Moray Integration Joint Board

Thursday, 30 September 2021

To be held remotely in various locations

NOTICE IS HEREBY GIVEN that a Meeting of the **Moray Integration Joint Board** is to be held at **To be held remotely in various locations**, on **Thursday, 30 September 2021** at **13:30** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

MEMBERSHIP

Councillor Shona Morrison (Chair)

Mr Dennis Robertson (Vice-Chair)
Professor Nicholas Fluck (Voting Member)
Mr Sandy Riddell (Voting Member)
Councillor Frank Brown (Voting Member)
Councillor Theresa Coull (Voting Member)
Professor Caroline Hiscox (Ex-Officio)
Mr Roddy Burns (Ex-Officio)

Ms Tracey Abdy (Non-Voting Member)
Mr Ivan Augustus (Non-Voting Member)
Professor Siladitya Bhattacharya (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)
Ms Heidi Tweedie (Non-Voting Member)
Dr Lewis Walker (Non-Voting Member)
Councillor John Divers (Non-Voting Member)
Simon Bokor-Ingram (Non-Voting Member)
Mr Neil Strachan (Non-Voting Member)

Clerk Name:	Tracey Sutherland
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MEETING OF MORAY INTEGRATION JOINT BOARD

THURSDAY 24 JUNE 2021

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY	UPDATE FOR 30 SEPTEMBER
1.	Revenue Budget Monitoring Quarter 2 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.	June 2021	Chief Financial Officer and Chair of AP&R	completed
2.	Moray Mental Health Services	Full report on MHS to MIJB in 3 month's time.	Sept 2021	Jane Mackie	To come to IJB in November 2021
3.	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	Sept 2021	Sean Coady	On agenda
4.	Prescribing Budget Requirements 2021-22	The Acting Lead Pharmacist to be invited back to update the Board later in the year.	Sept 2021	Chief Officer	To come to IJB in November 2021
5.	Outcome based Care at Home	Update paper to be presented to the Board in 6 months	Sept 2021	Jane Mackie	On agenda

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY	UPDATE FOR 30 SEPTEMBER
6.	Whistleblowing Standards	Implementation and organisation of training for third sector organisations	In progress	Corporate Manager and 3rd Sector Rep	completed
7.	Ministerial Strategic Group Improvement Action Plan	A progress update on the improvement actions identified within the improvement action plan will be provided.	January 2022	Chief Financial Officer	scheduled

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

Thursday, 24 June 2021

To be held remotely in various locations,

PRESENT

Ms Tracey Abdy, Simon Bokor-Ingram, Mr Sean Coady, Councillor Theresa Coull, Councillor John Divers, Jane Ewen, Professor Nicholas Fluck, Mr Steven Lindsay, Dr Malcolm Metcalfe, Councillor Shona Morrison, Mr Sandy Riddell, Mr Neil Strachan, Ms Heidi Tweedie, Dr Lewis Walker

APOLOGIES

Mr Ivan Augustus, Professor Siladitya Bhattacharya, Councillor Frank Brown, Mr Roddy Burns, Ms Karen Donaldson, Professor Caroline Hiscox, Mr Chris Littlejohn, Ms Jane Mackie, Mr Dennis Robertson, Mrs Val Thatcher

IN ATTENDANCE

Also in attendance at the above meeting were the Corporate Manager, the Provider Services Manager and Tracey Sutherland, Committee Services Officer.

1. Chair

The meeting was chaired by Councillor Shona Morrison.

2. Declaration of Member's Interests

The Board noted that no declarations of Members' interest were submitted.

3. Minutes of meeting of Moray Integration Joint Board of 27 May 2021

The minute of the meeting of Moray Integration Joint Board on 27 May 2021 was submitted and approved.

4. Action Log - 27 May 2021

The Action Log of the meeting dated 25 March 2021 was discussed and updated accordingly.

5. Minute of Meeting of Clinical and Care Governance Group on 25 February 2021

The Board noted the minute of the meeting of Clinical and Care Governance Group of 25 February 2021.

6. Chief Officer Report

A report by the Chief Officer informed 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, Remobilisation post second wave of Covid, supporting measures for the reduction of local Covid transmission and budget control.

The Chief Officer confirmed that 89.6 of all adults in Moray have received the 1st dose of the vaccine. He further added that there is a lot of work going on to increase the uptake in areas of Moray where it is between 60-80%.

Following consideration the Board agreed:

i) to note the content of the report; and

ii) that transforming services to meet the aspirations of the MIJBs Strategic Plan remains a priority, with a focus on key objectives as we remobilise from the Covid pandemic.

7. MIJB Revenue Budget Outturn 2020-21

A report by the Chief Financial Officer informed the Board of the financial outturn for 2020/21 for the core budgets and the impact this outturn will have on the 2021/22 budget.

Following consideration the Board agreed to:

i) note the unaudited revenue outturn position for the financial year 2020/21;

ii) note the impact of the 2020/21 outturn on the 2021/22 revenue budget; and

iii) approve for issue, the Directions shown in Appendices 4 and 5 to NHS Grampian and Moray Council respectively.

8. Local Code of Corporate Governance - Update

A report by the Chief Financial Officer provided the Board with an opportunity to comment on the updated sources of assurance for informing the governance principles as set out in the Chartered Institute of Public Finance (CIPFA)/Society of Local Authority Chief Executives (SOLACE) 'Delivering Good Governance in Local Government' Framework document.

Following consideration the Board agreed to:

i) note the contents of the report;

ii) note the sources of assurance utilised in reviewing and assessing the effectiveness of the MIJB's governance arrangements; and

iii) approve the updated Local Code of Corporate Governance which supports the Annual Governance Statement.

9. Unaudited Annual Accounts

A report by the Chief Financial Officer informed the Board of the Unaudited Annual Accounts of the Moray Integration Joing Board for the year ended 31 March 2021.

Following consideration the Board agreed to:

i) note the unaudited Annual Accounts prior to their submission to the external auditor, nothing that all figures remain subject to audit;

ii) note the Annual Governance Statement contained within the unaudited Annual Accounts; and

iii) note the accounting policies applied in the production of the unaudited Annual Accounts, pages 41 to 49 of the accounts.

10. Ministerial Strategic Group Improvement Action Plan

A report by the Chief Financial Officer sought endorsement from the Board on the Ministerial Strategic Group Improvement Action Plan.

Following consideration the Board agreed:

i) to approve the review of progress and identified actions within the MIJB Improvement Action Plan, see Appendix 1; and

ii) that an update will be received from the Chief Financial Officer in six months time on the improvement actions identified within the improvement action plan.

11. Adult Social Care Review

A report by the Chief Social Work Officer informed the Board of the current situation in respect to Adult Social Work and Social Care in Moray.

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

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 30 SEPTEMBER 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 (MIJB) strategic priorities articulated in the Strategic Plan, and the delivery against the 9 Health and Wellbeing outcomes.

2. RECOMMENDATION

2.1. It is recommended that the MIJB:

i) consider and note 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 focus on key objectives as the IJB remobilise from the Covid-19 pandemic, along with a look ahead, continuing to develop strategic planning.

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 aspirations set out in the Strategic Plan. Home First will remain a bedrock of aspirations to meet need more responsively, and to be more anticipatory in the approach. A Home First update is contained in a separate report on today's agenda.

Remobilisation

3.2 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/service users 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 through the backlog of referrals.

3.3 As part of the development of the performance framework, and to support remobilisation, further performance indicators are being sought from services to understand system pressures and how one part of the system impacts on other elements. A key risk to achieving the MIJBs objectives is the availability of staffing. Staff sickness/absence/vacancies will be monitored closely, on a weekly basis, and staff will work with the pan Grampian system to look at tackling the recruitment challenge.

3.4 The general picture across Scotland is of a significant rise in Covid-19 infections. This will lead to increased hospitalisations, at a time when services are already under pressure. Further work is underway to plan an increase in capacity across Grampian in readiness for a potential demand from this increase in Covid-19 transmission.

Covid-19 Vaccination Programme

3.5 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 rate information is available on the Public Health website at https://www.publichealthscotland.scot/news/2021/february/covid-19-daily-dashboard-now-includes-vaccination-data/

3.6 With a longer term campaign being predicted for repeated Covid-19 vaccinations, along with delivery of this winter's flu campaign and all the other immunisation programmes, the team are preparing and a dedicated Nurse Manager is now in post who will take forward the plan over the longer term.

Portfolio arrangements

3.7 Covid-19 has presented the greatest challenge the health service has faced. As NHS Grampian recovers, remobilises and renews as part of the North East system there has been reflection on how best to move forward to demonstrate learning and improvement from Covid-19 is an imperative. During the pandemic the effectiveness, efficiencies and improvement in outcomes achieved through public sector organisations working together have been demonstrated, as well as partners and communities rather than individual entities. To deliver further on this whole system, integrated approach, there is a desire to transition from an organisational leadership and management model to a system leadership and management approach. On an interim basis, as the model is developed, the Chief Officer is providing a leadership role for Dr Gray's Hospital alongside the responsibilities already carried, thus expanding the portfolio to encompass all Moray health and care services.

3.8 The senior management team membership for health and social care in Moray has been revised to incorporate community and acute leaders and is functioning with an integrated approach and a responsibility for the success of the whole Moray health and care system. The response to pressures and a

potential increase in demand from Covid-19 will be from Moray health and care across acute and community, with an integrated approach to balancing care across the system.

