Moray Integration Joint Board

Thursday, 25 March 2021

remote locations via video conference

NOTICE IS HEREBY GIVEN that a Meeting of the **Moray Integration Joint Board** is to be held at **remote locations via video conference**, on **Thursday, 25 March 2021** at **09:30** to consider the business noted below.

AGENDA

1.	**Welcome and Apologies**	
2.	**Declaration of Member's Interests**	
3.	**Minute of Meeting of 28 January 2021**	**5 - 10**
4.	**Action Log of the Meeting of the Moray Integration Joint Board dated 28 January 2021**	**11 - 12**
5.	**Chief Officer Report** Report by the Chief Officer	**13 - 18**
6.	**Revenue Budget Monitoring Qtr 3 2020-21** Report by Chief Financial Officer	**19 - 40**
7.	**Prescribing Budget Requirements 2021-22** Report by the Acting Lead Pharmacist	**41 - 48**
8.	**Revenue Budget 2021-22**	**49 - 64**
9.	**Discharge to Assess** Report by the Head of Service	**65 - 100**

MORAY INTEGRATION JOINT BOARD

MEMBERSHIP

Mr Dennis Robertson (Chair)

Councillor Shona Morrison (Vice-Chair)
Professor Siladitya Bhattacharya (Voting Member)
Nicholas Fluck (Voting Member)
Mr Sandy Riddell (Voting Member)
Councillor Frank Brown (Voting Member)
Councillor Theresa Coull (Voting Member)
Councillor John Divers (Voting Member)
Professor Caroline Hiscox (Ex-Officio)Mr Roddy Burns (Ex-Officio)

Ms Tracey Abdy (Non-Voting Member)
Mr Ivan Augustus (Non-Voting Member)
Ms Elidh Brown (Non-Voting Member)
Mr Sean Coady (Non-Voting Member)
Ms Karen Donaldson (Non-Voting Member)
Jane Ewen (Non-Voting Member)
Mr Steven Lindsay (Non-Voting Member)
Mr Chris Littlejohn (Non-Voting Member)
Ms Jane Mackie (Non-Voting Member)
Dr Malcolm Metcalfe (Non-Voting Member)
Mrs Val Thatcher (Non-Voting Member)
Dr Lewis Walker (Non-Voting Member)
Simon Bokor-Ingram (Non-Voting Member)

Clerk Name:
Clerk Telephone: 01343 563014
Clerk Email: committee.services@moray.gov.uk

MINUTE OF MEETING OF THE INTEGRATION JOINT BOARD

Thursday, 28 January 2021

remote locations via video conference,

PRESENT

Ms Tracey Abdy, Mr Ivan Augustus, Simon Bokor-Ingram, Ms Elidh Brown, Councillor Frank Brown, Mr Sean Coady (NHS), Councillor Theresa Coull, Councillor John Divers, Jane Ewen, Mr Steven Lindsay, Ms Jane Mackie, Dr Malcolm Metcalfe, Councillor Shona Morrison, Mr Sandy Riddell, Mr Dennis Robertson, Dr Lewis Walker

APOLOGIES

Mr Roddy Burns, Ms Karen Donaldson, Nicholas Fluck, Professor Caroline Hiscox, Mr Chris Littlejohn, Mrs Val Thatcher

IN ATTENDANCE

Also in attendance at the above meeting were Jane Mackie, Chief Social Work Officer, Jeanette Netherwood, Corporate Manager, Marjorie Kennie, Aberdeenshire Council, Charles McKerron, Integrated Services Manager, Lesley Attridge, Locality Manager, Lesley Pellegrom, Programme Manager, Duncan Sage, Principal Information Analyst and Tracey Sutherland, Committee Services Officer

1. Chair

The meeting was chaired by Mr Dennis Robertson. Due to connection issues experienced by Mr Robertson, Councillor Morrison chaired items 6 - 8.

2. Welcome and Apologies

The Chair welcomed everyone to the first meeting of the Integration Joint Board for 2021. He further advised that the meeting was being record for uploading later onto the Health and Social Care Moray website.

3. Declaration of Member's Interests

Mr Sandy Riddell declared and interest in Item 7 - Learning Disability Strategy and Item 12 - Annual Report of the Chief Social Work Officer 2019-20.

4. Minute of Meeting of the Moray Integration Joint Board dated 26 November 2020

The minute of the meeting of 26 November 2020 was submitted and approved subject to the following changes being made:

Mr Sandy Riddell declared an interest in Item 13 Moray Mental Health Services and not Item 12 as stated.

Councillor Brown also asked that the minute reflect his discussion on the maintenance charges for users of wash/dry toilets. It was agreed that the minute would be updated to reflect the discussion.

5. Action Log of the Meeting of the Moray Integration Joint Board dated 26 November 2020

The Action Log of the meeting dated 26 November 2020 was discussed and updated accordingly.

6. Chief Officer Report

The Board joined the Chair in congratulating Mr Bokor-Ingram on his permanent appointment of Chief Officer, Health and Social Care before asking Mr Bokor-Ingram to introduce the report.

A report by the Chief Officer, Health and Social Care informed the Board of the Chief Officer activities that support the delivery against the Moray Integration Joint Board's strategic priorities articulate in the Strategic Plan, and the delivery against the 9 Health and Wellbeing outcomes. Key work for the Partnership includes the implementation of Home First, alongside preparations for winter, responding to the ongoing covid pandemic, and budget control.

The Chief Financial Officer updated the Board on the additional funding from the Scottish Government for Covid-19 related costs.

Following consideration, the Board agreed:

i) to note the content of the report; and

ii) that transforming services to meet the aspirations of the MIJB's Strategic Plan remains a priority, with a temporary focus on a narrow set of objectives being a necessity in response to the covid pandemic.

7. Moray Integration Joint Board Increase of Voting Membership Report

A report by the Chief Officer informed the Board of the outcome of the request for

additional voting members to be appointed to the Moray Integration Joint Board from each partner organisation (Moray Council and Grampian Health Board).

Following consideration the Board agreed to:

i) note the approval for the additional voting member of the MIJB;

ii) approve the change to Section 3.1 of the Health and Social Care Integration Scheme set out in paragraph 4.5;

iii) instruct the Chief Officer to conduct a consultation exercise and follow due process, to present this amendment to the Scottish Government for ratification, at the earliest opportunity, for the reasons stated in 4.6; and

iv) the representation on Audit, Performance and Risk and Clinical Governance Committee as set out in Appendix 1.

8. Learning Disability Strategy

A report by the Interim Service Manager, Learning Disability informed the Board of the update to the Moray Learning Disability Strategy: Our Lives, Our Way 2013-2023 to ensure that it is aligned with the Moray Integration Joint Board Strategic Plan, Moray Partners in Care 2019 - 2029.

Following consideration the Board agreed:

i) to approve the updated Learning Disability Strategy aligned to the MIJB Strategic Plan; and

ii) that the Learning Disability Services with the Learning Disability Forum develop an Implementation plan based on the 6 Improvement Themes set out in the strategy and linked to the priorities set out in the MIJB's overarching Strategic Plan.

9. Housing for People with a Learning Disability

A report by the Interim Service Manager, Learning Disability informed the Board of progress on the development of housing for people with a learning disability and to ask the Board to agree to support the projects noted in the report.

Following consideration the Board agreed:

i) the housing projects noted in the report in paragraph 4.3 and 4.5 as approved and funded by the Scottish Government in accordance with Moray Council Housing Strategy and Moray Housing Need and Demand Assessment document (HNDA) are utilised for people with Learning Disability; and

ii) that i-house support services should be used initially for people who exhibit the highest level of challenging behaviour.

10. Home First in Moray

A report by the Head of Service provided an overview of the Moray Integration Joint Board on the current status and priorities for Home First in Moray.

Following an introduction of the report Susan Pellegrom (Programme Manager) and Duncan Sage (Principal Information Analyst) gave a comprehensive presentation on the Home First in Moray Project.

Ivan Augustus had some concerns on behalf of carers and it was agreed that he would email Sean Coady with his concerns. The Chair requested that a further report come back to update the Board on progress and also on the questions raised.

Following further consideration the Board agreed:

i) to note the progress towards delivering the identified aims for Home First in Moray and confirmed that this programme should remain a priority activity to meet the objectives of the Strategic Plan; and

ii) that further reports will be brought to the MIJB as specific decisions are required.

11. Jubilee Cottages Elgin - Pilot Project

A report by the Locality Manager informed the Board of the considerations for the continuing need for Jubilee Cottages, Elgin.

Following consideration the Board agreed:

i) to note the position of Health and Social Care Moray (HSCM) in retaining and continuing the use of Jubilee Cottages based on information provided within the report; and

ii) to instruct the Chief Officer to seek approval of Moray Council's Policy and Resources Committee to progress an amendment to the Trust Deed.

12. Governance Framework

A report by the Chief Officer presented the draft Health and Social Care Moray governance Framework for approval and implementation.

Following consideration the Board agreed to:

i) approve the draft Governance Framework at Appendix A to this report; and

ii) note that the framework will be reviewed on a regular basis and an update provided to the Board on any proposed significant amendments.

13. Annual Report of the Chief Social Work Officer 2019-2020

A report by the Chief Social Work Officer informed the Board of the annual report of the Chief Social Work Officer (CSWO) on the statutory work undertaken the Council's behalf during the period 1 April 2019 to 31 March 2020 inclusive.

The Board joined the Chair in thanking all the Health and Social Care Teams for their dedication and hard work over the last 10 months.

Following consideration the Board agreed to note the contents of the report.

14. Closure of Meeting

The Chair closed the meeting at 12:08pm.

MEETING OF MORAY INTEGRATION JOINT BOARD

THURSDAY 28 JANUARY 2021

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Action Log Dated 25 May 2020	MSG Improvement Action Plan – has not currently been prioritised, this will be taken forward through discussion at a MIJB development session	Feb 2021	Chief Officer
2.	Action Log Dated 26 Jun 2020	Department of Public Health Annual Report 18-19 & A Healthier and More Active Future for The North East of Scotland 2019-2022 Strategy Report with a detailed plan of approach be provided to the MIJB in 6 months time.	Jan 2021	Chris Littlejohn
3.	Action Log dated 24 September 2020	Children's Social Work Services and Home First - Agreed that development session be arranged to discuss including Children's Social Work Services in the Homefirst approach.	tbc	Chief Officer

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
4.	Revenue Budget Monitoring Quarter2 for 2020/21	Report to be submitted to Audit, Performance and Risk Committee providing further detail regarding governance relating to other services that carry a joint liability in terms of budgetary responsibility.	Mar 21	Chief Financial Officer
5.	Moray Prescribing Report	Copies of the presentation slides to be circulated to the Board	tbc	David Pfleger
6.	Moray Mental Health Services	Briefing to be arranged for IJB Members on the position on MHO Full report on MHS to IJB in 3 month's time.	tbc Mar 21	Jane Mackie
7.	Home First Moray	A further report to be presented to the Board on progress of the project and also to include the questions raised by the Carers Representative	tbc	Sean Coady

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 25 MARCH 2021**

SUBJECT: **CHIEF OFFICER REPORT**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To inform the Board of the Chief Officer activities that support the delivery against the Moray Integration Joint Board's strategic priorities articulated in the Strategic Plan, and the delivery against the 9 Health and Wellbeing outcomes. Key work for the Partnership includes the implementation of Home First, alongside preparations for winter, responding to the ongoing covid pandemic, and budget control.

2. RECOMMENDATION

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

i) note and comment on the content of the report; and

ii) agree that transforming services to meet the aspirations of the MIJBs Strategic Plan remains a priority, with a temporary focus on a narrow set of objectives being a necessity in response to the covid pandemic.

3. BACKGROUND

Operation Home First

3.1 Responding to COVID-19 has brought about rapid change, fast tracking many of the plans that had been under development to meet our aspirations set out in the Strategic Plan. The reduction of delayed discharges and the increased use of technology for consultations are two examples, where we had aspirations but the pace was slow.

3.2 The strong relationships that exist in North East Scotland between key partners has enabled a swift and cohesive set of responses to how services have been delivered, and challenges met. Whole system leadership has built the common approach, with rapid and decisive decision making within the limits of delegated authority.

3.3 The Home First principles include:

- Building on the initial response
- Maintaining agile thinking and decision making
- Retaining our ability to respond to Covid related demand, and winter surges in demand
- Using a home first approach for all care where that is safe to do so
- Utilising available technology to widen and ease access to services
- Avoidance of admission
- Removing delays for discharge from hospital
- Maintaining safe services for those Shielding
- Removing barriers between primary and secondary care, with as much care as possible in communities

3.4 Work is being co-ordinated and driven by the 3 health and social care partnerships and acute services, with a local programme of work in Moray sitting within that framework, supported by local clinicians, practitioners and managers. We were keen that locally Children's Social Work Services were included in the Home First approach, with the framework supporting the efforts to improve outcomes particularly for looked after children.

3.5 The work on reducing delayed discharges from hospital has seen some dramatic improvements in performance resulting from positive interventions. Further work is required to continue the improvement journey and to reduce delays where the downward trend has slowed. The Discharge to Assess pilot has been fully evaluated, and a decision is being sought from the MIJB in a separate paper on today's agenda to mainstream this initiative.

Winter Planning and Operation Snowdrop

3.6 The Health and Social Care Partnership has contributed to the NHS Grampian winter plan, ensuring that our local planning fits the Moray context and is cognisant of lessons learned from previous winters. NHS Grampian has developed the plan under the title "Operation Snowdrop". In response to the challenges in the system, Operation Snowdrop moved to level 4 of the Civil Contingencies approach on Tuesday 5 January 2021.

3.7 Operation Snowdrop aims to concentrate the whole organisation effort on a discrete number of activities to ensure that our finite workforce capacity is directed at the most urgent issues. Operation Snowdrop at level 4 comprises the following:

- Staff Health & Wellbeing
- Critical & Protected Services
- Test & Protect
- Vaccination
- Surge & Flow

3.8 NHS Grampian managed the first wave of COVID-19 under Operation Rainbow (civil contingencies level 4) and moved to a revised leadership structure as it exited this phase. As the demand on the system rose, it moved to a 'hybrid model' where there was a combination of activities managed through level 2 & level 3 of the civil contingencies approach.

3.9 NHS Grampian created a surge and flow plan for the 'winter period' in 2020/21 which created a mechanism to deal with normal winter pressures

alongside COVID-19. The Scottish Government has also prioritised a number of other critical functions, for example, the delivery of the COVID-19 vaccination programme and the delivery of the Test & Protect programme. NHS Grampian moved to Operation Snowdrop in November 2020 to approach the period from November 2020 through to May 2021; this was undertaken in the hybrid model with levels 2 and 3 of civil contingencies in place.

3.10 The intelligence predicted that for January to March 2021, there would be unprecedented demand on the system which could exceed the capacity of our staff cohort to deliver the wide range of services currently in place. On this basis NHS Grampian moved to level 4 Civil Contingencies, on a planned basis, for a discrete period of time to ensure enough staff capacity to deliver on the agreed priorities.

3.11 Silver Command has been staffed on a continuous basis and planned through to the end of March 2021, with a combination of an Executive from the Clinical Triumverate (Medical, Nursing and Public Health) and a Chief Officer from the Health and Social Care Partnerships. Bronze Control in Moray was stepped up to respond to the increasing flow of communication, which will have shorter deadlines for action. This will have a temporary impact on the capacity of the Partnership and the focus will be in line with the priorities set out.

3.12 To date the system has coped with some significant surges in demand, with a pan Grampian approach in how surge and flow through the system is managed to ensure patients/clients receive the care they require. Staff within Moray, across all sectors of health and social care, including independent providers and the third sector, have stepped up to the challenge on a daily basis. There is pressure in some service areas which will require a particular focus to work down a backlog of referrals, with adult social work and parts of the occupational therapy service seeing a rise in demand. Heads of Service will report to the senior management team on plans to improve the flow on referrals.

3.13 Remobilisation is now being planned for as we approach the end of the March milestone which was the potential duration of Operation Snowdrop. The HSCP is contributing to the NHS Grampian remobilisation plan which will be submitted to Scottish Government.

Covid Vaccination Programme

3.14 By the end of December 2020 all care home residents along with staff had been offered the first dose vaccine. Second dose vaccines have been administered in line with the Chief Medical Officer direction. Uptake rates are high, and up to date reports are available on the Public Health website. Further cohorts are being vaccinated in line with the national timetable, and alongside this we will also deliver the second dose programme. Vaccination doses have been supplied in a non-linear fashion, which has created a challenge for the team in planning workforce capacity. The team have responded dynamically, and continue to vaccinate at the rate at which supplies are made available.

3.15 With a longer term campaign being predicted for repeated covid vaccinations, along with delivery of this winter's flu campaign and all the other immunisation programmes, there is a need to rethink the size and shape of a future

workforce required to deliver an expanded vaccination programme into the future. The current workforce delivering the covid vaccination programme consists of a number of staff who have been redeployed, or who are on fixed term contracts. Planning for the future will be taken through the pan Grampian vaccination programme Board.

Budget Control

3.16 Transformational change that meets the test of quality and safety must also be efficient, making the best use of available resources. The senior management team in the Health and Social Care Partnership are meeting regularly to review spend, and to track progress on transformational redesign so that corrective action can be supported. Additional winter and covid related funding will offset the effects of needing to focus on more immediate priorities in response to the pandemic, however the risks associated with less long term planning remain, and will need to be addressed as part of remobilisation. .

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 We remain in a pandemic response phase, and are stepping up quickly where that is required. In parallel, there is the opportunity to accelerate work to achieve the MIJB ambitions as set out in the Strategic Plan, and Home First is the programme designed to do that.

4.2 The challenges of finance have not gone away and there remains the need to address any underlying deficit. Funding partners are unlikely to have the ability to cover overspends going forwards. Winter/covid funding will only cover additional expenditure in the short-term and so it is important to understand the emerging landscape.

4.3 Transformational change, or redesign, that provides quality and safe services, whilst bringing more efficient ways of operating, will be the focus for the senior management team as the route to operating within a finite budget, while meeting the health and care needs of the Moray population.

4.4 Planning for remobilisation has begun, and will build from achievements and learning from the current pandemic phase. The interdependencies between services will need to form part of the assessment on how to remobilise, as no part of the system operates in isolation.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

Working with our partners to support people so they can cope with, and where possible, overcome the health and wellbeing challenges they may face.

Ensuring that the right care is provided at the right place at the right time when people are in need. Ensuring that our systems are as simple and efficient as possible.

(b) Policy and Legal

The Chief Officer continues to operate within the appropriate level of delegated authority, ensuring that the MIJB is sighted on key issues at the

earliest opportunity, and continues to influence and agree the strategic direction.

(c) Financial implications

There are no financial implications arising directly from this report. The Chief Finance Officer reports regularly to Scottish Government (via NHS Grampian) on actual expenditure and estimates through the Local Mobilisation Plan to ensure that the Scottish Government are sighted on additional costs arising from COVID-19.

The key drive of Operation Home First is to secure quality and capacity. More efficient ways of working will cost less, allowing re-investment in services. There is a link between the aspirations of Home First and the set-aside, and also the potential to shift planned hospital outpatient activity to community settings. Staff and or finance will need to follow the patient in order to adequately resource the community setting.

(d) Risk Implications and Mitigation

The risk of not redesigning services will mean that Health and Social Care Moray cannot respond adequately to future demands. .

(e) Staffing Implications

Staff remain the organisation's greatest asset, and we must continue to engage with all sectors to ensure full involvement, which will create the best solutions to the challenges we face.

(f) Property

There are no issues arising directly from this report.

(g) Equalities/Socio Economic Impact

Any proposed permanent change to service delivery will need to be impact assessed to ensure that we are not disadvantaging any section of our community.

HSCM will continue to work closely with all our partners to ensure that we contribute to the health and well-being of the community and support the recovery phase of the COVID-19 pandemic.

(h) Consultations

Any major service change will be subject to proper consultation. There are no direct implications arising from this report.

6. CONCLUSION

The MIJB are asked to acknowledge the significant efforts of staff, across in-house providers, externally commissioned services, the Independent and Third Sector, who are supporting the response to the COVID-19 pandemic, and the drive to create resilience and sustainability through positive change.

Author of Report: Simon Bokor-Ingram, Chief Officer

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 25 MARCH 2021**

SUBJECT: **REVENUE BUDGET MONITORING QUARTER 3 FOR 2020/21**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1 To update the Moray Integration Joint Board (MIJB) of the current Revenue Budget reporting position as at 31 December 2020 and provide a provisional forecast position for the year-end for the MIJB budget.

2. RECOMMENDATIONS

2.1 It is recommended that the MIJB:

i) note the financial position of the Board as at 31 December 2020 is showing an overspend of £584,491 on core services;

ii) note the provisional forecast position for 2020/21 of an underspend of £36,073 on total budget;

iii) note the progress against the recovery and transformation plan and the support that has now been confirmed through Scottish Government Covid funding surrounding the underachievement of savings

iv) note the revisions to staffing arrangements dealt with under delegated powers and in accordance with financial regulations within the Council (MC) and NHS Grampian (NHSG) for the period 1 October to 31 December 2020 as shown in APPENDIX 3; and

v) approve for issue, the Direction arising from the updated budget position shown in Appendix 4.

3. BACKGROUND

3.1 The financial position for the MIJB services at 31 December 2020 is shown at **APPENDIX 1.** The figures reflect the position in that the MIJB core services are currently over spent by £584,491. This is summarised in the table below.

	Annual Budget £	Budget to date £	Expenditure to date £	Variance to date £
MIJB Core Service	123,906,757	92,870,518	93,455,009	(584,491)
MIJB Strategic Funds	9,194,672	4,297,865	4,269,335	28,530
Set Aside Budget	12,252,000	-	-	-
Total MIJB Expenditure	**145,353,429**	**97,168,383**	**97,724,344**	**(555,961)**

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

3.3 The updated provisional forecast outturn to 31 March 2021 for the MIJB services is included in **APPENDIX 1**. The figures reflect the overall position in that the MIJB core services are forecast to be over spent by £543,869 by the end of the financial year. This is summarised in the table below.

