support.
- We are committed to fully involving the health and social care workforce whether they be from the public, third or independent sectors in the planning and provision of health and social care services.

5.3 Methods of Communication

- Through the Locality Improvement Groups
- Newsletters e.g. Integration Matters, VAA and Angus Carers publications
- Face-to-face discussions
- Cascading of information through organisations and groups
- Media Coverage

- NHS Tayside and Angus Council Internet and Intranet pages
- Social Media channels e.g. Facebook and Twitter
- Highlight reports and briefings
- Leaflet and poster distribution in easy read and plain English versions
- Presentations

6. Participation and Engagement

6.1 Principles

We are proud of the progress we have made to involve and engage with the people of Angus to shape service and we have built up a sound knowledge base, skills and experience, for example; Public Partnership Forums, Patient Participation Groups, volunteer and carer groups third sector dialogues, third sector collaborative. However, we know that improvements can be made and that participation and engagement is a two way process with a focus on creating and maintaining open dialogue. We will:

- Develop an active community dialogue approach to understand what really matters to the people who live and work in our communities which will help us to create and improve services / building an Angus that actively cares.
- Go to where people are rather than expecting them to come to us.
- Redesign service delivery so that our organisation is more flexible in meeting the needs of all people
- Build upon established relationships to ensure strong networks are established in each of our four localities so that we understand the specific needs of each locality and better understand people's experiences. These networks will be built on trust and a shared understanding that we want to improve services in Angus. In turn, this will help us to develop services around the health and care needs and aspirations of each locality.
- Engage people who use services, carers, families and the wider public in plans for better integrated care. This involves ensuring that people who use services, or their representatives, are members of decision-making boards, and that people who use services shape, deliver and evaluate the services we provide.
- Ensure that volunteers, patients and carers know how to give feedback, are appropriately supported to do so and that they regularly receive reports on how this feedback has been used to improve services.
- Learn from other organisations about their approach to participation and engagement and share our learning with others.

6.2 Methods of participation and engagement

These will include:

- Locally based dialogue on what matters to people
- Face to face meetings
- Street surveys and co - investigations
- Events and focus groups
- Facebook, Twitter, Online discussion groups/e-panels, webpages and newsletters.

- Compliments and complaints received by the Partnership will also be a valued source of information to inform change.

We will also seek to use real life stories as case studies to help us and others to understand people's experiences of care and support.

7. How will this strategy be implemented?

To make this strategy work, the approach described above will be resourced through the existing infrastructure aligned to the Angus HSCP.

The Communication, Participation, Engagement Group (CPEG) will oversee progress of this strategy within the four localities of Angus. The CPEG will also ensure that links across the broader Angus Partnership are developed and sustained.

Progress on and review of this strategy will be reported regularly to the IJB.

Each Locality Improvement Group will be responsible for demonstrating how they communicate, participate and involve people who live and work in their locality. A representative from each locality will sit on the CPEG so that ideas can be shared, problems addressed and consensus achieved on the big decisions – priorities, commissioning or otherwise, that the Partnership needs to make.

8. How will we know this strategy has been successful?

- Stakeholders consistently report back to us their high levels of satisfaction and recognise our commitment to excellence.
- Communities demonstrate cultural change through the growth of voluntarism.
- All stakeholders feel better informed about health and social care in Angus.
- People know how to contribute to participation and engagement activities and feel that they have made a valued contribution.
- People in Scotland and beyond want to work in Angus because we have a reputation for being a great place to work, find creative solutions, make things work better and make a difference.
- Reduced numbers of patient complaints

Appendix 1

Public Bodies (Joint Working) (Scotland) Act 2014. Section 31 Integration delivery principles

(1) The integration delivery principles are:-

(a) that the main purpose of services which are provided in pursuance of integration functions is to improve the wellbeing of service-users,

(b) that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible:-

(i) is integrated from the point of view of service-users,

(ii) takes account of the particular needs of different service-users,

(iii) takes account of the particular needs of service-users in different parts of the area in which the service is being provided,

(iv) takes account of the particular characteristics and circumstances of different service-users,

(v) respects the rights of service-users,

(vi) takes account of the dignity of service-users,

(vii) takes account of the participation by service-users in the community in which service-users live,

(viii) protects and improves the safety of service-users,

(ix) improves the quality of the service,

(x) is 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),

(xi) best anticipates needs and prevents them arising, and

(xii) makes the best use of the available facilities, people and other resources.

(2) In subsection (1), "service-users" means persons to whom or in relation to whom the services are provided.

Appendix 2

Legislative and policy context for communication, participation and engagement

The **Public Bodies (Joint Working) (Scotland)** Act 2014 places a legal requirement upon the IJB to involve and consult and our annual performance report must include a description of the arrangements made in relation to consulting and involving localities.

The **Community Empowerment (Scotland) Act, 2015,** gives people a stronger voice in their communities by giving communities more of a say in how public services are to be planned and provided, new rights enabling communities to identify needs and issues and request action to be taken on these, and extends the rights of communities to buy or otherwise have greater control over assets.

The new **National Standards for Community Engagement,** launched in September 2016, outline best practice for engagement between communities and public agencies. The Standards have been simplified to seven Standards, reflecting the main elements of good community engagement - Inclusion, Support, Planning, Working Together, Methods, Communication and Impact.

The **Patients' Right (Scotland) Act 2011** aims to improve patients' experiences of using health services and supports people to become more involved with their health and healthcare.

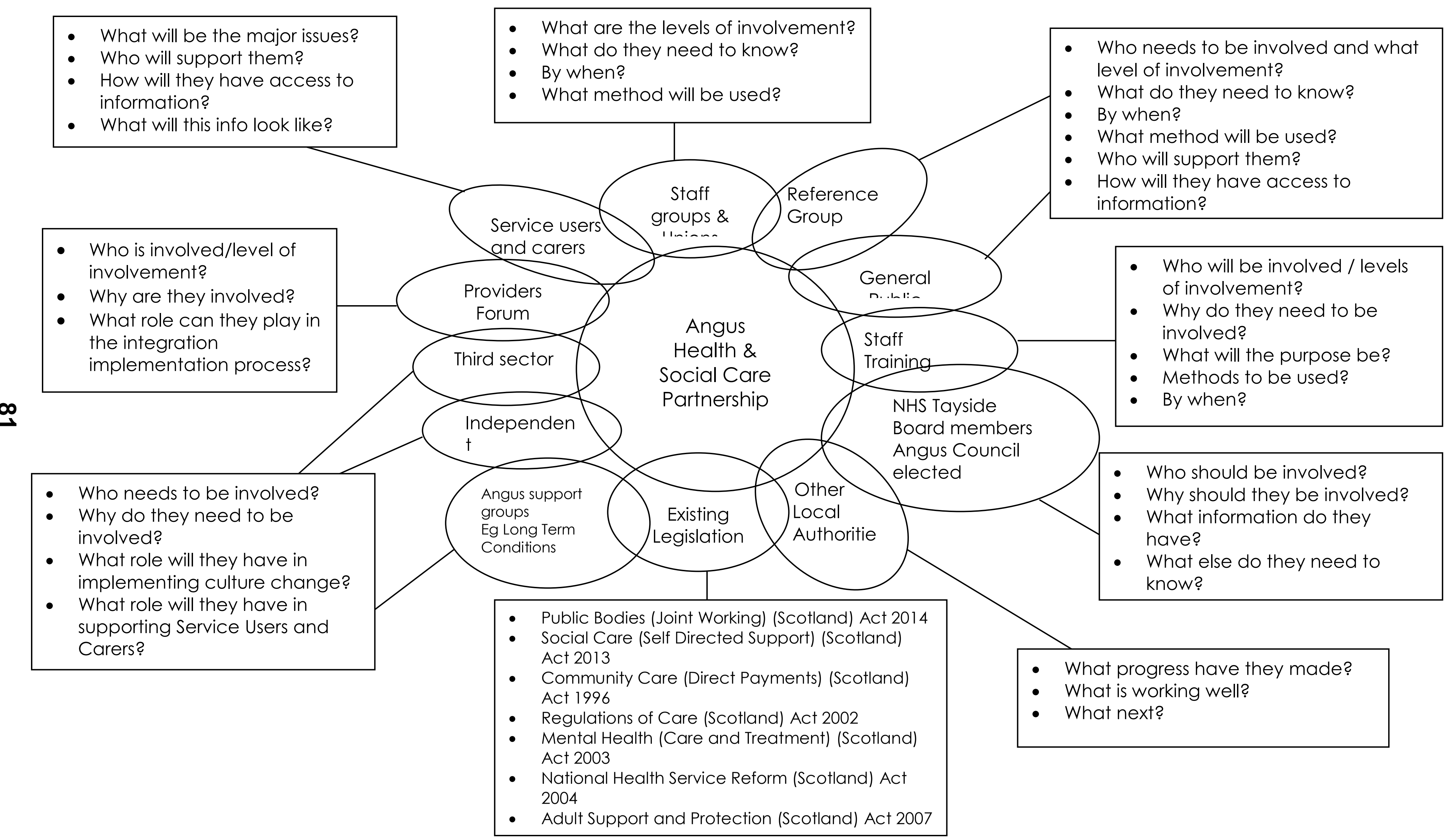
The **Equalities Act (2010)** sets out a public service duty to ensure that when planning and delivering services we contribute to eliminating discrimination, harassment and victimisation, advancing equality of opportunity and foster good relations between groups.

Scottish Health Council's **Participation Standard, 2010**. The Participation Standard builds on an agenda that has been developing over a number of years. To reflect the importance of participation, duties of public involvement and equal opportunities were placed on NHS Boards in the NHS Reform (Scotland) Act 2004.

This strategy supports the vision of the Scottish Health Council "Our Voice" where:

> *"People who use health and care services, carers and the public will be enabled to engage purposefully with health and social care providers to continuously improve and transform services."*

APPENDIX 3 How we will support effective and meaningful communication and engagement with all stakeholders



APPENDIX 4

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

COMMUNICATION, PARTICIPATION & ENGAGEMENT IMPLEMENTATION PLAN 2016-19

Table below has 2 columns and 12 rows. Row 1 has headings.

SERVICE AREA:	ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP
1. **Service Lead**	Gary Malone – Community Dialogue and Engagement Sally Wilson – Communication
2. **Name Of Service**	Health & Social Care Partnership Communication & Engagement Planning
3. **Description of Service**	The Angus Health and Social Care Partnership aims to place individuals and communities at the heart of our service planning and delivery to ensure we can deliver person centred outcomes.
4. **Aim / Purpose Of Engagement**: Involving, engaging and informing	Involving and engaging our staff and communities in the service improvement work so our stakeholders are able to influence and shape health and social care services in Angus.
5. **Stakeholders:** Identify and list service users groups, carer's forum, patient groups; public partners; voluntary organisations; general public; staff; clinicians etc.	Service users/patients/carers General Public People with protected characteristics Vulnerable/hard to reach groups Community Organisations/Groups Third sector independent sector Elected Members and NHS Board members Staff – Service Managers, Allied Health Professionals, Nursing staff groups, Clinical Partnership; General Practitioners; General Practice groups. Community pharmacists, social care officers; home care managers/assessors; care/case managers; occupational therapists; day centre officers; service managers; senior managers; union representatives. Staff outwith Health & Social Care Partnership, e.g. Community Learning and Development,

	Housing and Leisure & Recreation, etc Media: newly formed cross sector media
6. Support Needs: Identify the barriers to involvement and how they may be overcome. Timings of events, travel expenses, crèche facilities and carer provision must all be considered.	Engagement toolkits are available from NHS Tayside and Scottish Health Council that provide resources to use when engaging with service users, patients, their families, carers, staff groups and the public. Areas will include, for example: ▪ Health & Social Care Partnership newsletter ▪ Third sector media and training ▪ Dedicated website/Facebook presence and Twitter feed ▪ Dedicated email address and freepost address ▪ Links to other tools or materials that can support communication involvement and engagement ▪ Reimbursement of expenses ▪ Recognition of the needs of carers ▪ Building inclusive volunteering cultures ▪ Translation and interpretation as required
7. Methods Of Engagement: Consider methods appropriate for the target audience.	We want to make sure that everyone in Angus can engage. Different methods of engagement will be used as appropriate for each activity that is undertaken. The list is varied and very long from the tried and tested to new and innovative. Each method will have its merits and the activity plans for each stage will provide the detail. Examples include: Presentation to groups across Angus; Information on Angus Council/NHS websites/Online question and answer opportunities; Media/press releases/Radio Tay; Peer support to access or provide information; Twitter/Facebook presence; Leaflets, factsheets, and booklets as appropriate; Conferences/seminars/workshops; Use existing publications such as Angus Life to provide real life examples of what integration will mean to individuals; Integration Matters. Face to face contact through staff contact; carers group contact and email direct to individuals.
8. Working Together: consider how to enable participants to work with one another effectively and efficiently.	There are many good examples of effective partnership working in Angus and we will build on what works well to develop even more effective partnership working between individuals, communities, health and social care, the third sector and private sector.
9. Working with Others: Consider who needs to be part of the involvement	We will establish a reference forum with our partners in the Third and independent sectors, communities and individuals and health and social care colleagues work will be undertaken to

and engagement process across Angus. What are the desired outcomes?	create genuine opportunities for meaningful involvement and engagement across Angus. We will develop a range of ways in which we can connect with all stakeholders to increase opportunities for effective dialogue and feedback.
10. Feedback: Use appropriate feedback methods to ensure that all stakeholders are aware of the outcomes from the involvement and engagement activity.	Feedback will be encouraged in all communication with internal and external stakeholders and the range of ways in which communities, groups and individuals can comment or share ideas will be explicit in all involvement and engagement activity. This will be done through: The development of a specific Angus Health and Social Care website; the development of a joint newsletter for staff; information on Your NHS and in Angus Life; Provide 'keep me informed' request forms at every event; provide information via Facebook and Twitter; A new cross sector media will be developed. We will work collaboratively and innovatively with our stakeholders, using existing expertise across the partnership for example from within the Third Sector and Community Learning and Development and through evaluation on an ongoing basis from stakeholders to assess and improve our engagement and feedback.
11. Previous Record: How does this relate to/follow on from any earlier related involvement and engagement activity	Follows on from: Joint engagement activity to promote the establishment of Integration of Health & Social Care during 2014-16. Previous, separate work by Angus CHP and Angus Council Social Work & Health Department that influenced our locality model development: - Angus CHP work on Community Medicine & Rehabilitation Redesign Project 2008-2015 - Angus Council Social Work activities in relation to developing the Community Care Change Programme 2012-15. Takes cognisance of existing work relating to Health Inequalities Strategy and Self Directed Support.

AGENDA ITEM NO 12
REPORT NO. IJB 91/16

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 14 DECEMBER 2016

PERFORMANCE REPORT

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

The purpose of this report is to update the Integration Joint Board (IJB) on the progress made in developing the annual performance report. The annual performance report and additional quarterly performance reports will allow the IJB to track progress towards the delivery of the Partnership's vision, strategic shifts and planned outcomes for the people of Angus.

1. RECOMMENDATIONS

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

(i) approve the Quarter 2 2016/17 Performance Report for Angus (Appendix 1);

(ii) ask the Chief Officer to ensure that updated performance reports are provided to the IJB quarterly.

2. THE QUARTER 2 PERFORMANCE REPORT

2.1 The IJB have agreed previous reports related to the development of the partnership's performance framework.

2.2 The performance framework includes the partnership's approach to developing the annual report required by regulations set out by the Scottish Government (SSI 2104 no 326). The Scottish Government have recently issued guidance to partnerships in support of the regulations. The guidance is attached as Appendix 2. The first performance report is required in 2017.

2.3 The quarter 2 performance report aims to address strategic level performance described in the partnership's performance framework. This includes the national core indicators which demonstrate progress against the national outcomes.

2.4 A number of additional indicators have been developed to show progress against the four strategic priorities:

- Improving health wellbeing and independence
- Supporting care needs at home
- Developing integrated and enhanced primary care and community responses
- Improving integrated care pathways for priorities in care

2.5 In addition the performance report will provide information on a further three performance areas:

- Clinical and care governance
- Staff
- Resources

2.6 There is some overlap in indicators for each of these seven priority and performance areas. The aim in the performance report is to provide the information only once where there is best fit. Further indicators will be developed as progress is made with the implementation of the performance framework

2.7 The aim of the quarter 2 performance report (Appendix 1) provides evidence of progress through quarter 1 and quarter 2 of 16/17 with previous trend information.

2.8 A quarter 3 performance report will be brought to IJB in February 2017. This report will show the development of additional performance measures.

REPORT AUTHOR: Gail Smith, Head of Community Health and Care Services (North Localities) Executive Lead Performance and Improvement

Vivienne Davidson, Principal Planning Officer

EMAIL DETAILS: **gailsmith@nhs.net**
DavidsonVA@angus.gov.uk

23 November 2016

Appendix 1 - Quarter 2 2016/17 Performance Report
Appendix 2 – Guidance for HSCI Partnership Performance Reports

Appendix 1 to Report IJB 91/16

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

PERFORMANCE REPORT

2016 Quarter 2 Report

Angus Health and Social Care Partnership

Performance Report 2015/16

Introduction

The purpose of this performance report is to set the baseline performance from 2015-16 against the four priorities set out in our strategic plan. We are working with primary data providers including NHS Tayside business unit, Angus Council and nationally with Information Services Division (ISD) to develop data that reflects performance across Angus and within each of our localities.

ISD will be able to provide the partnerships with recent quarterly data (or at locality level) until January 2017, the Angus Improvement and Performance Team have decided to produce two interim reports before then. This report will show locality data for 2016/17 quarter 2. All of the health data shown in these reports will be sourced from national datasets, social care data will continue to be extracted locally until the national SOURCE data is available.

National Indicators 1-10 are gathered from a biennial survey. There is no further update on these indicators following the 15/16 baseline report provided previously. Not all indicators 11-23 are available at locality level at this time, so only the following indicators at locality level have been provided:

- Rate of emergency admissions for adults
- Rate of emergency bed days for adults
- Readmissions to hospital within 28 days of discharge
- Falls rate per 1,000 population in over 65s
- Number of days people spend in hospital when they are ready to be discharged
- Percentage of people who are discharged from hospital within 72 hours of being ready

The Angus Improvement and Performance team have extracted health information from a different source than the ISD Source team and there are some minor discrepancies between the ISD published and non-ISD published health information. For example, the emergency bed days rates show 112,685 per 100,000 population at 2014/15 and the locality level data shows Angus at 109,971; this is a difference of 2%. All non-published information, such as health information shown by localities, should therefore be treated with caution. The trends between the national data and data produced locally are very similar, as shown in the graph for "Rate per 100,000 Population of All Emergency Bed Days for People Aged 18+ by Locality and Financial Year".