Accommodation for Learning Disability Clients

3.9 As a result of the Covid-19 pandemic and the impact of Brexit there is volatility in the building sector due to the availability and rising cost of building materials. The development of a Woodview 2, approved by the MIJB in January 2021 (para 9 of the minute refers), is going to be delayed. The target date was for completion of the accommodation by Summer 2023, but there will now be an estimated 12 month delay. Application for planning consent is expected to be submitted to the Moray Council Planning and Regulatory Services Committee scheduled to meet on 16 November 2021. The developers, Grampian Housing Association, intend to wait until the new financial year before going out to tender in order to mitigate their risks. The timescale will depend on the availability and cost of building materials at that time.

3.10 This global situation is highly likely to have an effect on other housing developments for Learning Disability clients that have been planned to provide suitable accommodation for future years. This poses a risk to the ability to support clients and families, and the service know that there are families where they are nearing the end of their ability to continue caring for someone in the home, and where more specialist support along with suitable accommodation will be needed. The risk extends to temporary placements needing to be sourced, and these may have a greater cost attached, particularly if the placement is out of area if nothing suitable can be sourced within Moray.

3.11 Of the clients that were planned to be offered accommodation in purpose built units in Moray over the next 12 months, there are risks of care and support breakdowns for a variety of reasons; high levels of challenging behaviour with families struggling to cope; people who are out of area and the provider has set a discharge date; and young people coming into adult services. The service are looking at alternative ways to support those people and their families and are negotiating with providers in order to manage and mitigate the risk.

Potential delegation of Childrens Social Work and Criminal Justice to the IJB

3.12 Officers have continued to work on developing the business case, and this has been presented, refined and re-presented along with a number of supporting documents to the programme board, put in place to oversee the work to reach a point where both Moray Council and NHS Grampian could be formally approached to consider delegation of these services to MIJB. The business case has now been accepted, and a timeline of engagement with the Council and NHS Board will be firmed up at the next programme board, prior to any formal paper being presented. In parallel, the completion of more detailed due diligence will be completed by finance colleagues, taking into account the significant underspend that the services generated at the end of the last financial year.

Strategic Planning capacity

3.13 The role of Lead for Strategy and Performance has been filled and work is underway to develop local planning and performance arrangements and processes that increasingly support delivery of the MIJB strategy. This will include reforming and refreshing the Strategic Planning and Commissioning Group (SPCG) which is due to meet on 22 September 2021. The SPCG will oversee the development of key programmes of work across the interfaces between primary, secondary and social care, developing the locality planning approach and coordination of the many enabling elements upon which planning and/or delivery of services is reliant.

3.14 The SPCG brings together stakeholders from across the Moray system and wider, including the third and independent sectors and the voice of lived experience.

Budget Control

3.15 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, seek to identify additional savings and to track progress on transformational redesign so that corrective action and appropriate disinvestment can be supported. There is a continued commitment from Scottish Government to support the Covid-19 response which 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.

3.16 A separate report will be provided to the MJB in November 2021 to discuss the overspend in the Older Peoples' budget. This budget incorporates Care Home, External Home Care services and the Extra Care Models. Initially it was intended that this report would be provided to the MIJB at this meeting in support of the finance paper on this agenda today, but a more in-depth review is now required and is underway. The overall budget set for this area for the year is £18,170,999 and for the first three months of this financial year is showing an overspend of £824,942. This is an increase of £528,196 from the same point in the year in 2020/21. A comprehensive report will be prepared for November, allowing for an in-depth review of the complex factors contributing to the adverse financial position, detailing the areas of overspend and mitigating actions to ensure robust financial governance and oversight. Budget Managers and finance staff are currently meeting on a weekly basis.

Civil Contingencies - IJB Category 1 Responder

3.17 Work is progressing to establish the planning and response mechanisms following the amendment in status for IJBs. Training has been provided by the Scottish Government in 2 workshops for IJB Chairs and Vice-Chairs and also Chief Officers. The output of these will be considered and taken forward in partnership with Moray Council, NHS Grampian and other Local Resilience

Partnerships. The MIJB is now a full member of the national and local resilience infrastructure.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Moray remains 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, with the opportunities of an expanded portfolio of health and care that encompasses Dr Gray's Hospital on an interim basis.

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 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 we remobilise, as no part of the system operates in isolation. While the demand on the health and care system continues to be immense, we will continue to plan for the longer term to ensure that services will remain responsive to the community.

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 continues to report regularly on actual expenditure to ensure

that the Scottish Government are sighted on additional costs arising from COVID-19.

(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

The HSCM Senior Management Team have been consulted in the drafting of this report.

6. CONCLUSION

6.1 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 30 SEPTEMBER 2021**

SUBJECT: **REVENUE BUDGET MONITORING QUARTER 1 FOR 2021/22**

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 30 June 2021 for the MIJB budget.

2. RECOMMENDATIONS

2.1 It is recommended that the MIJB:

i) consider and note the financial position of the Board as at 30 June 2021 is showing an overall overspend of £1,009,961;

ii) consider and note the progress against the approved savings plan in paragraph 6, and update on Covid-19 in paragraph 8;

iii) consider and 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 April to 30 June 2021 as shown in APPENDIX 3; and

iv) approve for issue, the Directions arising from the updated budget position shown in Appendices 4 and 5.

3. BACKGROUND

3.1 The financial position for the MIJB services at 30 June 2021 is shown at **APPENDIX 1.** The figures reflect the position in that the MIJB core services are currently over spent by £1,073,403. This is summarised in the table below.

	Annual Budget £	Budget to date £	Expenditure to date £	Variance to date £
MIJB Core Service	125,147,731	30,777,686	31,851,089	(1,073,403)
MIJB Strategic Funds	9,824,916	979,617	1,006,175	(26,558)
Set Aside Budget	12,252,000	-	-	-
Total MIJB Expenditure	**147,224,647**	**31,757,303**	**32,857,264**	**(1,099,961)**

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

4. KEY MATTERS/SIGNIFICANT VARIANCES FOR 2021/22

Community Nursing

4.1 Community nursing service is underspent by £93,266. This is due to underspends in District Nursing £40,384, Health Visitors £43,132 and Maryhill, Elgin, where the team is combined £9,750.

4.2 For District Nursing the overall current underspend relates to the Varis Court Augmented Care Units (ACU's) budget which is underspent by £73,491. The Varis budget is underspent due to staffing vacancies as a result of the organisational change process. These posts are now in the process of being filled. The ongoing capacity in the Varis budget as a result of the organisational change will, in future contribute to the Hanover costs for the provision of care at the 4 ACU's. The variation of the contract has been signed and the ACU's will open in the near future. The overspend in the remaining District Nursing budget will be mitigated by further Scottish Government additional funding anticipated. The first tranche of £83,788 has been received and is already included in the annual budget. A second tranche is expected in November and it is estimated that further funding of £35,909 will be received to improve the overall District Nursing position.

4.3 For Health Visitors, vacancies, planned leave including maternity leave and retirements have contributed to the current underspend of £43,132 across the service. Challenges remain on the recruitment and retention of qualified and experienced Health Visitors and School Nurses at a local, regional and national level. To help mitigate or minimise risk in the delivery of the Service, two trainee Health Visitors will join the service this month (September), 1 trainee Health Visitor and 2 School Nurses will qualify in 2022 and 2 trainee Health Visitors and 2 School Nurses will qualify in 2023. With the increase in qualified, skilled and experienced practitioners, this will alleviate a number of key service pressures, stabilise the workforce, ensure modernisation and sustainability of the service, that it is responsive to local need and risk, and help maintain positive staff health and wellbeing.

Mental Health

4.4 The Mental Health service is overspent by £201,811. The overspend is primarily due to staffing in medical and dental, nursing and admin and assessment and care service, which is partly offset by underspends across Psychology and Allied Health Professionals (AHP's).

4.5 The staffing overspends relate to two consultant psychiatrist vacancies within the department being covered by locums. This is a financial risk to MIJB, which has been reported previously, due to high costs of locums compared to NHS substantive medical staff. An adult mental health psychology vacancy has been out to advert twice with no suitable applicants. Currently meeting HEAT (Health improvement, Efficiency and governance, Access, Treatment) targets but this may not be sustainable as staff reach capacity and referrals continue to come into the team. Nursing vacancies in community teams are not filled because of difficulties with recruitment due to lack of qualified staff.

4.6 Assessment and care is £69,531 overspent primarily due to the purchase of care. This includes a high cost care package now in place, this was anticipated to be incurred when the budget was set in March 2021 and was included as a budget pressure of £158,000 per annum. The budget pressure will be aligned in period 4 to reduce the reported overspend in the next quarters budget monitoring report. There are also overspends in nursing and residential care due to the timing of the increase in national care home contracts and the funding received. An additional funding of £39,000 per annum has been received in period 4, July 2021.

Older People and Physical Sensory Disability (Assessment & Care)

4.7 This budget is overspent by £824,942. This primarily relates to overspends for domiciliary care in the area teams £511,820, permanent care £313,383 and other minor variances of £261. The variances within this overall budget heading reflect the shift in the balance of care to enable people to remain in their homes for longer.