	Annual Budget £	Provisional Outturn to 31 Mar 2021 £	Anticipated Variance to 31 Mar 2021 £	Variance against base budget %
MIJB Core Service	123,906,757	124,450,626	(543,869)	(0.4)
MIJB Strategic Funds	9,194,672	8,614,730	579,942	6.3
Set Aside Budget	12,252,000	12,252,000	-	-
Total MIJB Expenditure	**145,353,429**	**145,317,356**	**36,073**	**(0.02)**

4. KEY MATTERS/SIGNIFICANT VARIANCES FOR 2020/21

Community Hospitals & Services

4.1 There are continuing overspends within community hospitals and services for the four localities: Elgin, Buckie, Forres and Keith/Speyside totalling £194,560 to 31 December.

4.2 Overspends continue to be realised for the services. The main overspend relates to community hospitals in Buckie £134,925 and Keith £47,536. Aberlour and Dufftown operating jointly are underspent by £3,413 and other minor variances including administration and medical costs total overspend of £15,512. The overspend in Buckie and Keith and are mainly longstanding relating to staffing. Services in Aberlour include additional cost of currently commissioned care beds which are offset by underspends in Dufftown.

4.3 This budget is forecasted to be £252,521 overspent by the end of the financial year, this is only slightly improved recognising the task of maintaining staffing and non-financial objectives including waiting times and delayed discharge objectives. The current forecast is based on the existing situation.

Community Nursing

4.4 Community nursing service is underspend by £262,757. This is primarily due to underspend across the Community Health Visiting service related to vacancies and development within the service.

4.5 This budget is forecasted to be £348,387 underspent by the end of the financial year. This position includes the impact of vacancies where new appointments are being made, staff still in training not yet at full cost and budgetary allocation provided in 2020/21 to allow for banding adjustment to qualified staff which was agreed nationally.

Learning Disabilities

4.6 The Learning Disability service is overspent by £287,123. The overspend is primarily due to overspends on the purchase of care for people with complex needs of £415,412 which includes young people transitioning from children's services and people being supported to leave hospital. Underspends in staffing of £130,962 mainly relating to physiotherapy, occupational therapy, speech and language and psychology services. Other minor non pay overspends total £2,673.

4.7 This budget is forecasted to be £463,949 overspent by the end of the financial year after including assumptions that the overspend on purchase of care will be £635,000 and staffing underspends will continue at a level of £171,051.

4.8 The whole system transformational change programme in learning disabilities can help to assure that every opportunity for progressing people' potential for independence is being taken, and every support plan is scrutinised prior to authorisation. The system can then have confidence that the money spent is required and appropriate to meet a person's outcomes, but it is not possible to remove the need for ongoing support. Whilst every element of expenditure is scrutinised prior to authorisation at service manager level, it has not been possible to reduce expenditure in line with the budget, as the nature of learning disabilities means that people will require on-going, lifelong support, The current level of scrutiny will remain in place, with only critical or substantial needs being met.

Mental Health

4.9 This budget is underspent by £90,534. The underspend on clinical and other services primarily relates to underspends in medical staffing due to vacancies £147,803 alongside other cumulative underspends totalling £56,256 (including nursing staff). This is being reduced by an overspend of £113,525 relating to the purchase of care for a high cost care package.

4.10 This budget is forecasted to be £145,526 underspent by the end of the financial year due to the above variances continuing. The underspend is not expected to continue in to 2021/22 as there has now been successful recruitment to the adult mental health vacancies.

Care Services Provided In-House

4.11 This budget is underspent by £1,024,252. This primarily relates to staffing costs totalling £932,327 (this includes underspends in Care at Home service £429,079; Community Support workers £230,600; Re-ablement £84,071, Barlink £14,725, Woodview £126,446 and Waulkmill of £47,406), due to vacancies and recruitment. There are also underspends in staff transport of £67,924 due to support staff not using transport because of Covid, client transport of £54,981 relating to day services, where the services have been closed, admin £44,715 relating to telephone contract and other minor variances totalling £951, which is being reduced due to less income received then expected of £76,646.

4.12 This budget is forecasted to be £1,378,000 underspent by the end of the financial year. The staffing cost underspends are expected to continue totalling £1,251,000 and corresponding under spends in staff transport £76,000 and client transport £113,000. Continuing underspends in Admin £29,000, and other various underspends totalling £5,000. This is being reduced by continued loss of income anticipated to be £96,000.

Older People and Physical Sensory Disability (Assessment & Care)

4.13 This budget is overspent by £1,690,760. This includes an overspend for domiciliary care in the area teams £1,607,296, permanent care £492,167 and loss of client income £33,507. This is being reduced by underspends in day care £219,879, day care client transport £70,357, respite £41,366, Shared Lives £105,382 and other minor underspends totalling £5,226 The variances within day care,Shared Lives, transport and respite relate to the services being closed due to Covid.

4.14 This budget is forecasted to be £2,292,000 overspent by the end of the financial year. The forecast overspend is expected to continue as detailed above, with domiciliary care overspend of £2,444,000, permanent care £500,000 and loss of client income under recovery £10,000, which is offset in part by continuing underspends in day care £333,000, day care client transport is forecast to underspend £101,000, respite £60,000, Shared Lives £163,000 and other minor underspends totalling £5,000. The underspends in day care, respite and shared lives are based on the assumption that whilst working towards re-mobilisation it is unlikely to be before the end of the financial year. The extent of the underspends and any likely reduction will be based on re-mobilisation over the coming months.

4.15 Monitoring the level of spend within domiciliary care with external providers will continue in the context of the wider budget and shifting patterns of expenditure and the progress being made in relation to increased investment into new housing models.

Care Services Provided by External Contractors

4.16 This budget is underspent by £310,178. This primarily relates to Learning Disability where day services have had to cease due to the Covid pandemic, the underspend is £375,740. This underspend also includes a one off credit for a decommissioned service totalling £147,833, where the clients have been provided with more suitable provision. The underspend is offset by prior year savings against services not achieved £46,000 and increase in OLM and Care Cubed licences £19,562.

4.17 This budget is forecasted to be £417,000 underspent by the end of the financial year primarily due to the above variances continuing. Learning Disability contracts are expected to underspend by £475,000 and other minor variances totalling £7,562. Which is being reduced by increase in OLM licences, care cubed costs £19,562, and prior year savings unachieved totalling £46,000.

Other Community Services

4.18 This budget is underspent by £245,365.This relates to underspends in Allied Health Professionals (AHP's) £100,807 (which includes underspends in Podiatry, Physiotherapy and Speech and Language Therapy where ongoing difficulties are being experienced in recruitment partially offset by an overspend

in Occupational Therapy and Dietetics), Dental services £67,277 where underspends exist in Community Dental services mainly arising from staffing, Public Health £26,960, and Specialist Nursing services £86,912 (where there is an ongoing underspend in the Oaks service where community hub is now located). These underspends are offset in part by an overspend in Pharmacy £36,591 which is related to staff costs that are expected to continue.

4.19 Total other community services is forecasted to be £380,141 underspent by the end of the financial year. Managers are aware of the position in relation to their services but the forecast broadly anticipates continuance of current expenditure patterns as detailed above although in Public Health the underspend is forecast to increase as services are delayed due to staff redeployment.

Admin and Management

4.20 Admin and Management is currently underspent by £31,978. This includes £80,716 overspend relating to staff costs and a reduction in income. Within Business Support an underspend to date of £112,694 includes, Step Down beds relating to contract compliance, Clinical governance and Business Support Team where expenditure is lower than budget to date.

4.21 This budget is forecasted to be £451,178 underspent by the end of the financial year. This is primarily due to the vacancy factor target which is expected to be exceeded by £388,757, underspends of £154,848 within Business Support offset by overspend of £92,437 in Management costs anticipated.

Primary Care Prescribing

4.22 The primary care prescribing budget is reporting an overspend of £455,792 to December 2020. This position is based on seven month's actuals from April to October and includes the continuing impact on price and volume from Covid-19. The prescribing budget now includes allocation from IJB Covid funding amounting to £177k for two drugs identified by Scottish Government as being specifically impacted upon by Covid. A national Short Lives Working Group met with expert colleagues from Public Health Scotland and the advice was that only two medicines, Sertraline and Paracetamol, were likely to contribute to material overspends as a result of COVID-19. Work continues both locally at Grampian Primary Care Prescribing Group to investigate this and nationally, where the prescribing advisors network are working with Primary Care (Family Health Services Executives) to analyse the situation.

4.23 This budget is forecasted to be £620,000 overspent by the end of the financial year reflecting assumed future volumes now consistent with current levels and for prices to remain consistent. The price per item remains higher than anticipated. The prescribing position is a major risk area.

Primary Care Services

4.24 Primary Care services budget is currently underspent by £115,683 which includes a non recurring rebate received in Premises expenditure for rents and rates and Board Administered Funds including seniority payments.

4.25 This budget is forecasted to be £83,000 underspent by the end of the financial year as impact of rebate is abated.

Hosted Services

4.26 Hosted Services, comprises of a range of Grampian wide services that are hosted and managed by a specific IJB on a Grampian wide basis. Costs are re-allocated to the three IJB budgets on a monthly basis. A list of these services is included in **APPENDIX 2.** Moray Hosted Services are overspent by £137,447 to December primarily due to the Grampian Medical Emergency Department (GMED) out of hours service (which is hosted and managed by MIJB), overspend of £243,789 that is offset by cumulative underspends of £137,477 in other hosted services including Intermediate Care, Sexual Health services and Diabetic Services.

4.27 This budget is forecasted to be overspent by £191,686 by the end of the financial year mainly attributable to the overspend within GMED out of hours service. Service managers are continuing to review the GMED service.

Improvement Grants

4.28 Improvement grants is underspent by £220,001 at 31 December 2020, however at the end of the financial year this budget is expected to be under spent by £300,000. This is predominately due to the impact of Covid upon the work that has been unable to be completed during the restrictions of the pandemic.

5. STRATEGIC FUNDS

5.1 Strategic Funds is additional Scottish Government funding for the MIJB, they include:

- Integrated Care Fund (ICF);
- Delayed Discharge (DD) Funds;
- Additional funding received via NHS Grampian (this may not be fully utilised in the year resulting in a contribution to overall MIJB financial position at year-end, which then needs to be earmarked as a commitment for the future year.
- Provisions for earmarked reserves has been made to fund unutilised allocation for Primary Care Improvement Funds and Action 15 in 2020/21, identified budget pressures, new burdens and savings that were expected at the start of the year.

5.2 By the end of the financial year, the Strategic Funds will reduce as the commitments and provisions materialise and the core budgets will increase correspondingly.

6. PROGRESS AGAINST THE RECOVERY & TRANSFORMATION PLAN

6.1 The Revenue Budget 2020/21 was presented to the MIJB 26 March 2020 (para 11 of the minute refers). The paper presented a balanced budget through the identification of efficiencies through Recovery and Transformation.

6.2 The progress against the Recovery and Transformation Plan is reported in the table below and will continue to be reported to the Board during the 2020/21 financial year. The table details progress during the third quarter against the original recovery plan.

Efficiencies	Para Ref	Full Year Target	Actual progress against target at 31 December 2020	Status (R A G)	Expected to achieve at 31 March 2020
		£'000	£'000		£'000
Accountancy driven		223	167	G	223
External Commissioning	6.3	249	0	R	0
Increased income from charging	6.4	261	30	R	40
In-house provided care	6.5	157	75	A	100
Transformational change	6.5	341	133	A	177
Prescribing – medicines management	6.6	206	0	R	0
Prescribing – National reduction in drug tariff	6.6	500	0	R	0
Other		7	0	R	0
Total Projected Efficiencies		**1,944**	**405**	R	**540**

6.3 Commissioning activity was stood down in March 2020 and staff were redeployed to support the Covid-19 response. In the second quarter commissioning activity had been re-established. However, due to the current lockdown progress has therefore been limited and it is unlikely to achieve any of the savings in this financial year.

6.4 Savings from increases in charging are being met in part currently where these formed part of the charging policy that was approved by Moray Council at its meeting of the Policy and Resources Committee on 14 January 2020 (para 9 of the minute refers). Some other elements to this area of recovery are subject to policy change, which require approval from Moray Council. Due to the timing of meetings and the process aligned to the the required policy changes, the majority of these savings will not be achieved this financial year.

6.5 Redesign and transformation of specific internal services formed part of the recovery and transformation plan. The response to the pandemic has taken precedence over review and redesign. As re-mobilisation continues, opportunities for alternative ways of delivering services are emerging. It is recognised that budget re-alignment will be required going forward.

6.6 Prescribing was set to deliver significant savings during 2020/21 in the main as a result of a national reduction in the drug tariff. The Covid-19 pandemic has placed significant pressure on this budget negating this element of efficiency. Whilst there are national conversations taking place as to how the prescribing situation can be supported going forward, the impact being felt currently is that this will have a significant impact on the savings programme.

6.7 On 5 February 2021, notification from Scottish Government was received in relation to additional Covid-19 funding that would be made available to Integration Authorites for the ongoing associated costs. Within this funding, it has been recognised that the pandemic has had significant impact on financial recovery plans. The allocation provides support for the under-delivery of current year savings. This becomes effective in the final financial quarter of the year and so it not reflected in **Appendix 1** or **3.1** and **3.2** of this report, however the impact will be such that a surplus position will be realised by 31 March 2021. This will create a general reserve that will be utilised to support a balanced budget for 2021/22.

7. IMPACT OF COVID-19 & WINTER PRESSURES

7.1 There has been commitment from Scottish Government to provide additional funding to support the impact of Covid-19. The latest submission of our local mobilisation plan was made on 22 January 2021 (via NHS Grampian). The plan estimates that additional spend relating to Covid-19 will be £5.4m to the end of the financial year. Additionally, the plan indicated that the underachievement of savings would be in the region of £1.4m that corresponds to 6.2 above in relation to the shortfall as at 31 December 2020 and as highlighted in para 6.7, funding has now been received to support this position.

7.2 This budget monitoring report for the third quarter of 2020/21 shows no adverse variance on the financial impact of Covid-19. The costs incurred up to 31 December 2020 can be summarised as:

Description	**Spend to 31 December 2020 £000's**
Reducing Delayed Discharge	462
Staffing	519
Provider Sustainability Payments	1,296
Payments to Primary Care Contracts	388
Cleaning, materials & PPE	18
Elgin Community Hub (Oaks)	670
Prescribing	133
Clinical leadership	108
Total	**3,594**

7.3 In addition to Covid funding, additional SG resource has been secured to address the winter period and the additional pressure this will exert on the wider system. This has been co-ordinated on a Grampian wide basis with input from the three IJB Chief Officers and the Chief Officer of Acute services. The total additional funding is £5.5m of which the Moray share is £0.871m. This will be monitored and reported through NHS Grampian and is required to

be spent by 31 March 2021. Oversight of the Moray element will be through the Health and Social Care Moray senior management team.

8. CHANGES TO STAFFING ARRANGEMENTS

8.1 At the meeting of the Board on 28 March 2019, the Financial Regulations were approved (para 11 of the minute refers). All changes to staffing arrangements with financial implications and effects on establishment are to be advised to the Board.

8.2 Changes to staffing arrangements dealt with under delegated powers through appropriate Council and NHS Grampian procedures for the period 1 October to 31 December 2020, and are detailed in **APPENDIX 3**.

9. UPDATED BUDGET POSITION

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

	£'s
Approved Funding 26.3.20	**123,818,000**
Set Aside Funding 26.3.20	**11,765,000**
Amended directions from NHSG 3.6.20	412,064
Balance of IJB reserves c/fwd. to 19/20	186,692
Amendment to Set Aside funding	487,000
Budget adjustments qtr 1	849,528
Budget adjustments qtr 2	1,593,186
Revised Funding to Quarter 3	**139,111,470**
Budget adjustments M07-M09	
Carers funding to Childrens services	(43,747)
Covid 19 Allocation	3,615,000
Adult Social Care	1,070,000
Primary Care	729,881
PCIF	701,031
Action 15	228,478
Mental Health	174,668
GP OOH	86,471
School Nurse Funding	55,200
Physio ARISE	32,465
Open University	20,000
Dental Priority Groups	18,000
Hosted Recharges	2,232
Prescribing	(447,720)
Revised Funding to Quarter 4	**145,353,429**

9.2 In accordance with the updated budget position, revised Directions have been included at **APPENDIX 4** for approval by the Board to be issued to NHS Grampian.

10. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan 2019 – 2029, 'Moray Partners in Care'

This report is consistent with the objectives of the Strategic Plan and includes budget information for services included in the MIJB Revenue Budget 2020/21.

(b) Policy and Legal

It is the responsibility of the organisation receiving the direction to work with the MIJB Chief Officer and Chief Financial Officer to deliver services within the resources identified. The Moray Integration Scheme (para 12.7 of the 2018 Integration Scheme) makes provision for dealing with in year variations to budget and forecast overspend by reference to agreed corrective action and recovery plans. It also makes provision for dealing with year-end actual overspend where such action and plans have been unsuccessful in balancing the relevant budget by reference to use of MIJB reserves and additional payments from NHS Grampian and Moray Council.

(c) Financial implications

The financial details are set out in sections 3-9 of this report and in **APPENDIX 1**. For the period to 31 December 2020, an underspend is reported to the Board of £36,073.

The staffing changes detailed in paragraph 8 have already been incorporated in the figures reported.

The movement in the 2020/21 budget as detailed in paragraph 9 have already been incorporated in the figures reported.

(d) Risk Implications and Mitigations

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

(e) Staffing Implications

There are no direct implications in this report.

(f) Property

There are no direct implications in this report.

(g) Equalities/Socio Economic Impact

There are no direct equality/socio economic implications as there has been no change to policy.

(h) Consultations

The Chief Officer, the Health and Social Care Moray Senior Leadership Group and the Finance Officers from Health and Social Care Moray have been consulted and their comments have been incorporated in this report where appropriate.

11. CONCLUSION

11.1 The MIJB Budget to 31 December 2020 has an over spend of £584,491 and the updated provisional forecast position of £555,961 overspend on core services. Senior Managers will continue to monitor the financial position closely.

11.2 The finance position to 31 December 2020 includes the changes to staffing under delegated authority, as detailed in APPENDIX 3.

11.3 The financial position to 31 December 2020 reflects the updated budget position and revised Directions have been prepared accordingly, as detailed in APPENDIX 4.

11.4 Officers must remain focussed on transformation and redesign, and the efficiency of services as the financial challenges will continue beyond this year, and planning carried out now will create opportunities in future years.

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

JOINT FINANCE REPORT APRIL 2020 - DECEMBER 2020

APPENDIX 1

	Para Ref	Annual Net Budget £'s 2020-21	Budget (Net) To Date £'s 2020-21	Actual To Date £'s 2020-21	Variance £'s 2020-21	Variance % 2020-21	Most recent Forecast £'s 2020-21	Variance To Budget £'s 2020-21
Community Hospitals	4.1	5,294,859	3,970,425	4,164,985	(194,560)	(4)	5,547,380	(252,521)
Community Nursing	4.2	5,104,427	3,830,692	3,567,935	262,757	5	4,756,040	348,387
Learning Disabilities	4.3	7,977,301	5,610,463	5,897,586	(287,123)	(4)	8,441,250	(463,949)
Mental Health	4.4	8,691,643	6,421,394	6,330,861	90,534	1	8,546,116	145,526
Addictions		1,140,273	851,792	836,832	14,960	1	1,130,485	9,788
Adult Protection & Health Improvement		153,630	95,779	95,216	563	0	152,630	1,000
Care Services provided in-house	4.5	16,642,024	12,287,086	11,262,834	1,024,252	6	15,264,024	1,378,000
Older People & PSD Services	4.6	17,976,279	13,638,484	15,329,244	(1,690,760)	(9)	20,268,279	(2,292,000)
Intermediate Care & OT		1,516,203	1,187,124	1,239,612	(52,488)	(3)	1,605,203	(89,000)
Care Services provided by External Contractors	4.7	8,385,546	6,280,949	5,970,771	310,178	4	7,968,546	417,000
Other Community Services	4.8	8,099,575	6,019,853	5,774,488	245,365	3	7,719,435	380,141
Admin & Management	4.9	2,769,203	2,044,974	2,012,996	31,978	1	2,318,025	451,178
Primary Care Prescribing	4.10	16,668,029	13,035,019	13,490,812	(455,792)	(3)	17,288,029	(620,000)
Primary Care Services	4.11	17,470,570	13,105,568	12,989,885	115,683	1	17,387,570	83,000
Hosted Services	4.12	4,410,328	3,303,768	3,441,216	(137,447)	(3)	4,602,014	(191,686)
Out of Area		669,268	525,414	608,004	(82,590)	(12)	818,000	(148,732)
Improvement Grants	4.13	937,600	661,733	441,732	220,001	23	637,600	300,000
Total Moray IJB Core		**123,906,757**	**92,870,517**	**93,455,009**	**(584,491)**	8	**124,450,626**	**(543,869)**
Other Recurring Strategic Funds in the ledger	5.1	567,833	253,122	253,122	0		337,496	230,337
Other non-recurring Strategic Funds in the ledger	5.1	1,411,340	1,098,664	1,070,133	28,531	2	1,369,776	41,563
Total Moray IJB Including Other Strategic funds in the ledger	5.1	**125,885,930**	**94,222,303**	**94,778,263**	**(555,961)**		**126,157,898**	**(271,968)**
Other resources not included under core and strategic:	5.1	7,215,498	2,946,080	2,946,080	0	0	6,907,458	308,041
Total Moray IJB (incl. other strategic funds) and other costs not in ledger	5.1	**133,101,429**	**97,168,383**	**97,724,344**	**(555,961)**	**0**	**133,065,356**	**36,073**
Set Aside Budget		12,252,000	-	-	-		12,252,000	0
Overall Total Moray IJB		**145,353,429**	**97,168,383**	**97,724,344**	**(555,961)**	**0**	**145,317,356**	**36,073**

Funded By:

NHS Grampian	87,971,537
NHS Earmarked Reserves	187,039
NHS Grampian - Set Aside	12,252,000
Moray Council	44,942,853
IJB FUNDING	**145,353,429**

Description of MIJB Core Services

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

2. Community Nursing related to Community Nursing services throughout Moray, including District Nurses and Health Visitors.