Overall Locality Performance

- Most improved locality for the majority of indicators is the South East, both in terms of its position across a number of performance indicators and in comparison to the baseline year 2015/16 (see table 2).
- Only West Dunbartonshire, Renfrewshire and Clackmannanshire have a higher proportion than Angus of all its care services (Care Homes, Care at Home, Day Care etc) graded as good or better by the Care inspectorate in Scotland as at 2015/16.
- Angus performs well nationally in relation to premature mortality rates, emergency admission rates, emergency bed day rates, last 6 months of life spent at home or in a community setting, falls and delayed discharges. The good performance in relation to these indicators shows the progress the partnership has made in addressing timely discharge and shifting the balance of care to more community based and responsive services.
- Angus performs above the Scottish average in relation to the percentage of time that people spend at home or in a community setting in the last 6 months. At 90% this is an improved performance area against previous years.
- Significant progress has been made in addressing hospital bed occupancy as Angus has seen a continual decrease in the bed day rates since 2012/13 and as at 2016/17 Q2, it is below the Scottish rate for the first time in the last 5 years.
- Enhanced Community Support, managing delays in timely discharge, and increasing levels of personal care have contributed to a significant (61%) reduction in bed days lost to delayed discharges for people aged 75+ between 2012/13 and 2015/16. The reduction in delayed discharges continues. There has been a 37% decrease in bed days lost to delayed discharge between 2015/16 and 2016/17 Q2 . These improvements contribute significantly to improvements in outcomes for individuals.
- The rate of hospital bed days in Angus when adults are admitted in an emergency is reducing and in 2015/16 fell below the Scottish average rate. The Scottish average rate is also falling.
- A high proportion (89%) of users of care rate the services as excellent or good.

Angus' Ranked Performance as between 2010/11 and 2015/16

The tables below show the summary of Angus performance in relation to the Scottish performance across a range of national indicators.

G	Angus is performing well against the Scottish average
A	Angus rate is approximately the same as the Scottish average
R	Angus has greater room for improvement against the Scottish average

Table 1: Angus' Ranked Performance for national indicators as between 2010/11 and 2015/16

National Indicators	2011/12	2012/13	2013/14	2014/15	2015/16
11. Premature mortality	G	G	G	G	G
12. Emergency Admissions	G	G	G	G	G
13. Bed Days following emergency admission	A	R	A	A	G
14. Re-admissions after 28 days	G	A	A	G	R
15. Last 6 months of life at home	G	G	G	G	G
16. Falls	G	G	G	G	G
17. Care Inspectorate grades	N/A	N/A	N/A	G	G
18. Intensive Needs at home	R	G	A	R	N/A *
19. Delayed Discharges	N/A	R	G	G	G
20. Spend on emergency admissions	R	R	R	R	R

* definition of indicator is changing

Performance in 2016/17 Q2 against baseline year 2015/16

Green	2016/17 performance Q2 has improved against the 2015/16 baseline rate
Amber	2016/17 performance Q2 is approximately the same as the 2015/16 baseline rate
Red	2016/17 performance Q2 has declined against the 2015/16 baseline rate

Table 2: Percentage change in 2016/17 Q2 against the baseline year 2015/16

National Indicator	Angus	North East	North West	South East	South West
12. Admissions	+1.1%	+0.1%	+2.3%	-0.4%	+2.2%
13. Bed Days	-2.4%	-3.5%	-4.0%	-4.7%	+0.2%
14. Re-admissions	-3.2%	-1.3%	-4.4%	-5.8%	+6.3%
16. Falls	+7.5%	+13.3%	+17.2%	+4.5%	-5.3%
19. Delayed Discharges	-4.3%	-8.0%	+10.2%	-24.2%	-27.8%

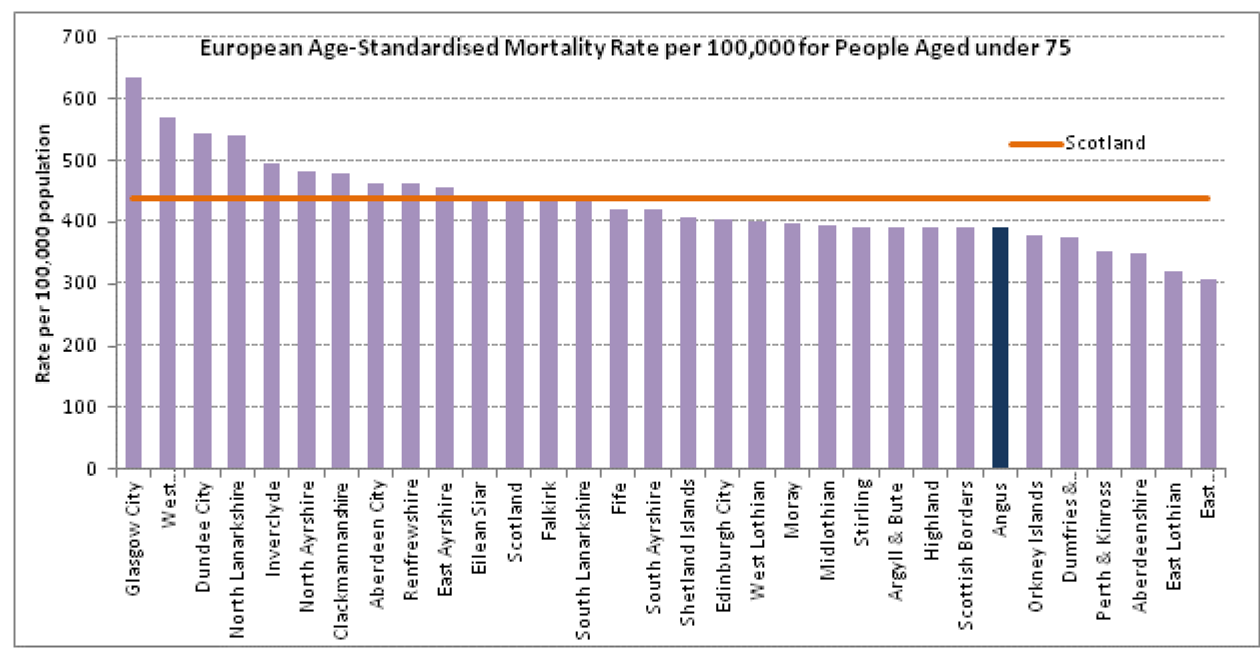
Performance against Strategic Priorities

Priority 1: Improving Health, Wellbeing and Independence

The aim of the Angus Health and Social Care Partnership's strategic plan is to progress approaches that support individuals to live longer and healthier lives. This includes having access to information and natural supports within communities. AHSCP's focus is on health improvement and disease prevention including addressing health inequalities; building capacity within our communities; supporting carers and supporting the self- management of long term conditions. There are health inequalities in some areas of Angus; these were identified in the Joint Strategic Needs Assessment. We are working with public health to determine appropriate measures which provide evidence in relation to health equity and the impact of services across Angus. This will include ensuring that data from primary providers is available so that we can see performance in the most and least deprived areas of Angus against the Angus average performance. Addressing performance variation will go some way to begin to address health inequalities. One indicator of health inequalities is premature mortality rates.

Graph 1 National Indicator 11: Premature Mortality Rate

Latest National Position as at Calendar Year 2015



Source: ISD Scotland

1.1 Angus is consistently below the Scottish average in relation to premature mortality rates. As at 2015, Angus is the 7th lowest ranked partnership for premature deaths with 391 per 100,000 population.

1.2 Angus continues to have high levels of volunteering. Voluntary Action Angus are supporting the development of voluntary organisations and volunteering across Angus. The capacity of communities to care is a focus of the work. In 2015/16 there were 902 voluntary organisations working and supporting communities in Angus. There were 6,017 adults volunteering in Angus, a volunteering rate of 65.5 adults per 1,000 adult populations. As yet this cannot be benchmarked nationally. AHSCP is supporting the development of the

voluntary sector and volunteering through integration care fund resources. Significant progress has been made in making information available about the range of opportunities for voluntary support in Angus. Information on most organisations can now be found on ALISS (a local system for Scotland).

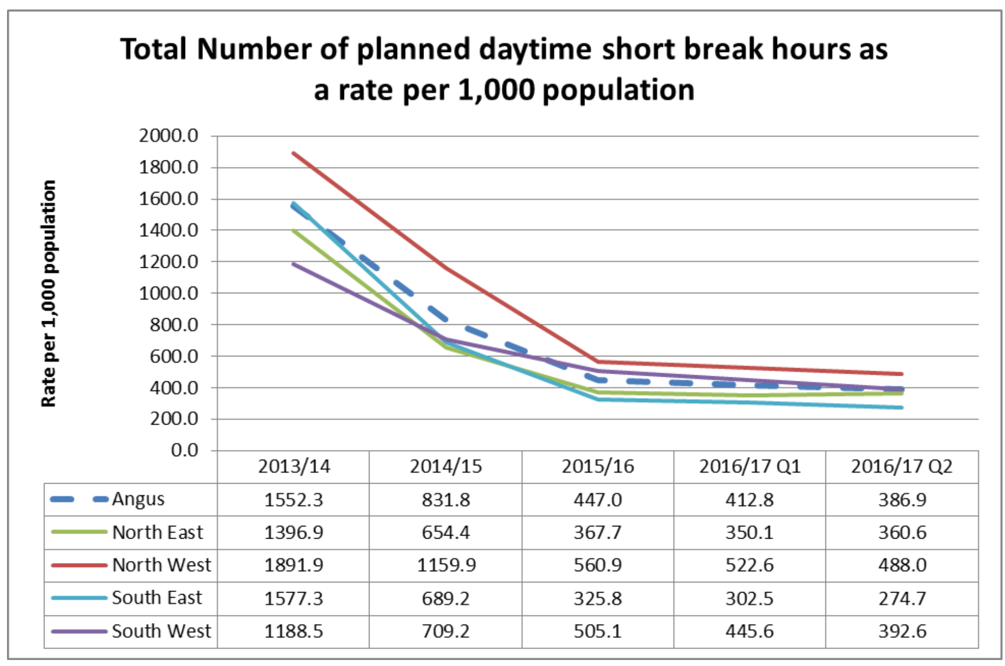
1.13 AHSCP is working with Angus Carers to continue to address support for carers, Angus performance in relation to carers feeling supported to continue their caring role is marginally less than the Scottish average. There is an improving picture of the number of carers that have been identified in Angus and the number of carers support plans that have been put in place. In 2015/16, Angus carers:

- provided 1,621 carers with one to one support,
- developed 178 new carers support plans with carers over 50 years old and 81 reviews
- achieved a total of 363 support plans in place with cares over 50 years

AHSCP has invested a significant amount of the integration care fund to ensure that accessible support for carers in available in each locality.

1.14 A range of supports are put in place following an assessment of carers needs, this includes daytime short breaks and overnight breaks.

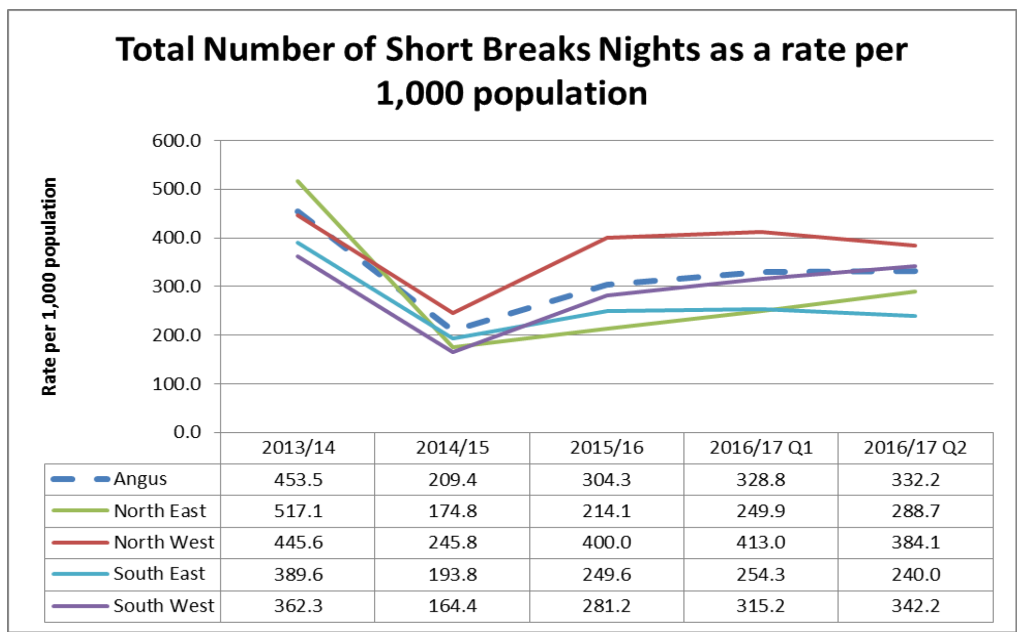
Graph 2 Management Information at Locality Level – rate of daytime short breaks hours



	2013/14	2014/15	2015/16	2016/17 Q1	2016/17 Q2
Angus	1552.3	831.8	447.0	412.8	386.9
North East	1396.9	654.4	367.7	350.1	360.6
North West	1891.9	1159.9	560.9	522.6	488.0
South East	1577.3	689.2	325.8	302.5	274.7
South West	1188.5	709.2	505.1	445.6	392.6

1.15 Day time short breaks saw a decrease between 13/14 and 15/16 following changes to specific short breaks services. These hours were merged into personal care services and in part contribute to the increasing rate of personal care provision.

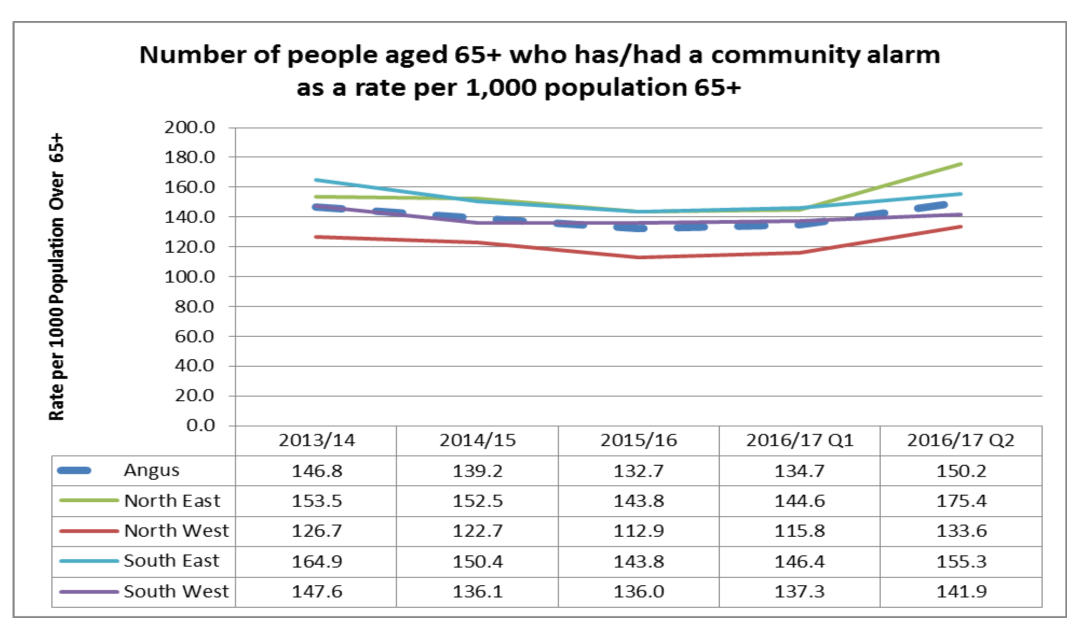
Graph 3 Management Information at Locality Level Rate of short breaks nights



1.16 There has been an increasing rate of provision of short break nights, whilst small this increasing trend has continued into Q1 and Q2.

1.17 Services all aim to enable individuals to be as independent as possible. Community alarm services contribute significantly towards supporting individuals to feel safe.

Graph 4 Management Information at Locality Level Rate of community alarm use



Source: Community Alarm.

1.18 There was a reduction in community alarm installations following the introduction of charging. Installation of community alarm has subsequently risen in both Q1 and Q2. This shows progress in our aim to improve tele-enabled care.

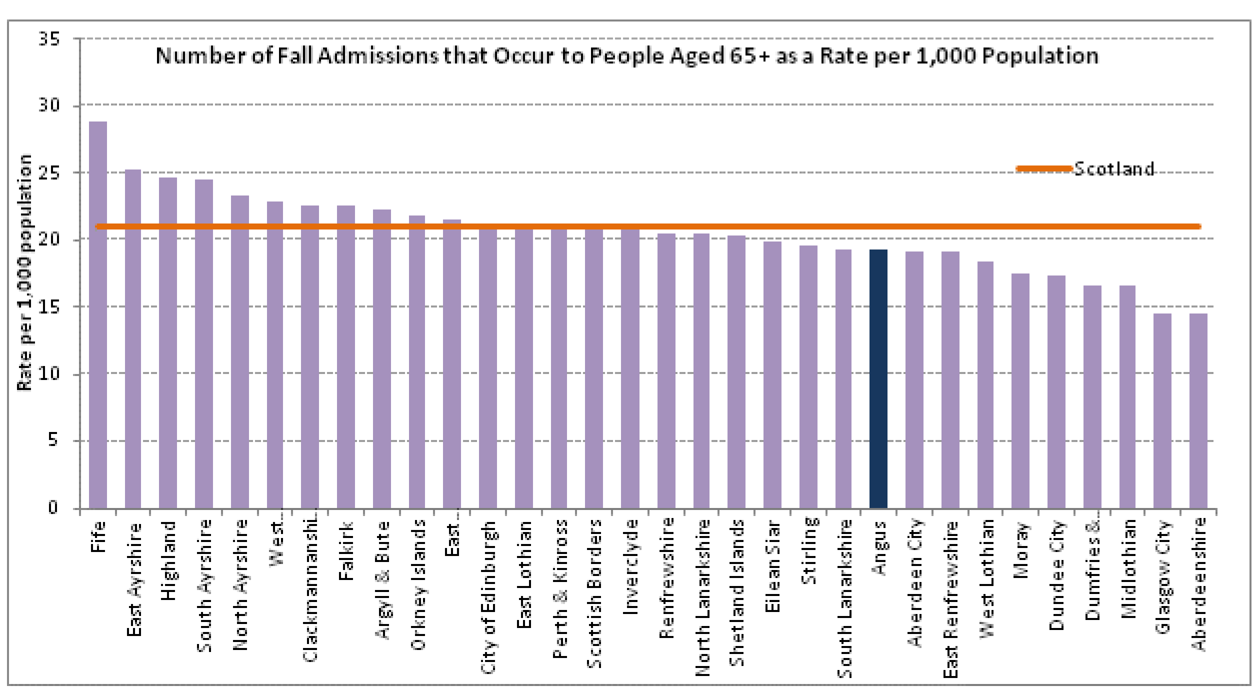
1.19 All new referrals for a social care service, where eligible needs exist, are supported by a period of enablement lasting between four to six weeks.