4.8 Initially it was intended that a separate report would be provided to the MIJB at this meeting in support of the finance paper, however, a more in-depth review is now required and is underway. The overall budget set for this area for the year is £18,170,999 and for the first three months of this financial year is showing an overspend of £824,942. This is an increase of £528,196 from the same point in the year in 2020/21. A comprehensive report will be prepared for November, allowing for an in-depth review of the complex factors contributing to the adverse financial position, detailing the areas of overspend and mitigating actions to ensure robust financial governance and oversight. Budget Managers and finance staff are currently meeting on a weekly basis.

Primary Care Prescribing

4.9 The primary care prescribing budget is overspent by £238,182 to June 2021. This position is based on only one month's actuals for April and an accrued position for May and June as information is received two months in arrears.

The budget to month 3 does not yet include any possible allocation from MIJB Covid funding for the two drugs, Sertraline and Paracetamol, identified by Scottish Government as being specifically impacted upon relating to Covid. The full year estimate of the Covid impact for 2021/22 in Moray is calculated as £154,243 yet to be included which would improve the position. For 2020/21 the overall prescribing volume of items in total was 4.15% lower than in 2019/20 and the prescribing pattern did not return to pre Covid levels. However, to June 2021 the estimate of items is greater to date than anticipated, with higher volume in April. The emerging volume pattern for 2021/22 is to be reviewed as the increase is greater than expected across Grampian. Since January 2021 the price per item has been relatively stable and an average price of £11.12 per item has been used to estimate position to June. The future average price per item will be affected by negotiations between the Scottish Government and Community Pharmacy Scotland still to be implemented.

Out of Area

4.10 Out of Area is overspent by £64,399, primarily due to the level of individual placements remaining higher than anticipated and cost increasing. These arrangements are subject to review but it is assumed existing placements will continue. Such placements are arranged on an individual basis and there is a risk that further placements may be required for other individuals. One of the places relates to a learning disabilities client, who will remain in their existing accommodation until such time that suitable accommodation becomes available and the individual can be brought back to Moray. It is unlikely that any of the Mental Health patients will return to Moray in the immediate future, although progress is being made in relation to two patients.

5. STRATEGIC FUNDS

5.1 Strategic Funds is additional 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, Action 15 & Covid in 2021/22, identified budget pressures, new burdens savings and general reserve that were expected at the start of the year.

5.2 Within the strategic funds are general reserves totalling £1,597,742 which are not allocated to services but will be used towards funding the overspend. However there will not be enough reserves to cover the overspend in total if the level of spend continues till the 31 March 2022.

5.3 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 APPROVED SAVINGS PLAN

6.1 The Revenue Budget 2021/22 was presented to the MIJB 25 March 2021 (para 9 of the minute refers). The paper presented a balanced budget through the identification of efficiencies through savings and the use of general reserves.

6.2 The progress against the savings plan is reported in the table below and will continue to be reported to the Board during the 2021/22 financial year. The table details progress during the first quarter against the original recovery plan.

Efficiencies	**Para Ref**	**Full Year Target**	**Expected progress at 30 June 2021**	**Actual Progress against target at 30 June 2021**
		£'000	£'000	£'000
Accountancy driven		150	37	26
External Commissioning		122	31	37
Increased income from charging		110	28	0
Transformational change		25	6	25
Total Projected Efficiencies		**407**	**102**	**82**

6.3 Increased income from charging was to reflect changes proposed to the taper relief, due to be agreed through the Contributions Policy. In November 2020, MIJB Members agreed to this recommendation (para 13 of the minute refers) being presented to Moray Council as part of the approval required for the Contributions Policy at an early date. Since this agreement, the Independent Review of Adult Social Care report was published and has placed this element of savings at risk https://www.gov.scot/groups/independent-review-of-adult-social-care/

7 IN-YEAR EFFICIENCIES / BUDGETARY CONTROL

7.1 Ordinarily, results for the first quarter of any financial year are approached with caution, with 2021/22 being no different and since Covid 19 continues to place additional uncertainty on the budget at this early stage in the year.

7.2 Through budget monitoring processes and further investigate work, we are pursuing opportunities to extract Covid related spend from core budgets and utilise Covid reserves to ensure core expenditure is protected as much as possible. This requires finance and operational areas to work together in effective identification that provides an audit trail.

7.3 The Health and Social Care Moray senior management team are meeting regularly to review spend, identify additional savings and to track progress on transformational redesign so that corrective action and appropriate

disinvestment can be supported. The risks associated with less long term planning remain, and will need to be addressed as part of remobilisation.

8. IMPACT OF COVID – 19

8.1 To date there has been continued commitment from Scottish Government to provide additional funding to support health and social care as a result of the pandemic. This includes the use of Covid 19 specific reserves to support the remobilisation of services. At the time of writing this commitment does not extend beyond 31 March 2022 and further guidance on support for provider sustainability is awaited, however, the expectation is that reliance should reduce on certain elements of this support beyond 30 September 2021.

8.2 Health and Social Care Moray (HSCM) continue to provide quarterly returns to Scottish Government on the Local Mobilisation Plan (LMP) via NHS Grampian. The plan for 2021/22 estimates that additional in-year spend relating to Covid 19 will be £2.176 million to the end of the current financial year. Reported expenditure at the end of quarter 1 was £0.502 million. The costs are summarised below:

Description	**Spend to 30 June 2021 £000's**
Reducing Delayed Discharge	
Staffing	39
Provider Sustainability Payments	275
Remobilisation	13
Cleaning, materials & PPE	6
Elgin Community Hub (Oaks)	93
Prescribing	39
Unachievable Savings	28
Other	9
Total	**502**

9. CHANGES TO STAFFING ARRANGEMENTS

9.1 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.

9.2 Changes to staffing arrangements as dealt with under delegated powers through appropriate Council and NHS Grampian procedures for the period 1 Apr to 30 June 2021, are detailed in **APPENDIX 3**.

10. UPDATED BUDGET POSITION

10.1 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.

10.2 In addition, the MIJB, concluded the financial year 2020/21 in an underspend position following the application of reserves. Reserves totalling £6,342,395 were carried forward into 2021/22, of which £4,744,650 are ear-marked and £1,597,745 are a general reserve of which £1,554,267 has been utilised to support a balanced budget position as set out in the revenue budget paper presented to this Board on 25 March 2021 (para 9 of the minute refers).

10.3

	£'s
Approved Funding 26.3.21	**128,425,128**
Set Aside Funding 26.3.20	**12,252,000**
Balance of IJB reserves c/fwd to 20/21	4,788,128
Amended directions from NHSG 3.6.21	80,661
Budget adjustments M01-M03	
Public Health Earmarked	57,406
Primary Care	258,827
Hosted Recharges	175,214
Immunisation	80,000
Forres HUB	-28,000
Moray Core Uplift	2,500
PCIF	1,196,547
Cervical Screening	117,000
Psychological Therapy	86,406
Plasma Products	1,283
Winter planning	(295,000)
Misc	26,548
Revised Funding to Quarter 2	**147,224,647**

10.4 In accordance with the updated budget position, revised Directions have been included at **APPENDICES 4 and 5** for approval by the Board to be issued to NHS Grampian and Moray Council.

11. 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'

This report is consistent with the objectives of the Strategic Plan and includes budget information for services included in the MIJB Revenue Budget 2021/22.

(b) Policy and Legal

It is the responsibility of the organisation receiving the direction to work with the Chief Officer and Chief Financial Officer to deliver services within the resources identified. The Moray Integration Scheme (para 12.8 of the 2015 Integration Scheme) makes provision for dealing with in year variations to budget and forecast overspend by reference to agreed corrective action and recovery plans. It also makes provision for dealing with year-end actual overspend where such action and plans

have been unsuccessful in balancing the relevant budget by reference to use of MIJB reserves and additional payments from NHS Grampian and Moray Council.

(c) Financial implications

The financial details are set out in sections 3-8 of this report and in **APPENDIX 1**. For the period to 30 June 2021, an overspend is reported to the Board of £1,099,961.

The staffing changes detailed in paragraph 9 have already been incorporated in the figures reported.

The movement in the 2021/22 budget as detailed in paragraph 10 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. In particular, in relation to the Older People & PSD service. A separate report to this Board will be made on the pressures facing this service. This will be presented in November.

There are general and earmarked reserves brought forward in 2020/21. Additional savings continue to be sought and a recovery and transformation plan is in place in order to support the 2021/22 budget and beyond, which will be under regular review. Progress reports will be presented to this Board throughout the year in order to address the financial implications the MIJB is facing.

(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, the Finance Officers from Health and Social Care Moray and Tracey Sutherland, Committee Officer, Moray Council have been consulted and their comments have been incorporated in this report where appropriate.

12. CONCLUSION

12.1 The MIJB Budget to 30 June 2021 has an over spend of £1,073,403 on core services. Senior Managers will continue to monitor the financial

position closely and continue to report on the Recovery and Transformation Plan.

12.2 The financial position to 30 June 2021 reflects the updated budget position and revised Directions have been prepared accordingly, as detailed in APPENDICES 4 and 5.