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

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

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

6. Adult Protection and Health Improvement

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

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

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

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

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

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

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

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

15. Hosted Services, comprises of a range of Grampian wide services. These services are hosted and managed by a specific IJB on a Grampian wide basis and costs are re-allocated to IJB budgets. These services include:-

    <u>Moray IJB Hosted & Managed services</u>:

    - GMED out of Hours service.
    - Primary Care Contracts Team

    <u>Aberdeen City/Aberdeenshire IJB Hosted & Managed services:</u>
    - Intermediate care of elderly & rehab.
    - Marie Curie Nursing Service – out of hours nursing service for end of life patients
    - Continence Service – provides advice on continence issues and runs continence clinics
    - Sexual Health service
    - Diabetes Development Funding – overseen by the diabetes Network. Also covers the retinal screening service
    - Chronic Oedema Service – provides specialist support to oedema patients
    - Heart Failure Service – provided specialist nursing support to patients suffering from heart failure.
    - Police Forensic Examiner Service
    - HMP Grampian – provision of healthcare to HMP Grampian.

16. Out of Area Placements for a range of needs and conditions in accommodation out with Grampian. These are managed centrally within NHS Grampian and charged to IJB's.

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

Other definitions:

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

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

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

APPENDIX 3

HEALTH & SOCIAL CARE MORAY

DELEGATED AUTHORITY REPORTS - PERIOD October 2020 – December 2020

Title of DAR	Summary of Proposal	Post(s)	Permanent/ Temporary	Duration (if Temporary)	Effective Dates	Funding
Clerical Assistant	Create temporary post to support CAH	1 x fte Grade 3 Clerical Asst	Temporary	1 year	From appointment	SG Covid funding
Staffing in START	Continuation of temporary acting up to 31st March 2021	Acting up from Grade 3 to Grade 5	Temporary		To 31.03.21	SG Covid funding
Information Systems Change to post	Create part time posts from vacant Grade 6 to meet needs of service	Delete 1xfte Grade 6 Create 18hrs Grade 6 Create 25hrs Grade 4	Permanent	N/A	N/A	Deleting G6 post to fund two part time posts
Create Clerical Asst in CCF team	Create 28.75hr Clerical Asst post by deleting vacant grade 4 Admin Asst post	Delete 25.50 hrs Grade 4 Create 28.75 hrs Grade 3	Permanent	N/A	N/A	Deleting G4 post to fund G3
Discharge to Access	Secondment of OT to lead on Discharge to Access	Grade 10 19.50hrs	Temporary	October 2020-March 2021	October 2020-March 2021	SG Winter Planning funding – Non recurring
Discharge Co-ordinator	Discharge Co-ordinator	Band 6 45 hours	Temporary	6 months	03/12/2020	Winter Planning Funds
Health Care Assistant	CTAC PCIF	Band 3 28hr+17hr posts	Permanent	-	26/10/2020	Recurring PCIF allocation from Scottish Govt.
Health Care Support Worker	Physiotherapy HCSW	Band 4 37.5 hours	Temporary	12 months	23/10/2020	ARISE funding from Scottish Govt.
Highly Specialist Physiotherapist	Physiotherapy Winter Surge plan	Band 7 37.5 hrs	Temporary	3 months	16/12/2020	NHSG Winter Plan allocation

MORAY INTEGRATION JOINT BOARD

DIRECTION

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

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

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

Services:	All services listed in Annex 1, Part 2 and Annex 4 of the Moray Health and Social Care Integration Scheme.
Functions:-	All functions listed in Annex 1, Part 1 of the Moray Health and Social Care Integration Scheme.
Associated Budget:-	£70.3 million, of which £4.4 million relates to Moray's share for services to be hosted and £17 million relates to primary care prescribing. An additional £12.3 million is set aside for large hospital services.

This direction is effective from 25 March 2021.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 25 MARCH 2021**

SUBJECT: **PRESCRIBING BUDGET REQUIREMENTS FOR 2021-2022**

BY: **ACTING LEAD PHARMACIST**

1. REASON FOR REPORT

1.1. To inform the Board of the predicted budget resource requirements for 2021-2022.

2. RECOMMENDATION

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

i) consider and note the recommendations made in this paper with regard to volume, costs, risks and the net predicted need for budget resource of £18.094m as part of the overall health and social care partnership budget setting process for 2021-22;

ii) consider and note the estimated budget requirements linkage to the locally enhanced services / Service Level Agreements (SLAs); and

iii) ensure that final prescribing budget allocations are notified to the pharmacy teams by support finance staff.

3. BACKGROUND

3.1. Current forecasting indicates Moray will end the 2020-21 year with a prescribing deficit, which will be further affected, by identified factors and estimates for these factors in 2020-21.

3.2. Resource assessment for prescribing has been undertaken for 2021-22 using the approach adopted in previous years which estimates growth in volume and spend in the coming year and offsets these with generic savings and approved efficiency plans. The key themes and data presented here are taken from the more comprehensive 'Health and Social Care Prescribing Budget Supporting Information and Data for 2019-2020' which has been scrutinised and approved by the multidisciplinary / cross sector Grampian Medicines Management Group. A breakdown of the components of the requested budget for 2020-21 is provided in **Appendix 1.**

3.3. During 2020-21, there have been variations in prescription volume related to COVID-19 impact. Cumulatively this results in a 4.25% reduction in Grampian from April to October 2020. Volume growth for 2021-22 is still variable due to multiple factors including changes in volumes and treatment as a result of COVID-19.

3.4. Previous years showed some consistency in cost per item as a number of significant medicines lost patent protection and generic equivalents became available. Since COVID-19 costs per item spiked in April to £11.33 in Grampian and then settled in October to £11.07 and remains unpredictable due to drug shortages and changes in treatments e.g. Warfarin changed to NOAC (newer anticoagulant) treatment.

3.5. Some examples of generic medication shortages have had significant cost increases e.g. sertraline 100mg from £1.21 to £17.95, and mirtazapine from £2.98 to £24.22.

3.6. New drugs moving into primary care as a result of Scottish Medicines Consortium (SMC) approval. It is noted that impacts of the EU exit on UK regulatory approval of medicines may have an effect on budget. It is expected that a small number of new medicines identified could have a significant financial impact on primary care e.g. SGLT2 drug class in treatment of diabetes. The budgetary risk has not been quantified.

3.7. Use of NOAC treatment in place of warfarin has increased vastly. Since COVID-19 NOACs monthly items increased by 24% at a 33% cost increase of £20,873 **every** month in Moray in 2020-21. Growth in this area is now expected to slow but patients will remain on the NOAC treatment.

3.8. During 2020 we saw the increased use of FreeStyle Libre®. The Diabetes Managed Clinical Network (MCN) are recommending to extend provision to further diabetes patients at an anticipated 26% cost increase (present costs in Grampian are £945,000 per annum).

3.9. Prescribing cost efficiency work has been adversely affected throughout 2020 due to the pandemic with GP and pharmacotherapy teams work focussed on essential care. In addition, factors to be considered are: Early/Additional medication ordering, an increase in serial prescriptions, therapeutic switching to reduce need for interventions during COVID-19.

3.10. The community hospital budget in Moray has a predicted underspend in 2021 and a small reduction in budget is recommended.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

The following are the main financial risks, which are not included in the recommended uplifts summary:

4.1. The risk that the future prices for generic medicines, and associated reimbursement levels set within the Scottish Drug tariff, remain difficult to predict. The Scottish Government has committed to rebalancing community pharmacy contractor payments by reducing the emphasis on margin share and moving these payments to within the guaranteed global sum.

4.2 The global supply chain remains fragile. Shortages in supply continue to be a significant problem for community pharmacy and dispensing doctor practices with the most recent examples including a wide range of medicines for a variety of conditions e.g. sertraline, metformin and hormone replacement therapy. Such shortages can lead to unpredictability in the cost per item during the year. There is potential for a significant worsening in shortages if border disruption occurs due to the EU exit.

4.3 The growth in consumption of medicines had been stabilising. Anecdotally this has been linked to the end of Quality and Outcomes Framework (QOF), strengthened approaches to medication review and associated reductions in polypharmacy. The variations in volume in 2020/21 are related to COVID-19 and changes in capacity within primary care. Repeat prescribing has continued however acute prescribing, outpatient/medication requests had reduced corresponding to service provision and patient flow

4.4 Primary care rebates, the system that provides the NHS in Scotland with post use discounts on spend for specific medicines, has remained generally stable but there remains a risk that these rebates change or are removed. N.B. These discounts accrue to the individual Health and Social Care Partnerships (HSCPs) based on spend.

4.5 The introduction of new medicines/new treatment modalities has resource implications above and beyond the costs of just the medicine. Whilst no significant impact for newer primary care medicines are anticipated there are a number of newer medicines and devices already on the market that have yet to achieve their steady state usage; NOAC oral anticoagulants and the flash glucose monitoring device, FreeStyle Libre are two examples.

4.6 Diminution in the new General Medical Services (GMS) contract support for medicines management activities focussed on the cost effective use of medicines and the transition to pharmacotherapy services between now and 2021 present a significant potential risk to finance as capacity to pursue cost effective prescribing diminishes. Such loss of medicines management activity was evidenced in the Inverclyde pilot forerunner of Pharmacotherapy.

4.7 Macroeconomic effects related to currency fluctuation and broader impacts of Brexit.

4.8 Expansion of Minor Ailments Service (MAS) to the entire NHS Grampian population. Minor ailments service and Pharmacy First was launched in July 2020 extending the service to all patients registered in Scotland. The potential effects of this expanded service should be considered a budgetary risk and has not been fully quantified.

4.9 The COVID-19 pandemic has had significant effects both in the short and longer term regarding patient pathways, the ordering and use of medicines. This will continue to have effects into 2021/22.

<u>Summary of Risk Mitigation</u>

4.10 Reinstate Cost Effective Review of prescribing by pharmacotherapy workforce.

4.11 Swift chasing of any overpricing bureau errors by lead technician.

4.12 Regular review of High Value Items Report by lead technician then forwarded to pharmacotherapy pharmacists for investigation.

4.13 Regular review of Generic Savings Report by the pharmacotherapy team for potential savings.

4.14 Tighter control of Specials items. With automatic authorisation of items £100 or less now removed.

4.15 Therapeutic equivalent drug switches are now recommenced in line with priorities at the Grampian Primary Care Prescribing Group (GPCPG).

4.16 A Grampian formulary tool is being trialled in Moray to steer appropriate cost effective prescribing choices.

4.17 Medication reviews by GPs and Polypharmacy reviews by Pharmacists which had lapsed during pandemic are currently being reinstated

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan

As set out within Moray's Integration Scheme.

(b) Policy and Legal

There are no policy or legal implications arising from this report.

(c) Financial implications

Primary Care prescribing remains a material financial risk area and this paper identifies the anticipated requirements for additional investment. This is described in **Appendix 1**.

(d) Risk Implications and Mitigation

There is a risk of financial failure, that demand for medicines outstrips budget and the MIJB cannot deliver priorities, statutory work, and project an overspend. Risk will be mitigated by actions set out in this report to manage the budget, but the key financial risks are highlighted above.
At the time of writing, there is still uncertainty as to whether there will be a 'no deal' Brexit, which could have a negative impact upon medicine supply and costs.

(e) Staffing Implications

There are no workforce implications arising from this report.

(f) Property

There are no property implications arising from this report.

(g) Equalities/Socio Economic Impact

There are no equalities/socio economic implications arising from this report.

(h) Consultations

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

- Lead Pharmacist, Health and Social Care Moray
- Chief Financial Officer, MIJB

6. CONCLUSION

6.1. This report recommends the MIJB:

- **consider the recommendations made in this paper with regard to volume, costs, risks and the net predicted need for budget resource of £18.094m as part of the overall HSCP budget setting process for 2021-22;**

- **note the estimated budget requirements linkage to the locally enhanced services / SLAs; and**

- **ensure that final prescribing budget allocations are notified to corporate finance and pharmacy teams.**

References:
Health and Social Care Prescribing Budget Supporting Information and Data for 2021-2022. NHS Grampian Pharmacy & Medicines Directorate, Grampian Area Drug &Therapeutics Committee & Finance Directorate.
BNF,
Pharmaceutical Journal,
NHS Inform,
Impact of Covid on GP Prescribing Sep 2020,
Scottish Drug Tarrif.
www.cps.scot/nhs-services/remuneration/drug-tariff/adjusted-prices

Author of Report: Christine Thomson, Acting Lead Pharmacist
Background Papers: with author

APPENDIX 1

Health and Social Care Moray

Tables A, B & C: Estimates for Prescribing

Table a – Growth, Expenditure and Savings – Primary Care Prescribing

Factor	Best case £000's		Best guess £000's		Worst case £000's	
	Level of		Level of		Level of	
Remove under accrual impact from 2019-20	-9		-9		-9	
Buprenorphine/Buvidal	45		45		45	
Demographic impact	177		177		177	
Volume estimate movement	0		183		360	
Price impact from 2020-21 movement	-32		-32		-32	
Price impact further movement	-33		0		98	
ScriptSwitch allocation and communications	44		44		44	
Discount income	0		-4		-8	
New Medicines affecting Primary care	0		0		0	
New patent lapsing savings	-3		-3		-3	
Branded & Generic Prescribing costs savings & tariff impact	-127		-127		-127	
Further Generic savings	-9		-9		-9	
Medical devices	43		43		43	
Further Prescribing Efficiencies	-35		-35		-35	
Total Movements	62		274		544	

Table B - Overall Moray HSCP Suggested Primary Care Prescribing Budget Requirement 2021-22

Factor	Best case £000's		Best guess £000's		Worst case £000's	
Full year Budget 2020-21	**16832**		**16832**		**16832**	
Predicted Year End Out-turn 2020-21	17820		**17820**		**17820**	
Total Movements	62		**274**		**544**	
Suggested Total budget 2021-22	17882		18094		18364	
% increase on 2020-21 budget	6.2%		7.5%		9.1%	
% increase on predicted 2020-21 expenditure	0.3%		1.5%		3.1%	

Table C: Moray HSCP Community Prescribing

Sector	Full Year Budget 2020-21 £000's	Predicted Out-turn 20-21 £000's	Suggested Budget 2021-22 £000's	Uplift on 2020-21-20 Budget %	Uplift on 2020-21 Out-turn %
Moray HSCP Total	350	290	307	-12.3%	5.9%

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 25 MARCH 2021**

SUBJECT: **REVENUE BUDGET 2021/22**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1. To agree the Moray Integration Joint Board's (MIJB) revenue budget for 2021/22.

2. RECOMMENDATION

2.1. It is recommended that the MIJB:

i) note the funding allocations proposed by NHS Grampian and Moray Council, detailed at 4.5;

ii) note the underlying underspend forecast for the 2020/21 financial year in 4.6 and the financial risks detailed in 4.19;

iii) formally approve the Revenue Budget for 2021/22 as detailed at APPENDIX 1 following consideration of the risks highlighted in 4.19; and

iv) approve Directions for issue as set out at APPENDICES 2 and 3 respectively to NHS Grampian and Moray Council.

3. BACKGROUND

3.1. On 28 January 2021 following the announcement of the Scottish Government's Budget for 2021-22 by the Cabinet Secretary for Finance, the interim Director of Health Finance and Governance wrote to Health Board Chief Executives providing details of the indicative allocation through the funding settlement for Health Boards. The announcement made on 28 January 2021 highlighted the immediate priority of the budget being to support the continuing response to the pandemic. There has been no subsequent communication following the UK Government's budget on 3 March. The Scottish Government budget is a one year budget for 2021/22 only.

3.2. The letter outlined that NHS payments to Integration Authorities for delegated health functions must deliver an uplift of at least 1.5% over the 2020/21 agreed recurring budgets.

3.3. In addition and separate to Health Board funding uplifts, the health portfolio will invest a further £72.6 million to be routed through Local Authorities for investment in adult health and social care integration. This additional £72.6 million is designed to support delivery of the Living Wage, the continued implementation of the Carers Act and the uprating of free personal care. The £72.6 million was presented as being additional and not substitutional to each Local Authority's 2020/21 recurring budget for adult social care services that are delegated.

3.4. The correspondence from Scottish Government on 28 January 2021 also indicated additional Scotland-wide funding for Primary Care (£45 million, taking the Government commitment to its target of investing an additional £250 million over the term of the Parliament) and Drug Deaths (£50 million). There is also additional funding for Community Mental Health (£22.1 million), the detail and timing of this funding is not yet known but will be reported as this information becomes available.

3.5. An additional £869 million has been announced to support the ongoing response to the pandemic. The approach to allocating this funding continues to develop and is based on the regular submission of remobilisation plans.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

MIJB BUDGET

4.1 The MIJB is required to consider its budget in the context of economic uncertainty in relation to the ongoing pandemic and the impact of Brexit. It is fair to say that the impact of both these extreme circumstances cannot as yet be fully assessed.

4.2 Following the announcement of the Scottish budget, NHS Grampian and Moray Council have notified the MIJB Chief Officer and Chief Financial Officer of the funding allocation for the forthcoming financial year.

4.3 On 3 March 2021, a special meeting of Moray Council (para 5 of the draft minute refers) agreed its revenue budget for the forthcoming financial year. The Local Government settlement is for one year only but the budget was set in the context of longer term planning. The paper presented made reference to the Moray share of the additional funding that is required to be passed through from the Council to the MIJB. This equates to £1.383 million and is made available to support the continued commitment to the initiatives as set out in 3.4 above. Funding is also provided to support the full year effect of an additional care package (£0.267 million) that was approved by Moray Council on 1 December 2020 (paragraph 7 of the minute refers) and also a contribution supporting transitions from children to adult services (£0.2 million). No funding is provided to meet the costs of the 2021/22 pay award.

4.4 The NHS Grampian budget setting process is based on the principle that funding allocations to the 3 Grampian IJB's will be uplifted in line with the increase in baseline funding agreed through the Scottish Government budget

settlement, with the total to each IJB being made on the National Resource Allocation Committee (NRAC) share. The Scottish Government budget correspondence received on 28 January 2021 announced that all health boards would receive a baseline uplift of 1.5%. The 1.5% uplift is based on an assessment of the Public Sector Pay Policy published by the Scottish Government. It should be noted that this policy does not apply in the NHS which is subject to Agenda for Change (AfC). Negotiations on the AfC pay deal are continuing and Scottish Government have indicated that funding arrangements for Health Boards will be revisited in line with the outcome of the negotiations. The 1.5% uplift provides MIJB with an increased funding allocation on the recurring budget of £0.940 million. NHS Grampian presented its budget to its System Leadership Team on 22 March 2021 and will go to its Board in April.

MIJB FUNDING 2021/22

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

	£'000
NHS Grampian (recurring 2020/21)	79,070
NHS Grampian 1.5% uplift on Core	940
NHS Grampian – Set Aside Services	12,252
Moray Council - Core	44,071
Moray Council – Improvement Grants*	940
Moray Council – SG additional investment	1,383
Moray Council – Care package previously approved	267
Moray Council – Transitioning Children	200
PARTNER MIJB FUNDING 2021/22	**139,123**

* Improvement Grants includes £0.440 million which requires to be ring-fenced as it relates to council house tenants.

4.6 For the 2020/21 financial year, MIJB is forecasting a small underspend of £0.036 Million as at 31 December 2020. More recent indications are that this underspend will increase by 31 March 2021. Additionally, on 5 February 2021 notification was received from Scottish Government regarding additional Covid-19 funding that would provide cover for the under-delivery of savings. This is a welcome confirmation and will support a significant underspend in 2020/21. This will be required to be carried forward as a general reserve to support a balanced budget for 2021/22.

4.7 Also announced on 5 February 2021 was additional Covid-19 related funding for the financial year 2020/21. Confirmed funding across Scotland is £491 million and a further £40 million for the second tranche of the £112 million announced in November 2020 to support the Adult Social Care Winter Plan. A further £20 million of Community Living Change Funding is allocated to support discharge from hospital of people with complex needs, to support the return to Scotland of those placed in care in the rest of the UK and costs associated with the redesign of service provision in order to avoid future

hospitalisation and inappropriate placements. For Moray, the cumulative total of the funding outlined in this paragraph is £3.2 million. Any funding that remains unspent at the end of the 2020/21 financial year will be carried forward through earmarked reserves for future use.

HOSTED SERVICES

4.8 Within the scope of services delegated to the MIJB are hosted services. Budgets for hosted services are primarily based on NRAC. Hosted services are operated and managed on a Grampian-wide basis. Hosting arrangements mean that the one IJB within the Grampian Health Board area would host the service on behalf of all 3 IJB's. Strategic planning for the use of the hosted services is undertaken by the IJB's for their respective populations.

4.9 The 2021/22 budget for Moray's share of all hosted services is £4.407 million as detailed below.

	£'000
Hosted by Aberdeen City IJB	
Intermediate Care	838
Sexual Health Services	435
Hosted by Aberdeenshire IJB	
Marie Curie Nursing	131
Heart Failure Service	52
Continence Service	120
Diabetes MCN including Retinal Screening	184
Chronic Oedema Service	41
HMP Grampian	450
Police Forensic Examiners	283
Hosted by Moray IJB	
GMED Out of Hours	1,763
Primary Care Contracts	110
TOTAL MORAY HOSTED SERVICES	**4,407**

LARGE HOSPITAL SERVICES (SET ASIDE)

4.10 Budgets for Large Hospital Services continue to be managed on a day to day basis by the NHS Grampian Acute Sector and Mental Health Service, however the MIJB has an allocated set aside budget, designed to represent the consumption of these services by the Moray population. The MIJB has a responsibility in the joint strategic planning of these services in partnership with the Acute Sector. The table below details the areas included as part of the large hospital services.