Enablement services have been successful in returning individuals to full independence. Currently 52% of people who are over 65 years require no further services following a period of enablement. The success rate has reduced over the past 3 years, partly due to individuals having repeated enablement referrals. Individuals using enablement in 2015/16 are much more likely to have had previous successful enablement contacts. There are people who require ongoing services but cannot be discharged from enablement due to a shortage of long term personal care services in all localities. This is being addressed through the Help to Live at Home programme. Due to changes in operational procedures we are currently unable to show enablement performance into 2016/17.

1.20 The level of falls in our community contribute significantly to hospital admissions and place ongoing pressure on services as individuals are more likely to need ongoing support. Community alarm addresses some support needs but we must continue to identify opportunities to reduce falls across Angus

Graph 5 National Indictor 16: Falls rate per 1,000 population in over 65s

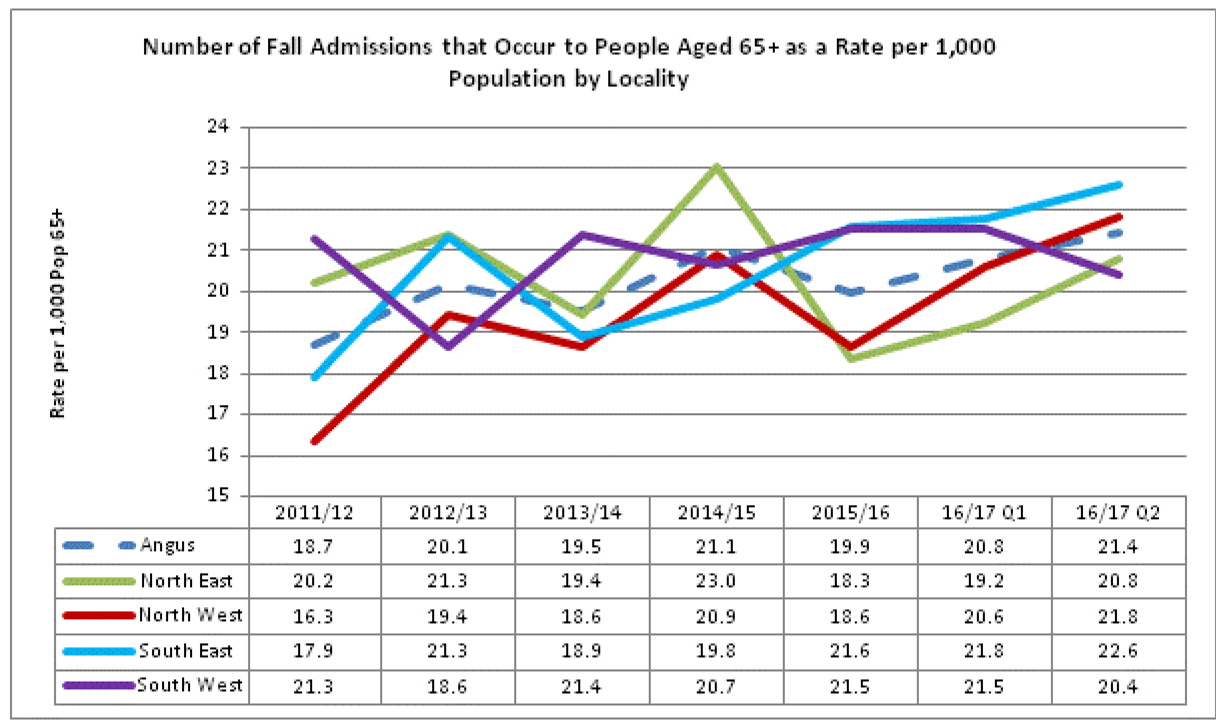
Latest National Position as at 2015/16



Source: ISD Scotland

1.21 The rate of fall admissions in Angus is at 19.2 per 1,000 population which is just below the Scottish rate of 21 per 1,000 population. There is no significant change in the rate of fall admissions in Angus from the 14/15 rate (19.6).

Graph 6 Management Information at Locality Level for 2016/17 Q2



	2011/12	2012/13	2013/14	2014/15	2015/16	16/17 Q1	16/17 Q2
Angus	18.7	20.1	19.5	21.1	19.9	20.8	21.4
North East	20.2	21.3	19.4	23.0	18.3	19.2	20.8
North West	16.3	19.4	18.6	20.9	18.6	20.6	21.8
South East	17.9	21.3	18.9	19.8	21.6	21.8	22.6
South West	21.3	18.6	21.4	20.7	21.5	21.5	20.4

Source: SMR01 Dataset (management information)

1.22 The rate of fall admissions per 1,000 population aged 65+ are highest in the South East and North West. The South West is the only locality that showed a decrease between Q1 and Q2 in 2016/17. Previously the South West had the highest rate of fall admissions for 4 of the last 6 years. The reason for this recent improvement in the South West is not known and requires to be investigated in order that any improvement opportunities can be shared across Angus. The North localities have both seen sharp increases in the rate of falls since 2015/16.

Priority 2: Supporting care needs at Home

The Joint Strategic Needs assessment identifies that the population of Angus is growing older and that the population of Angus will continue to age for the next 20 years. It is anticipated that this change in demographics will place a significant demand on services if they continue to be delivered in the same way. The strategic plan aims to address demographic change by changing the way that services are provided. The focus of the strategic plan is to support care needs at home by enhancing opportunities for technology enabled care; further progressing self-directed support, and; delivering change in care at home services through the Help to Live at Home project.

2.1 Access to long term support requires an assessment of need with an individual making choices about what services would meet their personal outcomes, how and when those supports will be delivered/accessed and who will provide them. Self-directed support is the mechanism by which these choices are provided. Option 1 is a direct payment, option 2 directed services, option 3 arranged services, and option 4 a mixture of options 1,2 and 3. Option 2 was not available before the introduction of the Social Care (Self-Directed Support) (Scotland) Act 2013 and has therefore seen a significant rise. Most people in Angus continue to access option 3, continuing to ask social work staff to organise care on their behalf. As yet there is very little shift from traditional models of support provision with most resources continuing to be spent on personal care

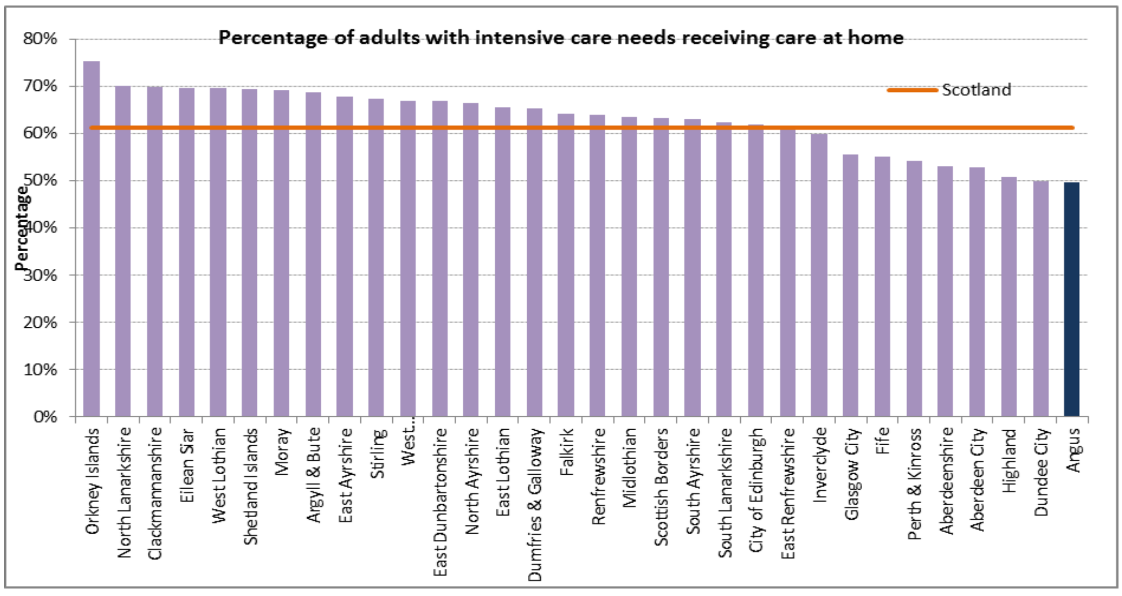
Table 3 Self-Directed Support Uptake of Options

Indicator	2015/16 Value
Percentage of people who access SDS (Option 1)	4%
Percentage of people who access SDS (Option 2)	13%
Percentage of people who access SDS (Option 3)	79%
Percentage of people who access SDS (Option 4)	4%

Graph 7 National Indicator 18: Percentage of adults with intensive needs receiving care at home

Percentage of adults with intensive needs receiving care at home

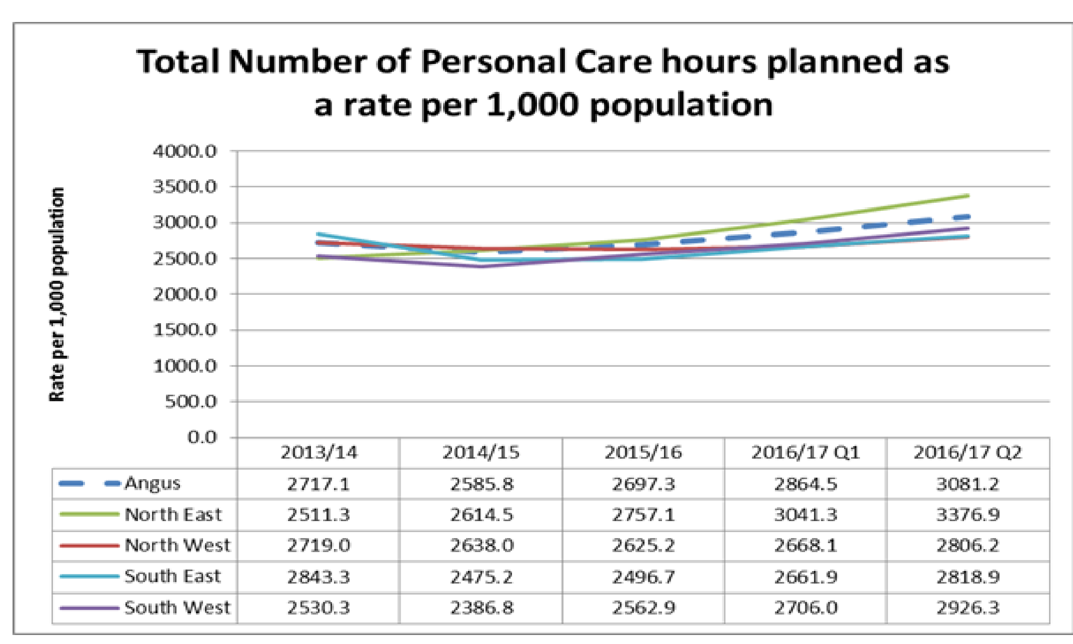
Latest National Position as at 2014/15 (15/16 update not yet available)



Source: ISD Scotland

2.2 The percentage of adults with intensive care needs receiving care at home in Angus is 50%. This is below the Scottish average of 61%. To date this indicator has been based on the percentage of people receiving 10 hours or more of home care, it excludes all other community based social care provision such as community alarm, community meals, short breaks and day care. This indicator is being redeveloped to focus on the percentage of people receiving care at home, who receive personal care as part of their support plan.

Graph 8 Management Information at Locality level rate of Personal Care Hours

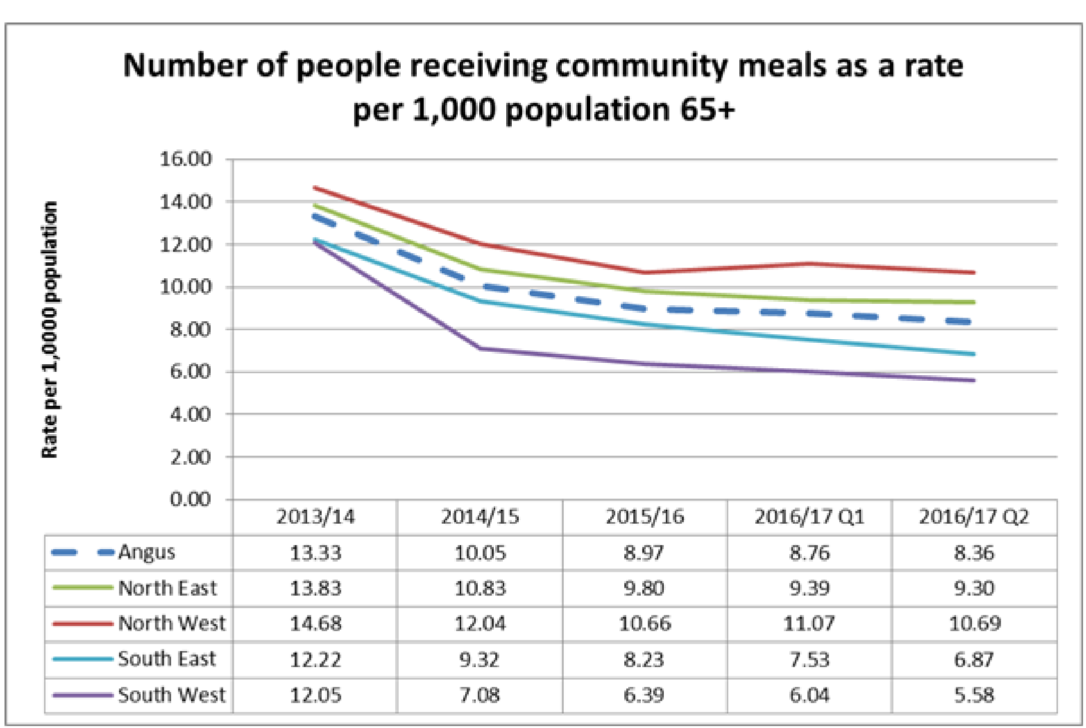


	2013/14	2014/15	2015/16	2016/17 Q1	2016/17 Q2
Angus	2717.1	2585.8	2697.3	2864.5	3081.2
North East	2511.3	2614.5	2757.1	3041.3	3376.9
North West	2719.0	2638.0	2625.2	2668.1	2806.2
South East	2843.3	2475.2	2496.7	2661.9	2818.9
South West	2530.3	2386.8	2562.9	2706.0	2926.3

2.3 Levels of personal care provision are currently increasing in Angus. The rate of personal care hours delivered in Angus has grown from 2015 into Q1 and Q2. Both more individuals and individuals with greater needs are being supported in the community. The increase in the number of people supported does not wholly account for the increase in the total number of hours provided. Further work is required to identify the median level of personal care an individual might receive and the age from which personal care might be required to better understand the increase in provision. The Help to Live at Home project has expanded both the range of provider choice and the availability of personal care.

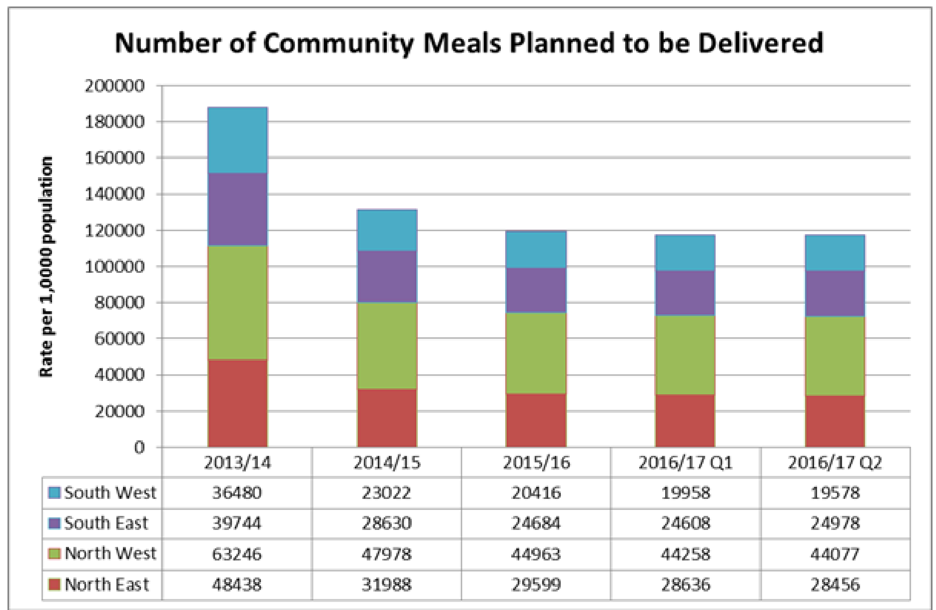
2.4 Social Care in Angus is not focused solely on personal care. There are a range of different types of supports available, including community meals, community alarm, volunteer arrangements for transport and befriending and day care. These different types of support are excluded from this indicator. Such services may not exist in other partnership areas where the focus may be wholly on 'home help' type services. The rate of uptake of community meals declined following the withdrawal of the tea time hot service. The number of people using the tea time sandwich service, delivered along with a hot lunch, continues to decline. This rate of decline is now reducing. It should be noted however that although the rate is reducing the number of meals delivered remains reasonably constant in Q1 and Q2.