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

MORAY INTEGRATION JOINT BOARD

JOINT FINANCE REPORT APRIL 2021 - JUNE 2021

	Para Ref	Annual Net Budget £'s 2021-22	Budget (Net) To Date £'s 2021-22	Actual To Date £'s 2021-22	Variance £'s 2021-22
Community Hospitals	4.1	5,395,111	1,314,546	1,338,775	(24,229)
Community Nursing		5,362,049	1,312,605	1,219,339	93,266
Learning Disabilities		8,061,332	1,680,623	1,744,272	(63,649)
Mental Health	4.4	8,881,466	2,125,157	2,326,967	(201,811)
Addictions		1,151,088	283,298	291,045	(7,748)
Adult Protection & Health Improvement		159,517	31,658	32,319	(661)
Care Services provided in-house		17,327,726	4,110,089	3,902,306	207,784
Older People & PSD Services	4.7	18,170,999	4,427,434	5,252,376	(824,942)
Intermediate Care & OT		1,617,142	447,831	426,149	21,682
Care Services provided by External Contractors		8,296,351	2,091,526	2,086,841	4,685
Other Community Services		8,324,141	2,047,475	1,969,490	77,985
Admin & Management		2,252,477	795,119	812,847	(17,728)
Primary Care Prescribing	4.9	16,948,172	4,352,878	4,591,060	(238,182)
Primary Care Services		17,176,100	4,298,321	4,308,137	(9,815)
Hosted Services		4,415,192	1,089,626	1,115,026	(25,400)
Out of Area	4.10	669,268	141,435	205,834	(64,399)
Improvement Grants		939,600	228,067	228,307	(240)
Total Moray IJB Core		125,147,731	30,777,686	31,851,089	(1,073,403)
Other Recurring Strategic Funds in the ledger	5	281	0	0	0
Other non-recurring Strategic Funds in the ledger	5	678,905	548,371	575,074	(26,703)

	Para Ref	Annual Net Budget £'s 2021-22	Budget (Net) To Date £'s 2021-22	Actual To Date £'s 2021-22	Variance £'s 2021-22
Total Moray IJB Including Other Strategic funds in the ledger		**125,826,916**	**31,326,057**	**32,426,163**	**(1,100,106)**
Other resources not included in ledger under core and strategic	**5**	**9,145,731**	**431,246**	**431,101**	**145**
Total Moray IJB (incl. other strategic funds) and other costs not in ledger		**134,972,647**	**31,757,303**	**32,857,264**	**(1,099,961)**
Set Aside Budget		**12,252,000**	**-**	**-**	**-**
Overall Total Moray IJB		**147,224,647**	**31,757,303**	**32,857,264**	**(1,099,961)**

Funded By:

NHS Grampian	100,182,649
Moray Council	47,041,998
IJB FUNDING	**147,224,647**

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.

HEALTH & SOCIAL CARE MORAY

DELEGATED AUTHORITY REPORTS - PERIOD April 2021 to June 2021

Title of DAR	Summary of Proposal	Post(s)	Permanent/ Temporary	Duration (if Temporary)	Effective Dates	Funding
Woodview Client	Client has left secure care at Kibble and is currently living at home with her Mother and Siblings. This situation is no longer sustainable and the plan is for her to move into a newly registered package of care/support at Woodview	Create 9.3FTE Support Workers @ Grade 4 Create 1FTE keyworker @ Grade 5	Permanent		From appointment	Funding via the Children's service
West Community Team Manager	Increase hours from 29 hours to 36.25 hours for grade 11 and reduce hours from 36.25 to 18 hours for grade 3	Grade 11 Team Manager 36.25 hours Grade 3 Clerical Assistant 18 hours	Permanent		From appointment	Fund variance from vacancy target
Advanced Practitioner SW for Mental Health	Amalgamate funds to create grade 10 post	Delete grade 4 and 2 x grade 9 posts and create 1 x grade 10 post	Permanent		From appointment	This leaves a surplus to be retained
Social Workers Access Team	Recruit 3.68FTE Social Workers for 10 months	Create 3.68FTE Grade 9	Temporary	10 months ends March 22	From Appointment	Funding via Covid

Staffing in START	Acting up from grade 3 to grade 5	Acting Grade 5 1FTE	Temporary	April to October	April	Funding via Covid
Commissioning team changes	Delete grade 10 and create grade 7 and grade 3	Delete Grade 10 Create grade 7 36.25 hours Create grade 3 30 hours	Permanent		From Appointment	This proposal creates a budget saving
Care Broker Service – clerical assistant posts	Transfer posts from delayed discharge to access team	Transfer Grade 3 x 2	Permanent		From Appointment	No budget implication
Assistant Self Directed Support & Carers Officer	Establish a temporary grade 5 36.25 hours post	Create temp Grade 5 Assistant Self Directed Support Officer	Temporary	12 months	From Appointment	Funding via Covid
Budget reallocation	Relocate budget from ESS to Artquins	Transfer Grade 7 36.25 hours	Permanent		From Appointment	No budget implication
OPDS/MRC	Address the needs of Older peoples day service and MRC	Delete grade 7 x 3 and grade 8 Create 3 x grade 7	Permanent		From Appointment	This proposal creates a budget saving
Care Home Assurance Nurse Moray	Moray Care Home Infection Control	Band 6 Full time	Permanent		From Appointment	Scottish Government recurring allocation
Community Nurse	Buckie District Nurses	Band 5 21.5hrs	Permanent		From Appointment	Scottish Government recurring allocation

Admin Assistant	Varis FNCT Administration (As part of the organisational change)	Band 3 37.5 hrs	Permanent		From Appointment	Internal budget reconfiguration.
Advanced Nurse/Clinical Practitioner - Discharge to Assess	Moray Discharge to Assess	Band 7 37.5hrs`	Permanent		From Appointment	New D2A team initially to be funded from General Reserves carry forward from 20/21 in 21/22. Now IJB Covid funding balance. Thereafter funding to be identified relating to Set Aside budget development.
Programme Manager for PCIP Implementation	PCIF Non Recurring	Band 8a 37.5 hrs	Temporary	24 months fixed term	From Appointment	From PCIF Slippage funding
Community Nurse	Varis FNCT (As part of the organisational change)	Band 6 90hrs	Permanent		From appointment	Internal budget reconfiguration
Heath Care Support Worker	Varis FNCT (As part of the organisational change)	Band 3 146hrs	Permanent		From appointment	Internal budget reconfiguration
Occupational Therapist	Occupational Therapy service	Band 6 22 hrs	Permanent		From appointment	Internal budget reconfiguration
Occupational Therapist	Homefirst delivery group Test of change to look at reducing the number of transfers to ED	Band 5 37.5	Temporary	12 months	From appointment	IJB Covid funding balance

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 30 September 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:-	£57.0 million, of which £0.4 million is ring fenced for Housing Revenue Account aids and adaptations.

This direction is effective from 30 September 2021.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 30 SEPTEMBER 2021**

SUBJECT: **MEMBERSHIP OF BOARD AND COMMITTEES**

BY: **CORPORATE MANAGER**

1. REASON FOR REPORT

1.1. To update the Board of progress in relation to the increase in membership, amendments to the Integration Scheme and re-appointments required.

2. RECOMMENDATION

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

i) notes the update provided in relation to the increase in voting membership;

ii) considers and notes the amendments to the Integration Scheme highlighted in Appendix 1;

iii) approves the re-appointment of members specified in section 4.3.

3. BACKGROUND

3.1. At the meeting of the Board on 28 January 2021 (para 7 of the minute refers) the board approved the changes to the integration scheme to increase voting membership from 3 to 4 from each of the partner organisations (Moray Council and Grampian Health Board) and instructed the Chief Officer to progress with the consultation and to submit to Scottish Government.

3.2. These actions were taken forward following the consultation process and the request was submitted to Scottish Government on 10 May 2021.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. Scottish Government returned the proposed changes to the Integration Scheme on 22 July 2021 and highlighted areas that they wished amended. This largely

related to minor points for additional definitions or formatting and some areas that required to be updated for terminology. These have been addressed and the tracked changes can be viewed in **Appendix 1**.

4.2. As part of this review it was identified that the length of time that a voting member should remain on the board is three years, at which time they should be reappointed or stand down and another member appointed from the relevant partner organisation.

4.3. Cllr. Shona Morrison, Cllr. Frank Brown, Cllr. Tim Eagle and Cllr Sonya Warren have been on the Board, representing the Council, for three years and require to be reappointed. At their meeting on 20 September 2021, Moray Council agreed the housekeeping exercise to reappoint all their representatives to the MIJB. Mr Sandy Riddell will have been on the board for three years in November 2021.

4.4. The second consultation process for the proposal to increase the number of voting members requires to be undertaken and will commence following approval from the Board. There were no comments received to the previous consultation. The last phase of consultation will be completed once the paper is considered by Moray Council on 11 November 2021. If there are no objections then it will be submitted to Scottish Government for ratification at this point.

4.5. Discussions are progressing for establishing representation from Third Sector, patients, service user and people with lived experience and carers in localities, strategic planning and commissioning group and for MIJB. An update will be provided to the next meeting.

4.6. Due to the imminent retiral of the council's Internal Audit Manager and the IJB's Chief Internal Auditor an appointment has now been made through an open recruitment process. The effective date is to be confirmed.

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"

Effective governance arrangements support the development and delivery of priorities and plans.

(b) Policy and Legal

The Board, through its approved Standing Orders for Meetings, established under the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014, ensures that affairs are administered in accordance with the law, probity and proper standards.

(c) Financial implications

There are no financial implications arising as a direct result of this report.