	£'000
General Medicine	6,174
Geriatric Medicine	963
Rehabilitation Medicine	79
Respiratory Medicine	197
Palliative Care	25

A & E Inpatient	54
A & E Outpatient	4,051
Learning Disabilities	42
Psychiatry of Old Age	88
General Psychiatry	579
TOTAL SET ASIDE BUDGET	**12,252**

BUDGET PRESSURES

4.11 Budget pressures are a major consideration for the MIJB and are an intrinsic part of the budget setting process. The additional funding highlighted in the Scottish Government budget for health and social care is welcomed, however, will not address the expected budget pressures arising from contractual inflation and pay awards. There is also an expectation as we continue to re-mobilise, an element of budget pressure experienced prior to the 2020/21 financial year will return and so an estimate has been included for this. The identified cost pressures below are based on estimates and remains an ongoing consideration in financial planning. The table below outlines the anticipated budget pressure the MIJB needs to address in the forthcoming financial year:

	£'000
BUDGET PRESSURES	
Pay Inflation & Staffing	1,151
Contractual Inflation & Scottish Living Wage	1,018
Prescribing & Community Pharmacy	484
High Cost Individuals – full year effect	425
Home First Delivery – D2A	497
Children in Transition	200
Re-mobilisation Pressures	1,063
Other	75
TOTAL BUDGET PRESSURES	**4,913**

4.12 Not included in the pressures noted in 4.11 above are the anticipated inflationary costs of the National Care Home Contract. Through the previously established budget setting protocols, the Moray Council Chief Financial Officer has made a provision within the council budget and has confirmed support to the MIJB for the increase, at the time of writing the costs are still unknown.

SAVINGS PLAN

4.13 The budget setting for 2020/21 included a savings plan totalling £1.944 million. Members will note through in-year reporting that the progress falls short of the plan. Whilst the attention now needs to be turned to transformational change to support budget recovery, there is a need to continue to identify a level of efficiency. The starting point for the 2021/22 budget has been to consider what realistically could be achieved, that proved difficult to deliver in 2020/21. The Senior Management Team have considered and agreed on a small element from 2020/21. The newly identified savings have in the main arisen through accountancy scrutiny of budgets. MIJB is acutely aware of the challenges it faces surrounding both its

people and financial resources which remains a focus within its decision making. A focus on savings will be provided through reporting during 2021/22.

4.14 The table below summarises the progress made by the Health and Social Care Moray management team in identifying opportunities for efficiency. Close monitoring of progress will be considered and reported during 2021/22.

	2021/22
	£ 000's
Projected Efficiencies 2021/22	
Accountancy Driven Efficiency	150
External Commissioning	122
Increased Income from Charging	110
Transformational Change	25
Total Projected Efficiencies	**407**

4.15 Members will note that a budget pressure has been built into the table at 4.11 in respect of the Discharge to Assess project (D2A) that was a focus of the MIJB development session on 25 February 2021 and is the subject of a separate paper on this agenda. Should the decision be made to progress with the continuation of this Home First initiative, it will be necessary to identify areas of disinvestment to enable D2A to be fully embedded beyond the 2021/22 financial year. To support this process further reports will be brought before the MIJB to outline progress and provide direction on budget movements. As more Home First initiatives are progressed, this will form part of regular reporting on transformational change.

BUDGET OVERVIEW

4.16 The MIJB Revenue Budget for 2021/22 is £140.677 million (including £12.252 million Set Aside). The detail is provided in **APPENDIX 1** and summarised below:

	£'000
BUDGET	
Recurring Budget	123,485
Strategic Funds	434
Inflationary Pressure and Transformation	4,913
Savings Plan	(407)
Set Aside	12,252
TOTAL BUDGET	**140,677**
FUNDED BY	
NHS Grampian Recurring (inc Set Aside)	92,262
Moray Council (inc Improvement Grants)	46,861
Forecast Underspend & General Reserves 2020/21	1,554
TOTAL FUNDING	**140,677**

FINANCIAL OUTLOOK

4.17 Health and Social Care in Scotland continues to experience increasing demands for services in times of challenging financial settlements and the uncertainties associated with Covid-19. An additional factor that will impact on future year's budgets will be the effects of the Independent Review of Adult Social Care in Scotland report that was published in February 2021. The report can be accessed here: https://www.gov.scot/binaries/content/documents/govscot/publications/independent-report/2021/02/independent-review-adult-social-care-scotland/documents/independent-review-adult-care-scotland/independent-review-adult-care-scotland/govscot%3Adocument/independent-review-adult-care-scotland.pdf. As it becomes clearer on how the recommendations are to be taken forward, an assessment of the associated financial challenge will become part of future reporting.

4.18 The MIJB is acutely aware of the ongoing financial challenge it faces and has approved a Medium Term Financial Framework (MTFF) that supports its Strategic Plan 2019-29 (Partners in Care). During 2021/22 as the MIJB remobilises, transforms and emerges from the pandemic, there will be a need to review and update the MTFF.

FINANCIAL RISKS

4.19 The budget assumptions made within this report carry a degree of financial risk, meaning that variations that may arise will impact on financial performance. Acceptance of risk is a necessary part of the budget setting process. The main risks are summarised:

- Financial Settlement – the 2021/22 financial settlement is based on one year only and the increased level of funding does not meet the arising budget pressures from pay awards and inflationary increases. Whilst the benefits of longer-term financial planning are well documented in assisting the delivery of strategic priorities, at this stage, financial planning is subject to continuous change and there is a need to adapt to the changing landscape.

- In considering the financial requirement for the forthcoming financial year, it is necessary to take into account the financial performance of the previous financial year. In doing so, the underlying underspend forecast in 2020/21, has been factored into the 2021/22 position.

- The budget pressures identified in paragraph 4.11 are based on continued discussion and assessment and through monitoring, this process is reasonably accurate. However, the risk lies, in the main within commissioned services and the required negotiation with providers. The 2021/22 financial year will be particularly challenging as the continued support to providers is maintained through sustainability payments and supporting the remobilisation of services.

- The risk associated with Covid-19 remains in place. There is the commitment from Scottish Government to continue to support the ongoing associated costs as outlined in paragraph 4.7 which helps

mitigate this risk. Any unused funding will be held appropriately in reserves.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan 2019 – 2029, 'Partners in Care'

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

(b) Policy and Legal

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

(c) Financial implications

The 2021/22 revenue budget (excluding Set Aside) as detailed in **Appendix 1** is **£128.425 million**.

The funding allocated to the MIJB by Moray Council and NHS Grampian totals **£126.871 million** (excluding Set Aside).

The notional Set Aside budget for Moray's share of the Large Hospital Services is currently **£12.252 million**. The Set Aside budget is provided by NHS Grampian.

A balanced budget is presented based on the use of anticipated general reserves arising from 2020/21 of **£1.554 million**.

(d) Risk Implications and Mitigation

The revenue budget for 2021/22 is subject to the following risks:

- GP Prescribing – represents around 13% of the total MIJB budget. It is well documented that the Prescribing budget can be extremely volatile in nature with volume and price increases potentially leading to substantial adverse variances. A separate report on Prescribing is being presented to this meeting.

- Growth and demand in the system, together with service users with complex care needs are attracting additional financial challenge. These issues require to be managed within the overall resource of the MIJB.

- The need to transform at pace and drive forward opportunities arising through changes to working practice experienced through the pandemic. The risk being the ability to capture and embed in a timely manner.

- This report highlights the anticipated budget pressures at paragraph 4.11. It will be necessary to note that budget pressures may exceed allocation. This will be closely monitored

and reported accordingly to the MIJB as part of the budget monitoring reports.

(e) Staffing Implications

There are no staffing implications arising directly from this report.

As the MIJB continues to address the financial balance, impacts on staffing will be kept under close review and reported back to this Board as appropriate.

(f) Property

None arising directly from this report

(g) Equalities/Socio Economic Impact

None arising directly from this report as there is no change to policy. Any subsequent changes to policy arising from proposals made within this paper will be considered appropriately.

(h) Consultations

Consultations have taken place with the Senior Management Team and System Leadership Group of Health and Social Care Moray, the finance teams of both Moray Council and NHS Grampian.

6. CONCLUSION

6.1. Legislation requires the MIJB to set its Revenue Budget for the forthcoming year by 31 March each year. The budget presented displays a balanced position. The Section 95 Officer as Chief Financial Officer to the Board recommends the budget as presented at Appendix 1

6.2. Close monitoring of the continuing effects of the pandemic and the savings plan will be required in order to ensure the MIJB can remain within the funding allocation proposed by NHS Grampian and Moray Council.

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

MORAY INTEGRATION JOINT BOARD
PROPOSED REVENUE BUDGET 2021/22

		Annual Net Budget £000's 2021-22
Community Hospitals		5,334
Community Nursing		5,017
Learning Disabilities		8,030
Mental Health		8,618
Addictions		1,150
Adult Protection & Health Improvement		162
Care Services provided in-house		17,335
Older people & PSD - Assessment & Care		18,185
Intermediate Care & OT		1,628
Care Services provided by External Contractors		8,517
Other Community Services		
Allied Health Professionals		4,081
Dental		2,090
Public Health		411
Pharmacy		297
Specialist Nurses		1,054
Admin & Management		1,761
Primary Care Prescribing		16,948
Primary Care Moray		16,851
Hosted Services		4,407
Out of Area Placements		669
Improvement Grants		
General Services		500
Housing Revenue Account (Ring-fenced)		440
Total Moray IJB Core		**123,485**
Strategic Funds		434
Identified Budget Pressures		4,913
Savings Plan		(407)
Total Budget Requirement for 2021/22		**128,425**
Funded By:		
NHS Grampian		80,010
Moray Council		46,861
Forecast Underspend and General Reserve 2020/21		1,554
Total Available Budget for 2021/22		**128,425**
SET ASIDE BUDGET		**12,252**

MORAY INTEGRATION JOINT BOARD

DIRECTION

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

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

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

Services:	All services listed in Annex 1, Part 2 and Annex 4 of the Moray Health and Social Care Integration Scheme.
Functions:-	All functions listed in Annex 1, Part 1 of the Moray Health and Social Care Integration Scheme.
Associated Budget:-	£69.8 million, of which £4 million relates to Moray's share for services to be hosted and £17 million relates to primary care prescribing. An additional £12.252 million is set aside for large hospital services.

This direction is effective from 1 April 2021.

MORAY INTEGRATION JOINT BOARD

DIRECTION

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

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

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

Services:	All services listed in Annex 2, Part 2 of the Moray Health and Social Care Integration Scheme.
Functions:-	All functions listed in Annex 2, Part 1 of the Moray Health and Social Care Integration Scheme.
Associated Budget:-	£58.6 million, of which £0.4 million is ring fenced for Housing Revenue Account aids and adaptations.

This direction is effective from 1 April 2021.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 25 MARCH 2021**

SUBJECT: **DISCHARGE TO ASSESS**

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

1. REASON FOR REPORT

1.1. To inform the Board of the outcome of the Discharge to Assess (D2A) pilot project and to request D2A is embedded into the health and social care system in Moray.

2. RECOMMENDATION

2.1. It is recommended that the Moray Integration Joint Board (MIJB) agrees to scale up the D2A team and secure permanent funding in order to continue to support patients, flow and capacity within the health and social care system.

3. BACKGROUND

3.1. Operation Home First is a partnership between all three of Grampian's health and social care partnerships and Grampian's Acute Services. The shared ambition is to:

- Maintain people safely at home
- Avoid unnecessary hospital attendance or admission
- Support early discharge back home after essential specialist care

3.2. The Home First approach in Moray is being driven forward at pace. A delivery group was formed back in June 2020, Chaired by Sean Coady, Head of Service. Lead officers were identified under each of the Home First Workstreams to pull together colleagues and partners to establish and take forward improvement projects.

3.3. The workstreams are Discharge to Assess (D2A), Prevention and Self-management, Hospital at Home and Delayed Discharges.

3.4. The Moray D2A work stream was activated through the formation of a multidisciplinary, multiagency working group comprising key stakeholders from acute and health and social care which has met virtually via Microsoft teams and formed smaller working groups for specific tasks.

3.5. D2A is an intermediate care approach for hospital in-patients who are clinically stable and do not require acute hospital care but may still require rehabilitation or care services provided with short-term support.

3.6. Patients are discharged home where assessment for longer term requirements is then undertaken in the most appropriate setting i.e. the person's own home and at the right time, by a trusted assessor.

3.7. Newcastle University in partnership with ADL Smartcare Research developed a model of compressed functional decline named the Lifecurve™ which is based on evidence in literature proving there is a hierarchical order to the loss of functional ability. In short, we lose our ability to carry out everyday activities of daily living in a set order. Please see **Appendix 1**. It was hypothesised that a D2A therapy-led approach would offer an opportunity to maintain patients on their Lifecurve and prevent care requirements sooner than necessary.

3.8. The working group identified 12 in-patients whom they considered would have benefitted from a D2A approach. These patients' journeys were mapped in detail and common characteristics were identified which led to the formulation of criteria for Moray D2A. On full analysis of the data for these 12 patients, the group were also able to formulate the process of how and where people could enter the D2A model and key professionals required at each of these stages.

3.9. A D2A pilot was then carried out with 6 patients. The purpose of this pilot was to test criteria, process and measurments.

3.10. As a result of the success of the pilot, temporary funding was identified and allocated to D2A through winter planning to support a 6-month test of change project from 5 October 2020 to 31 March 2021. The full report of this pilot is attached at **Appendix 2.**

4. KEY MATTERS RELEVANT TO RECOMMENDATION

D2A Pilot Project

4.1. From 5 October 2020 to 17 February 2021 (19 weeks) **48 patients** were assessed by the D2A Team.

- **29** (60%) were female and **19** (40%) male, with an average age **84 years** with the eldest being 96 years and the youngest being 64 years.
- **46** of 48 of patients were referred from Dr Grays Hospital with the majority (17 or 35%) referred from Ward 7 – almost all geriatric medicine.

Avoiding Unnecessary Admission and Early Supported Discharge

4.2. **Forty** in-patients were referred to D2A. For these patients and average length of stay was **8 days**. An average length of stay for a geriatric medicine and orthopaedic trauma admission and discharge from Dr Gray's Hospital is **9 days**. This is a saving of 40 bed days.

4.3. **8** (17%) of the 48 patients were referred from the Emergency Department at Dr Gray's Hospital and discharged straight home with D2A. Preventing admission of these patients saved 72 bed days at a cost of £41,040.

Whole System Flow & Capacity

4.4 As part of the pilot all anticipated journeys, based upon functional abilities (in the absence of D2A) were mapped.

- **1/3** of D2A patients would have been referred for assessment for care directly from DGH.
- **2/3** of D2A patients would have been transferred to a Moray Community Hospital for longer rehabilitation or assessment for care.

4.5 Average length of stay for a community hospital in Moray for 2020 was 38 days. D2A has reduced the amount of patients transferred to a Moray Community Hospital by supporting a Home First approach. Lower readmission rates were also recorded.

Outcomes

4.6 The Canadian Occupational Performance Measure was used by Occupational Therapist with patients for patients to self-rate their functional status

- **81%** of patients rated their performance had improved with D2A input
- **88%** of patients rated their satisfaction with their functional performance had improved

4.7 The Barthel Functional Index scoring showed an increase in functional performance in **91%** of patients.

4.8 The Tinetti Assessment Tool and Elderly Mobility Scale (EMS) are used by physiotherapists to show outcomes of treatment with mobility, gait and balance.

- **100%** of D2A patients assessed using Tinetti saw an increase in their scores showing an improvement in their gait, balance and mobility and reducing their risk of falls.
- **100%** of D2A patients assessed using EMS saw an increase in their scores showing an improvement in their mobility.

Onward Referrals

4.9 D2A takes a blended approached with joint working across the health and social care partnership. The D2A Team were able to work with some patients alongside input from the Community Response Team (CRT) for individuals particularly living in rural areas (Speyside & Forres) where there was a presence of the CRT members and they were able to supplement the D2A input.

4.10 There has also been a blended approach with Forres patients with the Forres Neighbourhood Care Team (FNCT) particularly at the weekend when D2A resource was stretched across Moray geographicaly.

- Just **5** of the 48 patients were referred to Short Term Assessment and Reablement Team (START). One of these patients was discharged from START after a short period of frther enablement.
- **10** of the 48 patients have required referral to Community Physiotherapy for ongoing mobility, outdoor mobility, gait and balance issues.
- **4** of the 48 patients have been referred to the Access Team – 3 for adaptations to their bathrooms and one for a carer assessment of his needs.

- **One** patient has been referred onto Community Rehabilitation Occupational Therapy.

Patient and Family Feedback

4.11 All patients and their carers who were interviewed as part of the pilot project stated they were 'highly satisfied'.

4.12 Recognition was given to a reduction in their anxieties around discharge from hospital and recognition of an improvement in the patient's ablity to engage in activities of daily living as a result of targeted therapy intervention.

4.13 Carers commented on perceptions of the requirement for care being dispelled as a result of targeted therapy interventions and person centred functional assessment.

Summary

4.14 Targeted therapy input leads to improved patient functional outcomes and therefore reduced requirement for care for those patients.

4.15 Intevention early in a patient's journey with a targeted functional approach results in patients remaining independent after a hospital admission / attendance supporting their health and wellbeing.

4.16 D2A evidences early supported discharge from hospital, prevention of admission to hospital & reduced readmission rates in Moray and therefore has an impact on the whole health & social care system and is cost effective.

4.17 Additional and permanent funding will enable the recruitment of a robust team that will have the ability to expand the work significantly across Moray.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

Primary strategic drivers for D2A in Moray are set out in the Strategic Plan 2019-2029, Living Longer Living Better in Moray Plan 2013-2023, the Active and Independent Living Programme for AHPs and the 6EA programme, as well as the Operation Home First agenda.

(b) Policy and Legal

D2A is a work stream under Homefirst aligned to the Strategic direction in Moray within Partners in Care.

(c) Financial implications

The table below details the annual funding required to operate D2A on an ongoing basis. The 2021/22 Revenue Budget paper is also subject of a report on today's agenda. The costs associated with D2A for the 2021/22 financial year have been built into the budget as an area of pressure. The Chief Financial Officer has been clear that it will be necessary to identify areas of disinvestment and to engage in wider conversations around the set aside budget to enable D2A to be fully embedded beyond the 2021/22 financial year. Progress reports on transformational change are suggested.

Band	FYR Costing Top	Number Required	Total Cost
Band 7 Occupational Therapists – Team Leads & Governance	£60,987	1.5	£91,481
Band 7 ANP	£60,987	1	£60,987
Band 6 Occupational Therapist	£51,744	1	£51,744
Band 6 Physiotherapist	£51,744	1	£51,744
Band 6 Nurse	£51,744	0.6	£31,046
3 - Generic Support Workers (OT & PT competencies)	£29,334	6	£176,004
Band 3 – Administration Support	£29,334	1	£29,334
Mileage Costings based on projections from project			£5,000
Total yearly costs			**£497,340**

(d) Risk Implications and Mitigation

The project completes end of March. D2A underpins other transformations under Homefirst and has evidenced benefit to shift the balance of care out of hospitals and into the community. If we do not proceed to take D2A forward on a permanent basis into full implementation then we will not realise the change we need to make.

(e) Staffing Implications

Scaling up of the D2A team would require Occupational Therapy Leadership, Physiotherapy input, generic Occupational Therapy and Physiotherapy support workers. ANP input for comprehensive geriatric assessment is also required and administration support.

(f) Property

There are no property implications.

(g) Equalities/Socio Economic Impact

An Equalities Impact Assessment is not required because there are no service, policy or organisational changes being proposed.

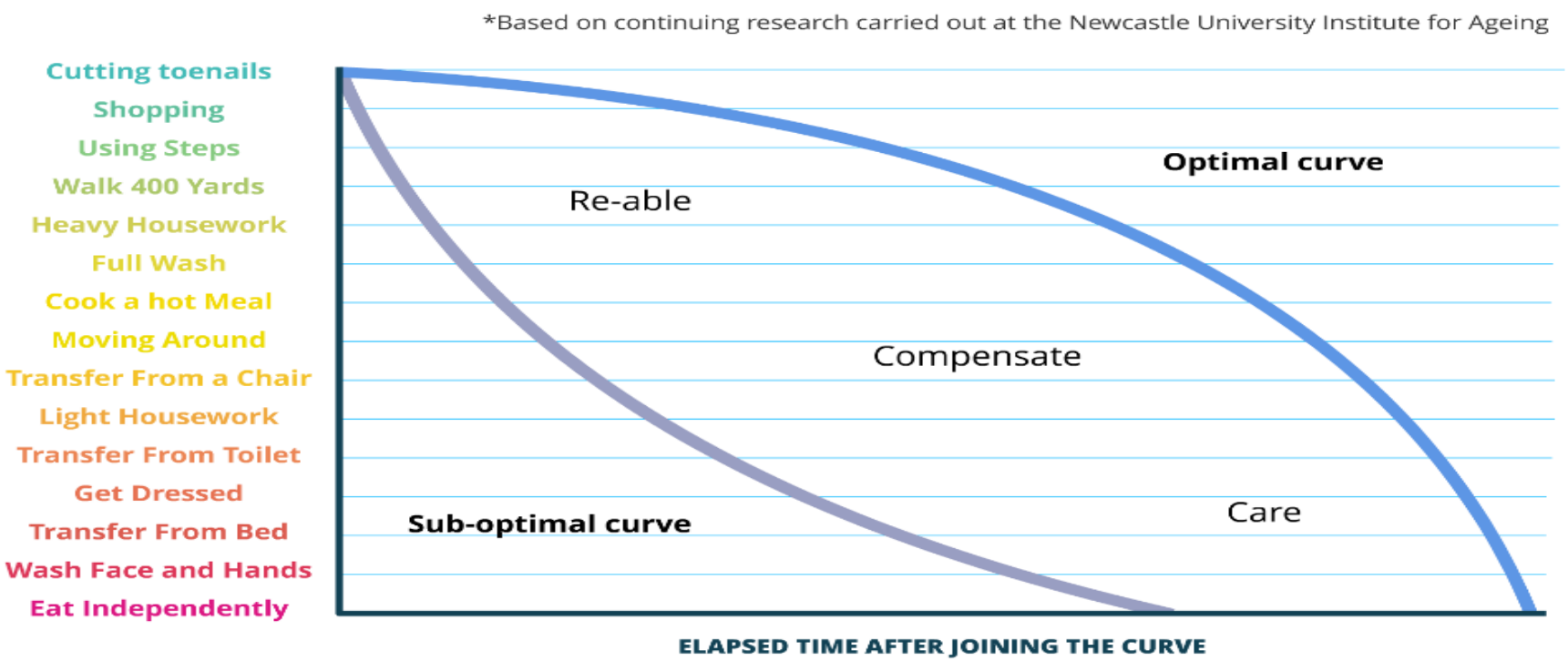
(h) Consultations

Consultation on this report has taken place with the HSCM Senior Management Team and Home First Delivery Group (Moray).