Graph 9 Management Information at Locality level rate of Community Meals provision



	2013/14	2014/15	2015/16	2016/17 Q1	2016/17 Q2
Angus	13.33	10.05	8.97	8.76	8.36
North East	13.83	10.83	9.80	9.39	9.30
North West	14.68	12.04	10.66	11.07	10.69
South East	12.22	9.32	8.23	7.53	6.87
South West	12.05	7.08	6.39	6.04	5.58

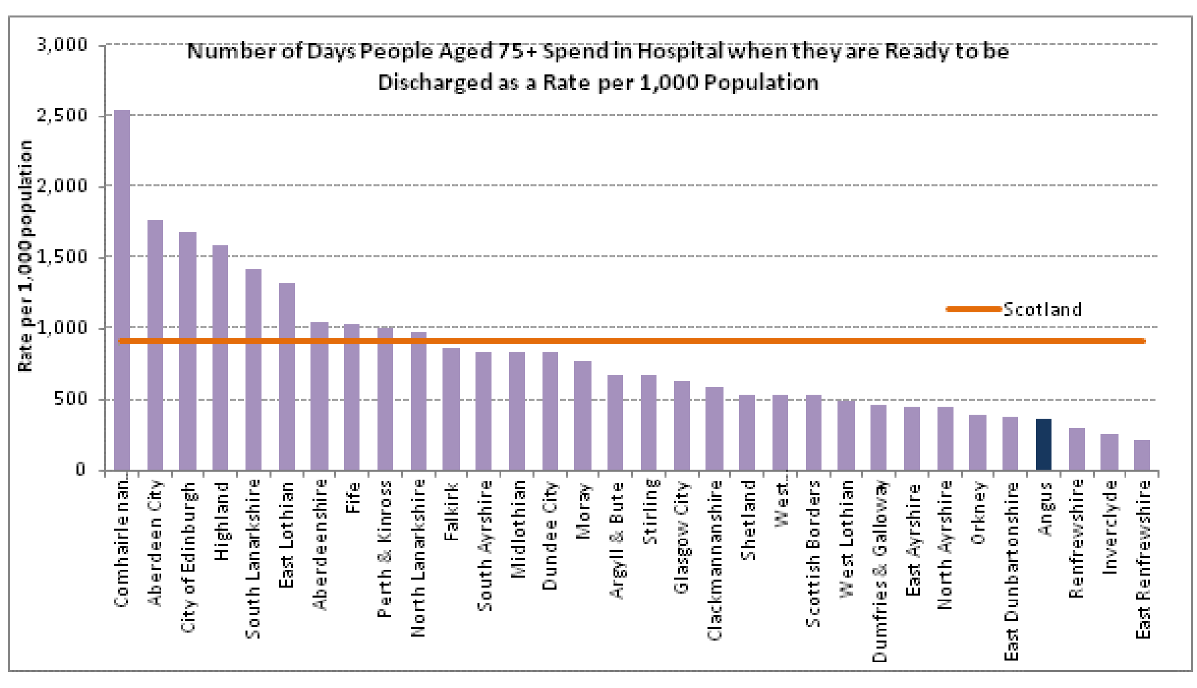
Graph 10 Management Information at locality level Community Meals Delivered



2.5 One of the recorded reasons for delays in timely discharge is the lack of capacity in personal care services. The Help to Live at Home project has made progress in addressing this. There been an increase in personal care provision and a commensurate decrease in bed days lost to delayed discharge.

Graph 11 National Indicator 19: Number of days people aged 75+ spend in hospital when they are ready to be discharged

Latest National Position as at 2015/16

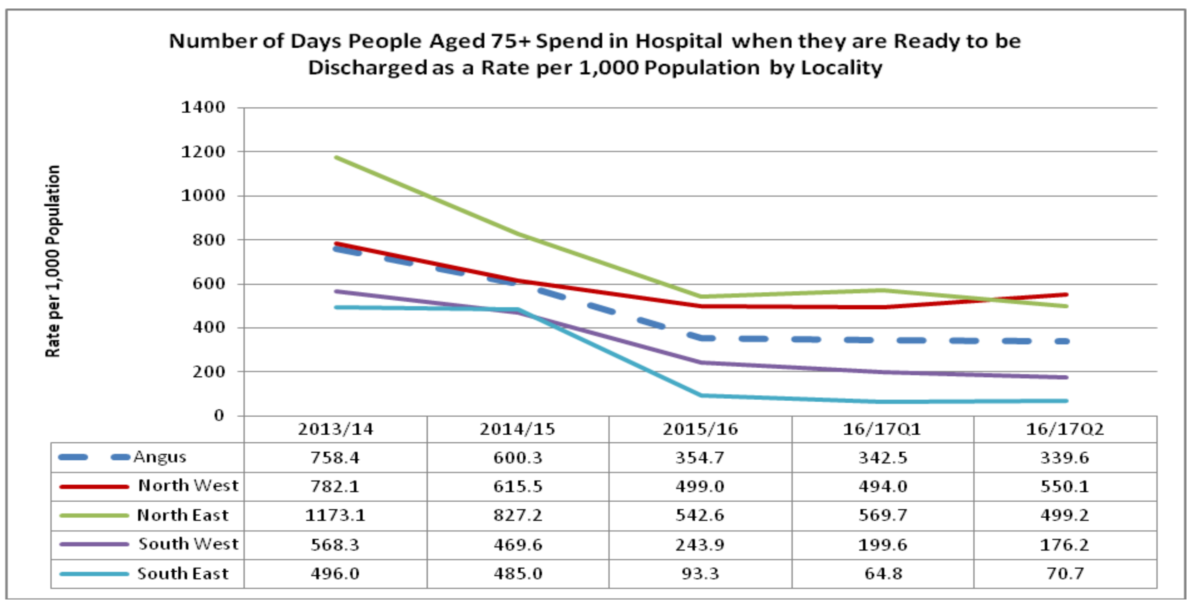


Source: ISD Scotland

2.6 The number of days people spend in hospital when they are ready to be discharged as a rate per 1,000 population, is 368 per 1,000 in Angus. This is

below the Scottish rate of 915 per 1,000 population. This places Angus as the 4th best performing partnership and demonstrates the improving performance from 14/15 when Angus was 8th best performing partnership with a rate of 601 per 1,000 population.

Graph 12 Management Information at Locality Level for 2016/17 Q2



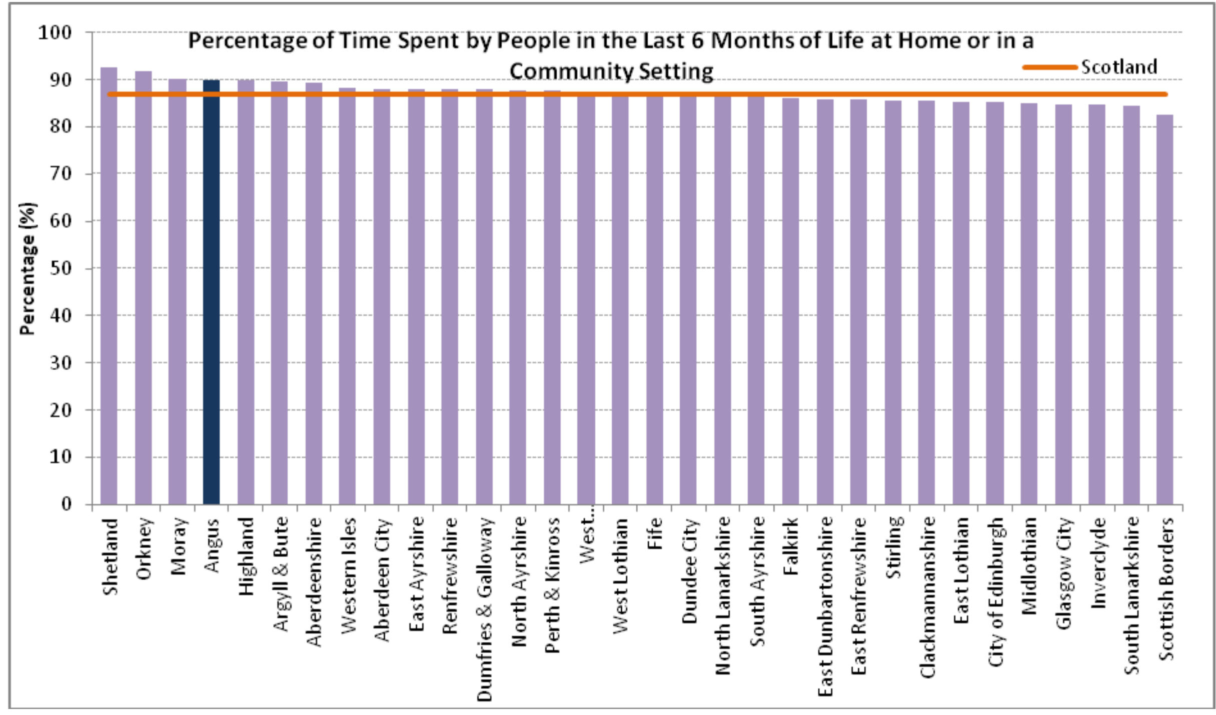
	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Angus	758.4	600.3	354.7	342.5	339.6
North West	782.1	615.5	499.0	494.0	550.1
North East	1173.1	827.2	542.6	569.7	499.2
South West	568.3	469.6	243.9	199.6	176.2
South East	496.0	485.0	93.3	64.8	70.7

Source: Edison Dataset

2.7 Delayed discharge bed day rates for people aged 75+ has fallen sharply in Angus between 2013/14 and 2015/16, by approximately 53%. The rate has started to level out into Q1 and Q2. The South East has the lowest delayed discharge bed day rate in Angus at 2016/17 Q2 with 70 per 1,000. This is approximately 87% less than the North East rate of 550 per 1,000 population. Help to Live at Home is focusing on addressing capacity issues for personal care in the North East. The North East has commenced the implementation of Enhanced Community Support.

Graph 13 National Indicator 15 Proportion of last 6 months of life spent at home or in a community setting

Latest National Position as at 2015/16



Source: ISD Scotland

An example of success is the percentage of time that people spend at home or in a community setting in the last 6 months of their life in Angus is 90%. This is an increase of 1% on 14/15 and is above the Scottish rate.

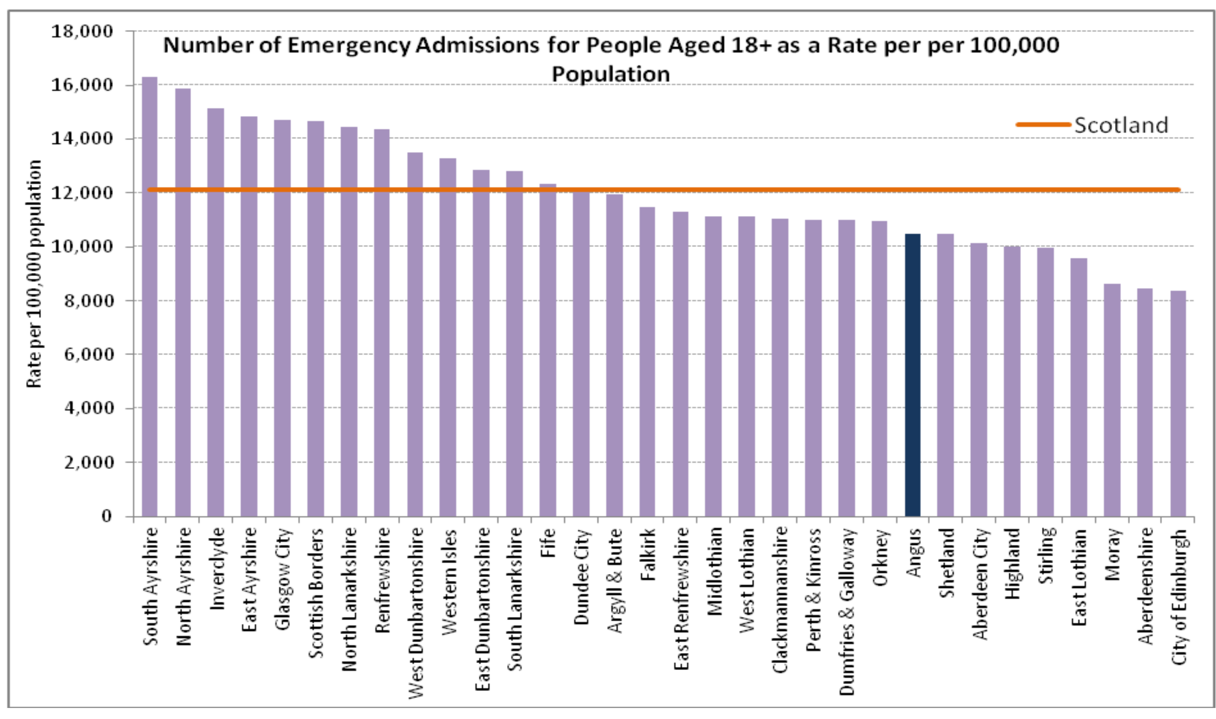
Priority 3: Developing integrated and enhanced primary care and community responses

Over the next three years AHSCP aims to deliver performance that meets the aspirations of Angus communities. The aspiration is to support individuals to stay at home when appropriate; if a hospital admission is necessary then to ensure a timely discharge plan with relevant support available at home or in localities is important. In Priority 3 we consider the impact of improvements on the unplanned use of hospital beds.

3.1 Understanding emergency admissions to hospital helps identify where improvements need to be developed and enhanced.

Graph 16 National indicator 12: Rate of Emergency Admissions for Adults

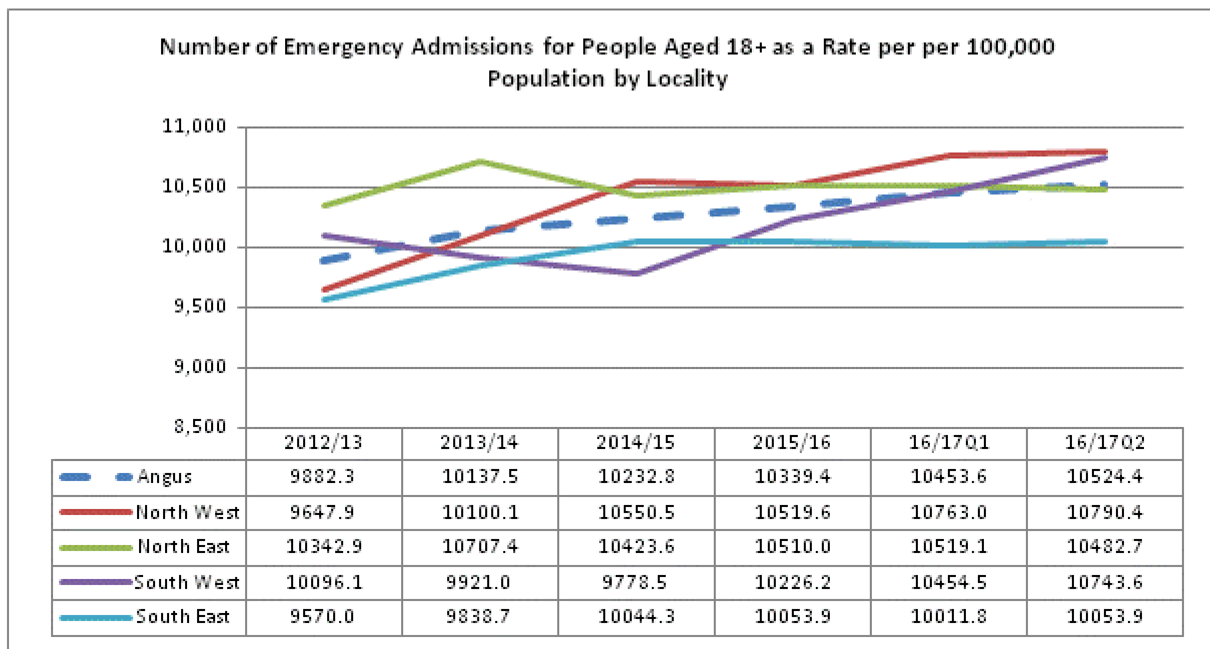
Latest National Position as at 2015/16



Source: ISD Scotland

3.2 Angus continues to perform well against the national picture, although the rate of emergency admissions has increased since 2012/13, from 9,882 to 10,524 per 100,000 population in 2016/17 quarter 2 (an increase of 6%). Opportunities for improving performance in this area need to be identified by exploring what, if any, admissions are potentially preventable if appropriate responses in localities could be further developed.

Graph 17 Management Information at Locality Level for 2016/17 Q2



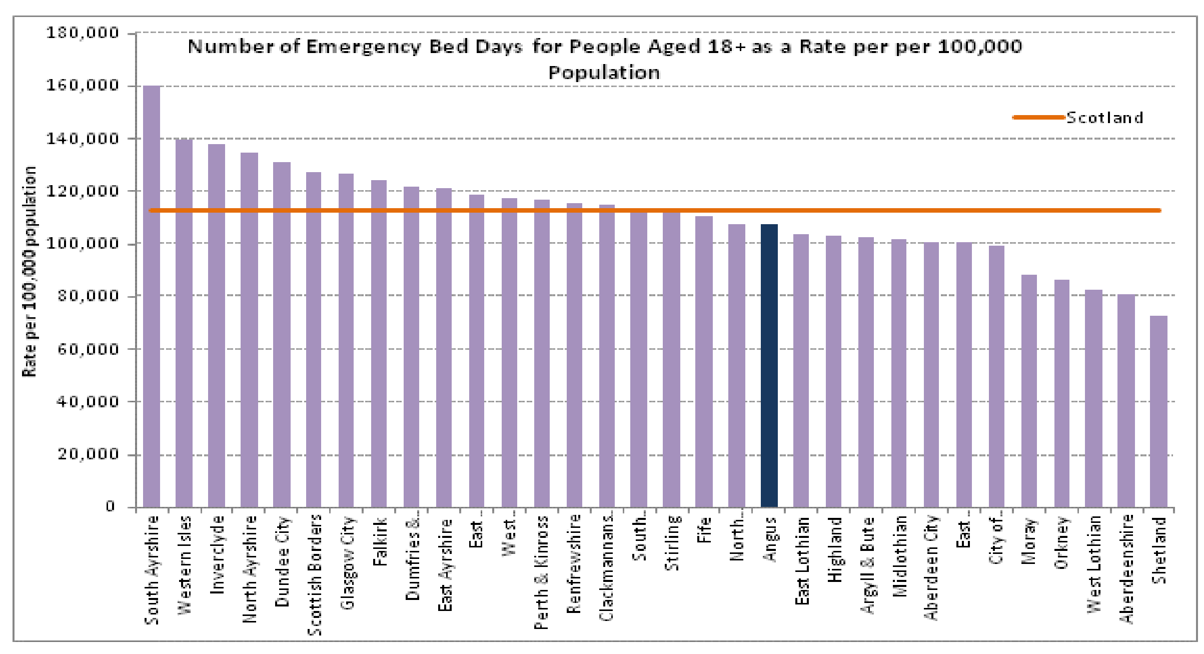
	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Angus	9882.3	10137.5	10232.8	10339.4	10453.6	10524.4
North West	9647.9	10100.1	10550.5	10519.6	10763.0	10790.4
North East	10342.9	10707.4	10423.6	10510.0	10519.1	10482.7
South West	10096.1	9921.0	9778.5	10226.2	10454.5	10743.6
South East	9570.0	9838.7	10044.3	10053.9	10011.8	10053.9

Source: SMR01/SMR50/SMR04 Datasets (management information)

3.3 The South East has the lowest emergency admission rate for people aged 18+ in Angus. This has remained the same from 2015/16 to 2016/17 quarter 2. The North West and the South West have the seen the highest increase in emergency admission rates since 2012/13. The variation between the North East, North West and South West is very small as at 2016/17 Q2. The South East however, has a much lower emergency admission rate than the other three localities. Linked to the rate of emergency admission is the use of bed days following those admissions.