(d) Risk Implications and Mitigation

There are no risk implications arising as a direct result of this report.

(e) Staffing Implications
There are no staffing implications arising as a direct result of this report.

(f) Property
There are no property implications arising as a direct result of this report.

(g) Equalities/Socio Economic Impact
An Equalities Impact Assessment is not required as there are no changes to policy or procedures as a result of this report.

(h) Consultations
Consultation on this report has taken place with the Senior Solicitor (Litigation and Social Care) and Lissa Rowan, Committee Services Officer, Moray Council, who are in agreement with the report where it relates to their area of responsibility.

6. CONCLUSION

6.1. This paper sets out the position in relation to the membership of MIJB and the revisions required to the Scheme of Integration.

Author of Report: Jeanette Netherwood, Corporate Manager
Background Papers: None
Ref:

APPENDIX 1

Health and Social Care Integration Scheme for Moray

~~March 2018~~September 2021

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

Introduction

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

In revising the 201~~5~~8 Integration Scheme we have engaged with carers, people who currently use health and social care services in Moray, and our joint workforce. We have also subjected the draft revised Scheme to an extensive consultation exercise and have made further changes to the document based on the views and comments expressed both by people and the organisations ~~expressed by people and the organisations~~ who took the opportunity to respond.

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

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

Aims and Outcomes of the Integration Scheme

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

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

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

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

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

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

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

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

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

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

Our Vision, Purpose, Local Principles and Values

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

Our Vision

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

Our Purpose

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

Our Local Principles

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

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

Our values

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

Integration Scheme

The parties:

MORAY COUNCIL,

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

And

GRAMPIAN HEALTH BOARD,

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

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

1. Definitions and Interpretation

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

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

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

"Chief Social Work Officer" means the officer appointed by Moray Council in terms of Section 3 of the Social Work (Scotland) Act 1968

"Clinical, Care and Governance Committee" means the IJB committee that ~~To~~ supports and assists" the Board in achieving their clinical and care governance responsibilities in compliance with the Health and Social Care Integration, Clinical and Care Governance Framework Version 1 (Scottish Government published October 2015).

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

"Community Planning Board" means the Moray Community Planning Board established in terms of the Community Empowerment (Scotland) Act 2015 to consider the strategic development and monitor the performance of the partner agencies within Moray (which include both Moray Council and NHS Grampian ~~Health Board~~) in delivering Locality Plans, the Local Outcomes Improvement Plan and any wider CPP national matters.

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

"Executive Director of Nursing and Midwifery" means the post that is accountable for professional leadership for Nurses, Midwives and Allied Health Professionals within the organisation; setting standards and enuring the delivery of compassionate, caring and effective patient and family centred services.

"IJB" means the Moray Integration Joint Board established ~~by~~ by an Order made in accordance with section 9 ~~Order under section 9 of the Act;~~

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

"Integrated Budget" means the b~~B~~udget for the delegated resources for the functions set out in the Scheme;

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

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

"Integrated Workforce Plan" means the three year plan for workforce resources, produced collaboratively with Moray Council and NHS Grampian, aligned to the objectives of IJB and in accordance with the guidance from Scottish Government.

"NHS Grampian Clinical and Care Governance committee" means the committee that is responsible for demonstrating compliance with statutory requirements in relation to clinical governance, authorising an accurate and honest annual clinical governance statement and responding to scrutiny and

improvement reports by external bodies such as Healthcare Improvement Scotland (or any successor)

"Organisational Development Strategy" means the overarching planned and systematic approach to developing the culture and improving the effectiveness of the organisation, through engagement, communication, training and development of staff. It aligns strategy, individuals processes and values.

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

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

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

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

"Strategic Planning and Commissioning Group" means the forum that assists the IJB and Chief Officer through the development of key strategic outcomes and oversees, drives and strengthens strategic planning and commission of health and social care services across Moray.

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"Strategic Risk Register" means the register that outlines the identified risks to the implementation and achievement of the outcomes contained in the strategic plan, showing the controls, mitigation actions and potential impacts if the risk materialises.(17)

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

"The Administration Scheme" means the document that sets out the governance and structure by which the MIJB conducts its affairs. It details the structure of its Committees and the functions referred to these Committees

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

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

"tThe Scheme" means this Integration Scheme;

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

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

2. Local Governance Arrangements

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

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

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

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

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

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

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

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

3. Board Governance

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

3.1.1 The Council shall nominate four councillors; and

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

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

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

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

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

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

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

g) staff of the constituent authorities engaged in the provision of services provided under integration functions;

h) third sector bodies carrying out activities related to health or social care in the area of the local authority;

i) service users residing in the area of the local authority; and

j) persons providing unpaid care in the area of the local authority.

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

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

3.7.1 The first Chair was nominated by the Council.

3.7.2 The first term of the ~~Chair began~~Chair began on the date the IJB was established ~~and continued~~and continued until 30 September 2016 and second term of the Chair commenced 1 October 2016..

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

3.7.4 The Parties are entitled to change the person appointed by them as Chair or Vice Chair during the appointed period via the appropriate governance procedures within the Parties.

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

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

4. Delegation of Functions

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

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

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

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

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

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

5. Local Operational Delivery Arrangements

5.1 The local operational arrangements agreed by the Parties are:

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

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

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

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

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

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

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

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

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

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

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

5.8 For Inintegrated Sservices that the IJB does not have operational oversight of, the IJB shall be responsible for the strategic planning of those services. The IJB shall monitor performance of those services in terms of Ooutcomes delivered by comparison against the Strategic Plan via the Strategic Plan.

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

5.10 NHS Grampian will provide such information as may be reasonably required by the Chief Officer or the IJB in respect of the delivery of I~~i~~ntegrated S~~s~~ervices provided within hospitals that the IJB does not have operational oversight of.

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

6. Corporate Support Services

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

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

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

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

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

~~6.6 Before the end of April 2018, t~~The Parties ~~and the IJB~~ shall identify and keep under regular review suitable resources for corporate support for the IJB to allow it to fully discharge its duties under the act. These resources shall be considered as part of the IJB's annual budget setting and review process. Corporate support resources shall include appropriate advice and support to be given on areas such as finance, legal, human resources, information and Information and communication technologies. ~~will review the support services being provided to ensure that these are sufficient. The Parties and the IJB shall agree on the arrangements for future provision, including specifying how~~

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~~these requirements will be built into the IJB's annual budget setting and review process.~~

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7. Support for Strategic Planning

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

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

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

8. Targets and Performance Measurement

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

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

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

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

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

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

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

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

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

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

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

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9. Clinical and Professional Governance

9.1 Outcomes

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

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

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

9.2 General Clinical and Professional Governance Arrangements

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

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

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

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

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

9.3 Clinical and Professional Governance Framework

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

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

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

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

9.3.4 The Scottish Government's *Clinical and Care Governance Framework for Integrated Health and Social Care Services in Scotland, 2014* (or any updated version or replacement) outlines the proposed roles, responsibilities and actions that will be required to ensure governance

arrangements in support of the Act's integration planning and delivery principles and the required focus on improved Outcomes.

9.4 Staff Governance

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

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

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

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

9.4.4 The Standard places a reciprocal duty on staff to:

- Keep themselves up to date with developments relevant to their job within the organisation;

- Commit to continuous personal and professional development;
- Adhere to the standards set by their regulatory bodies;
- Actively participate in discussions on issues that affect them either directly or via their trade union/professional organisation;
- Treat all staff and patients with dignity and respect while valuing diversity; and
- Ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients, ~~and~~ carers and those with lived experience.

9.5 Interaction with the IJB, Strategic Planning Commissioning Group and Localities

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

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

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

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

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

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

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

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

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

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

9.6 Professional Leadership

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

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

9.6.3 In addition to the IJB's Clinical and Care Governance Committee, advice can be provided to the IJB and the Strategic Planning and Commissioning Group through the Clinical Executive Directors of NHS Grampian and the Chief Social Work Officer of the Council on professional / workforce, clinical / care and social care / social work governance matters relating to the development, delivery, and monitoring of the Strategic Plan, including the development of integrated service arrangements. The professional leads of the Parties can provide advice and raise issues directly with the IJB either in writing or through the representatives that sit on the IJB. The IJB will respond in writing to these issues where asked to do so by the Parties.

9.6.4 The key principles for professional leadership are as follows:

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

10. Chief Officer

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

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

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

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

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

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

10.7 The Chief Officer will have a formal relationship with service portfolio leads across Grampian, this includes those leading the delivery of acute services and fellow Chief Officers across the Grampian systemthe acute sector management team to determine that appropriate progress is made on the delivery of the Strategic Plan and to influence the development of wider system plans which may impact on the Moray population. Currently, the Chief Officer will line manages the Hospital General Manager and leadership team of Dr Gray's Hospital and will develop a combined performance and assurance reporting approach in accordance with the Chief Officer's remit as a member of the NHSG Grampian Chief Executive Team. This remains subject to final approval of the

NHS portfolio approach.~~meet with the General Manager of Acute Services under chairmanship of the Chief Executive of NHS Grampian on a monthly basis at the NHS Grampian Operational Management Board. It is anticipated that these meetings will also be attended by the Chief Officers of Aberdeen City and Aberdeenshire integration authorities.~~

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

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

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

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

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

11. Workforce

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

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

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

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

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

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

12. Finance

12.1 Financial Governance

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

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

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

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

12.1.5 Further details of financial governance and ~~fi~~Financial ~~r~~Regulations are contained in a separate document ~~outwith~~out with th~~e~~i~~s~~ Scheme.