6. CONCLUSION

6.1. D2A requires to be permanently funded in its entirety in order to continue to support patients and to continue to contribute to flow and capacity within the health and social care system in Moray.

Author of Report: Dawn Duncan, Professional Lead for OT – Moray
Background Papers: **Appendix 2**
Ref:


*Based on continuing research carried out at the Newcastle University Institute for Ageing
Cutting toenails
Shopping
Using Steps
Walk 400 Yards
Heavy Housework
Full Wash
Cook a hot Meal
Moving Around
Transfer From a Chair
Light Housework
Transfer From Toilet
Get Dressed
Transfer From Bed
Wash Face and Hands
Eat Independently
Optimal curve
Re-able
Compensate
Care
Sub-optimal curve
ELAPSED TIME AFTER JOINING THE CURVE

DISCHARGE TO ASSESS (D2A)

Supporting Operation Home First for Moray

A report of findings from the D2A Project to date

Dawn Duncan (NHS Grampian)
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February 2021

Executive Summary

- 48 patients seen by D2A Team – 40 inpatients and 8 redirected from Emergency Department
- Saved an estimated 112 acute bed days through supported early discharge and admission avoidance
- 32 patients directed away from community hospital resulting in an estimated saving of 1,216 bed days
- Just 5 patients required onward referral to START, one of whom was discharged from START following reablement, demonstrating a reduction in the requirement for care following a D2A intervention
- 81% - 91% of patients saw improvement in Occupational Therapy standard assessment scores (Barthel and COPM)
- All patients saw improvement in standard Physiotherapy standard assessment scores (Tinetti and EMS)
- Patients and carers provided very positive feedback for their experience of D2A
- Fully supported by Senior Management & Clinicians in Dr Gray's Hospital
- High degree of interest in Moray D2A from across Grampian and Scotland

Discharge to Assess – Home First for Moray

Background

Operation Home First is a phase of the Grampian-wide health and social care response to "living with COVID-19" phase of the pandemic. The Moray Home First Delivery Group met for the first time at the end of June 2020. The 3 key ambitions of Operation Home First for Moray are:

1. To maintain people safely at home
2. To avoid unnecessary hospital attendance or admission
3. To support early discharge back home after essential specialist care.

The agreed principles for Home First are:

- "Home First" for all interventions
- Agreed strategic direction set out by the Integrated Joint Boards (IJBs) and NHS Grampian
- Focus on outcomes for people
- Whole system working and improving primary/secondary care joint working
- Maintain agile thinking and decision making
- Retain flexibility to respond to surge (COVID/winter)
- Work without constraints of segregation
- Maximise digital solutions

Discharge to Assess (D2A) Work Stream

Prior to the COVID-19 pandemic, D2A was identified through the 6 Essential Actions Programme for Unscheduled Care (6EA) as a vehicle for patients to be discharged from Dr Grays Hospital (DGH) in a safe and timely way and for their functional needs to be assessed in the most appropriate setting. It was recognised that extra or alternative resource would be required for this.

The Moray D2A work stream was activated through the formation of a multidisciplinary, multiagency working group comprising key stakeholders from acute and health and social care which has met virtually via Microsoft teams and formed smaller working groups for specific tasks.

Occupational Therapy had explored established D2A Team models across the UK through the 6EA framework and provided a definition and key principles of D2A as well as the requirement to establish a therapy–led model with senior medical decision making at point of discharge.

Definition of D2A

D2A is an intermediate, early supported discharge approach where hospital in-patients who are clinically stable and do not require acute hospital care but may still require rehabilitation or care services provided with short term support, are discharged to their own home where assessment for longer term requirements is then undertaken in the most appropriate setting i.e. the person's own home and at the right time by a trusted assessor.

Principles of D2A

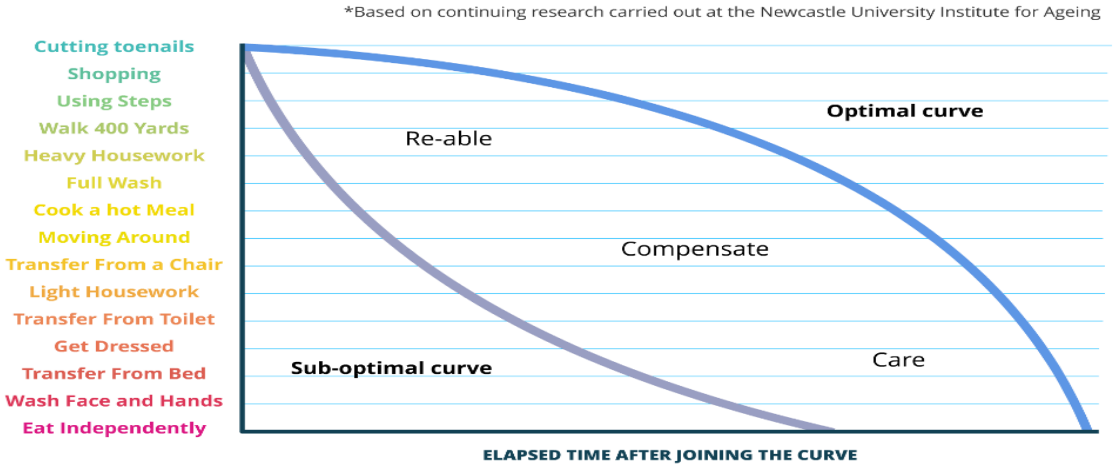
- Essential criteria
- Patient focused care
- Easy & rapid access to services
- Effective assessment
- Easy information flow
- Networks of blended care
- Blurred boundaries
- Continuous evaluation & feedback

Moray Model for D2A

- Moray lacked intermediate care options and an appetite for positive risk taking for patients – patients were placed on a journey for care as there were no other options available to robustly support discharge. This meant that patients often waited in hospital longer than was necessary.
- D2A Moray is for in-patients who have not, cannot or should not be fully functionally assessed by Allied Health Professional (AHPs) in the hospital environment but can be supported to be assessed at home in a risk-assessed timely way.
- D2A is led by AHPs in the community once the person is deemed medically stable for discharge.
- D2A is reliant upon quick and easy access to AHPs and rehabilitation Support Workers with Occupational Therapy and Physiotherapy competencies.
- D2A in Moray also offers the input of an Advanced Nurse Practitioner (ANP) for Geriatrics to complete Comprehensive Geriatric Assessment.
-

D2A and the Lifecurve™

Newcastle University in partnership with ADL Smartcare Research developed a model of compressed functional decline named the Lifecurve™ which is based on evidence in literature proving there is a hierarchical order to the loss of functional ability. In short, we lose our ability to carry out everyday activities of daily living in a set order.



The Lifecurve™ model means that if we know which activity a person cannot currently perform independently we have advanced knowledge of what their next challenge will be and allows us to target rehabilitative interventions earlier in the individual's Lifecurve™. This assists patients in self-managing their condition and associated functional difficulties more effectively and reduce their dependency upon care services in the longer term. If we provide care too early in a patient's Lifecurve™ they become more dependent quicker on that care and less functionally able.

In 2017, all Allied Health professional (AHPs) across Scotland completed the Lifecurve™ Survey with their patients for a set period as part of the Active and Independent Living Programme (AILP).
The aim of the survey was to establish where people were on their Lifecurve™ when receiving AHP services and the results showed that AHPs require to intervene higher or quicker in a patient's Lifecurve™ in order to influence their trajectory. We also need to understand the cost of the consequence of intervening "late" in the trajectory.
The recommendations of the survey were the promotion of discussion around prevention of functional decline and supporting innovation for delivery of earlier intervention and the subsequent improvements in health and wellbeing as a result.
It was hypothesised that a D2A therapy-led approach would offer an opportunity to maintain patients on their Lifecurve™ and prevent care requirements sooner than necessary.

Drivers for D2A

Primary strategic drivers for D2A in Moray are the Moray Partners in Care Strategic Plan 2019-2029, Living Longer Living Better in Moray Plan 2013-2023, the Active and Independent Living Programme for AHPs and the 6EA programme, as well as the Operation Home First agenda.

- Research shows attendances at Emergency Departments (ED) by the elderly are often an indication of increasing frailty and a decline in function in the 6 months preceding a crisis which culminates in ED attendance.
- Research has also shown that prolonged unnecessary hospital admissions cause harm to individuals resulting in deconditioning, harm from exposure to hospital acquired infections, falls, confusion and many people never returning home.
- The health outcomes of people improve quicker and more effectively if those individuals are assessed and managed at home.
- It is for these reasons the D2A Working Group consider multidisciplinary Comprehensive Geriatric Assessment (CGA) to be an important element of the identification and management of frailty factors in this population as part of the Moray model.

D2A Mapping – July 2020

- The working group identified 12 in-patients whom they considered would have benefitted from a D2A approach.
- These patients' journeys were mapped in detail and common characteristics were identified which led to the formulation of criteria for Moray D2A – **See Appendix One**.

- It was agreed by the working group that short term support would be up to 2 working weeks with flexibility to increase this period should patient need deem it necessary.
- It was agreed by the working group that with analysis of D2A teams across Scotland, the mapping of these 12 patient journeys and the Lifecurve™ Survey that rehabilitation as opposed to care was what was required and would therefore be the primary focus of the D2A Team in Moray.
- On full analysis of the data for these 12 patients, the group were also able to formulate the process of how and where people could enter the D2A model and key professionals required at each of these stages – **see Appendix Two**

D2A Pilot – July/August 2020

A D2A pilot was then carried out with 6 patients – 2 of which attended the Emergency Department at Dr Grays Hospital and 4 were in-patients. The purpose of this pilot was to test criteria, process and measurements.

Measurements considered:

- Personal functional outcomes based on AHP assessment at hospital attendance or admission and at the end of D2A intervention
- Qualitative patient evaluation and feedback of their D2A journey
- To consider anticipated patient journeys (Delayed discharges)
- Transfers to Community Hospitals
- Admission prevention from ED into DGH
- Length of stay for those patients who experience D2A compared with what their projected journeys may have been
- Readmission rate to DGH for those patients who experience D2A

This pilot highlighted the following:

- **Staffing** – it was clear Occupational Therapy was central to all referrals for D2A. Physiotherapy input was not required for all patients. Senior medical review was necessary to confirm and document each patient medically stable for discharge. The intervention of a Consultant Geriatrician sped up the process of identifying appropriate patients for D2A intervention. Follow up for some individuals by an Advanced Nurse Practitioner (ANP) for Geriatrics provided Comprehensive Geriatric Assessment within the person's own home which addressed decompensating frailty syndrome, added to the quality of the discharge process for that individual and established links with Primary Care.
  It was clear a 7 day D2A service was required.

- **Measurement** – the Canadian Occupational Performance Measure (COPM) is a person-centred and person-rated individualised tool for establishing a person's functional goals and outcomes. COPM requires the person to prioritise their functional goals and occupations and rate their performance and satisfaction with

their performance at the start and end of therapy intervention. COPM and the Barthel Index were piloted with the 6 people in the test of change. Physiotherapy used the Tinetti Assessment Tool and the Elderly Mobility Scale as outcome measures for those people who were appropriate although functional mobility was usually also measured via COPM. The test group were also issued with a satisfaction form to complete by mail.

- **Process** – the pilot clarified the D2A process of referral, assessment, review and also referral onto other agencies. The criteria was proven to be appropriate and through a D2A process patients were less likely to require care.

- **Outcomes** – feedback from our 6 people showed that they benefited and appreciated the input of D2A – individuals perceived an improvement with their performance in functional tasks and also an improvement in their satisfaction with that performance of functional tasks, their anxiety on discharge was dissipated, their individual needs were identified and dealt with through a Making Every Opportunity Count (MEoC) approach and they felt listened to and supported.

  An SBAR report detailed the success and opportunities D2A, if resourced, could play in the achievement of the key ambitions of Operation Home First for Moray but in particular the key ambition of early supported discharge back home after essential specialist care. Estimated costings for a permanent service were provided for staffing, travel and equipment costs.

As a result of the success of the pilot for D2A funds were allocated to run a 6-month project from 5th Oct 2020 to 31st March 2021.

D2A Project – 5th Oct to 31st March 2021

- **Funding** – was identified from 5th Oct 2020 to 31st March 2021 to run a 6-month project to fully test D2A.
- **Staffing –** the timeframe meant that recruitment was not an option. It was clear that full-time leadership was required therefore secondments were offered to Occupational Therapy staff to provide operational management of the project as well as clinical input and also a development opportunity for those staff members. One WTE Occupational Therapist (2 staff members) were seconded with backfill for their substantive posts.
  The Physiotherapy Service was carrying a number of vacancies at the beginning of the project and could offer 4 extra hours to support D2A. However, as recruitment has taken place, 2 days per week for Physiotherapy have been allocated since mid-Dec.
  Generic Occupational Therapy/Physiotherapy Support Workers on the Moray Bank were offered the opportunity for extra hours to support D2A and there was a healthy response. Two Support Workers from The Oaks were offered secondments for the duration of the project to D2A. This was advantageous to both parties in that D2A had Support Worker input of minimum 43.5 hours per week and also an opportunity

for those staff members to expand their competencies for their return to their substantive roles.
The Consultant Geriatrician left at the end of Oct 2020 and a temporary seconded Consultant Geriatrician is in post for 6 months. The ANP for Geriatrics was to continue to provide input to D2A where possible and when required.
Measurement and monitoring support from Quality Improvement, Public Health and Health Intelligence was also made available.

- **Equipment –** laptops and SMART phones were purchased and have been pivotal to the real-time gathering and recording of data and communication.
Diagnostic and monitoring equipment has been purchased – a bladder scanner, thermometers, a blood pressure monitor and an ECG machine is on order.

D2A Project – The Story So Far

From 5th Oct 2020 to 17th Feb (19 weeks) **48 patients** have been assessed by the D2A Team. **29** (60%) were female and **19** (40%) male.

The average age of people referred was **84 years** with the eldest being 96 years and the youngest being 64 years.

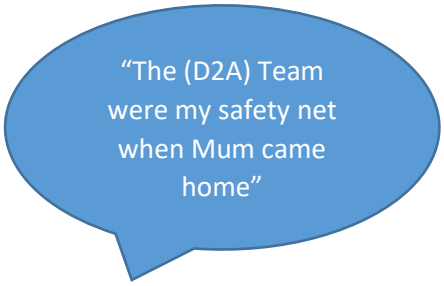
All bar two of the patients were referred from Dr Grays Hospital with the majority (17 or 35%) referred from Ward 7 under the specialism of geriatric medicine.

8 (22%) of the 48 patients were referred from the Emergency Department at Dr Grays Hospital, preventing unnecessary admission. One of these patients was referred out of hours and assessed the following day at home.

Each individual has been assessed in their own home. The geographical spread of patients is all over Moray from Forres in the West to Cullen in the East, Dufftown in the South and Lossiemouth in the North.

12 (29%) of the 41 people assessed were from Elgin, 9 (23%) from Forres and 4 (10%) from Buckie and Lossiemouth respectively.

Please refer to appendices for Case Studies



Outcomes

Canadian Occupational Performance Measure

The Canadian Occupational Performance Measure (COPM) is a person-centred and person-rated individualised tool administered by Occupational Therapists for establishing a person's functional goals and outcomes. COPM requires the person to prioritise their functional goals and occupations and rate their performance and satisfaction with their performance out of 10 at the start and end of therapy intervention. COPM is used with patients with multiple and complex goals.

- **26** (81%) of the 32 patients using COPM rated their performance in activities of daily living (ADL) as **improved**
- **6** rated their performance in ADL had been **maintained**
- **28** (88%) of the 32 patients rated their satisfaction with their performance in ADL had **improved**
- **4** rated their satisfaction with their performance in ADL had been **maintained**
- Evidence of functional improvement and/or maintenance of ADL as perceived by our patients

81% of patients rated their performance in activities of daily living as improved
88% of patients rated their satisfaction with their performance in activities of daily living as improved

The Barthel Index

The Barthel Index is one of earliest standardised functional assessments and is an ordinal scale used to measure performance in activities of daily living (ADL) in the domains of personal care and mobility in patients with chronic, disabling conditions especially in rehabilitation settings.
Domains assessed include toileting, transfers, bathing eating, dressing, continence and mobility. Patients receive numerical scores based on whether they require physical assistance to perform the task or can complete it independently.

Functional tasks are assessed and scored at first and last assessment and scored out of a total of 100. Scores are weighted according to the functional assessment and professional judgement of the therapist. A score of 0 would represent a patient dependent in all assessed activities of daily living, whereas a score of 100 would reflect independence in these activities,

91% of patients have shown an **increase in their scoring**.
The average patient score at first assessment was **79** and the average patient score at final assessment was **94**. This shows an increase in independence in activities of daily living in those patients assessed using the Barthel Index.

"The (D2A) girls were great – they motivated Dad and showed him he was able to do more and it took the pressure off me"

Tinetti Assessment Tool

The Tinetti Assessment Tool is a simple, easily administered test used by Physiotherapists to measure a person's gait and balance. The test is scored on a person's ability to perform specific tasks and can give an indication of that person's risk of falls.

Where the Tinetti Assessment Tool was administered with D2A patients – all patients had an increase in their scores indicating an improvement in their gait and balance and a reduction in their risk of falls.

Elderly Mobility Scale

The Elderly Mobility Scale (EMS) is a 20-point validated assessment tool for the assessment of frail elderly individuals. The EMS is measured on an ordinal scale.

Where Physiotherapists used the EMS as an outcome measure, all D2A patients showed an improvement in their mobility.

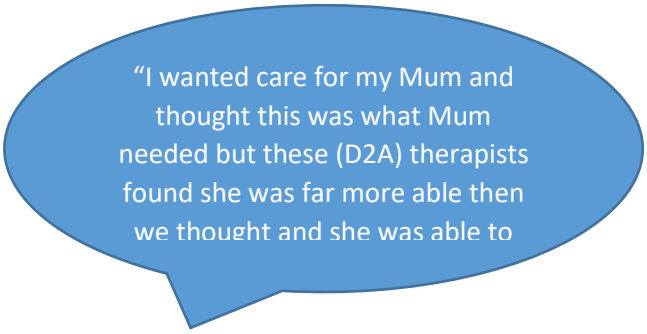
Please note patients' functional mobility was also measured using the Barthel Index and COPM.

"I'd give them a medal, a very hard job [dealing with people like me]. I don't even like old people!"

Patient Outcomes – Onward Referrals

The primary aim of the D2A project was to provide effective intermediate support for early supported discharge based upon therapy input. We know that patients wait longer in hospital if they are awaiting care.

Of those 48 patients assessed thus far, 5 patients have required referral for ongoing care from START (Short Term Assessment Reablement Team) and one of these patients was discharged from START within 2 weeks. This shows that the premise of D2A as a functional therapy-led assessment programme for early supported discharge works.



Of those 48 patients assessed thus far, 4 have required referral to the Access Team – 3 of which were referred to Community Occupational Therapy for adaptations to their bathrooms (bath to shower or level access showers) and one to Social Work for a carers assessment where the patient's son required support himself.

Ten patients have been referred on to the Community Physiotherapy service (Glassgreen Therapy Team) for ongoing mobility, outdoor mobility, gait, strength and balance issues. One patient was referred on to the Glassgreen Therapy Team for ongoing Occupational Therapy rehabilitation.

The majority of patients were issued with the Moray Occupational Therapy Falls Bundle which details how individuals can prevent falls through a self-administered assessment and the provision of self-management information and supported by practical activities.

The D2A Team used a Making Every Opportunity Count (MEOC) approach with all patients and this included signposting to local community and national resources to assist those patients to live as full and independent a life as possible at home.

D2A has proven that therapy-led services, when they can intervene early on a patient's Lifecurve™ after a decline in function which necessitates a hospital admission/attendance, can maintain and improve patient's functional abilities rather than compensate for their functional problems with care.

"This (D2A) team is a great idea – when Dad had been discharged previously we were just left to get on with it"

Advanced Nurse Practitioner Role and Input to D2A

Eleven D2A patients have been reviewed by the Advanced Nurse practitioner (ANP).

Actions and benefits identified by the ANP as a result of those reviews were:

- Comprehensive Geriatric Assessment of frail elderly individuals in their own home.
- Patients perform better in their own familiar environment with improved longer term outcomes.
- Prevented unnecessary lengthy hospital admissions which lead to deconditioning in the elderly – patients were deemed medically stable for discharge but medically optimised at home.
- Actions for GPs including referrals to other specialities
- Medication reviews which identified poor compliance in patients with medication at home as a result of problems with physical dexterity accessing medication and cognitive issues. The prescribing of appropriate medication regimes reduces the risk of harm to the patient through reducing the falls risk and if the medication is of no clinical benefit. Waste is reduced.
- Examinations, monitoring and diagnostics leading clinical decision making – this was expedited through access to equipment (bladder scanner, thermometers, blood pressure monitors etc.) and support workers to carry this out
- Patient ownership and more control of their health at home under a patient centred model rather than a medical model.

"Lovely [K] showed me how to boil potatoes without lifting the pan. It was practical but really useful ways of doing things"

Blended Approach

The D2A Team were able to work with some patients alongside input from the Community Response Team (CRT) for individuals particularly living in rural areas (Speyside & Forres) where there was a presence of the CRT members and they were able to supplement the D2A input.
There has also been a blended approach with Forres patients with the Forres Neighbourhood Care Team (FNCT) particularly at a weekend when D2A resource was stretched across Moray geographically.
A blended approach when working alongside families has also been of great importance and the support of families for the ethos of D2A is vital.