Graph 18 National Indicator 13: Rate of Emergency Bed Days for Adults

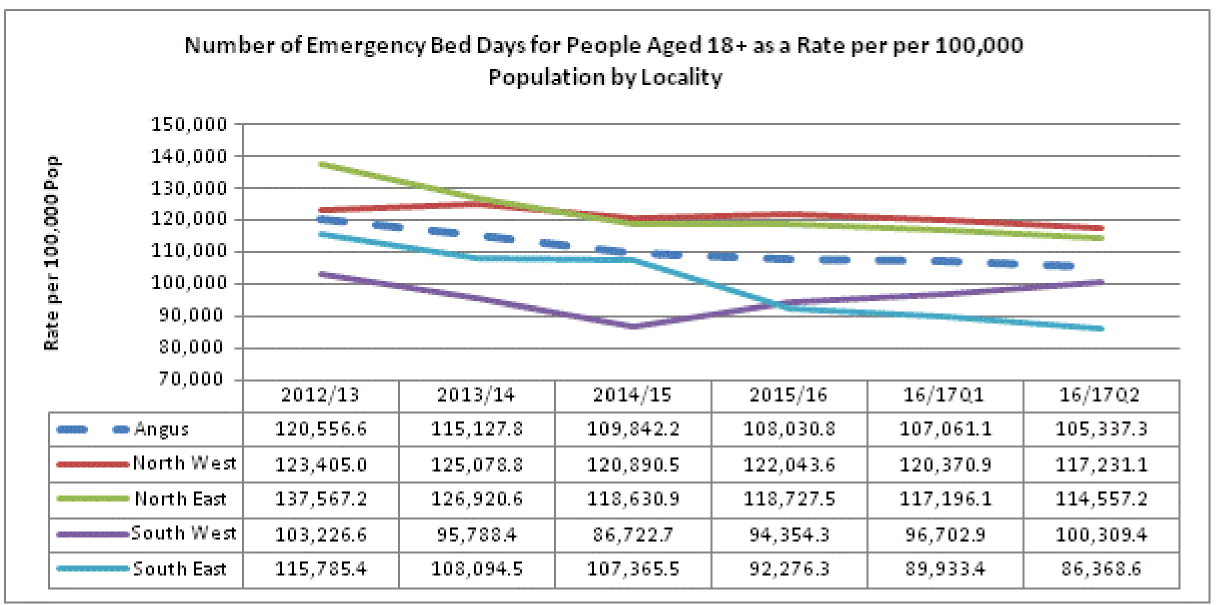
Latest National Position as at 2015/16



Source: ISD Scotland

3.4 Angus has a slightly lower emergency bed day rate than the Scottish average at 107,489 per 100,000 population. This is an improving performance from 14/15 when Angus was at the national average rate.

Graph 19 Management Information at Locality Level for 2016/17 Q2



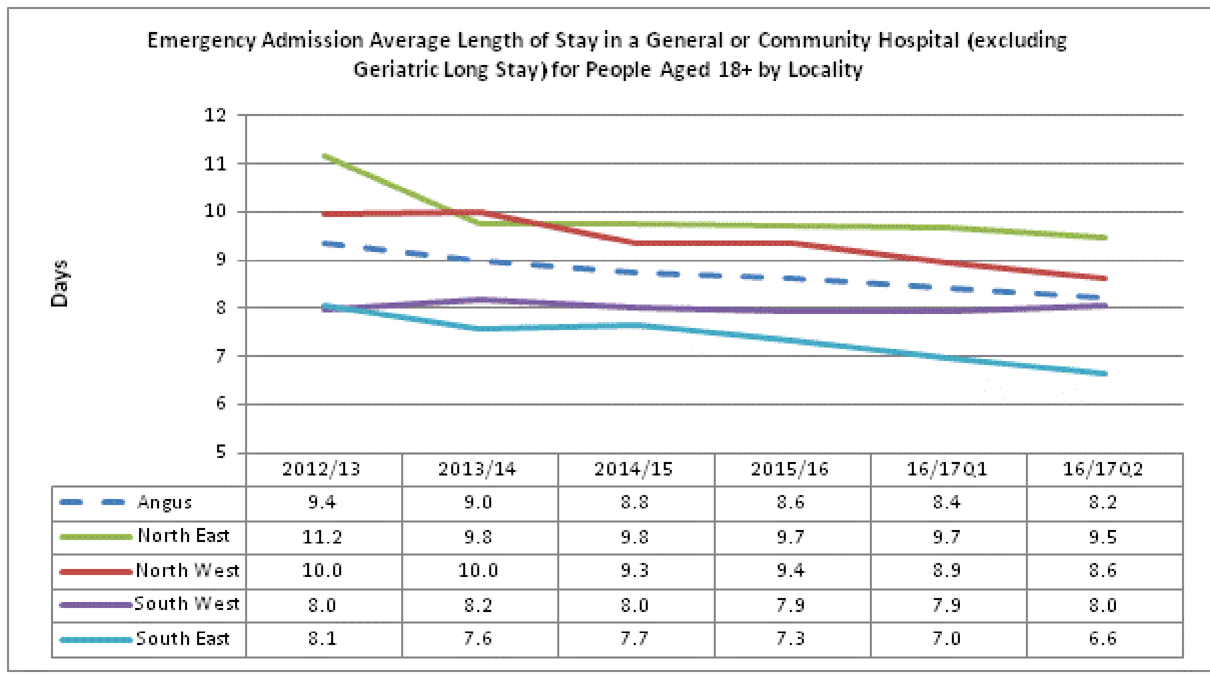
	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Angus	120,556.6	115,127.8	109,842.2	108,030.8	107,061.1	105,337.3
North West	123,405.0	125,078.8	120,890.5	122,043.6	120,370.9	117,231.1
North East	137,567.2	126,920.6	118,630.9	118,727.5	117,196.1	114,557.2
South West	103,226.6	95,788.4	86,722.7	94,354.3	96,702.9	100,309.4
South East	115,785.4	108,094.5	107,365.5	92,276.3	89,933.4	86,368.6

Source: SMR01/SMR50/SMR04 Datasets (management information)

3.5 Although emergency admission rates have been increasing, emergency bed day rates in Angus have been steadily decreasing since 2012/13 from 120,252 to 105,533 per 100,000 population in 2016/17 quarter 2 (a decrease of 12%). The lowest bed day rates are in the South East. The South West is the only locality that has seen an increase since 2015/16. Both the North West and the North East have experienced very similar bed day rates since 2013/14.

3.6 Enhanced Community Support (ECS) has contributed to the success of supporting shorter hospital stays and thereby reducing bed day rates in the South localities. ECS has not yet commenced in the North West and is currently being implemented in the North East. The overall bed day rate has reduced due to improvements in average length of stay following an emergency admission. Average length of stay continues to improve in 3 of the 4 localities, variance in the rates remains at 38%. Following the implementation of Enhanced Community Support in all localities the variation is expected to narrow.

Graph 20 Management Information at Locality Level Length of Stay (not updated for Q2)

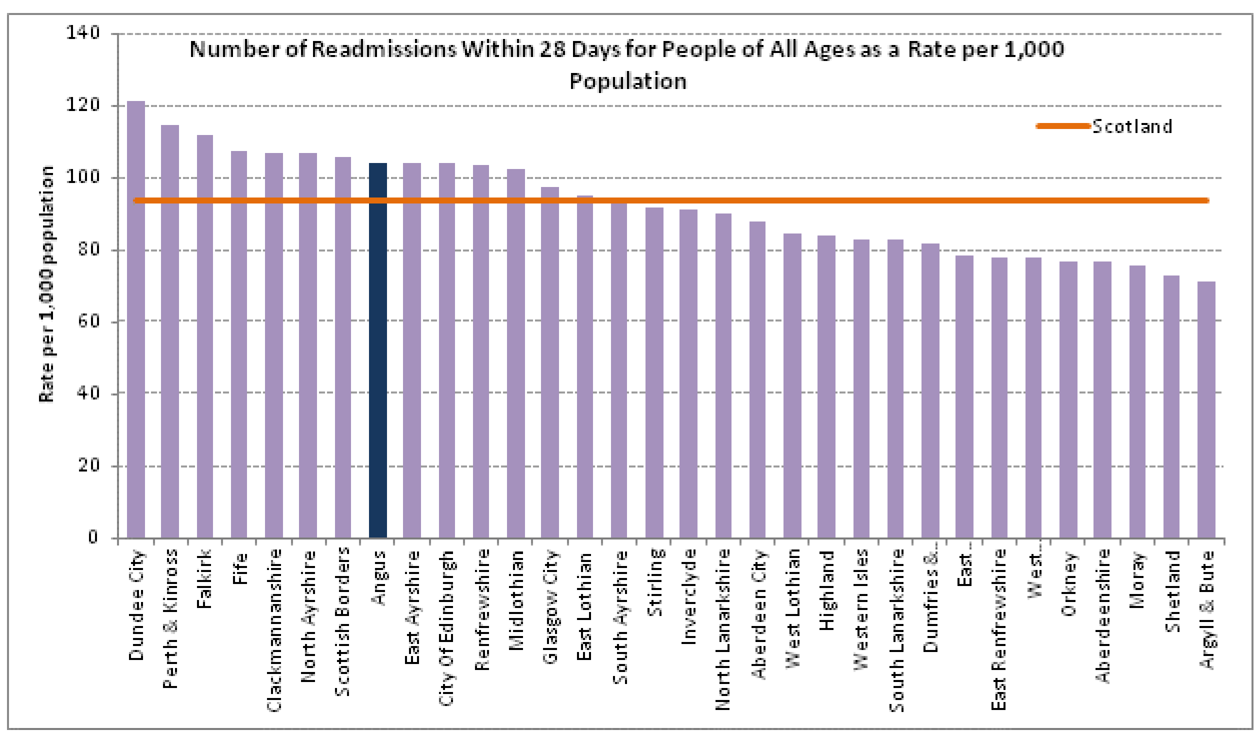


	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Angus	9.4	9.0	8.8	8.6	8.4	8.2
North East	11.2	9.8	9.8	9.7	9.7	9.5
North West	10.0	10.0	9.3	9.4	8.9	8.6
South West	8.0	8.2	8.0	7.9	7.9	8.0
South East	8.1	7.6	7.7	7.3	7.0	6.6

Source: Linked Catalogue SMR01 Dataset (ISD Scotland)

Graph 21 National Indicator 14: Readmissions to Hospital within 28 Days of Discharge

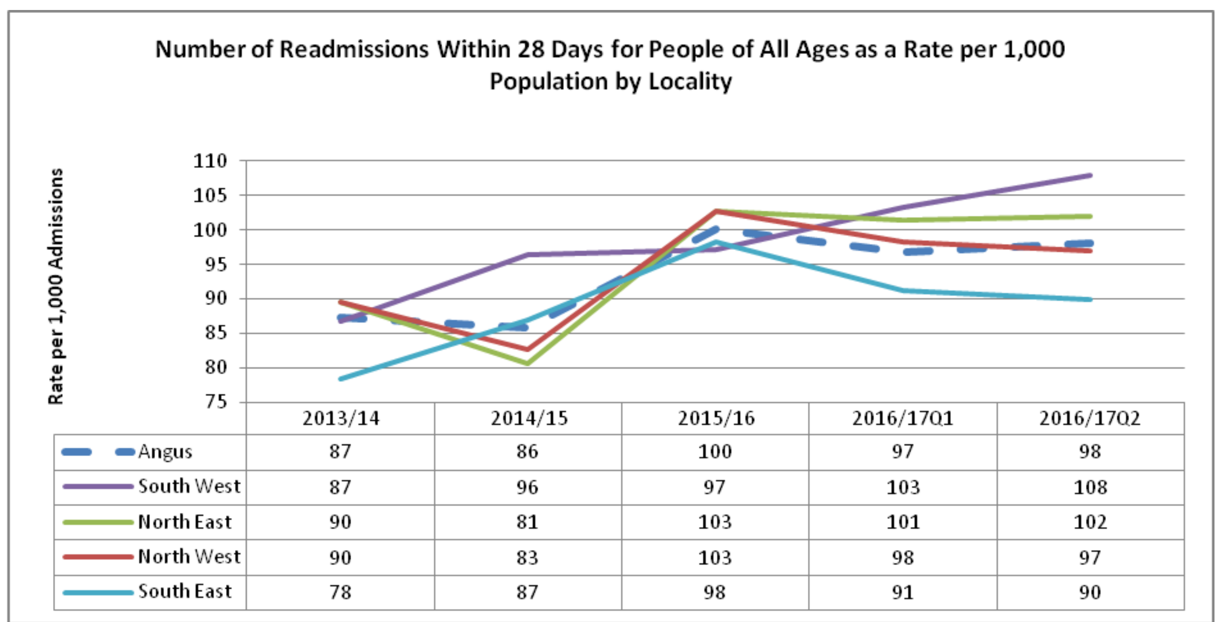
Latest National Position as at 2015/16



Source: ISD Scotland

3.8 The readmission rate for Angus is 104 readmissions for every 1,000 admissions. This is above the Scottish readmission rate and ranks Angus as the 8th highest ranked partnership. Opportunities to improve in this area require further investigation of the reason for readmission and further detail in relation to the time of readmission.

Graph 22 Management Information at Locality Level for 2016/17 Q2



	2013/14	2014/15	2015/16	2016/17Q1	2016/17Q2
Angus	87	86	100	97	98
South West	87	96	97	103	108
North East	90	81	103	101	102
North West	90	83	103	98	97
South East	78	87	98	91	90

Source: ISD Discovery (localities are defined by GP Practice locations)

3.9 Readmission rates have increased slightly in Angus. South West locality has seen a more marked increase in readmissions between 2013/14 and 2016/17 Q2. This is the only locality that has seen a continual increase during this period. The other three localities have a similar pattern of readmissions and have all shown a decrease since 2015/16. Greater understanding of readmission data is required to understand how community responses might reduce readmission to hospital.

Priority 4: Improving Integrated care pathways for priorities in care

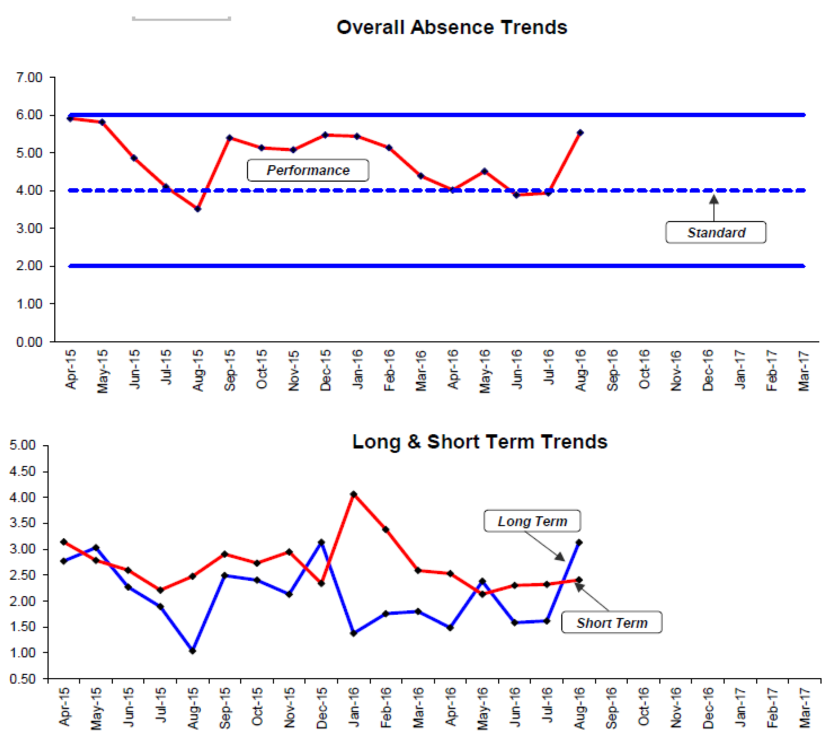
Angus Health & Social Care Partnership is working with housing, learning disability, adult mental health and other services to identify appropriate measures

Performance Area 5 Workforce

There appears to be a significant variation in sickness absence rates between those staff employed by Angus Council and those employed by NHS Tayside. The organisations measure sickness absence differently. Angus Health & Social Care Partnership is working with employers to improve the comparability of the data and present information in a consistent way.