12.2 Payments to the IJB – General

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

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

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

12.3 Payments to the IJB

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

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

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

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

12.4 Method for determining the amount set aside for hospital services

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

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

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

12.5 Financial Management of the IJB

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

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

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

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

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

12.6 Financial reporting to the IJB and the Chief Officer

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

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

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

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

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

12.7.1 Increases in payment by Parties to the IJB

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

12.7.2 Reductions in payment by Parties to the IJB

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

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

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

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

12.7.3 Variations to the planned payments by the IJB

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

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

12.7.4 IJB Overspend against payments

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

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

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

12.7.4.4 In future years of the IJB, either:

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

or

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

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

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

12.7.5 IJB underspend against payments

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

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

12.7.5.3 In the event of a return of funds to the Parties, the split of returned payments between Parties will be based on each Party's proportionate share of the baseline payment to the IJB,

regardless of which arm of the operational budget the underspend occurred in.

12.7.6 Planned Changes in Large Hospital Services

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

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

- activity changes based on demographic change;
- agreed activity changes from new interventions;
- cost behaviour;
- hospital efficiency and productivity targets; and
- an agreed schedule for timing of additional resource / resource released.

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

12.8 Capital

12.8.1 The use of capital assets in relation to integration functions

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

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

12.8.1.3 The Strategic Plan will drive the financial strategy and will provide the basis for the IJB to present proposals to the Parties to influence capital budgets and prioritisation.

12.8.1.4 A business case with a clear position on funding is required for any change to the use of existing assets or proposed use of new assets. The Chief Officer of the IJB is to develop business cases for capital investment for consideration by NHS Grampian and the Council as part of their respective capital planning processes.

12.8.1.5 The Chief Officer of the IJB will liaise with the relevant officer within each Party in respect of day-to-day asset related matters including any consolidation or relocation of operational teams.

12.8.1.6 It is anticipated that the Strategic Plan will outline medium term changes in the level of budget allocations for assets used by the IJB that will be acceptable to the Parties.

12.8.1.7 Any profits or loss on sale of an asset will be held by the Parties and not allocated to the IJB.

12.8.1.8 Depreciation budgets for assets used on delegated functions will continue to be held by each Party and not allocated to the IJB operations in scope.

12.8.1.9 The management of all other associated running costs (e.g. maintenance, insurance, repairs, rates, utilities) will be subject to local agreement between the Parties and the IJB.

13. Participation and Engagement

13.1 A comprehensive joint consultation on the December 2015 Scheme took place with further comprehensive joint consultations taking place in respect of the 2018 reviewed Scheme and 2021 revised Scheme. ~~between November 2014 and February 2015. Consultation on this revised Scheme took place in January 2018.~~

13.2 Media notifications were issued for the public and a newsletter for staff alerting them to the proposed revisions to the Scheme.
An email address was supplied for people to send their views.

13.3 The consultation draft revised Scheme was presented to NHS Grampian ~~Board~~ and elected members of the Council each time the Scheme was revised.

13.4 Principles endorsed by the Scottish Health Council and the National Standards for Community Engagement were followed in respect of ~~the~~ each consultation process, which included the following:

13.4.1 It was a genuine consultation exercise: the views of all participants were valued; ~~-~~

13.4.2 It was transparent: the results of the consultation exercise were published; ~~-~~

13.4.3 It was an accessible consultation: the consultation documentation was provided in a variety of formats; ~~-~~

13.4.4 It was being led by the Chief Officer: the Chief Officer and the IJB will be answerable to the people of Moray in terms of the content of the revised Scheme; ~~-~~

13.4.5 It is an on-going dialogue: the revised ~~Integration~~ Scheme will establish the parameters of the future strategic plans of the IJB.

13.5 The stakeholders consulted in the development of this revised Scheme were:

Health professionals;

Users of health care;
Carers of users of health care;
Commercial providers of health care;
Non-commercial providers of health care;
Social care professionals;
Users of social care;
Carers of users of social care;
Commercial providers of social care;
Non-commercial providers of social care;
Staff of NHS Grampian and the Council who are not health professionals or social care professionals;
Non-commercial providers of social housing; and
Third sector bodies carrying out activities related to health or social care and;
Other local authorities operating with the area of NHS Grampian preparing an integration scheme.

13.6 The Parties enabled the IJB to develop a Communications and Engagement Strategy by providing appropriate resources and support. The Communications and Engagement Strategy ensures significant engagement with, and participation by, members of the public, representative groups and other organisations in relation to decisions about the carrying out of integration functions. The Parties will encourage the IJB to access existing forums that the Parties have established, such as Public Partnership Forums, Community Councils, groups and other networks and stakeholder groups with an interest in health and social care.

14. Information Sharing and Confidentiality

14.1 The Parties shall agree to an appropriate information sharing accord and procedures for the sharing of information in relation to Inintegrated Ssservices. These shall set out the principles, policies, procedures and management

strategies around which information sharing is carried out. They will encapsulate national and legal requirements.

14.2 The Parties will work together to progress the specific arrangements, practical policies and procedures, designated responsibilities and any additional requirements for any purpose connected with the preparation of an integration scheme, the preparation of a strategic plan or the carrying out of integration functions.

14.3 The Parties shall be assisted in this process by a Joint Information Sharing Group. This group reviewed the existing Memorandum of Understanding and Information Sharing Protocol to see whether these were suitable for the purposes of integration, or whether replacements, modifications or supplements were considered necessary. The Group reported that the existing Memorandum of Understanding was sufficient.

14.4 If the Joint Information Sharing Group consider that a further high-level accord or information sharing protocol is required, or if amendments are necessary to existing ones, they shall assist the Parties and the IJB by preparing these and making them available with their recommendation to the IJB in the first instance for comment.

14.5 The information sharing accord and procedures may be amended or replaced by agreement of the Parties and the IJB. Regard will be taken of the NHS Information Governance Toolkit~~SASPI~~ template when revising or replacing these.

14.6 The Parties will continue to develop information technology systems and procedures to enable information to be shared appropriately and effectively between the Parties and the IJB.

15. Complaints

15.1 The Parties agree the following arrangements in respect of complaints:

15.2 Complaints should continue to be made to the Council and NHS Grampian using the existing mechanisms.

15.3 Complaints can be made to the Parties through any member of staff providing integrated services. Complaints can be made in person, by telephone, by email, or in writing. On completion of the complaints procedure, complainants may ask for a review of the outcome. At the end of the complaints process, complainants are entitled to take their complaint to the Scottish Public Services Ombudsman (or any such successor). Where appropriate, complainants will also be advised of their right to complain to the Care Inspectorate.

15.4 The Parties shall communicate with each other in relation to any complaint which requires investigation or input from the other organisation. This shall ensure that complaints procedures operate smoothly and in an integrated and efficient manner for the benefit of the complainant.

15.5 The Chief Officer will have an overview of complaints made about integrated services and subsequent responses. Complaints about integrated services will be recorded and reported to the Chief Officer on a regular and agreed basis.

15.6 Complaints will be used as a valuable tool for improving services and to identify areas where further staff training may be of benefit.

15.7 The Parties will ensure that all staff working in the provision of integrated services are familiar with the complaints procedures and that they can direct individuals to the appropriate complaints procedures.

15.8 The complaints procedures will be clearly explained, well-publicised, accessible, will allow for timely recourse and will sign-post independent advocacy services.

15.9 The Parties will aspire to have a streamlined and integrated process for complaints and will work to ensure that any future arrangements for complaints are clear and integrated from the perspective of the complainant. When this is achieved, the Scheme will be amended using the procedure required by the Act.

15.10 In developing a streamlined and integrated process for complaints, the Parties shall ensure that all statutory requirements will continue to be met, including timescales for responding to complaints.

15.11 In developing a single complaints process, the Parties will endeavour to develop a uniform way to review unresolved complaints before signalling individuals to the appropriate statutory review authority.

16. Claims Handling, Liability & Indemnity

16.1 The Parties and the IJB recognise that they could receive a claim arising from or which relates to the work undertaken on behalf of the IJB.

16.2 The Parties agree to ensure that any such claims are progressed quickly and in a manner which is equitable between them.

16.3 So far as reasonably practicable the normal common law and statutory rules relating to liability will apply.

16.4 Each party will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.

16.5 Each party will assume responsibility for progressing and determining any claim which relates to any heritable property which is owned by them. If there are any heritable properties owned jointly by the Parties, further arrangements for liability will be agreed upon in consultation with insurers.

16.6 In the event of any claim against the IJB or in respect of which it is not clear which party should assume responsibility then the Chief Officer (or his/her representative) will liaise with the Chief Executives of the Parties (or their representatives) and determine which party should assume responsibility for progressing the claim.

16.7 If a claim is settled by either party, but it subsequently transpires that liability rested with the other party, then that party shall indemnify the party which settled the claim.

16.8 Claims regarding policy and/or strategic decisions made by the IJB shall be the responsibility of the IJB. The IJB may require to engage independent legal advice for such claims.

16.9 If a claim has a “cross boundary” element whereby it relates to another integration authority area, the Chief Officers of the integration authorities concerned shall liaise with each other until an agreement is reached as to how the claim should be progressed and determined.