All of these examples of joint working have concerned all parties working with the patient to the same clearly documented rehabilitation goals identified by a trusted assessor from the D2A Team

Patient/Carer/Family Feedback

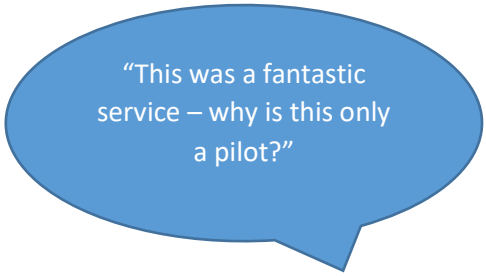
Patient and carer feedback has been pivotal to providing a person-centred D2A service. Semi-structured telephone interviews have been completed by Public Health colleagues to ensure objectivity and quotes from these interviews are included throughout this report. Evaluation is ongoing.

All patients and their carers interviewed have been **highly satisfied** with the intervention of the D2A Team on their discharge from hospital and their discharge from the D2A Team.

Patients recognised a **reduction in their anxieties** around discharge from hospital following a period of illness and their carers supported this view in their feedback.

Both patients and carers recognised and reported on an **improvement in the patient's ability to engage in activities of daily living** as a result of targeted therapy intervention.

Carers commented on **perceptions of the requirement for care being dispelled** as a result of targeted therapy interventions and person centred functional assessment. Evidence of **positive risk taking** as a result of robust functional assessment has emerged.



Impact of D2A on Flow & Capacity

Prevention of Inappropriate Admission to Hospital

Eight of the 48 patients were referred and assessed at home directly from attendance at the Emergency Department at Dr Grays Hospital thus preventing unnecessary admission to hospital.

The Occupational Therapist in the Emergency Department at Dr Grays Hospital is able to swiftly identify those patients appropriate for D2A and ensure these patients are then assessed at home by a trusted assessor. The D2A Team and ANP are actively screening patients over 85 years of age attending the Emergency Department at Dr Grays Hospital.

The average general medical & orthopaedic trauma hospital admission for Dr Grays Hospital is 9 days therefore we can extrapolate that by discharging these 8 patients directly from the front door, D2A prevented an unnecessary patient admission and saved 72 bed days in the system with the associated costs of £41,040.

Reducing Length of Hospital Stay

The advantages of reducing hospital unnecessary length of stay have already been explored and we know this is beneficial to the patient in a number of ways.

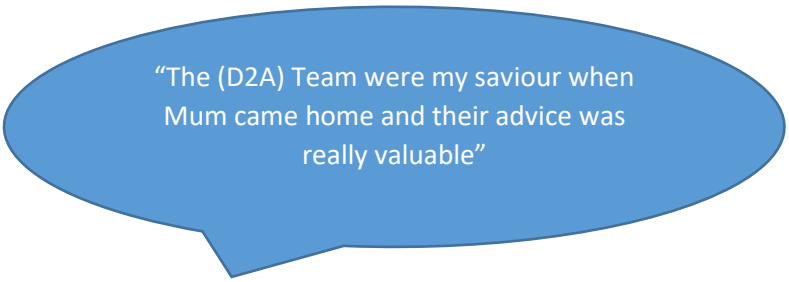
The average length of stay for a patient admitted to Dr Grays Hospital under the specialism of geriatric medicine or orthopaedic trauma from 2019 to 2020 was 9 days.
The average length of stay for a D2A patient was **8 days**.
A cost saving of one bed day per each in-patient seen for D2A amounts to 40 beds day at a saving of **£18,810**.
We know with greater capacity in the D2A Team this number would increase.
Within the 19 weeks of this pilot thus far, it is estimated a total of **112 acute beds days were saved.**

All of the patients assessed by D2A have had their anticipated journeys mapped (in the absence of D2A).

32 (2/3) of the patients assessed by D2A would have been transferred to a Moray Community Hospital for slower stream rehabilitation and/or for assessment for care. The average length of stay in Moray Community Hospital for 2019/20 was **38 days**. Estimated D2A **1,216** bed days.
1/3 of patients would have been directly referred for assessment for care from Dr Grays Hospital.

In providing early supported discharge through D2A there has been a **decrease in the number of patients transferred to a Moray Community Hospital.** There has seen an improvement in efficacy in the team decision making regarding the transferring of patients to a Moray Community Hospital and a contribution to flow mechanisms in the system.

Readmission rate for D2A patients was lower at both 7 days and 28 days – **7.3 %** at 7days compared with average rate of 9.91% and **15%** at 28 days compared with 19% for medical patients



Reducing the Requirement for Care Packages

Only five of 48 patients assessed by D2A required onward referral to START and one of these patients was discharged from START after a short period of further enablement.

D2A reduces risk adversity in the system by providing an intermediate support service with agility to discharge patients early with person-centred targeted interventions identified with the patient by a trusted assessor. In mapping all D2A patients' anticipated journeys it is projected that almost all of these patients would have either experienced longer stays in hospital or would have been referred for assessment for care and potentially START either whilst in Dr Grays Hospital or most certainly whilst in a Community Hospital.

The D2A Team with ANP are also screening patients over 85 who attend the Emergency Department to ensure we are capturing any frailty issues in those patients, anticipating patient need and attempting to prevent unnecessary referrals for care.

Key Stakeholder Feedback

The staff groups were canvassed for their feedback on the D2A project. Key themes emerging were:

Benefits to the patient

- "Rapid comprehensive assessment of patients at home"
- "Home is the best environment to assess patients"
- Improved patient outcomes – feedback post D2A input to inpatient teams has shown a positive difference in patients at home in comparison with perceived abilities on discharge
- Reduced length of stay and therefore reduced deconditioning of patients – described as discharge when patients are "medically stable"
- Patients not having to wait unnecessarily for care because this was the only option for follow up at home
- Facilitating positive risk taking
- Joint working of the MDT

- A “safety net” of trusting your colleagues to pick up patients quickly and comprehensively at home
- Reducing patient and carer anxiety about discharge – a “seamless transition from hospital to home”
- An increased understanding of the role of the D2A as the project has gone on leading to earlier appropriate referral

Benefits to the MDT & the System

- Improving and development of skills and knowledge in the D2A Team
- Early supported discharge and subsequent reduced length of stay
- Improved flow and capacity in the system
- Reduction in unnecessary admissions
- Increased staff competencies
- Wider and more effective discharge planning and communication within the MDT
- Support Worker have reported they have felt well-supported, valued and listened to by both qualified staff in the D2A team and by the patients and their families
- Support Workers have reported that in working more generically they have felt of greater value to D2A patients at home as their work was function not task based

Challenges Identified as a result of the D2A Project & Future Considerations

- Staff education and understanding of the principles of Home First and D2A
- Risk adversity in a number of professionals
- Organising the logistics of morning discharges to support early assessment by D2A that afternoon
- D2A Team capacity – this is a project and capacity of the team has limited capacity of the amount of patients who can be accepted onto the caseload
- Input from Occupational Therapy and Physiotherapy into D2A has been dependent upon their being capacity within the existing teams in Moray and Bank staff. At the beginning of the project the Physiotherapy service was carrying a number of vacancies and therefore able to provide limited input to the project. From mid-December 2 days of Physiotherapy has been released for D2A.
- Rurality of patients spread across Moray made capacity and rota planning difficult when having to be in two spaces for example, for self-care in the early morning at opposite ends of Moray.
- The rurality of the pan-Moray caseload has seen mileage costs attached to the D2A project. The Occupational Therapy pool cars based at Dr Grays Hospital have been used for the majority of visits but visits have also been planned logistically to fit where staff live to enable staff to visit patients at the beginning and end of the day where realistic to reduce unnecessary travel and mileage costs
- There has been a risk to the project as a result of staffing as Generic Support Workers have been offered extra hours on a voluntary basis to provide shifts for D2A. If these staff had felt unable to provide this input and had withdrawn capacity would

have dwindled for the team to be able to safely provide early supported discharge in a timely way.

- Lone working as with many community based services. Every staff member was issued with a mobile phone, Smart phone or laptop and a "Buddy System" is in operation.

Feedback from the Moray Community Hospitals Stakeholders

- More appropriate patients are being transferred to Community Hospitals i.e. those patients with complex rehabilitation and discharge arrangements.
- Less inappropriate patients coming to a Community Hospital to await smaller packages of care – these are being discharged from Dr Grays Hospital with D2A.
- Keen for D2A to be in place post-COVID when Moray Community Hospitals can admit directly from the community as these patients would be appropriate for D2A and be able to be turned around quicker.

"Thank you for sharing the preliminary results of your Discharge to Assess project at the Moray Community Hospital Directors meeting today. We are aware that you have been preventing admissions at Dr Grays or pulling them from the wards and preventing transfer to community hospital.
We all see the sense of this and would unanimously agree that it as a project as part of Home First which is producing results and is taking significant pressure off the wards as well as care system, and as such would strongly support that this work is continued to be funded and becomes mainstream." Ewen Riddick, Community Hospital Director, Seafield Hospital.

D2A – Spreading the Word

There has been a high degree of interest across NHS Grampian in Moray's D2A project. The work stream lead has presented to Aberdeenshire Health & Social Care Partnership and has provided information to Acute and City colleagues regarding the Moray model.

A video has been produced with NHSG Corporate Communications which is currently being edited.

The D2A Team have presented to a number of forums in Dr Grays Hospital including the Clinical Forum, Senior Staff Committee and Senior Charge Nurses forum.

We have also presented to the IJB and provided a virtual staff engagement session in December 2020.

We have also produced a patient, carer and staff booklet which explains the ethos and process of D2A

Summary & Recommendations

- Feedback from patients and their carers supports that a D2A approach has been successful for them in reducing anxieties, supporting positive risk taking and in meeting their functional goals.
- D2A evidences early supported discharge from hospital, prevention of admission to hospital & reduced readmission rates in Moray and therefore has an impact on the whole health & social care system and is cost effective.
- D2A evidences targeted therapy input improves patient functional outcomes and there is reduced requirement for care for those patients.
- D2A evidences by intervening early in a patient's LifecurveTM with a targeted functional approach, patients can improve or maintain independence after a hospital admission/attendance.
- D2A requires Occupational Therapy leadership over 7 days – all 48 patients' required Occupational Therapy assessment as a result of patient's chosen goals for activities of daily living. With a 7 day service senior decision making can maintain effective flow and early supported discharge over 7 days from Dr Grays Hospital.
- D2A requires Physiotherapy input – just less than half of the patients assessed so far have required Physiotherapy.
- D2A requires Generic Occupational Therapy and Physiotherapy with Support Workers with generic competencies at a Band 3 level.
- D2A requires ANP input for Comprehensive Geriatric Assessment and also succession planning in the form of additional nursing hours.
- D2A requires its own administration support

D2A requires to be permanently funded in its entirety in order to continue to support patients and to continue to contribute to capacity and flow within the health and social care system in Moray.

The following is a breakdown of the costs required to establish D2A in Moray permanently:

Band	FYR Costing Top	Number Required	Total Cost
Band 7 Occupational Therapists – Team Leads & Governance	£60,987	1.5	£91,481
Band 7 ANP	£60,987	1	£60,987
Band 6 Occupational Therapist	£51,744	1	£51,744
Band 6 Physiotherapist	£51,744	1	£51,744
Band 6 Nurse	£51,744	0.6	£31,046
Band 3 - Generic Support Workers (OT & PT competencies)	£29,334	6	£176,004
Band 3 – Administration Support	£29,334	1	£29,334
Mileage Costings based on projections from project			£5,000
Total yearly costs			**£497,340**

Appendix One

D2A Criteria

- Person informed consent
- Resident of Moray
- 18 years and over
- Medically stable
- Rapid diagnostics completed e.g. Bloods, ECG, Chest X-Ray /Plain Film X-Rays, CT Head if deemed required
- Initial combined AHP assessment completed at Emergency Department front door/early on admission
- Independently mobile with/without aids
- Anticipated short term assessment period ≤ 2/52
- Continence can be managed – independent with equipment/pads or support including overnight
- Admission to hospital likely to be detrimental to cognitive status
- Person's family in agreement

Appendix Two

Referral Sources:

Discharge to Assess Process -

Acute Medical Assessment Unit (AMAU)

Seen 8am ward round + stable

Emergency Department (ED)

Identified by ED team

Case finding people ≥ 80 years of age

Falls

Trauma & Orthopaedics

Stable fractures

Criteria*

Discharge2Assess

Single combined Assessment

Or

Several interventions & follow up

Essential Team Kit

- *ECG machine*
- *BP meters x 2*
- *Bladder scan*
- *Access to essential ADL equipment*
- *Access to pool cars*
- *Smart phones & laptops*

Essential Education

- *ED staff*
- *AMAU staff*
- *Scottish Ambulance Service (SAS)*
- *Social care/enabling services*
- *Primary Care*

Home with D2A Team input within 24 hours

Blended approach to diagnostics and functional assessment

Occupational Therapist/Physiotherapists

Geriatrician/GP with Special Interest – 3 sessions per week

Geriatric ANP

Access to Support Workers

Access to Social Work/Care to move patients on

Discharge

Rapid onward referral

Discharge to Assess – Home First for Moray

Case Study 1 - Person and context

Lives alone

Family locally, fall at home, fractured clavicle, admitted to hospital

- Occupational Therapy assessment - able to transfer from chair and bed independently; mobilising with a quad stick
- Washing and dressing difficult due to collar and cuff in situ
- Patient and family concerns - meal preparation and transfer; convinced longer term care was required to enable safe discharge at home
- Discharge to assess criteria met and seen by the Discharge to Assess Team (D2AT) on ward prior to discharge
- Afternoon discharge from hospital

Outcomes

- Visited at home and assessed by the D2AT on day of discharge
- Goals identified for two week intervention period with lady
- Health Care Assistant 3 x daily visits initially and reduced over time
- Initial progress limited due to collar and cuff
- Two week intervention period extended slightly due to readmission (medical reasons)*
- Successful use of kitchen trolley for meal preparation and transportation
- Marked improvement in function across all areas, lady expressed increase in confidence with own functional abilities, no further interventions required, discharged
- No longer an identified need for formal care
- Making Every Opportunity Count (MEOC) signposted to McLintock Eye service (provide home visits) – lady took up this opportunity

Lessons Learned

- **Reassessing following readmission* and Investing additional Discharge to Assess team time beyond 2 weeks ensured there was no need for any formal input from care services**
- **Essential to ensure information is fedback clearly to individuals and family members to confirm understanding and clarity throughout service provision**
- **Discharge from hospital early in the day is essential to avoid delays in the discharge process and ensure patients can be followed up the same day at home by the Discharge to Assess Team**

Anticipated outcome without D2A – would have required formal care potentially resulting in lengthy hospital stay

Case Study 2 - Person and context

Limited outside social support, admitted to hospital with sciatic hip pain

- Occupational Therapy assessment - able to transfer from chair and bed independently; needed assistance of a leg lifter and small stool; mobilising with a zimmer frame
- Effortful lower body dressing and time consuming impacting on energy reserves and activity
- Attends to meal preparation at home
- Occupational Therapy and Physiotherapy rehabilitation goals identified
- Discharge to assess criteria met and seen by the D2ATeam on ward prior to discharge
- Morning discharge from hospital (Friday am)

Outcomes

- Friday afternoon, visited at home by the D2AT, assessed, goals identified with lady
- Health Care Support Worker 2 x daily visits over the weekend to work on rehabilitation goals with lady – practice personal care and mobility with kitchen trolley
- Marked improvement in function across all areas, no further Occupational Therapy input required, discharged from Discharge to Assess Service
- Physiotherapist reviewed lady at home on Monday and further telephone review the following week then referred to Advanced Nurse Practitioner (ANP)
- Visit arranged by ANP to optimise medications and pain management
- Making Every Opportunity Count - provided with list of private domestic help

Lessons Learned

- **Morning discharge from hospital enabled the Discharge to Assess Team to assess that day and prior to the weekend, allowing input to commence over the weekend**
- **Had the discharge been later in the day assessment would have taken place on the Monday**
- **Early in the admission process lady was identified as meeting the Discharge to Assess criteria enabling timely discharge and assessment in own home**
- **Input over the weekend enabled notable functional improvement by the Monday, clearly demonstrating benefits of input over the weekend and 7 day working**

- **As part of the Discharge to Assess process having multidisciplinary interventions available in a timely manner clearly benefited the lady**

Anticipated outcome without D2A input – would not have had tailored support, therefore would not have achieved rehabilitation goals so soon after discharge

Case Study 3 - Person and context

Admitted to hospital following a fall

- Occupational Therapy assessment - able to transfer from chair, toilet and bed independently
- Reduced vision, anxiety and unfamiliar ward environment impacting on functional ability
- High importance placed on housework and meal preparations at home
- Occupational Therapy rehabilitation goals identified
- Discharge to assess criteria met and seen by the Discharge to Assess Team (D2AT) on ward prior to discharge
- Family fully informed of the role of the D2AT and provided with information leaflets
- Morning discharge from hospital (Tuesday)

Outcomes

- Visited at lunchtime on day of discharge by the Occupational Therapist from the D2AT, assessed, rehabilitation goals identified with lady
- Health Care Support Worker initially 3 x daily visits to work on rehabilitation goals with lady – reassurance, encouragement to build confidence with personal care and meal preparations, support was very quickly reduced
- Within 4 days (by Friday), visits were reduced to 1 x daily as noted improvement in all abilities
- Reviewed by Occupational Therapy (Saturday), rehabilitation goals met, showed significant improvement in function, therefore discharged from services

Lessons Learned

- **Early Tuesday morning discharge from hospital enabled the Discharge to Assess Team to assess at lunchtime that day and input to commence straight away**
- **The Occupational Therapist from the Discharge to Assess Team was able to meet with the patient and the family, all were fully aware of the role of the D2A Team and the plan for input. This facilitated a more streamlined discharge from**

the ward and maintained open communication with all parties' e.g. patient, Ward staff, D2A Team.

- **Had the discharge been later that day, assessment would have taken place the following day, which would have impacted on the patient and the family's confidence with discharge**
- **The Health Care Support Worker input 3 x daily enabled reduction to 1 x daily by the 4th day, review by the Occupational Therapist on 5th day confirmed all rehabilitation goals had been met. This demonstrated maximised utilisation of all resources and enabled all rehabilitation goals to be achieved in a short time frame**
- **Timely intervention following discharge clearly indicate the benefits and outcomes achieve through seven day working**

Anticipated outcome without D2A input – likely to have resulted in a longer stay in hospital/peripheral hospital for further assessment and care

Case Study 4 - Person and context

Admitted to hospital following a fall, sustained back injury

- Occupational Therapy assessment - able to transfer from chair and toilet independently, bed transfer using bed lever, mobilising with a walking stick
- Struggling with personal care, washing and dressing
- Occupational Therapy and Physiotherapy rehabilitation goals identified
- Discharge to assess criteria met
- Patient and family member fully informed of the role of the Discharge to Assess Team (D2AT) and provided with information leaflets
- Afternoon discharge from hospital to care of family member

Outcomes

- Visited next morning and assessed by the Occupational Therapist from the D2A Team
- Rehabilitation goals agreed – to wash and dress independently and increase confidence in mobility
- Falls prevention advice given to person/family member and discussion on community alarm
- Health Care Support Worker (HCSW) input 1 x daily supported personal care
- Visited by Physiotherapist and HSCW, exercises demonstrated and completed daily supported by HCSW and family member

- Reviewed a week later by Physiotherapist referred to Community Rehabilitation Physiotherapy to support ongoing rehabilitation goals
- Visited by the Advanced Nurse Practitioner, medication review, blood pressure assessed and bladder scan carried out. GP add in
- Blended approach with the family member identified constraints they were experiencing in their caring role - referred to Social Work for assessment and to explore additional carer support/other resources e.g. Key Safe

Lessons Learned

- **Family support is very beneficial to support Discharge to Assess planning**
- **As an inpatient having discussion with family to ascertain the baseline (in hospital) and the family capacity to support is crucial to the D2A planning**
- **Evidence of the benefits from Multidisciplinary input – Physiotherapy, Advanced Nurse Practitioner, Social Work, Dementia and Frailty Nurse provision**
- **Opportunity to formalise referral pathway with the Short Term Assessment Reablement Team (START)**

Anticipated outcome without D2A input – discharge directly home to care of family member who was unsupported, likely to have been unsustainable; potential lengthy stay in a peripheral hospital awaiting care

Case Study 5 - Person and context

Admitted to hospital following a fall, reduced mobility and urinary retention

- Occupational Therapy assessment – independent with transfers and basic personal care; supervision required due to confusion, not at baseline function; household tasks shared with wife. Mobilising with a zimmer frame in hospital (normally independently without mobility aids)
- Discharge to assess criteria met, patient and family fully informed of the role of the Discharge to Assess Team (D2AT) and provided with information leaflets
- Equipment provided for use at home on discharge
- Late afternoon discharge from hospital (Friday), family happy to support

Outcomes

- Occupational Therapist from the D2A Team contacted, visit agreed 4 days after discharge due to risk assessment and patient/family choice

- No immediate rehabilitation goals identified as mobilising well around the house without mobility aids and managing personal care
- Telephone review agreed in one week including Physiotherapy input if required
- Following week admitted to hospital again for medical reasons
- D2A input again following discharge, functional abilities improving; input from Physiotherapy and Health Care Support Work 2 x weekly to support exercise programme and practice; Advanced Nurse Practitioner and Occupational Therapist reviewed cognition and functional abilities, both improving, no further input required

Lessons Learned

- **Family support is hugely beneficial to support Discharge to Assess planning. This discharge would have been delayed if family support not available and due to current D2A capacity particularly for weekend discharges**
- **Prompt D2A reconnection with person and family following 2nd medical admission to hospital enabled continued rehabilitation support on discharge**
- **Having Multidisciplinary Team members a part of the D2A Team clearly benefits the person particularly through joint assessment process, maximisation of MDT skills and communication to identify most appropriate support required for the person**

Anticipated outcome without D2A input – may have placed further stress on family member particularly due to change in cognition and function

REPORT TO: MORAY INTEGRATION JOINT BOARD ON 25 MARCH 2021

SUBJECT: OUTCOME BASED CARE AT HOME

BY: CHIEF SOCIAL WORK OFFICER

1. REASON FOR REPORT

1.1. To inform the Board of the commissioning plans for an outcome-based Care at Home service

2. RECOMMENDATION

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

i) agree the plan for commissioning an outcome-based care at home service; and

ii) note the indicative timeline for the delivery of an alternate model for commissioning care at home;

3. BACKGROUND

3.1 The delivery of Social Care (Self-directed Support) (Scotland) Act 2013 places the individual at the centre of the assessment process recognising they are best placed to define their needs, make choices and take more control of their lives. The traditional way of providing care at home through time and task does not underpin the values and principles of Self-Directed Support, which is focussed around person centred planning, identifying personal outcomes, and establishing the most appropriate way to meet those outcomes in an individualised and flexible way.