4.1 NHS Tayside Staff of Angus Health and Social Care Partnership

Graph 23 Management Information Staff Absence



Statistics from Data Table

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2016/17	4.14%				
2015/16	5.53%	4.34%	5.23%	4.99%	5.02%
Trend	-1.39% ▼				

Previous Mth v Current Mth

	Jul-16	Aug-16		Notes		
Overall	3.94%	5.54%	▲	Increase	by	1.60%
Long	1.62%	3.13%	▲	Increase	by	1.51%
Short	2.32%	2.41%	▲	Increase	by	0.09%

Last Year v Current Mth

	Aug-15	Aug-16				
Overall	3.52%	5.54%	▲	Increase	by	2.02%
Long	1.04%	3.13%	▲	Increase	by	2.09%
Short	2.48%	2.41%	▼	Decrease	by	-0.07%

4.2 Angus Council Staff of Angus Health & Social Care Partnership

The percentage absence by Council staff working in Angus Health and Social Care Partnership is much higher than the percentage for all Angus Council staff (4.66%)

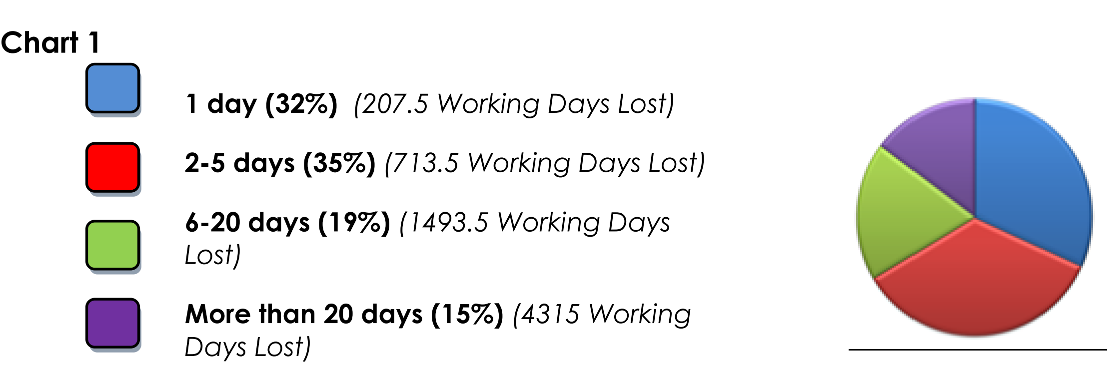
Table 4 Management Information Days lost to absence – Angus Council staff

	Top 5 Reasons for Absence
6729.5 working days lost due to sickness absence **7.66%** of total productive days available	1. Other Medical Reason (28% of days lost) 2. Stress-related (24% of days lost) 3. Lower Limb (9% of days lost) 4. Back (8% of days lost) 5. Stomach (8% days lost)

Absence Duration – Angus Council Staff

There were 720 spells of absence with in the period April to September 2016. The distribution of these absences is detailed below. The number of working days lost within each duration range is also given.

Chart 1



Source: Angus Council

Table 5 Management Information – mileage costs

Service	Q1 16/17	Q2 16/17
Angus Council staff	**£81,258.23**	**£72,480.73**

Performance Area 6 Clinical, Care and Professional Governance

Clinical, Care and Professional governance is overseen through a governance group established under the agreed Clinical and Care Governance Framework. The group are actively developing systems using an exception reporting approach which will allow any governance issues to be raised through services. All reporting approaches will use the 6 domains of assurance set out in the clinical and care governance framework. The R2 has identified a service reporting framework though exception reporting to begin to understand any clinical and care governance issues and good performance. Some arrangements in relation to data gathering have to be addressed. These areas will be highlighted in each domain

6.1 Domain 1 - Information Governance

Angus Council Internal Audit has completed an audit of data security. The objectives of the audit were to review the controls in place to manage the following business risks:

- The Council has not put appropriate arrangements in place for the physical and environmental security of information and data including when transferring data to third parties.
- Staff and approved users of Angus Council's information are not aware of or do not understand policy and procedures relating to information security resulting in non- compliance.
- The Council is subject to fines from the Information Commissioner due to staff and users not complying with existing policies and processes.

The results from the audit testing demonstrate that the objectives of the audit have not been met in full in adult services. A number of areas have been identified where improvements could be made to strengthen the control environment and ensure compliance with existing guidance. The most material recommendations are:

- Managers ensure that the data security e-learning module is completed by all of their staff in compliance with the reminder issued by the Strategic Director (People) in June 2015 and that guidance is issued to staff to ensure that work data is not transferred to personal email accounts.
- Management review the security of archive filing at Bruce House to ensure that unauthorised access is restricted and that storage arrangements are appropriate.
- Managers ensure that the clear desk policy at Bruce House is adhered to and all confidential files are locked away when not in use.

Whilst all actions have been completed consideration is being given to how to better monitor the uptake of the information governance e-learning module through the e-learning system. An information governance group has been established in order to develop an internal information governance plan which complies with policy.

No breaches in information governance have been reported during Q2.

6.2 Domain 2 - Professional Regulation and Workforce Development

A registration policy exists within Angus Council. The policy states that all staff that require to be registered must be registered within the timescales set out by the registering body. Where registration requirements are not met individuals continued employment is at risk.

Of the 91 Angus Council staff working in AHSCP who require professional registration 64 are registered with the Scottish Social Services Council (SSSC); 12 with the Nursing and Midwifery Council (NMC) and 15 with the Health and Care Professions Council (HCPC).

Of those registered: 4 NMC registrants and 6 SSSC registrants require to revalidate prior to April 2017. Two new social workers require to have registrations in place before March 2017. 1 NMC registration appears to have lapsed prior to the end January 2016.

Robust processes in place within NHS systems/services which ensure renewal of registration is completed within required timescales. One breach recorded in the last year.

From April 2016 all nurses and midwives will have to revalidate every three years to maintain their registration with the Nursing & Midwifery Council (NMC).

Revalidation will encourage a culture of sharing, reflection and improvement amongst nurses and midwives which relates directly to the NMC Code of Conduct. It will also allow nurses and midwives to demonstrate that they practise safely and effectively, strengthening public confidence in the nursing and midwifery professions.

NHS Tayside and local governance assurance processes are in place to monitor compliance in view of the associated risks to the workforce and the organisation.

6.3 Domain 3 - Patient, Service User and Staff Safety

New indicators are being developed in relation to adult protection.

Adverse events

Approaches to care that encourage rehabilitation and enablement carry a greater risk of falls as greater mobilisation is part of the rehabilitation. This likely accounts for the higher levels of falls which are category 3 (green event/ negligible impact)) and all falls in designated rehab facilities. The available information does not include the number of individuals who have fallen. One person may account for multiple recorded falls. Given the number of individuals who pass through premises each year, the falls rate is low. All falls are investigated and any required action is taken.

In Q2 there has been 91 falls with harm on NHS premises, only 35 of those falls were category 2 of which 24 were minor events. The remaining falls were considered to be negligible.

There have been no incidents of unintended weight loss recorded during Q2.

Local NHS Adverse Event Reviews or Incident Reviews

221 NHS adverse events have been recorded in Q2, 36 were considered to be category 1(major/red) events.

Operational Risks

Three red risks in relation to operational NHS services continue to be held on the risk register for Angus. The information does not identify when these were last reviewed. Two of those risks have been on the register at red since 2014.

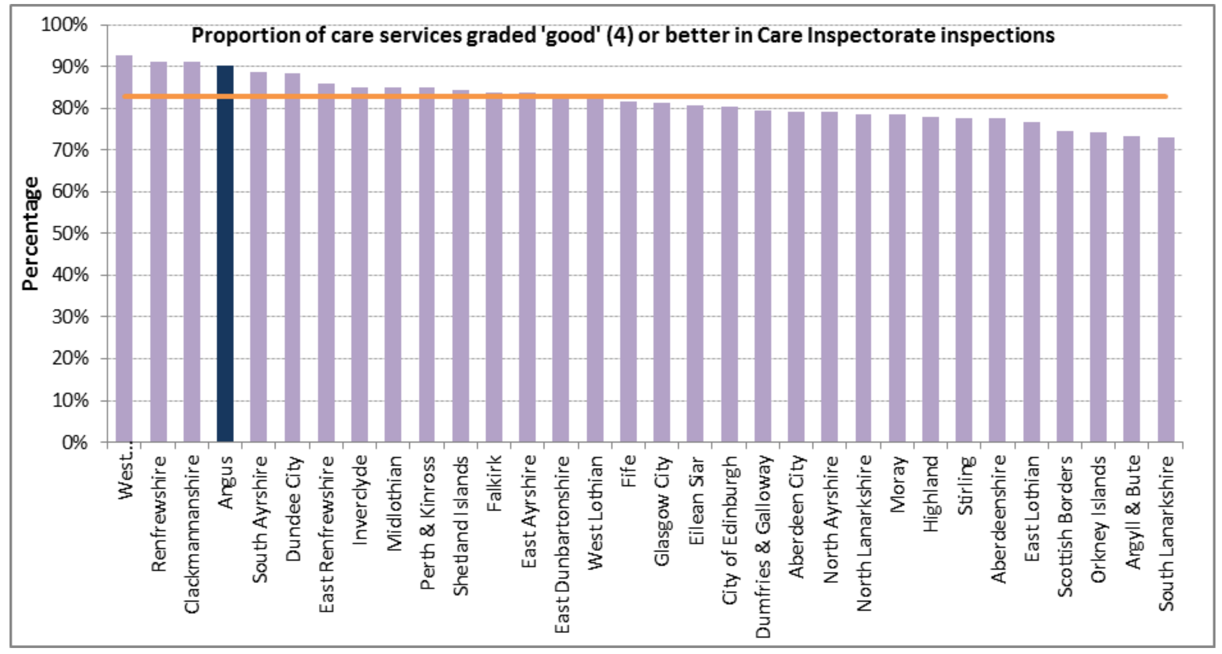
3.4 Domain 4 - Patient, Service User and Staff Experience

As at 2013/14, 89% of Angus adults care/support users rates their care as excellent or good. (Source: Biennial Health and Care Experience Survey 2013/14).

3.5 Domain 5 - Regulation of Quality and Effectiveness of Care

Graph 24 National Indicator 17 Proportion of care and care services rated good or better in care inspectorate inspections

Latest National Position as at 2015/16



Source: ISD Scotland

The proportion of care services graded good or better in Care Inspectorate inspections in Angus is 90% which is above the Scottish rate of 83%. This ranks Angus as the 4th best performing partnership for this indicator. Care services includes all registration categories: for example care home, day care, care at home.

Complaints

Three formal complaints were received by NHS Tayside in July and August in relation to Angus services. All complaints were responded to within 20 working days.

Angus Council (Adult Services) received one formal complaint in Q2.

3.6 Domain 6 - Promotion of Equality and Social Justice

The IJB has approved a set of equality outcomes and mainstreaming report in May 2016. Indicators which show how services and outcomes vary between the most and least deprived communities in Angus are being developed.

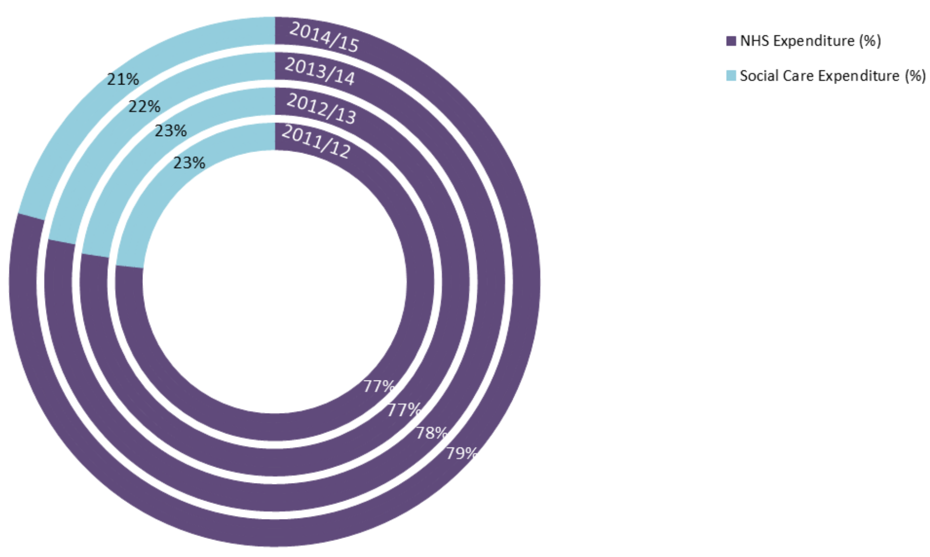
Performance Area 7 Resources

Detailed reports on finance are submitted by the Chief Finance Officer. The aim of our strategic plan is to evidence a shift in resources from health to social care provision and from institutional based care to community based support within our localities. We are working with Information Services Division (ISD) on the development of Source. This is a system which matches health and social care data and generates information from spend on individuals to demonstrate the split between health and social care spend and between spend on institutions and community based services. We are working with ISD to improve the information we submit to the source project and to work towards accessing the analysed data more quickly.

7.1 For Scotland as a whole, between 2011 and 2015, the balance of spend on social care decreased from 25.4% to 24.4% with a commensurate increase from 75.6% to 76.6 on healthcare. During this period the total expenditure for Scotland as a whole increased both for social care and for health care.

In Angus the proportion of expenditure on social care has declined at a faster rate than in Scotland as a whole. During this period in Angus there has been no increase in expenditure on social care whilst there has been an increase in health care expenditure.

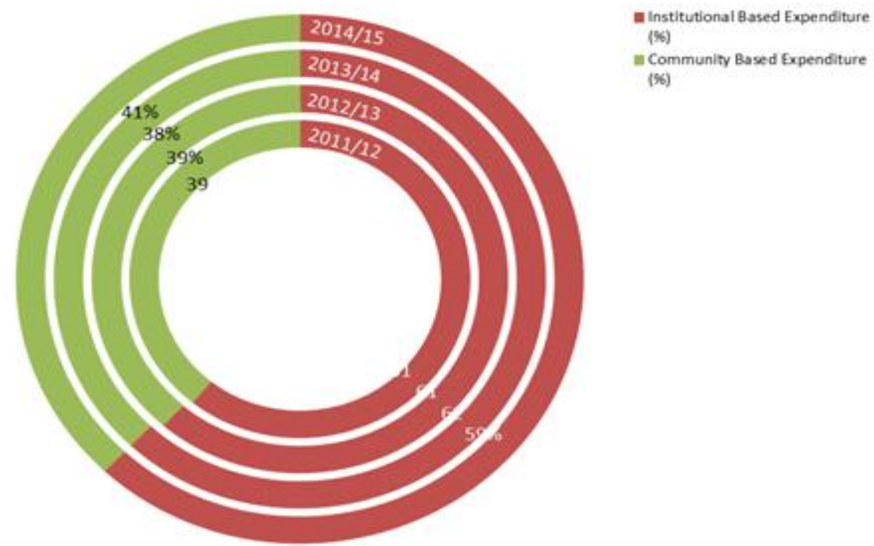
Chart 2 Balance of spend 2011-2015 -Health versus social care expenditure



Source ISD

7.2 For Scotland the proportion of expenditure on community based services increased between 2001 and 2015 from 43.7% to 46.4% and declined from 56.3% to 53.6% expenditure on institutional based services. Although the balance of expenditure between community and institutional expenditure also improved from 39% to 41% on community expenditure this shift in the balance of expenditure is not as fast as Scotland as a whole. Angus continues to have a worse picture in relation to the balance of expenditure than Scotland as a whole.

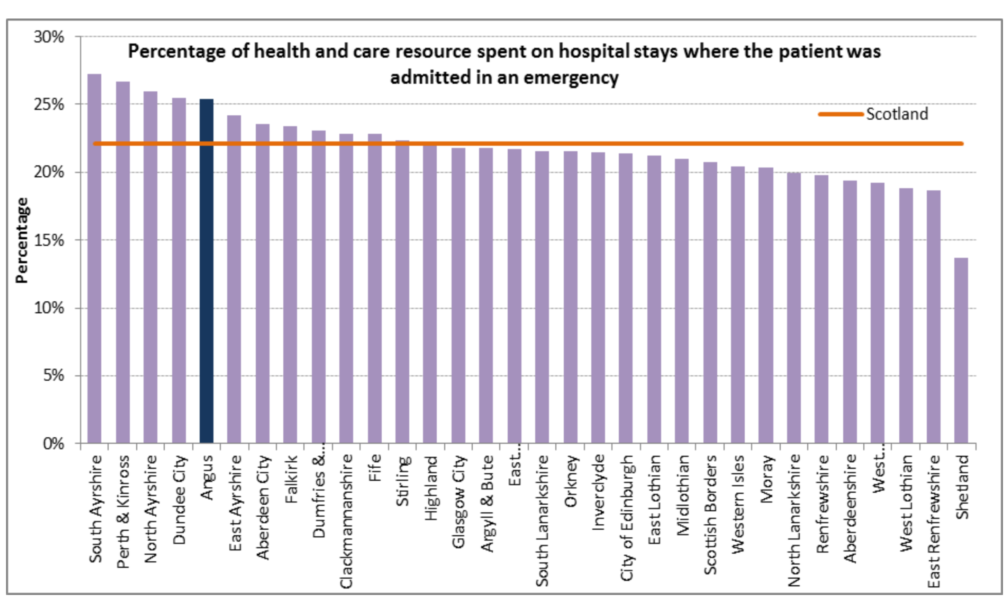
Chart 3 Balance of spend 2011-2015 -Community versus institutional expenditure



Source ISD

Graph 25 National Indicator 20: Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency

Latest National Position as at 2015/16



Source: ISD Scotland

7.3 Angus has one of the biggest percentages of total health and care spend on hospital stays where the patient was admitted as an emergency. This is not directly in the control of the IJB as most admissions are of an acute nature and are to Ninewells Hospital.

Guidance

Guidance for Health and Social Care Integration Partnership Performance Reports

Health and Social Care Integration

Public Bodies (Joint Working) (Scotland) Act 2014

1 What is this Guidance about?

1.1 Integration of health and social care is one of Scotland's major programmes of reform. At its heart health and social care integration is about ensuring that those who use services get the right care and support whatever their needs, at any point in their care journey. With a greater emphasis on community-based and more joined-up, anticipatory and preventative care, integration aims to improve care and support for those who use health and social care services.

1.2 The Public Bodies (Joint Working) (Scotland) Act 2014 ("the 2014 Act") established the legislative framework for the integration of health and social care services in Scotland under either an Integration Joint Board or Lead Agency model. These new bodies have real power to drive change and manage approximately £8 billion of resources jointly that NHS boards and Councils previously managed separately.

1.3 Section 42 of the 2014 Act requires that Performance Reports are prepared by the "*Integration Authority*". This term broadly means the person or body which is responsible for the planning and direction of integrated health and social care services. Section 42 of the 2014 Act covers both the Integration Joint Board and Lead Agency model. However, '*Health and Social Care Partnership*' (or in this context, simply '*Partnership*') is in more common usage, and is the terminology used throughout this document to refer to the body with responsibility for preparing Performance Reports.

1.4 To ensure that performance is open and accountable, the 2014 Act obliges Partnerships to 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.