16.10 The IJB will develop a procedure for claims relating to hosted services with the other relevant integration authorities. Such claims may follow a different procedure than as set out above.

16.11 Claims which pre-date the establishment of the IJB will be dealt with by the Parties through the procedures used by them prior to integration.

17. Risk Management

17.1 A shared risk management strategy is in place, which includes risk monitoring and a reporting process for the Parties and the IJB. This will be updated as needed and particularly when the ~~his~~ Ss~~c~~heme is revised and any additional functions delegated so that it is updated by the time such functions are delegated to the IJB. In developing this shared risk management strategy, the Parties reviewed the shared risk management arrangements in operation, including the Parties ~~'~~ own Risk Registers.

17.2 There will be shared risk management across the Parties and the IJB for significant risks that impact on integrated service provision. The Parties and the IJB will consider these risks as a matter of course and notify each other where the risks may have changed.

17.3 The Parties will provide the IJB with support, guidance, and advice through their respective Risk Managers, to enable the IJB to maintain an ongoing fit for purpose risk management strategy to ensure that the risk management of the IJB is delivered to a high standard.

17.4 Any changes to the risk management strategy shall be requested through formal paper to the IJB.

17.5 A single Risk Register has been developed for the IJB. The process used in developing a single Risk Register was to involve members of the IJB establishing a risk framework by identifying risks to the development of the Strategic Plan. This risk ~~framework in~~framework in turn was used by operational units of ~~i~~integrated ~~-S~~services and each unit was required to contribute towards the Risk Register by identifying relevant risks and mitigation of those risks.

17.6 The single Risk Register will continue to be developed alongside the Strategic Plan, and will be modified as necessary in line with the development of the Strategic Plan~~...~~

18. Dispute resolution mechanism

18.1 This provision relates to disputes between NHS Grampian and the Council in respect of the IJB or their duties under the Act. This provision does not apply to internal disputes within the IJB. ~~itself.~~

18.2 Where either of the Parties fails to agree with the other on any issue related to the~~is~~ Scheme and/or the delivery of integrated health and social care services, then they will follow the process as set out below:

(a) The Chief Executives of NHS Grampian and the Council and the Chief Officer of the IJB will meet to resolve the issue;

(b) If unresolved, NHS Grampian and the Council and the IJB will each prepare a written note of their position on the issue and exchange it with the others within 21 calendar days of the meeting in (a);~~.~~

(c) Within 14 calendar days of the exchange of written notes in (b) the Chief Executives and Chief Officer must meet to discuss the written positions.

(d) In the event that the issue remains unresolved, the Chief Executives and the Chief Officer will proceed to mediation with a view to resolving the issue. The Chief Officer will appoint a professional independent mediator. The cost of mediation, if any, will be split equally between the Parties. The mediation process will commence within 28 calendar days of the meeting in (c);~~.~~

(e) Where the issue remains unresolved after following the processes outlined in (a)-(d) above and if mediation does not allow an agreement to be reached within 6 months from its commencement, or any other such time as the parties may agree, either party may notify Scottish Ministers that agreement cannot be reached;~~.~~

(f) Where the Scottish Ministers make a determination on the dispute, that determination shall be final and the Parties and the IJB shall be bound by the determination.

Annex 1

Part 1

Functions delegated by NHS Grampian~~the Health Board~~ to the Integration Joint Board

The functions which are to be delegated by ~~the Health Bo~~NHS Grampian ~~ard~~ to the Integration Joint Board are set out in this Part 1 of Annex 1 and are subject to the exceptions and restrictions specified or referred to. The services to which these functions relate are set out in Part 2 of this Annex 1.

Functions prescribed for the purposes of section 1(8) of the Act

Column A	*Column B*
The National Health Service (Scotland) Act 1978	

All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of—
	
	section 2(7) (Health Boards);
	
	section 2CB([1]) (Functions of Health Boards outside Scotland);
	
	section 9 (local consultative committees);
	
	section 17A (NHS Contracts);
	
	section 17C (personal medical or dental services);
	
	section 17I([2]) (use of accommodation);

([1]) Section 2CA was inserted by S.S.I. 2010/283, regulation 3(2).
([2]) Section 17I was inserted by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2 and amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4. The functions of the Scottish Ministers under section 17I are conferred on Health Boards by virtue of S.I. 1991/570, as amended by S.S.I. 2006/132.

section 17J (Health Boards' power to enter into general medical services contracts);

section 28A (remuneration for Part II services);

section 38([3]) (care of mothers and young children);

section 38A([4]) (breastfeeding);

section 39([5]) (medical and dental inspection, supervision and treatment of pupils and young persons);

section 48 (provision of residential and practice accommodation);

section 55([6]) (hospital accommodation on part payment);

section 57 (accommodation and services for private patients);

section 64 (permission for use of facilities in private practice);

([3]) The functions of the Secretary of State under section 38 are conferred on Health Boards by virtue of S.I. 1991/570.
([4]) Section 38A was inserted by the Breastfeeding etc (Scotland) Act 2005 (asp 1), section 4. The functions of the Scottish Ministers under section 38A are conferred on Health Boards by virtue of S.I. 1991/570 as amended by S.S.I. 2006/132.
([5]) Section 39 was relevantly amended by the Self Governing Schools etc (Scotland) Act 1989 (c.39) Schedule 11; the Health and Medicines Act 1988 (c.49) section 10 and Schedule 3 and the Standards in Scotland's Schools Act 2000 (asp 6), schedule 3.
([6]) Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

section 75A([7]) (remission and repayment of charges and payment of travelling expenses);

section 75B([8])(reimbursement of the cost of services provided in another EEA state);

section 75BA ([9])(reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);

section 79 (purchase of land and moveable property);

section 82([10]) use and administration of certain endowments and other property held by Health Boards);

section 83([11]) (power of Health Boards and local health councils to hold property on trust);

section 84A([12]) (power to raise money, etc., by appeals, collections etc.);

([7]) Section 75A was inserted by the Social Security Act 1988 (c.7), section 14, and relevantly amended by S.S.I. 2010/283. The functions of the Scottish Ministers in respect of the payment of expenses under section 75A are conferred on Health Boards by S.S.I. 1991/570.

([8]) Section 75B was inserted by S.S.I. 2010/283, regulation 3(3) and amended by S.S.I. 2013/177.

([9]) Section 75BA was inserted by S.S.I. 2013/292, regulation 8(4).

([10]) Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 7) section 1(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.

([11]) There are amendments to section 83 not relevant to the exercise of a Health Board's functions under that section.

([12]) Section 84A was inserted by the Health Services Act 1980 (c.53), section 5(2). There are no amendments to section 84A which are relevant to the exercise of a Health Board's functions.

section 86 (accounts of Health Boards and the Agency);

section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);
section 98 ([13]) (charges in respect of non-residents); and

paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);

and functions conferred by—

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ([14]);

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302;

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000/54;

The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004/114;

([13]) Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.S.I. 1991/570.
([14]) S.I. 1989/364, as amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/455; S.S.I. 2005/572 S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

	The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004;
	The National Health Service (Discipline Committees) Regulations 2006/330;
	The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006/135;
	The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183;
	The National Health Service (General Dental Services) (Scotland) Regulations 2010/205; and
	The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55([15]).

Disabled Persons (Services, Consultation and Representation) Act 1986

Section 7 (Persons discharged from hospital)	

Community Care and Health (Scotland) Act 2002

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	

([15]) S.S.I. 2011/55, to which there are amendments not relevant to the exercise of a Health Board's functions.

Mental Health (Care and Treatment) (Scotland) Act 2003

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (Approved medical practitioners); section 34 (Inquiries under section 33: co-operation)([16]); section 38 (Duties on hospital managers: examination notification etc.)([17]); section 46 (Hospital managers' duties: notification)([18]); section 124 (Transfer to other hospital); section 228 (Request for assessment of needs: duty on local authorities and Health Boards); section 230 (Appointment of a patient's responsible medical officer); section 260 (Provision of information to patients); section 264 (Detention in conditions of excessive security: state hospitals); section 267 (Orders under sections 264 to 266: recall);

([16]) There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.
([17]) Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards under that Act.
([18]) Section 46 is amended by S.S.I. 2005/465.

section 281([19]) (Correspondence of certain persons detained in hospital);

and functions conferred by—

The Mental Health (Safety and Security) (Scotland) Regulations 2005([20]);

The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005([21]);

The Mental Health (Use of Telephones) (Scotland) Regulations 2005([22]); and

The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008([23]).

([19]) Section 281 is amended by S.S.I. 2011/211.
([20]) S.S.I. 2005/464, to which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([21]) S.S.I. 2005/467. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([22]) S.S.I. 2005/468. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([23]) S.S.I. 2008/356. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

Education (Additional Support for Learning) (Scotland) Act 2004

Section 23 (other agencies etc. to help in exercise of functions under this Act**)**	

Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by— section 31(Public functions: duties to provide information on certain expenditure etc.); and section 32 (Public functions: duty to provide information on exercise of functions).

Patient Rights (Scotland) Act 2011

All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36([25]).

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(6) of the Public Bodies (Joint Working) (Scotland) Act 2014
Colums A and B

Carers (Scotland) Act 2016

Section 31([24])	

([24]) Inserted by Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Amendment Regulations 2017/381 (Scottish SI) reg. 2 (December 18, 2017)
([25]) S.S.I. 2012/36. Section 5(2) of the Patient Rights (Scotland) Act 2011 (asp 5) provides a definition of "relevant NHS body" relevant to the exercise of a Health Board's functions.