3.2 Care at home nationally and locally is facing significant challenges in workforce and provider sustainability as well as increasing demands and costs. Change is needed as the system is unable to operate with traditional models of delivery. Currently care at home is commissioned via a competitive tendering exercise where we contract with our providers to deliver the task which needs to be completed and the time that will be required. This is commonly referred to as “time and task” commissioning.

3.3 The independent review of adult social care in Scotland (published 3 February 2021) recommended a range of changes needed in commissioning. A shift from

competitive to collaborative commissioning must take place and alternatives to competitive tendering developed and implemented at pace is required. Decisions must focus on the person's needs, not solely driven by budget limitation. Moray's existing traditional care at home contract has been extended to allow sufficient time to focus on the proposed new outcome-based commissioning, supporting recommendations in the independent care review.

3.4 The new model of care at home service underpins the Home First approach whilst committing to working with people not as passive recipients but as partners in their own care, treatment and support. It is therefore vital to have a sustainable care at home market providing flexible and good quality outcome-based care.

3.5 The plan for the new model of care at home involves Health and Social Care Moray (HSCM) working with a care at home external partner to jointly deliver an outcomes-based care at home service across Moray, whilst meeting the specific needs of each locality. The external partner will work in close partnership with our internal service through virtual team meetings. The contract will be awarded on the 1st July 2021 with implementation on the 1st November 2021. The following three-month period is the transition period when the existing care packages will transfer, and any staff transfers under TUPE legislation will take place. The transition is a complex process and at this current time, there may be factors/elements which are not yet known and will have to be dealt with as and when they arise.

3.6 The operational process involves Social Workers assessing and agreeing high level outcomes with the individual. The care provider and the individual agree how best to meet their needs. Over the first 6-8 weeks of care and support, the provider and individual will review their needs collaboratively and agree the future plan. A philosophy of re-ablement and/or recovery is at the core of service delivery. This includes reducing service provision as appropriate if the person has been re-abled which is defined as being able to carry out an activity of daily living independently. This will be underpinned by the use of supportive technology.

3.7 In line with the Commissioning timeline and to complement the retendering of the care at home service, a project group was formed to support the delivery of the overarching aims which are to:

- Support the delivery of a personal outcomes approach between the care provider and service user based on a good conversation;

- Develop the underpinning processes and procedures to support this change in the way that care at home support is provided; *and*

- Through a three month development phase ensure that underpinning processes are fit for purpose.

3.8 The underpinning project plan will aim to ensure that the necessary training and the revised operational and performance management frameworks are in place by the time that the new care at home contract begins on 1 November 2021. The three month development period will also be used to refine the project plan to meet the aims of the project.

The project plan includes the following workstreams:

Phase 1 (pre contract) Oct – July

- **Process and Documentation** – Develop and refine processes and associated documentation which are outcome based and co-produced with homecare staff;
- **Communication and Engagement** – Communicate and inform all internal and external stakeholders;
- **Commissioning** – Create a commissioning document setting out requirements for outcome-based care at home with evaluation including Service User involvement;
- **Training and Development -** Develop a package of training materials and information sessions to support the delivery of change management and behavioural changes;
- **Service User Transition** – Support service users and families to be prepared for a possible change in provider through SDS conversations;
- **Workforce Structure** - Review and audit existing workforce structure to be redesigned if required;
- **Reporting** – Gain organisational approval and understanding; and
- **Performance Management** – Develop a personal outcomes performance management framework capturing qualitative data which is able to be shared at management and front-line level.

Phase 2 (Contract awarded) Aug-Nov

- **Process and Documentation** – Develop and refine processes and associated documentation which are outcome based and co-produced with homecare staff;
- **Communication and Engagement** – Communicate and inform all internal and external stakeholders;
- **Continuous Professional Development -** Support change management and behavioural change through coaching, mentoring and supervision**;** and
- **Workforce Changes –** Implement workforces changes identified within the three-month development period.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 There have been several research reports looking at what people want from care delivered in their home and exploring what good-quality care looks like, with strong common themes including:

- **Person-centred care** – caring for all the person's needs together in a holistic, integrated way;
- **Valuing and involving people,** as well as their carers and family members – ensuring that people are able to express their preferences, views and feelings. This may include ensuring that people have choices and that their views about how to make improvements are sought, listened to and acted on;
- **Continuity of care** – ensuring that care is consistent and reliable. This may include ensuring that people have a properly reviewed care plan, that care workers are known to the person and limited to a small number of people visiting, providing reliable and flexible visit times, planning for missed or late

visits, and ensuring that people are able to contact services between appointments;

- **Personal manner of staff** – a caring and compassionate approach to care. This may include effective communication, getting to know the person and building relationships to ensure that care happens the way the person likes it;
- **Development and skills of staff** – ensuring that staff are equipped with the training, supervision and experience to do their jobs effectively. This may include regular meetings for staff, personal development and training on particular conditions such as dementia; and
- **Good information about services and choices** – ensuring that people know where to get advice and understand their choices about local care options, including quality and financial advice. Focus on wellbeing, prevention, promoting independence and connection to communities – to be able to stay in their own homes and be supported to do things themselves. This may include linking people to be able to contribute to their local communities and social groups. (*Healthwatch 2017; Maybin et al 2016; CQC 2013; ADASS et al 2017.2017); SCIE 2014; NICE 2016).*

4.2 The new model of outcome-based care at home aligns with what people are saying they want and value from a care at home service. It supports the values and principles of SDS, supports Moray's strategic plan whilst underpinning recommendations from the Independent Care Review for Adult Social Care Scotland.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

Moving towards outcomes-based care has a good strategic fit with two of the three strategic drivers in the IJB Strategic Plan, namely HOME FIRST (being supported at home or in a homely setting as far as possible) and PARTNERS IN CARE (making choices and taking control over decisions affecting our care and support).

(b) Policy and Legal

There are 2 main legal reference points for this project which the MIJB are legally responsible for:

- Section 12A of the Social Work (Scotland) Act 1968 – the duty to assess adults need for care and support; and
- The Social Care (Self-Directed Support) (Scotland) Act 2013 the legal basis for choice over care and support.

(c) Financial implications

Assuming an implementation date of 1 November 2021, it is estimated that the additional costs associated with this project will be £260,000 for the 2021/22 financial year. The full year effect of which would be in the region of £600,000. This estimate is based on the national benchmark rate. The Chief Financial Officer has acknowledged this budget pressure in financial planning for 2021/22.

(d) Risk Implications and Mitigation

The scale of this work should not be underestimated. The risks around being unable to successfully embed an outcome-based care at home service in our culture and system will be identified through the project plan and mitigations identified accordingly. The change management required will be resource intensive and is likely to require re-prioritisation of existing resources and priorities.

There is a perceived risk that market choice will be reduced. HSCM are facilitators in the health and social care market development whilst service users are their own commissioners through SDS.

(e) Staffing Implications

The staffing implications associated with this project are still to be defined. There is a specific project workstream focusing on potential staff implications and any proposals for change will be progressed in line with respective employers agreed policies and procedures in respect of change management and organisations changes as appropriate.

(f) Property

No property issues identified at this point.

(g) Equalities/Socio Economic Impact

EIA will be further developed as the project continues, in liaison with the Equal Opportunities Officer.

(h) Consultations

Chief Social Work Officer; Chief Financial Officer MIJB, Self-Directed Support Officer; Senior HR advisor; Service Manager Internal Services, Internal Home Care Managers, Equal Opportunities Officer and Tracey Sutherland, Committee Services Officer have been consulted.

6. CONCLUSION

6.1. The Board are asked to agree the plan for commissioning an outcomes-based care at home service, noting the shift in paradigm for delivering homecare from time and task to personal outcomes, whilst recognising the linkages to national and local policy.

Author of Report: Carmen Gillies Senior Project Officer HSCM
Background Papers: With Author
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 25 MARCH 2021**

SUBJECT: **WHISTLEBLOWING STANDARDS – PLAN FOR IMPLEMENTATION**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To outline the requirements of the whistleblowing standards and present the proposal for implementation.

2. RECOMMENDATION

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

i) agree the application of the standards across all staff groups, contractors and external providers be undertaken in a phased basis as described at 4.6;

ii) consider and note the phases of implementation; and

iii) approve the proposed implementation plan at APPENDIX 1.

3. BACKGROUND

3.1 National Whistleblowing Standards (The Standards) are about to come into effect across all NHS services across Scotland. This requires all NHS Boards, Health and Social Care Partnerships, Primary Care and Contracted Service Providers, Third Sector Organisations (TSOs) and Healthcare Education Institutes (HEI) to familiarise themselves with The Standards and be ready to implement them in full by 1 April 2021.

3.2 It also required NHS Boards to replace their locally appointed Whistleblowing Champions with a Scottish Government recruited independent Whistleblowing Champion. This was completed in February 2020 by NHS Grampian Board with the appointment of Mr Bert Donald. In addition, Boards will replace their local whistleblowing policies with a new national policy which was agreed in January 2021.

3.3 NHS Grampian has a clear ambition to create a positive concern raising a response culture that welcomes whistleblowing concerns from staff and others that deliver their services. To achieve this an efficient, consistent, system wide approach will need to be embedded to promote, encourage, record, report and learn from whistleblowing concerns raised throughout Grampian.

3.4 To support readiness to implement The Standards across the system, a Whistleblowing Standards Implementation Group (WSIG) led by the Head of

Engagement, NHS Grampian, was established in July 2020 and met monthly up to December 2020. The WSIG's membership comprises representation from across Grampian to ensure cross-system input, a consistent approach and to identify areas that will require additional support.

3.5 The Scottish Government had a soft launch of the Standards on 1 January 2021 and national e-learning modules are available on Turas, (the NHS Education for Scotland's single unified platform for health and social care professionals) to raise awareness and understanding of the Standards amongst staff.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 A whistleblower can be defined as: 'a person who delivers or used to deliver services, raising a concern that relates to speaking up in the public interest, where an act or omission has created, or may create, a risk of harm or wrong doing'. This is different from raising a grievance, which is generally about the staff member's own employment situation and not about public interest issues.

4.2 A key part of whistleblowing is that when a concern is raised which meets the legal test that the person 'reasonably believes' the concern they are raising is in the public's best interest, then it is considered a 'protected disclosure' under the Public Interest Disclosure Act (PIDA) 1998.

4.3 This allows legal protection against discrimination for people using the whistleblowing procedure and is why, when concerns are raised anywhere in the system, by anyone who is providing NHS services on behalf of NHS Grampian, that staff are able to identify the appropriate way to handle that concern and afford the person raising the concern the protection they legally deserve.

4.4 The Standards are set out in a 92 page document which is broken into ten parts. To allow a high level understanding of The Standards, the key points from each of these parts were summarised, and is shown in **Appendix 1**. The WSIG have been working through each part of The Standards, to support the relevant discussions that need to take place with key stakeholders.

4.5 In order to meet the requirements of the standard and facilitate the implementation across all staff the following areas need to be addressed. Whilst good proactive progress was made prior to December 2020, the impact of the second lockdown and implementation of Operation Snowdrop command and control arrangements, which resulted in key officers undertaking other priority duties. The key areas, comments and challenges in implementing in full by 1 April 2021 are identified in the table below:

Area	Comment	Concerns and Challenges
1) Promoting the Standard and the ability for staff to raise concerns	Anyone providing health NHS services on behalf of NHS Grampian should know about The Standards and should receive support to raise their concern. To do this we are asked to ensure 'Confidential Contacts' are available across the system. Louise Ballantyne, Head of Engagement and Steve Stott, Consultant ITU of NHS Grampian will be the confidential contacts in the first instance. Final stages for concerns relating to social work and care services will be signposted to the Care Inspectorate instead of the Independent National Whistleblowing Officer for review.	Timescale now available to promote the Standard adequately to everyone who provides services, or support on behalf of NHS Grampian during the Pandemic.
2) Embedding a system wide, consistent, best practice approach to responding to, handling and recording whistleblowing concerns.	There is a requirement for all whistleblowing concerns to be recorded in a way that protects confidentiality, but allows efficient handling and recording. Although Datix is used and is accessible to many staff it is not available to everyone. There needs to be a way for concerns raised in Primary Care, Commissioned Services, TSOs and HEIs, etc. to be recorded which enables a consistent approach to the information being held confidentiality. There also needs to be consideration for H&SCPs who have health and local authority (LA) staff, if they intend for an extended agreement to be in place for LA staff to also use the national policy.	The ability to embed a system wide, consistent, best practice approach to responding to, handling, recording and reporting on whistleblowing concerns The ability to update NHS Datix system, provide training and arrange access to those who will be responsible for reporting and responding to whistleblowing concerns. The development of another mechanism to raise a concern that is available to all staff, such as an electronic form, and then the communication of such to all parties.
3) Ensuring mechanisms	There is a requirement for H&SCPs, Primary Care and other Contracted Service Providers, HEIs and TSOs to report any whistleblowing concerns raised to	Our ability to influence all primary care and commissioned services, Third Sector Organisations and Health

	are in place to take and share learning from investigations or cases raised.	them each quarter to the NHS Board, and also to the IJB for H&SCPs. They must also report annually to the Board of any whistleblowing concerns raised throughout that year or report that they have received none. There is also a requirement for NHS Boards and IJBs to have a management review and publish themes from whistleblowing concerns raised to them each quarter, and to provide an annual report for the Scottish Government.	Education Institutes at this time, to ensure they are fully compliant in promoting the Standards, and that they can handle, record and report on concerns, with the strict confidentiality, and protecting anonymity as required, as well as updating commissioning and service level agreements to reflect this. The ability of the Integrated Joint Board Chief Officers and Local Authority (LA) Chief Officers to fully engage in discussions, reach agreement and put the processes and policies in place to be able to extend the Standards to also be available for LA staff, as recommended.
4)	Creating a positive concern raising and response culture, to get ahead of the curve and minimise the need for whistleblowing.	There is a requirement to have a culture that truly values and encourages concern raising as one of the ways of ensuring the care we provide is the best it can be. That staff feel concerns raised are gifts of knowledge and not a criticism of each other or the system.	The ability of all those mentioned above to be able to work in partnership together, creating create a culture that truly values and encourages concern raising as one of the ways of ensuring the care we provide is the best it can be, that staff can feel concerns raised are gifts of knowledge and not a criticism of each other or the system and for us to get ahead of the curve and minimise the need for whistleblowing.

4.6 The recommendation from NHS Grampian is that we adopt a phased approach to implementation and the steps and timescales are outlined in **APPENDIX 2.**

4.7 There have been discussions at HSCM Workforce forum and HSCM System leadership group and the consensus is that the Standards should be made available to all staff, NHS Grampian or Moray Council employed from 1 April 2021 and that a phased approach, as described in **APPENDIX 2**, be adopted. It should be noted however, that further discussion and consultation is required with Moray Council HR Officers and trade unions to more fully consider the implications and management of the NHS Standards for Moray Council employees and the links to the Council's existing Whistleblowing Policy.

4.8 In summary, during the soft launch period 1 January to 31 March 2021 work is underway and on target to ensure:-

- Cross system communications are made to raise awareness of the Standards the Whistleblowing Champion, Confidential contract and expectations, support and protection for those providing services on behalf of NHS Grampian.
- Systems to record concerns are developed and operational – Datix, or digital survey tool
- Systems to report concerns are in place – Limesurvey or digital survey tool
- Awareness raising of Turas training for staff and managers is undertaken.
- Locally agreed procedures for identification of investigators and sign off of concerns implemented.

4.9 In the period to end of Summer 2021, the plan is to progress

- Implementation of arrangements across the wider staff groups
- Defining and implementing a form of words into contracts and service level agreements that the Standard and requirement to report will be adhered to
- Promotion and rolling out further whistleblowing confidential contact roles across Grampian
- Continuing to support the recording of concerns, the compilation of reports and publication of system wide learning from whistleblowing concerns.
- Continuing to promote the value of concern raising, as a way to benefit service users and our colleagues, by highlighting improvements that can be made to the services we provide.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

As defined within the Moray Integration Scheme values.

(b) Policy and Legal

The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS Service providers to handle concerns that are raised with them and which meet the definition of a "whistleblowing concern". This report outlines the steps and timescales being taken to implement the Standards.

(c) Financial implications

None directly associated with this report

(d) Risk Implications and Mitigation

None directly associated with this report

(e) Staffing Implications

None directly associated with this report

(f) Property

None directly associated with this report

(g) Equalities/Socio Economic Impact

An Equality Impact Assessment is not required as the report does not deal with actions which may impact adversely on groups with protected characteristics.

(h) Consultations

Consultation on this report has taken place with the Workforce Forum, System Leadership Group, Chief Officer and Chief Financial Officer and Tracey Sutherland, Committee Services Officer who are in agreement with the content in relation to their area of responsibility.

6. CONCLUSION

6.1 This report outlines the work that has been undertaken and the work that still requires to be completed to embed the standards for implementation across all NHS services. It is recommended that progress continues on the phased approach in line with NHS Grampian's plans as outlined in this report and appendices.

Author of Report: Jeanette Netherwood, Corporate Manager
Background Papers: held by Louise Ballantyne, Head of Engagement, NHS Grampian.
Ref:

APPENDIX 1

Grampian-wide Whistleblowing Standards Implementation Action Plan 2020-2021

The National Whistleblowing Standards (The Standards) were finalised in the summer of 2020 and are due to be implemented across Scotland by 1 April 2021. This requires NHS Boards, Health and Social Care Partnerships, Primary Care and Contracted Service Providers to familiarise themselves with The Standards and be ready to implement them in full.

To explore readiness to implement The Standards across Grampian and to support the actions required to achieve this, a Whistleblowing Standards Implementation Group (WSIG) was established in July 2020. The WSIG's membership includes representation from across Grampian to ensure cross system input, a consistent approach and to identify any areas that require additional support.

The Standards are set out in a 92 page document which is broken into ten parts. To allow a high level understanding of The Standards, the key points from each of these parts are summarised below. The WSIG are working through each part of The Standards, will support the relevant discussions to take place with key stakeholders, with the aim of complete readiness for implementation of the Standards across the Health and Social Care System in Grampian.

The Standards, Part 1 – THE PRINCIPLES (pages 7 - 10) (The introduction covers pages 1-6)	**Action**
Establish a culture that values concern raising, handles them openly and transparently, and has a focus on system wide learning and improving.	
Ensure clear governance and accountability arrangements exist to support staff to follow, monitor and review the whistleblowing procedure.	
Have systems in place to ensure all concerns are investigated quickly, appropriately, and we are able to monitor how they were handled and identify trends to support continuous improving.	
Staff investigating concerns should be impartial, independent, accountable and ensure the investigation is handled objectively, confidentially and sensitively.	
Procedures for raising concerns should be well known, easy to access, written clearly, leaving no doubt that staff raising concerns will be well supported and can remain anonymous.	

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Outcomes of investigations should be appropriate to the findings and set out what action will be taken to put things right or improve practice.	

The Standards, Part 2 – THE PROCEDURE (pages 11 - 28)	**Action**
Whistleblowing can be defined as: a member of staff (or ex-staff member) raising a concern that relates to speaking up in the public interest, where an act or omission has created, or may create, a risk of harm or wrong doing.	
Grievance raising is different to whistleblowing/concern raising, as it is generally about the staff member's own employment situation and not about public interest issues.	
Concerns can be raised by anyone providing services for the NHS, or working with NHS staff; agency workers, contractors (including third sector service providers), students, volunteers, etc.	
The Public Interest Disclosure Act 1998 (PIDA) allows legal protection against discrimination for people who use the whistleblowing procedure. A concern is considered a 'protected disclosure' when the legal test is met that the person 'reasonably believes' the concern they are raising is in the public's best interest.	
It is important to be aware that some people may feel at greater risk of raising concerns, such as; agency staff, students who are due to be assessed, people who need a visa to work in the UK or are from recognised equality groups.	
The Standards should only normally be used if; a concern is raised where no other HR procedure or processes are being used, or have been used (with the outcome not being what they expected), or if the person says they want to use the whistleblowing procedure.	
Raising a concern can be stressful and isolating, with trust being placed in an organisation when an opportunity is given to put right a wrong or reduce risk. This trust should be repaid by ensuring protection is given throughout the process, ensuring no harm comes as a result of speaking up.	

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As people who raise concerns may not know about The Standards, managers are responsible for identifying if issues would be appropriate to be handled in this way and highlight this to the person.	
Concerns about fraud can be raised through The Standards but must be raised within 2 days with the NHS Board's fraud liaison officer to allow this to be reported to the NHS Counter Fraud Services.	
Immediate action must be taken if a concern is raised that could pose any risk to patient safety.	
Disciplinary action should be taken if a false concern is knowingly raised maliciously.	