1.5 The required content of the performance reports is set out in The Public Bodies (Joint Working)(Content of Performance Reports)(Scotland) Regulations 2014 This guidance should be read in conjunction with these regulations, and lays out the minimum expectations on the content of these reports, with particular reference to the reporting of the Core Integration Indicators to support assessment of performance in relation to the National Health and Wellbeing Outcomes.

2 Who is this Guidance for?

2.1 This guidance is primarily intended for those within Partnerships who will be responsible for the production of Partnerships' Performance reports. It will also be of interest to:

- Integration Joint Board Chief Officers
- Planning and Performance Leads

- Strategic Commissioning Leads
- Locality Managers/Leads
- Finance Officers ('Section 95 Officer)
- Participation and Engagement Officers, and
- Members of Integration Joint Boards

It may also be of interest to a wider range of staff working in Health and Social care, members of the public and other interested commentators.

2.2 By virtue of section 53 of the 2014 Act, a Partnership is required to have regard to this guidance when preparing a performance report.

3 What other Guidance is relevant?

3.1 This guidance should be read alongside the Scottish Government's guidance on:

- National Health and Wellbeing Outcomes
- Integration Planning and Delivery Principles
- Core Suite of Integration Indicators
- Clinical and Care Governance Framework
- Strategic Commissioning Plans
- Financial Assurance
- Localities

4 Legislative Context and Reporting Arrangements

4.1 The 2014 Act obliges all Partnerships to publish a Performance Report covering performance over the reporting year no later than four months after the end of that reporting year. Reporting years begin on 1 April annually. For example, a Performance Report covering the period April 2016 to March 2017 is required to be published no later than the end of July 2017.

4.2 All Partnerships were to be fully operational, by 1 April 2016, and the first year for which Partnerships **must** report is 2016/17. In practice, many have been operational ahead of 1 April 2016. Where this is the case, a Partnership may wish to consider publishing a report covering the period of establishment until the 1 April 2016, or to include an assessment of performance during this period in their 2016/17 Performance Report. However, this is a decision for the Partnership, and is outwith the scope of the legislation.

4.3 Performance Reports are produced for the consideration of the Partnerships themselves, and it is primarily their responsibility to act upon the information and recommendations within them. The 2014 Act requires that copies of each

report are provided to certain other parties, depending on the integration model that has been put in place, and that it should also be published. Publication should include making the report available online, and that Partnerships should take due consideration to ensure that these are as accessible as possible to the public; Partnerships may wish to consider a range of media to engage with the public, illustrate performance and disseminate the Performance Report.

4.4 Performance reports will be of interest to the Health Board and Local Authorities in monitoring the success of the arrangements that they have put in place for integrated health and social care, and in particular in determining whether a review of their integration scheme is required. The Scottish Government's interest in these reports is in how it can inform evidence at a national, strategic level on the effectiveness of health and social integration policy and how to drive and support improvement.

Layout of Reports

4.5 It is for Partnerships to decide the layout of their own Performance reports. The Scottish Government does not intend to restrict how this reporting should take place, nor provide a standardised template for the report which Partnerships must use, other than for a brief annex to reports to ensure that National Indicator data is presented consistently, and which will be covered later in this guidance.

4.6 However, as part of the Scottish Government's on-going engagement with Partnerships, support will be offered for the development of reports as necessary, such as providing optional model templates, workshops, sharing of best practice, etc.

5 Content of Reports

Assessing Performance in Relation to the National Health and Wellbeing Outcomes

5.1 The Performance Report Regulations require Partnerships to assess their performance in relation to the National Health and Wellbeing Outcomes. These outcomes are set out in the Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014 and 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 those services, carers and their families, and more information can be found in the National Health and Wellbeing Outcomes Guidance.

5.2 Performance must be assessed in the context of the arrangements set out in a Partnerships' strategic commissioning plan and financial statement, and how the expenditure allocated in the financial statement have achieved, or contributed to achieving, the health and wellbeing outcomes. It should also cover how significant decisions made by the Partnership over the course of the reporting year have contributed to progress towards the outcomes.

5.3 To support this, a set of core integration indicators have been developed in consultation with a wide range of stakeholders across all sectors, and with significant input from COSLA. They have been agreed by the Ministerial Strategic Group for Health and Community Care. Partnerships should report against these core indicators in their Performance Reports. In line with the Performance Report Regulations, data should be included for both the year which the report covers, and the 5 preceding years, or for all previous reporting years, if this is less than 5 years.

This requirement only relates to **reporting years**, the first of which will be 2016/17. For example, the first year's report will only need to cover 2016/17, the 2017/18 report will cover 2017/18 and 2016/17, and so on. The first performance report to include the full set of historical information will be 2021/22, which will include data for that year, and for the five year period 2016/17 to 2020/21. This is the case throughout the document where there is reference to reporting on both the year which the report covers, and the 5 preceding years, or for all previous reporting years, if this is less than 5 years. However, Partnerships remain free to include as much historical data beyond this minimum requirement as they see fit.

5.4 Separate guidance is available summarising the rationale behind each of the indicators, their definition and data sources. Although many of these indicators use data which is already available from a variety of sources, Information Services Division (ISD) will provide each Partnership with their data for all the indicators in a single spread sheet in order to facilitate consistency and clarity around the core indicators. This will include data from previous years in line with the requirements set out in section 5.3.

5.5 ISD will publish the core integration indicators in a way which will allow national benchmarking, and this will be publicly available. However, consistent with approach of the rest of the Performance Report, Partnerships are expected to report these indicators in a way that best suits their own local needs and that of the public in terms of understanding what they say about local progress towards the national outcomes, with support provided as necessary by ISD and the Scottish Government.

5.6 The core integration indicators provide an indication of progress towards the outcomes that can be compared across Partnerships and described at Scotland level and over the longer term. In addition, Partnerships will need to collect and understand a wide range of data and feedback to help understand the system at local level, and report on these within their Performance reports.

5.7 As well as covering performance at Partnership level, where appropriate, they may also wish to consider reporting on the performance for each locality in the Partnership, and how performance in localities contributes towards the performance of the Partnership as a whole. To facilitate this, locality data will be provided by ISD along with Partnership data where possible. More information on localities is covered later in this document.

5.8 Again, a wide range of support is available from both ISD and the Scottish Government, but ultimately it is for Partnerships to decide what these local measures should be and how they should be presented and interpreted.

Financial Performance and Best Value

5.9 The Performance Reporting Regulations require Partnerships to include information on their financial performance, for the reporting year and by comparison with the 5 preceding years, or with all previous reporting years if this is less than 5 years.

5.10 This must include not only the total amount spent by the Partnership in the course of the year, but also the total amount and proportion of spend in the reporting year broken down by the various services to which the money was allocated. It should also identify whether there has been an under or overspend against the planned spending for the year and, if this is the case, an assessment as to why this occurred.

5.11 The report must also set out the amount paid to, or set aside for use by, each locality. Information on the proportion of money spent on particular services, and on any underspends or overspends within the Partnership, must be provided both for the reporting year and the 5 preceding years, or for all years for which the information is available if this is less than 5 years.

5.12 The report must also assess whether the best value has been achieved in terms of the planning and delivery of services. This should include, where applicable, identification of whether there were opportunities for further efficiencies. For more information, Partnerships are referred to the Scottish Government's statutory Best Value Guidance for Local Authorities.

5.13 The Scottish Government has also issued Finance Guidance for Health and Social Care Integration and Integration Financial Assurance which Partnerships will wish to consider when preparing this section of the report.

Reporting on Localities

5.14 The 2014 Act requires a Partnership's strategic commissioning plan to specify two or more localities within its area. A locality is a smaller area within the borders of a Partnership the purpose of which is to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the Partnership's strategic commissioning plan. More information on Localities can be found in the relevant guidance document.

The Performance Report Regulations require that each performance report includes a description of the arrangements made in relation to consulting and involving localities, an assessment of how these arrangements have contributed to the provision of services and the proportion of the Partnership's total budget that was spent in relation to each locality.

In line with the Performance Report Regulations, a comparison of the proportion of spend should be included for both the year which the report covers, and the 5 preceding years, or for all previous reporting years, if this is less than 5 years.

Inspection of Services

5.15 The Performance Reporting Regulations require the performance report to include details of any inspections carried out relating to the functions delegated to the Partnership, by any of the following scrutiny bodies, including joint inspections, in the course of the year:

- Healthcare Improvement Scotland
- Social Care and Social Work Improvement Scotland (The Care Inspectorate)
- Audit Scotland
- Accounts Commission
- Scottish Housing Regulator

5.16 This must include any recommendation which the body has made alongside the actions taken by the Partnership to implement the recommendation.

5.17 Where appropriate, information may be provided via a link where the inspection reports and action plans can be found through their usual routes of publication.

Integration Joint Monitoring Committee Recommendations

5.18 For Partnerships who have adopted a lead agency model, should the Integration Joint Monitoring Committee have made any recommendations in the course of the year as to how integration functions should be carried out, then the Performance report must include a list of these, and how the Partnership is responding to each recommendation.

Review of Strategic Commissioning Plan

5.19 Should the Partnership decide to review its Strategic Commissioning Plan during the reporting year, the Performance report must include a statement as to why the review was carried out, whether this resulted in any changes to the plan, and if changes were made, a description of what these were.

6 Summary

1.1 These Performance reports are key to ensuring Partnerships and their local communities are clear on how health and social care integration is performing, and therefore it is the intention of this guidance to give as much flexibility as possible in the content and format of the reports whilst ensuring that the minimum requirements are met, as set out in the regulations.

1.2 Partnerships are expected and encouraged to include additional relevant information beyond the minimum set out here in order to build as full and accurate an assessment as possible as to how the integration of health and social care is delivering for people and communities, and be presented in a way that is clear for non-experts. The Scottish Government will continue to offer support to Partnerships in order to develop a Performance Report which best suits their own local needs.

© Crown copyright 2016

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit **nationalarchives.gov.uk/doc/open-government-licence/version/3** or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: **psi@nationalarchives.gsi.gov.uk**.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at **www.scotland.gov.uk**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78652-187-3 (web only)

Published by The Scottish Government, March 2016

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS68137 (03/16)

AGENDA ITEM NO 13

REPORT NO IJB 92/16

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 14 DECEMBER 2016

EQUALITY MONITORING & IMPACT ASSESSMENT

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

This report aims to inform IJB members of progress with the delivery of the Equalities mainstreaming report. It sets out recommendations for improving delivery of equalities approaches.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:-

(i) continues to mainstream the equality in the Board's functions

(ii) proactively monitors an ongoing progress towards achieving equality outcomes

(iii) nominates one IJB member to a role of an Equality Champion with a responsibility for assuring compliance with Equality Act 2010 and associated Public Sector Equality Duties.

(iv) adopts an Integrated Equalities Impact Assessment **(Appendix 1)**

(v) homologates and publishes the Equality Impact Assessment of the Strategic Plan **(Appendix 2).**

(vi) promotes evidence-based practice in assessing equalities and health inequalities.

2. BACKGROUND

The IJB approved an Equalities Mainstreaming report and equality outcomes at the meeting held in May 2016 (Report Ref. IJB 47/16). The report agreed to the use of Angus Council's Equalities Impact Assessment (EIA) until an Integrated Equalities Impact Assessment is developed. As part of the development of the strategic plan an EIA was required.

3. CURRENT POSITION

The Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015 has applied to the functions of Integrated Joint Boards since June 2016. The Equality and Human Rights Commission (EHRC) requires that IJBs consider whether an EIA is required in relation to all reports and if so, assesses the impact of proposed policies and practices as well as of any changes to and revisions to the existing policies and practices that may affect people with Protected Characteristics defined by the Equality Act 2010.

Reports considered by the IJB since that date should have given consideration to the need for an EIA and conducted submitted to the IJB since should have included an EIA. However, none of those submitted to date has had an EIA done. This report aims to address and improve equality governance and monitoring arrangements.

In order to improve equalities performance, an Equalities evidence base, tailored to the Angus integration agenda, has been developed by a Public Health Officer aligned to Angus for the purpose of, for example:

- supporting evidence-based decision making in Angus
- supporting staff in conducting evidence-based Impact Assessments
- supporting evidence-based training development

An EIA on the strategic plan was produced in June following the extension of equality duties to the IJB. The Equality and Human Rights Commission Scotland has advised that this must be formally approved by the IJB and published with the strategic plan. A copy of the EIA is attached for approval by the IJB.

4. PROPOSALS

It is proposed that the IJB take a more proactive role in ensuring that equalities are mainstreamed in activity directed by the IJB. The mainstreaming report approved by the IJB at its meeting in May 2016 recommended the use of Angus Council's EIA until an integrated EIA could be developed. The IJB is asked to approve use of an integrated EIA for the next six months in order that consideration can be given to its appropriateness, after which it will be reviewed and updated based on comments from users. Completion of an EIA is the responsibility of the report writer. As stated previously a comprehensive evidence base is now available to support officers in completing the integrated EIA.

It is proposed that the Angus Health and Social Care Partnership Board strengthens its leadership and governance capacity in relation to mainstreaming of the equality and health inequality agendas in Angus by means of adopting the recommendations outlined in section 1 of this report.

5. FINANCIAL IMPLICATIONS

There are no financial implications arising directly from this report.

6. OTHER IMPLICATIONS (IF APPLICABLE)

The Angus Strategic Plan was approved prior to equalities duties being placed on the IJB, nevertheless it was informed by results of a significant public engagement.

REPORT AUTHOR: ANNA MARIA KACZMAREK, PUBLIC HEALTH OFFICER
EMAIL DETAILS: akaczmarek@nhs.net

List of Appendices:
1. Integrated Equalities Impact Assessment
2. Integrated Equalities Impact Assessment (IEIA) of Strategic Plan.

EQUALITY IMPACT ASSESSMENT

BACKGROUND

Date of Assessment: **(dd/mm/yyyy)**	**IJB Report Number:**
Title of document being assessed:	
1. This is a new policy, procedure, strategy or practice being assessed. (If **Yes** please check box) ☐	**This is an existing policy, procedure, strategy or practice being assessed?** (If **Yes** please check box) ☐
2. Please give details of the Lead Officer and the group responsible for considering the Equality Impact Assessment (EQIA)	
3. Please give a brief description of the policy, procedure, strategy or practice being assessed, including its aims and objectives, actions and processes.	
4. What are the intended outcomes of this policy, procedure, strategy or practice and who are the intended beneficiaries?	
5. Has any local consultation, improvement or research with protected characteristic communities informed the policy, procedure, strategy or practice being EQIA assessed here? **If Yes, please give details.**	

EQUALITY IMPACT ASSESSMENT (EQIA) - RELEVANCE SCREENING

1. Has the proposal already been assessed via an EQIA process for its impact on ALL of the protected characteristics of: age; disability; gender; gender re-assignment; pregnancy/maternity; marriage and civil partnership; race; religion and belief; and sexual orientation?

YES
Unless there have been significant changes, no further action is required. Please add your name, position and date below at 2.
Please note that it is a legal requirement that any EQIA is officially published on a public sector's website.

NO
Please answer the 1a and 1b questions below.

1 a. Does the proposal have a potential to impact in ANY way on <u>the public and/or service users</u> holding any of the protected characteristics of age; disability; gender; gender re-assignment; pregnancy/maternity; marriage and civil partnership; race; religion and belief; and sexual orientation? This applies to service users of not only NHS Tayside and Angus Council, but also the 3rd sector.

Yes - Proceed to the Full Equality Impact Assessment (EQIA).

No - please state why not (specify which evidence was considered and what it says)?

1 b. Does the proposal have a potential to impact in ANY way on <u>employees</u> holding any of the protected characteristics of age; disability; gender; gender re-assignment; pregnancy/maternity; marriage and civil partnership; race; religion and belief; and sexual orientation? This applies to employees of not only NHS Tayside and Angus Council, but also the 3rd sector.

Yes - Proceed to the Full Equality Impact Assessment (EQIA).

No - please state why not (specify which evidence was considered and what it says)?

---

2. Name: ______________________

Position: ______________________ **Date:** ______________

FULL EQUALITY IMPACT ASSESSMENT (EQIA)

Step 1.
Is there any reason to believe the proposal could affect people differently due to their protected characteristic? Using evidence (e.g. statistics, literature, consultation results, etc.), justify whether yes or no. If yes, specify whether impact is likely to be positive or negative and what actions will be taken to mitigate against the undesired impact of both positive and negative discrimination.

1a. The public and/or service users holding the Protected Characteristics:

	POSITIVE IMPACT		**NEGATIVE IMPACT**	**Intended mitigating actions against the a) and/or c)**
	a)Positive discrimination	**b)Positive Action**	**c)Negative discrimination**	
AGE				
GENDER				
DISABILITY				
ETHNICITY/ RACE				
SEXUAL ORIENTATION				
RELIGION/ BELIEF				
GENDER REASSINGMENT				
MARRIAGE/CIVIL PARTNERSHIP				
PREGNANCY/ MATERNITY				
OTHER: CARERS OF OLDER AND/OR DISABLED PEOPLE (Equality Act 2010 protects carers from "discrimination by association" with the PCs of age and disability)				

1b. The employees holding the Protected Characteristics:

	POSITIVE IMPACT		NEGATIVE IMPACT	Intended mitigating actions against the a) and/or c)
	a)Positive discrimination	b)Positive Action	c)Negative discrimination	
AGE				
GENDER				
DISABILITY				
ETHNICITY/ RACE				
SEXUAL ORIENTATION				
RELIGION/ BELIEF				
GENDER REASSINGMENT				
MARRIAGE/CIVIL PARTNERSHIP				
PREGNANCY/ MATERNITY				
OTHER: CARERS OF OLDER AND/OR DISABLED PEOPLE				

1c. Does the proposal promote good relations between any of the Protected Characteristics?

YES* ☐ NO ☐ NOT SURE ☐

*If Yes, specify between which of the PCs, and in what way

1d. What steps will you take to collect the Equality Monitoring information needed to monitor impact of this proposal on PCs, and when will you do this?

Step 2

Please complete the Health Determinants Impact Assessment Checklist below. Please clarify whether the impact will be on public/service users or employees, and whether relating to NHS Tayside (NHST), Angus Council or 3rd sector, or all.

	Impact on health related behaviour? (e.g. diet & nutrition; physical activity; substance use; sexual health; learning & skills	**Impact on the social environment?** (e.g. social status; employment; income; crime & fear of crime; family support & social networks; stress, resilience & community assets; participation & social interaction; influence and sense of control; identity and belonging	**Impact on the physical environment?** (e.g. daily living conditions; working conditions/healthy working lives; natural environment/pollution (waste, energy, resource use, transport patterns); unintentional injuries & public safety; transmission of infectious disease	**Impact on access to & quality of services of NHST, Angus Council or 3rd sector?**	**Impact on social justice?** (e.g. discrimination against groups of people; promoting equality of opportunity, positive attitudes and community relations/ cohesion, and community capacity building; tackling harassment
AGE					
GENDER					
DISABILITY					
ETHNICITY/ RACE					
SEXUAL ORIENTATION					
RELIGION/ BELIEF					
GENDER REASSINGMENT					
MARRIAGE/ CIVIL PARTNERSHIP					
PREGNANCY/ MATERNITY					
CARERS (of older and/or disabled people)					

Step 3

Publish The Equality Impact Assessment.

Where will the Equality Impact Assessment (EQIA) be published?

CONTACT INFORMATION

Name of Department or Partnership:	

Type of Document	
Human Resource Policy	☐
General Policy	☐
Strategy/Service	☐
Change Papers/Local Procedure	☐
Guidelines and Protocols	☐
Other (please specify):	☐

Manager Responsible	**Author Responsible**
Name:	**Name:**
Designation:	**Designation:**
Base:	**Base:**
Telephone:	**Telephone:**
Email:	**Email:**

Signature of author of the policy:	**Date: (dd/mm/yyyy)**
Signature of Director/Head of Service:	**Date: (dd/mm/yyyy)**
Name of Director/Head of Service:	
Date of Next Policy Review: (dd/mm/yyyy)	

For additional information and advice please contact:
hsciangus.tayside@nhs.net

For assistance with accessing equalities evidence and completing the EQIA, please contact:
akaczmarek@nhs.net

Equality IMPACT ASSESSMENT

Screening DOCUMENT

Name of Proposal	AHSCP Strategic Plan
Lead Service	AHSCP

What is the aim of the proposal?

This plan sets out the vision and future direction of health and social care services in Angus. It takes forward the approach of strategic commissioning recommended by the Scottish Government. It is not a list of actions outlining everything that Angus Health and Social Care Partnership are doing or plan to do over the coming years. The aim has been to create a broader discussion-based approach where shared learning influences change. In this approach communities will, in time, effectively commission their own care. This aspiration for health and social care integration show our commitment to new ways of working and learning together where all contributions help shape the delivery of good outcomes for people who live in Angus.

Is this a new or a review of an existing policy, procedure, function or report?

New policy

Screening Process

1. Has the proposal already been assessed for its impact on age; disability; gender; gender re-assignment; pregnancy/maternity; marriage and civil partnership; race; religion and belief; and sexual orientation? **NO**
If yes, go to 1 a. If no, go to 1 b.

1 a. Unless there have been significant changes, no further action is required. **Please add your name, position and date below at 3.**

1 b. Does the proposal involve or have consequences for the people the council serves or employs? **YES**
If yes, go to 2. If no, go to 1 c.

1 c. Please state why not

The proposal is not relevant and no further action is required. **Sign and date below at 3.**

2. Is the proposal relevant to one or more of the protected characteristics? **YES**
If yes, go to 2 a. If no, go to 2 b.

2 a. Proceed to Step 1 of the Full Equality Impact Assessment on page 3.

2 b. Please state why not

The proposal not relevant and no further action is required. Add your name, position and date below at 3.

3. Name: ____________________

Position: ____________________ **Date:** ________________

Full EQUALITY Impact Assessment

Step 1
Are there any statutory requirements affecting this proposal? If so please describe.

Public Bodies (Joint Working) Scotland Act 2015 places a duty on local authorities and health boards to work together to develop an Integration Joint Board to manage and deliver integrated community health and social are services for adults. In order to assume responsibility for services and resources the IJB must approve a strategic plan.

Step 2
What data/research is available to assess the likely impact of the proposal?

We have started building up a library of evidence based on the national outcomes which require to the delivered through the strategic plan. We have undertaken an audit of data to identify potential gaps in equality monitoring information (please see attached)

Step 3
Is there any reason to believe the proposal could affect people differently due to their protected characteristic i.e. age; disability; gender; gender re-assignment; pregnancy/maternity; marriage and civil partnership; race; religion and belief; and sexual orientation? Please **place a cross** in each box that applies, and give details alongside.

All protected characteristics are included in our aims to mainstream equalities and in the equality outcomes.

Characteristic	
Age	☒
Disability	☒
Gender	☒
Gender Re-assignment	☒
Pregnancy/maternity	☒
Marriage and civil partnership	☒
Race	☒
Religion and belief	☒
Sexual orientation	☒

Step 4
Is there evidence to suggest that any part of the proposal could unlawfully discriminate against people? If so, how?

No

Step 5
Can the proposal be seen to favour one section of the community

Yes ☐ No ☒

or deny opportunities to another?

Yes ☐ No ☒

If yes, please give details.

Step 6
Does the proposal advance or restrict equality?

Yes ☒ No ☐

If yes, give details

The strategic plan advances equality as it aims to:

Reduce health inequalities
Ensure that the individual needs of, and outcomes for, people who use services, their families and their carers, are improved.
Embed personalisation within our service delivery and support models
Develop and deliver best practice through an integrated workforce
Ensure that services and supports are coproduced with individuals and communities

The Strategy has been supported by comprehensive Strategic Needs Assessment with information at locality level. The development of the strategy was underpinned by significant engagement with communities.

Step 7
Are there any other actions which could have been taken to enhance equality of opportunity?
If so please state

In monitoring progress towards the implementation of the plan we need to consider who we improve data and information on people with protected characteristics who work in and use the services to be developed and delivered through the strategic plan.

Step 8
Based on the work you have done, rate the level of relevance being allocated to this proposal.

High ☒ Medium ☐ Low ☐ Unknown ☐

Step 9
If during **Steps 3 - 6** there has been an adverse impact identified, consider whether this can be justified.

Yes ☐ No ☐

If yes please give details.

No adverse impact identified.

If no, consider alternative ways of delivering the proposal to minimise negative impact or eliminate unlawful discrimination. Give details of the changes to be made to the proposal.

Step 10
Do you need to carry out a further impact assessment?

Yes ☐ No ☒

If yes, what actions do you need to take?

Step 11
Make arrangements to monitor and review the impact assessment.

The impact assessment will be reviewed annually along with the publication of the annual report which includes review of progress with the delivery of the strategic plan.

Step 12
Publish impact assessment.

Where will the Equality Impact Assessment be published?

http://www.angus.gov.uk/downloads/download/356/health_and_social_care_partnership_strategic_plan_2016-19

Please state your name, position and date, and forward this pro forma either to your designated Equality Impact Assessment Co-ordinator, or if it refers to a committee report, it should be forwarded with the report to committee services.

Name: Vivienne Davidson

Position: Principal Officer **Date: 16 June 2016**

For additional information and advice please contact:
hsciangus.tayside@nhs.net

AGENDA ITEM NO 14

REPORT NO IJB 93/16

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 14 DECEMBER 2016

RISK MANAGEMENT REGISTER

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

The purpose of this report is to approve the status of the Angus Integration Joint Board's (IJB's) Risk Management arrangements. This report informs IJB members of the Angus IJB Risk Management arrangements which covers risk policy, procedure, process, systems, risk management roles and responsibilities, developed following the IJB development session on 26 October 2016.

1.0 RECOMMENDATIONS

It is recommended that the Angus Integration Joint Board:

(i) Notes the content of the attached draft Risk Management arrangements **(Appendices 1, 2 and 3);**

(ii) Supports the ongoing work to measure, manage and monitor the risks identified;

(iii) Approves the proposed arrangements for reporting of strategic risks and management priorities.

2.0 BACKGROUND

This is defined within the IJB's Risk Management Policy and Strategy approved by IJB members at their meeting of 11 November 2015 which outlines the IJB's responsibilities which include;

- oversight of the IJB's risk management arrangements;
- receipt, review and scrutiny of reports on strategic risks and any key operational risks that require to be brought to the IJB's attention;
- ensure IJB members are aware of any risks linked to recommendations from the Chief Officer concerning new priorities/policies.

3.0 CURRENT POSITION

The attached report represents the risk management arrangements identified using the 'standard methodologies' and involving the subject experts who have knowledge and experience of the activity process under consideration.

The scope of the framework applies to all risks, whether relating to the clinical and care environment, employee safety and wellbeing, business risk, opportunities or threats.

All risks have been analysed consistently with an evaluation of risk as being probability/likelihood x consequence/impact.

Cognisance will also be taken of new risks that emerge through the due diligence process and the consequences that may be inherited from NHS Tayside and Angus Council plans around finance, workforce and structures.

4.0 PROPOSALS

It is recommended that strategic risks and key operational risks will be reported to the IJB on a quarterly basis as defined within the IJB's Risk Management Policy and Strategy.

Routine reporting of risk information within and across teams and a commitment to a 'lessons learned' culture that seeks to learn from both good and poor experience in order to replicate and promote good practice and reduce adverse events and associated complaints and claims.

5.0 FINANCIAL IMPLICATIONS

There are no financial implications arising directly from this report.

6.0 OTHER IMPLICATIONS

. There are no other implications arising directly from this report.

Report Author:

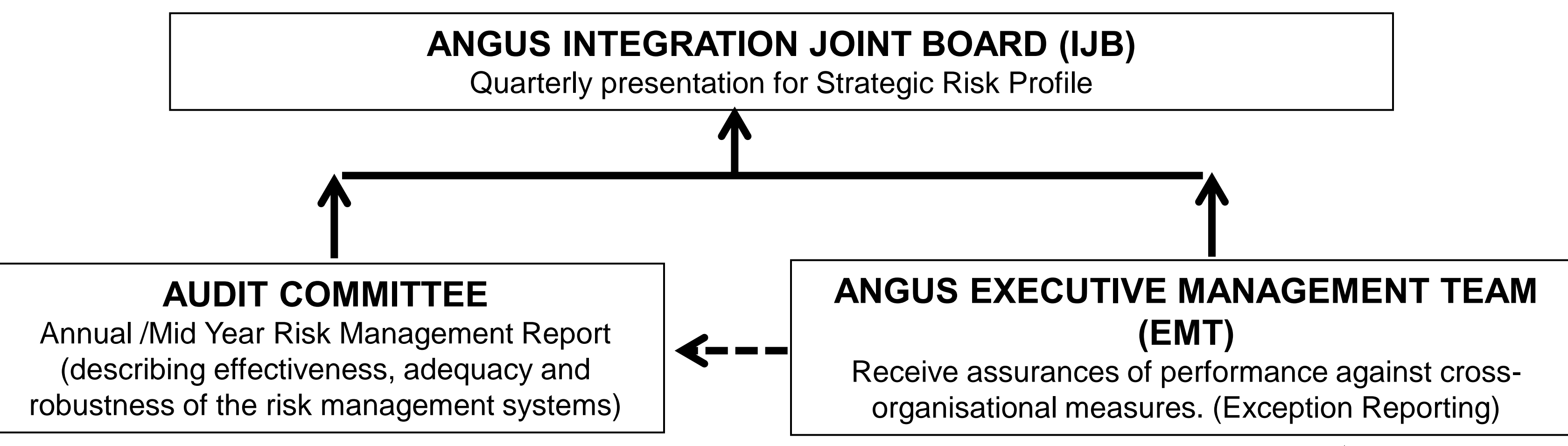
Gail Smith
Head of Community Health and Care Services
(Executive Lead for Audit, Improvement & Performance)

Date: 22 November 2016

List of appendices:
Appendix 1 - Angus Risk Management Flowchart
Appendix 2 - Angus Health & Social Care Partnership IJB Strategic Risks
Appendix 3 - Angus Health & Social Care Partnership Risk Management Register

ANGUS RISK MANAGEMENT FLOWCHART

APPENDIX 1



ANGUS INTEGRATION JOINT BOARD (IJB)
Quarterly presentation for Strategic Risk Profile

AUDIT COMMITTEE
Annual /Mid Year Risk Management Report (describing effectiveness, adequacy and robustness of the risk management systems)

ANGUS EXECUTIVE MANAGEMENT TEAM (EMT)
Receive assurances of performance against cross-organisational measures. (Exception Reporting)

THE UNDERNOTED WILL RECEIVE QUARTERLY ASSURANCE REPORTS FROM RISK OWNERS ALIGNED TO SPECIFIC FORUMS/FORA;

1. **STRATEGIC PLANNING GROUP (SPG)**
2. **CLINICAL, CARE & PROFESSIONAL GOVERNANCE R2 FORUM (R2)**
3. **TAYSIDE PRIMARY CARE STRATEGIC MANAGEMENT & TRANSFORMATION BOARD (TPC SMTB)**
4. **STAFF PARTNERSHIP FORUM (SPF)**

SERVICE LEVEL (R3)
These groups are required to establish, implement and monitor their own arrangements for clinical governance and risk management. They are required to provide assurance to the Senior Leadership Team (SLT) that mechanisms are in place and effective .
(Older People's Services, Mental Health, Primary Care Services etc)

Angus Health & Social Care Partnership
IJB STRATEGIC RISKS

RISK	OWNER	Manager	Reports Through
Strategic Risk Profile (quarterly) *Includes Cover, Risk Matrix and individual risk templates*	Chief Officer	Head of Community Health & Care Services (North Angus)	Integration Joint Board (through Audit Committee)

OPERATIONAL MANAGEMENT RISKS

RISKS	OWNER	Manager	Reports Through
1. Sustainability of Primary Care Services	Associate Director – Primary Care	Head of Prisoner Healthcare/Out Of Hours/Forensic Medical Services	Tayside Primary Care Strategic Development & Transformation Board
2. GP Prescribing	Clinical Director	Primary Care Manager/Long Term Conditions Lead	Prescribing Management Group /Executive Management Team
3. Effective Financial Management	Chief Officer	Chief Finance Officer	Executive Management Team
4. Enhanced Community Support Rollout	Head of Community Health & Care Services (North Angus)	Clinical Services Manager, Adult Services	Executive Management Team
5. Clinical, Care & Professional Governance	Clinical Director	Chief Social Worker/Associate Nurse Director	Clinical, Care & Professional R2 Forum (R2)
6. Implementation of Strategic Planning Priorities	Head of Community Health & Care Services (South Angus)	Principal Planning Officer, Strategic Planning & Performance	Strategic Planning Group (SPG)
7. Performance Management	Head of Community Health & Care Services (North Angus)	Principal Planning Officer, Strategic Planning & Performance	Executive Management Team
8. Workforce Optimisation	Head of Mental Health Services	Head of HR, IT & Organisational Development/HR Business Lead	Executive Management Team /Staff Partnership

Management Priorities (Exception reporting)	OWNER	Manager	Managed by	Exceptions to
Care Home Review	Head of Community Health & Care Services (South Angus)	Principal Officer, Strategic Planning & Performance	Senior Leadership Team	Executive Management Team
Care Management & Community Nursing	Head of Community Health & Care Services (North & South Angus)	Principal Planning Officer / Clinical Services Manager, Adult Services	Senior Leadership Team	Executive Management Team
Community Mental Health Services	Head of Mental Health Services	Clinical Team Manager, General Adult Psychiatry	Senior Leadership Team	Executive Management Team
Effective Discharge Pathway (Winter Planning)	Head of Community Health & Care Services (North Angus)	Clinical Team Manager, Community Hospitals/MIIU / Locality Integration Improvement Manager	Delayed Discharge Task and Finish Group	Executive Management Team
Help to Live at Home / Self Directed Support	Head of Community Health & Care Services (South Angus)	Programme Manager, Help to Live at Home/Principal Officer	Senior Leadership Team	Executive Management Team
Medicines Administration Review	Head of Community Health & Care Services (North Angus)	Locality Integration Improvement Manager/Clinical Services Manager, Adult Services	Senior Leadership Team	Executive Management Team
Out of Hours / MIIU	Head of Community Health & Care Services (North Angus)	Head of Prisoner Healthcare/OOH/FMS/Clinical Team Manager, Community Hospitals/MIIU	Senior Leadership Team	Executive Management Team
Specialist Accommodation	Head of Community Health & Care Services (South Angus)	Service Manager, Learning Disabilities /Principal Officer, Clinical & Care Governance	Senior Leadership Team	Executive Management Team
Technology Enabled Care	Head of Community Health & Care Services (South Angus)	Locality Integration Improvement Manager	Senior Leadership Team	Executive Management Team

Angus Health & Social Care Partnership – Risk Rating Matrix

No	Risk Title	Risk Owner	Current Risk Exposure	16 Jan 2017	24 April 2017	11 Sept 2017	8 Jan 2018	16 April 2018	10 Sept 2018	Planned Risk Exposure
1.	Sustainability of Primary Care Services	Associate Director – Primary Care	12 (4x3) AMBER							9 (3x3) YELLOW
2.	GP Prescribing	Clinical Director	25 (5x5) RED							20 (4x5) RED
3.	Effective Financial Management	Chief Officer	25 (5x5) RED							20 (4x5) RED
4.	Enhanced Community Support	Head of Community Health & Care Services (North Angus)	In development							In development
5.	Clinical, Care & Professional Governance	Clinical Director	9 (3x3 YELLOW							6 (2x3) YELLOW
6.	Implementation of Strategic Planning Priorities	Head of Community Health & Care Services (South Angus)	16 (4x4) AMBER							8 (2x4) YELLOW
7.	Performance Management	Head of Community Health & Care Services (North Angus)	20 (5x4) RED							8 (2x4) YELLOW
8.	Workforce Optimisation	Head of Mental Health Services	9 (3x3) YELLOW							6 (2x3) YELLOW

Risk Exposure Rating

Critical/Extreme (5)	5 YELLOW	10 AMBER	15 AMBER	20 RED	25 RED
Major (4)	4 YELLOW	8 YELLOW	12 AMBER	16 AMBER	20 RED
Significant/Moderate (3)	3 GREEN	6 YELLOW	9 YELLOW	12 AMBER	15 AMBER
Marginal/Minor (2)	2 GREEN	4 YELLOW	6 YELLOW	8 YELLOW	10 AMBER
Negligible (1)	1 GREEN	2 GREEN	3 GREEN	4 YELLOW	5 YELLOW
	Very Low/Rare (1)	Low/Unlikely (2)	Low to High/Possible (3)	High/Likely (4)	Very High/Almost Certain (5)

Key:

Green	**0 - 3**
Yellow	**4 - 9**
Amber	**10 - 19**
Red	**20 - 25**