The Standards, Part 3 – INVESTIGATING CONCERNS (pages 29-45)	**Action**
Concerns raised under The Standards follow an almost identical process, and timescales, to the way concerns and complaints are handled when received from members of the public, including that concerns can usually only be investigated if they are raised within 6 months of becoming aware of an issue.	
Early resolution should be first attempted within 5 working days, if appropriate and possible, if not a full investigation should take place and be reported back within 20 working days.	
All whistleblowing concerns must be recorded on a system, and the person raising the concern provided with a written acknowledgement and response.	
There is no flexibility to pause or delay the whistleblowing procedure, and the 5 or 20 working day timescales can only be extended if a senior manager authorises this and a new timescale agreed and explained to the concern raiser along with the reason for the delay.	
Following an investigation it must always be considered if wider learning is needed across other services, departments, health care providers, etc. or with other Boards across Scotland and shared as appropriate.	
If the person who raised the concern is unhappy with the outcome of the investigation they are able to contact the Independent National Whistleblowing Officer (INWO) to ask that the investigation is looked into.	
The INWO can only usually look into concerns raised to them within 12 months of the person becoming aware of the issue they are raising, and if the concern has gone through the full whistleblowing procedure.	

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The Standards, Part 4 – NHS BOARD AND STAFF ROLE RESPONSIBITIES (pages 46-57)	Action
Board members have a critical role in setting a tone and culture in their organisation that values the contribution of all staff, including those who identify the need for changes through speaking up.	
Board members need to show interest and enthusiasm for issues that arise through concerns raised and support the learning an improvements that stem from them.	
Board members need to ensure the arrangements in place promote trust between staff and the board.	
The Board must ensure there is clear descriptions of roles and responsibilities of staff in relation to raising and receiving concerns at each level of the organisation.	
The Board is responsible that quarterly reporting of whistleblowing concerns is on time and accurate, and show an interest in what these reports say in regards of service delivery and culture. Board members should challenge information or seek additional evidence of outcomes and improvements as appropriate.	
The Board is responsible for ensuring that services contracted out by their organisation (including primary care and on site contracted services) have arrangements in place encouraging staff to raise concerns.	
The Board is responsible for ensuring arrangements are in place ensuring students and volunteers are aware of their right to access the procedure, and that concerns can be raised by universities and colleges.	
The Board is expected to work with integrated joint boards (IJBs) to ensure that all staff in the partnership can raise concerns through this procedure.	
As non-executive directors, whistleblowing champions are part of the Board and are responsible for monitoring and supporting the effective delivery of the whistleblowing policy. They should receive support from and be listened to by the Board, and action taken as a result of the issues they raise.	
The whistleblowing champion is an assurance role, providing critical oversight that managers are responding to concerns in accordance with The Standards, and raising issues of concerns to the Board.	

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The whistleblowing champion is responsible for ensuring appropriate systems are in place for services delivered indirectly, including primary care and contracted services, and those delivered by H&SCPs, meaning they may need to work with IJB colleagues to clarify expectations and requirements.	
Overall responsibility and accountability for the management of whistleblowing concerns lies with the chief executive, executive directors and appropriate senior management.	
The chief executive should ensure there is an effective whistleblowing procedure, with a robust investigation process, that organisational learning from concerns raised can be demonstrated and must work with board members to decide how oversight of the implementation of the standards can be achieved and who will have responsibility for this. Responsibility if delegated, must be clearly stated and accepted.	
Executive directors are responsibility and accountability for signing off stage 2 decision letters, so must be satisfied that the investigation is complete and the response addresses all aspects of the concern raised.	
Decisions on concerns should be made by an independent senior member of staff from another directorate, but the area director will retain ownership and accountable for managing and reporting the concerns.	
The director responsible for primary care services (PCSs) has specific responsibilities for concerns raised within and about PCSs, and must ensure that all PCSs contracted by the board are reporting appropriately.	
Workforce directors are responsible for ensuring that all staff are aware of the Standards, have access to the procedure and the support they need, that managers are appropriately trained to identify concerns and handle them at stage 1, and that concerns raised within HR procedures which could amount to whistleblowing is appropriately signposted to this procedure.	
HR teams will assist managers and confidential contacts to identify HR issues, but HR functions should not be involved in investigating whistleblowing concerns unless the concern directly relates to staff conduct.	
Appropriately skilled senior members of staff, from another directorate, with no conflict, or perceived conflict of interest should carry out investigations into whistleblowing concerns and draft any recommendations.	
All organisations that deliver services for NHS Scotland must provide staff with at least one point of contact who is independent of normal management. Smaller organisations, such as in Primary Care should work with their board to allow their staff to access these confidential contacts.	

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Confidential contacts should be appropriately skilled to support staff to raise concerns, work with the whistleblowing champion to ensure all staff are aware of the arrangements, promote a culture of trust, which values raising of concerns as a route to learning and improving, assist managers to use concerns to influence change and work with the chief executive, or delegated others, to oversee application of The Standards to ensure they are being applied and functioning at all levels of the organisation.	
The Board will have an INWO liaison officer who is the main point of contact between the INWO and the organisation and have overall responsibility to provide the INWO with whistleblowing concern information in an orderly, structured way, within given timescales, and confirm and provide evidence that any INWO recommendations have been implemented.	
The Board's Fraud liaison officer must be aware of the Standards, so if a concern about fraud is raised with them, they enquire if the person wishes to use the Standards and if so they are signposted appropriately.	
All managers should be aware of the whistleblowing procedure and how to handle and record concerns that are raised to them. They must be trained and empowered to make decisions on stage 1 concerns.	
All staff who deliver an NHS service should feel able and empowered to raise concerns about harm or wrong-doing. They should be trained so they are aware of the channels available to raise concerns.	
Union representatives can provide helpful insights in the functioning of systems for raising concerns and should be involve in implementation and monitoring of these systems where possible.	
The Board need to ensure that staff have the knowledge, skills and appropriate training to implement the Standards, including; whistleblowing champions, confidential contacts/ whistleblowing ambassadors, executive directors signing off investigations and investigators, i.e. supportive conversation skills.	
The organisation must ensure there are strong governance arrangements in place that set out clear procedures for handling whistleblowing concerns raised about senior staff, ensuring instigations are conducted by an individual independent of the situation and empowered to make decision on any finding of the investigation.	
The Board must ensure that all services they use to deliver their services, including primary care organisations or contractors, have procedures in place in line with the Standards and that external service providers are meeting the requirements of the Standards and mechanisms in place to provide assurance.	

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The Board must ensure that systems are in place to facilitate reporting by the above providers and that quarterly reports about concerns raised and performance against the Standards are received.	
There must be systems in place to gather reports of concerns from primary care and contractors on a quarterly basis. (DOES NOT SAY WHO SHOULD ENSURE THIS)	
The Board must ensure staff under contract with higher education institutions (HEIs) have equal access to any systems and arrangements for raising concerns as with those under contract with the NHS.	
The Board must ensure students have access to the standards, meaning placements must include information for students and course representatives on how to raise a concern and confidential contacts.	
The Board must ensure concerns raised by staff or students of HEIs about the board's services and considered through the standards are included in reporting of concerns to the board and externally.	
The Board is expected to work with local authority (LA) colleagues to ensure arrangements are made by IJBs to enable all those working in NHS services to raise concerns about these services in line with the Standards, whether employed by the LA or directly by the NHS.	
Each IJB is required to develop an agreement that allows for staff working across the partnership to raise concerns in line with the Standards, however the final stage for concerns relating to social work and care services is to be signposted to the Care Inspectorate instead of the INWO for review.	
The Board must ensure concerns raised by staff in integrated services are included in any reporting of concerns to the board and externally.	
The Board must ensure there is clear information for voluntary organisations (VO) who work alongside or with the NHS on how concerns can be raised in line with the Standards, and that all VO staff and volunteers have access to the board's confidential contacts or other representative for raising concerns.	
The Board must ensure concerns raised by volunteers or volunteer coordinators about the board's services are considered through the standards and included in any reporting to the board and externally.	

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The Board is expected to work with organisations that regulate their services or staff, ensuring investigations are as effective and efficient as possible, inform regulators if investigations identify issues in fitness to practice and ensuring whistleblowing concerns are kept separate from disciplinary issues.	

The Standards, Part 5 – RECORDING AND LESSONS LEARNED (pages 58-65)	**Action**
One of the main aims of the whistleblowing procedure is to ensure learning occurs from concerns raised.	
Structured systems must be in place to record concerns, their outcomes and any action taken, and be able to hold records in a way that protects staff confidentiality and ensures compliance with General Data Protection Regulations and Scottish Government Records Management Code of Practice requirements.	
All managers, confidential contacts and whistleblowing ambassadors must be able to record concerns on the system but shouldn't be able to access other records without good reason.	
The systems used must allow for full reporting of all concerns raised, regardless of who they have been raised with and must as a minimum include the confidential contact or whistleblowing ambassador and the Board's whistleblowing champion.	
All NHS service providers must record and review information about the concerns raised about their services quarterly, the key performance indicators (KPIs) are the same as used in public complaint handling and include timescales achieved, learning and changes that have occurred, whistleblowers experience of raising a concern and staff awareness, perceptions and training.	
Any related HR processes should progress in parallel with whistleblowing concern investigations with every effort to avoid delay which could risk unsafe service delivery occurring.	
Senior management review should take place quarterly to look for trends and service failings, and include consideration if any policies or procedures need reviewed, and if any new INWO recommendations have been made. Root cause analysis should be proactively undertaken if failings are identified and every opportunity explored when service improvements can lead to wider organisational change.	

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NHS Boards are responsible for ensuring all primary care and other contracted service providers supply their KPI information to their Board as soon as possible after the quarter end.	
For contacted services, the contract must set out the requirements in relation to reporting concerns.	
If no concerns are raised within primary care or contracted services, they do not need to report this to the Board quarterly, but will need to submit an annual report setting out concerns raised in that year, or explaining there had been no concerns raised during that time.	
Boards should monitor the reporting of concerns to gain insurances that staff have confidence in the systems in place.	
Boards must publish an annual report which sets our performance in handling whistleblowing concerns and build on the quarterly KPI reports. Boards must work with their services providers (including primary care) to ensure they get the information required so the annual report covers all the NHS services provided through the board. IJB reporting will also be covered in this report unless a separate annual report covering all IJB services is published by the IJB itself. The report must also include concerns raised by students, trainees and volunteers.	

The Standards, Part 6 – NHS BOARD AND EXTERNAL SERVICE PROVIDERS (pages 67-71)	**Action**
Boards must ensure that all services delivered by them or on their behalf have appropriate procedures in place for their staff, students, contractors, volunteers and others.	
Boards must have effective mechanisms for oversight of the concerns raised about their own services, the services they fund or support through alternative delivery routes.	
Boards will be expected to compile reports quarterly on concerns raised with primary care providers and contracted services, and must review these quarterly reports and take a considered approach to what these reports say about the culture of speaking up within the organisation and follow up any issues raised.	
The requirement for primary care and other contracted services to have procedures in place in line with the Standards is the Board's responsibility and must form a part of all contracts or service level agreements.	

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Boards must have mechanisms for ensuring compliance with these requirements, including the requirement to report concern handling information to the board on a quarterly basis.	
Students must be able to raise concerns and have access to support services in line with the Standards.	
Students should be encouraged to raise concerns with an appropriate manager and have access to the board's confidential contact.	
Health Education Institution (HEI) courses must identify a contact for students working in an NHS service.	
HIE staff should be encouraged to raise concerns with an appropriate manger in the department they are working in, and should have access to this procedure and the support needed to raise a concern.	
Voluntary organisations (VOs) most commonly work with the NHS by providing additional services, i.e. Macmillan nurses, providing services contracted by the NHS, i.e. nursing care at home and by recruiting volunteers to enhance patient experience in care settings. All these groups must be able to access the procedure, support and protection provided by the Standards.	
People working for VOs contracted to provide a service, are treated in line with other contracted service providers.	
Each VO that works within an NHS setting will have at least one member of staff who is informed and able to support volunteers or colleagues through the procedure, acting as an advocate if preferred.	
Confidential contacts must be aware of the board's obligation to receive concerns and provide support to anyone working within or alongside a service provided by the board.	
Confidential contacts are encourage to develop relations with representatives from HEIs and voluntary sector providers to develop a mutual understanding of roles and ensure effective communication.	

The Standards, Part 7 – PRIMARY CARE AND CONTRACTED SERVICE PROVIDERS (pages 72-77)	**Action**
Staff in small teams can find it particularly difficult to raise concerns so support is often needed.	

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Leadership behaviours set the tone for the way other staff behave, all NHS services must strive for a culture that welcomes concerns from people working within their services, whoever they are.	
Anyone delivering NHS services must be able to raise concerns, access the Standards and support, including those working for another organisation but within these services i.e. district or agency nurses.	
When a primary care or contracted service is being delivered by a much larger organisation, such as a local pharmacy that is run by a national company, this company must ensure that any services delivered on behalf of NHS Scotland are compliant with the Standards.	
Small organisations face varying challenges around raising concerns, including due to the size of the team it might be obvious who raised the concern. A way to overcome this is for confidential contacts to be shared amongst other local services or practices allowing them to act as an advocate.	
NHS Boards are required to provide a confidential contact for primary care and contracted providers, if necessary the confidential contact will ensure that appropriate action is taken to reduce immediate risk.	
If there would be a potential conflict of interest for an investigation to take place internally, the provider must discuss the concern with board and work with the board to investigate the issue.	
Boards must be willing to assist with contactors investigations if appropriate, this may include providing an investigator or advising how to conduct an investigation, but boards must gain assurances that appropriate action has been taken to address the concerns raised.	
Staff must be encouraged to raise concerns, know who they can raise them to, and other routes to do this.	
Primary care services must report concerns data annually to the board, even if to report no concerns were raised, in addition a quarterly report of concerns raised in that period should be reported to the board.	
All primary care and contracted services must publish information about concerns that have been raised with them, unless this is likely to identify anyone, if so high level reporting may only be appropriate.	

The Standards, Part 8 – HEALTH AND SOCIAL CARE PARTNERSHIPS (pages 78-83)	**Action**

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HSCPs, having employees from two organisations delivering services together, may find staff feel uneasy raising concerns about staff with different lines of management or where arrangements in place for whistleblowing are different, meaning IJB and partnership managers must promote a culture that encourages concern raising.	
IJBs must ensure that all HSCP staff across both local authority and the NHS, as well as students, trainees, agency staff or volunteers are able to raise concerns through this procedure, that all concerns are recorded and reported to the IJB and NHS board quarterly, and that service improvements made as a result of concern raising are shared.	
It may be that in considering concerns about NHS services, issues are identified which relate to local authority services. If so the whistleblower should be signposted to the INWO for the NHS service issues and the Care Inspectorate or other appropriate regulatory or oversight body for issues that relate to local authority services.	
An agreement by the IJB may be required to ensure support and protection for all those working within the HSCP, in raising concerns about NHS services.	
There is a requirement for all concerns raised to be recorded and reported to the IJB and NHS board quarterly.	
To ensue equity for staff, the INWO recommends that HSCPs adopt the same approach to handling concerns raised about local authority services as they do in relation to NHS services, the only difference being at the final stage, the whistleblower would be signposted to the Care Inspectorate, or in some cases Audit Scotland, instead of the INWO.	
The detail of any extended agreement are for each IJB and their HSCP to consider; each HSCP have different arrangements in place for the delivery of their services, and it will be for them to consider whether such an agreement should cover all of their services; it would not be appropriate to create confusion for local authority staff in how to raise concerns about their services.	
Chief Officers are responsible for ensuring that systems are in place for raising concerns within these Standards. They must also take a leading role in reviewing arrangements in relation to local authority services and taking forward any changes to ensure the Standards can be met, and any other changes ensuring equity of access across HSCPs.	
Within HSCPs, the confidential contact will need to be familiar with the way concerns are handled across its services, as well as the board's expectations around handling concerns.	
The board's whistleblowing champion has a role in ensuring appropriate arrangements are in place to ensure delivery of the Standards, and will be able to provide guidance for HSCP managers on how concerns raised in relation to NHS services must be handled, as well as sharing information about appropriate governance arrangements.	
Each HSCP needs to consider how they hold information about concerns that have raised through this procedure. In particular there need to be systems in place to ensure that personal information is only shared with individuals as	

Grampian-wide Whistleblowing Standards Implementation Action Plan 2020-2021

agreed or explained to the person raising the concern. The details of the concern itself, and how it has been handled, need to be stored in a way that will enable reporting and monitoring of concerns and concern handling.	
This may mean concerns raised about local authority services are recorded separately from those relating to NHS services. Any joint systems developed will need to be able to separate out local authority from NHS service concerns so the NHS board can carry out appropriate monitoring of these concerns.	
NHS boards are responsible for collating reports of concerns raised in relation to the services they deliver, including those raised within the HSCPs in its area. In this way, boards will be able to identify areas for specific attention, based on the themes and trends across the HSCPs.	
All IJBs must ensure that information is published and promoted about the concerns that have been raised about their services, unless likely to identify individuals, in which case only high level information can be provided as appropriate.	

The Standards, Part 9 – STUDENTS AND TRAINEES (pages 84-87)	**Actions**
All students, trainees, apprentices and interns working, or studying within NHS services must have access to The Standards and must be able to speak out about patient safety or malpractice concerns, and access support to do this.	
Students may be deterred from raising concerns if they feel this could impact on their marks and this must be taken into consideration when responding to concerns raised by students.	
NHS Boards must be open to receiving whistleblowing concerns from students directly or through representatives from their course, but concerns about their course should be raised through the university.	
Students can remain anonymous to the board if they choose to raise their concern through a course advocate, and all communication would be with the advocate who would share with the student.	
Trainees under a direct contract with NHS Education Scotland (NES) can raise their concern with NES or the board they are working for, and should be told the contact at NES if they wish to do so.	

The Standards, Part 10 - VOLUNTEERS (pages 88-91)	**Actions**

APPENDIX 1

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All volunteers working within NHS services must have access to The Standards and must be able to speak out about patient safety or malpractice concerns, and access the support they need to do this.	
Volunteers should be encouraged, and given the opportunity, to share any concerns they might have and be told about the procedure and how to access it, as volunteers do not have access to most HR policies.	
NHS Boards must be open to receiving whistleblowing concerns from volunteers or volunteer leads. If the volunteer chooses to, they can use the volunteer lead to raise the concern on their behalf, allowing them to remain anonymous to the board, but this means all communication will be with the volunteer lead.	
Boards must ensure that volunteers have the same access to support that staff do, including counselling which would normally be provided through an employee assistance scheme.	

Summarised by Louise Ballantyne, Head of Engagement, NHS Grampian, October 2020

New Whistleblowing Standards Implementation: High Level Communication & Engagement Plan

The table below provides an overview of the various mechanisms, timings and target audiences in relation to communication and engagement.

Mechanism	2021 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Comments
Stage 1 – Pre-launch preparation													
Staff Communication													
Establish named communication leads for different staff groups (Members of WSIG)	♦												Named leads required to • Advise on the diversity of methods required to reach all staff equitably • Provide assurance communication is reaching staff effectively.
Establish what graphic communication assets are available and required to achieve		♦	♦										Opportunities: • National materials are now available – contact DA • One for Scotland Comms Plan – contact MM
Whistleblowing Standards pre-launch briefing – video and written brief agreed		♦	♦										Briefing setting the scene for the Standards and how it will affect all staff and service providers including: • Promotion of the Standards • Recruiting confidential contacts • Reporting Whistleblowing concerns • Publishing whistleblowing concerns in the public domain on IJB and NHSG websites.
Whistleblowing Standards pre-launch briefing shared across the system.			♦										Shared widely via: • Covid-19 Brief and other regular communication methods and networks in place across the system, including for staff with limited IT access.
Preparation of staff information at Team level			♦										Confirm launch date and expectations of our staff: • Digital briefing packs shared for team meetings and external service providers to use. • All staff to do Turas training (1 hr) • All managers to do Turas training (2hrs)
Reporting													
Whistleblowing Standards Implementation Group	♦	♦	♦	♦	♦								Didn't meet in Jan and Feb due to Covid-19, staff being deployed and Operation Snowdrop priorities.
Whistleblowing Standards Steering Group	♦	♦	♦	♦	♦								Continuing to meet and communicate regularly on issues needing addressed and support needed.
System Leadership Team	♦												Progress reported and awareness raised to SLT through an SBAR paper in Dec 2020.
Gold Command		♦											Concerns raised to Gold Command in Feb 2021 about the system's readiness for full implementation.
Grampian Area Partnership Forum		♦											Verbal update on the Standards and the requirements given to GAPF in Feb 2021.
NHS Board Meetings			♦	♦									Whistleblowing awareness raising discussion Mar 2021, and paper planned for April 2021.

Done = ♦ On Track = ♦ Not on Track = ♦

Mechanism	2021 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Comments
Stage 2 – Go live													
Staff Communication (Internal)													
Launch survey/live period				♦									Publicity around launch of Standards. • Video and written staff briefing • Share link to survey to all staff groups, utilising methods established during pre-launch stage
Digital Updates				♦	♦	♦	♦						Share updates as agreed by the WSIG to go out across the system in newsletters, the intranet and other regular communication mechanisms in place.
Reporting													
System Leadership Team								♦					An update go to SLT after the first quarter's reports should have been received.
NHS Board Paper/Meetings											♦		An update go to the Board after 6 months to give an overview of the success and evaluation of implementing the Standards.
Stage 3 – Feeding back													
Staff Communication													
Feeding back staff and key stakeholder briefing								♦					Prepare communications to let key stakeholders know how well the Standards have been implemented and any areas in need for action.
Reporting													
System Leadership Team								♦					Frequency and when to be confirmed.
NHS Board Paper/Meetings											♦		Frequency and when to be confirmed.
Stage 4 – Evaluation													
Staff Communication													
Support to managers and teams with development and implementation of improvement plans.								♦	♦	♦	♦		How and when this will be done is to be confirmed.
Digital Updates								♦	♦	♦	♦		Use digital opportunities to share information across the system using the daily brief, the intranet, etc
Reporting													
System Leadership Team											♦		Frequency and when to be confirmed.
NHS Board Paper/Meetings											♦		Frequency and when to be confirmed.

Louise Ballantyne, NHS Grampian Head of Engagement, March 2021 – V3

Done = ♦ On Track = ♦ Not on Track = ♦