(Duty to prepare local carer strategy)

Part 2

Services currently provided by NHS Grampian~~the Health Board~~ which are to be delegated

A

Interpretation of this Part 2 of Annex 1

1. In this part—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

"general medical practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004([26]); and

"the public dental service" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

([26]) S.S.I. 2004/115.

B

Provision for people over the age of 18

The functions listed in Part 1 of this Annex 1 are delegated only to the extent that:

a) the function is exercisable in relation to persons of at least 18 years of age;
b) the function is exercisable in relation to care or treatment provided by health professionals for the purpose of health care services listed at numbers 2 to 7 below; and
c) the function is exercisable in relation to the following health services:

2. Accident and Emergency services provided in a hospital.

3. Inpatient hospital services relating to the following branches of medicine—

(a) general medicine;
(b) geriatric medicine;
(c) rehabilitation medicine;
(d) respiratory medicine; and
(e) psychiatry of learning disability.

4. Palliative care services provided in a hospital.

5. Inpatient hospital services provided by General Medical Practitioners.

6. Services provided in a hospital in relation to an addiction or dependence on any substance.

7. Mental health services provided in a hospital, except secure forensic mental health services.

8. District nursing services.

9. Services provided outwith a hospital in relation to an addiction or dependence on any substance.

10. Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

11. The public dental service.

12. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([27]).

13. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([28]).

14. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([29]).

15. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([30]).

([27]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.
([28]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.
([29]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.
([30]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28),

16. Services providing primary medical services to patients during the out-of-hours period.

17. Services provided outwith a hospital in relation to geriatric medicine.

18. Palliative care services provided outwith a hospital.

19. Community learning disability services.

20. Mental health services provided outwith a hospital.

21. Continence services provided outwith a hospital.

22. Kidney dialysis services provided outwith a hospital.

23. Services provided by health professionals that aim to promote public health.

24. Sexual health services provided in the community.

section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

C

Provision for people under the age of 18

The functions listed in Part 1 of Annex 1 are also delegated to the extent that:

a) the function is exercisable in relation to persons of less than 18 years of age; and

b) the function is exercisable in relation to the following health services:

25. The public dental service.

26. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([31]).

27. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([32]).

28. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([33]).

29. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([34]).

([31]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.

([32]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.

([33]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.

([34]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28), section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

Part 3

Services currently provided by NHS Grampian~~the Health Board~~ to those under 18 years of age, which are to be operationally devolved to the Chief Officer of the Integration Joint Board.

30. Health Visiting

31. School Nursing

32. All services provided by Allied Health Professionals, as defined in Part 2A of this Annex 1, in an outpatient department, clinic, or outwith a hospital.

Annex 2

Part 1

Functions delegated by the Local Authority to the Integration Joint Board

The functions which are to be delegated by the Local Authority to the Integration Joint Board are set out in this Part 1 of Annex 2 and are subject to the exceptions and restrictions specified or referred to. The services to which these functions relate are set out in Part 2 of this Annex 2.

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A *Enactment conferring function*	*Column B* *Limitation*
National Assistance Act 1948([35])	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958([36])	
Section 3 (Provision of sheltered employment by local authorities)	

([35]) 1948 c.29; section 48 was amended by the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 39, paragraph 31(4) and the Adult Support and Protection (Scotland) Act 2007 (asp 10) schedule 2 paragraph 1.

([36]) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
The Social Work (Scotland) Act 1968([37])	
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.

([37]) 1968 c.49; section 1 was relevantly amended by the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Children Act 1989 (c.41), Schedule 15; the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), schedule 10; S.S.I. 2005/486 and S.S.I. 2013/211. Section 4 was amended by the 1990 Act, Schedule 9, the Children (Scotland) Act 1995 (c.36) ("the 1995 Act"), schedule 4; the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ("the 2003 Act"), schedule 4; and S.S.I. 2013/211. Section 10 was relevantly amended by the Children Act 1975 (c.72), Schedule 2; the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 13; the Regulation of Care (Scotland) Act 2001 (asp 8) ("the 2001 Act") schedule 3; S.S.I. 2010/21 and S.S.I. 2011/211. Section 12 was relevantly amended by the 1990 Act, section 66 and Schedule 9; the 1995 Act, Schedule 4; and the Immigration and Asylum Act 1999 (c.33), section 120(2). Section 12A was inserted by the 1990 Act, section 55, and amended by the Carers (Recognition and Services) Act 1995 (c.12), section 2(3) and the Community Care and Health (Scotland) Act 2002 (asp 5) ("the 2002 Act"), sections 8 and 9(1). Section 12AZA was inserted by the Social Care (Self Directed Support) (Scotland) Act 2013 (asp 1), section 17. Section 12AA and 12AB were inserted by the 2002 Act, section 9(2). Section 13 was amended by the Community Care (Direct Payments) Act 1996 (c.30), section 5. Section 13ZA was inserted by the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 64. Section 13A was inserted by the 1990 Act, section 56 and amended by the Immigration and Asylum Act 1999 (c.33), section 102(2); the 2001 Act, section 72 and schedule 3; the 2002 Act, schedule 2 and by S.S.I. 2011/211. Section 13B was inserted by the 1990 Act sections 56 and 67(2) and amended by the Immigration and Asylum Act 1999 (c.33), section 120(3). Section 14 was amended by the Health Services and Public Health Act 1968 (c.46), sections 13, 44 and 45; the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Guardianship Act 1973 (c.29), section 11(5); the Health and Social Service and Social Security Adjudications Act 1983 (c.41), schedule 10 and the 1990 Act, schedule 9. Section 28 was amended by the Social Security Act 1986 (c.50), Schedule 11 and the 1995 Act, schedule 4. Section 29 was amended by the 1995 Act, schedule 4. Section 59 was amended by the 1990 Act, schedule 9; the 2001 Act, section 72(c); the 2003 Act, section 25(4) and schedule 4 and by S.S.I. 2013/211.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982([38])	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986([39])	

([38]) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.
([39]) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000([40])	
Section 10 (Functions of local authorities.)	
Section 12 (Investigations.)	

([40]) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions.
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions.
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions.
The Housing (Scotland) Act 2001([41])	
Section 92 (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002([42])	

([41]) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.
([42]) 2002 asp 5.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 5 (Local authority arrangements for of residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003([43])	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	

([43]) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	
Section 259 (Advocacy.)	
The Housing (Scotland) Act 2006([44])	
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007([45])	
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	
Section 6 (Duty to consider importance of providing advocacy and other.)	
Section 7 (Visits)	

([44]) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.
([45]) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 8 (Interviews)	
Section 9 (Medical Examinations)	
Section 10 (Examination of records etc)	
Section 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 16 (Moving adult at risk in pursuance of removal order)	
Section 18 (Protection of moved persons' property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Social Care (Self-directed Support) (Scotland) Act 2013([46])	
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	

([46]) 2013 asp 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
Carers (Scotland) Act 2016([47])	
Section 6([48]) (Duty to prepare of adult carer support plan)	
Section 21([49]) (Setting of local eligibility criteria.)	
Section 24([50]) (Duty to provide support)	
Section 25([51]) (Provision of support to carers: breaks from caring)	
Section 31([52]) (Duty to prepare local carer strategy)	
Section 34([53]) (Information and advice service for carers)	
Section 35([54]) (Short breaks services statements)	

([47]) Section 21 was inserted into the Schedule of the Public Bodies (Joint Working) (Scotland) Act 2014 by paragraph 6 of the schedule of the Carers (Scotland) Act 2016 (asp 9).
([48]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([49]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017/190 (Scottish SI) reg. 2(2) (June 16 2017).
([50]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([51]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([52]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([53]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)
([54]) Inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg. 3(2) (December 13th 2017)

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A	*Column B*
Enactment conferring function	*Limitation*
The Community Care and Health (Scotland) Act 2002	
Section 4([55]) The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([56])	

([55]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 62(3).
([56]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

Part 2

Services currently provided by the Local Authority which are to be integrated

The functions listed in Part 1 of this Annex 2 are delegated only to the extent that:

a) the function is exercisable in relation to persons of at least 18 years of age; and

b) the function is exercisable in relation to the following services:

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptions
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare

Annex 3

Hosted Services

NHS Grampian has noted the services that are currently hosted across the areas of the Grampian IJBs and offer this for consideration to the IJB as they take forward strategic planning:

Service	Current Host
Sexual Health Services	Aberdeen City
Woodend Assessment of the Elderly (including Links Unit at City Hospital)	Aberdeen City
Woodend Rehabilitation Services (including Stroke Rehab, Neuro Rehab, Horizons, Craig Court and MARS)	Aberdeen City
Marie Curie Nursing	Aberdeenshire
Heart Failure Service	Aberdeenshire
Continence Service	Aberdeenshire
Diabetes MCN (including Retinal Screening)	Aberdeenshire
Chronic Oedema Service	Aberdeenshire
HMP Grampian	Aberdeenshire
Police Forensic Examiners	Aberdeenshire

Annex 4

This Annex lists the services provided within hospitals which the IJB will have strategic planning responsibilities for which will continue to be operationally managed by NHS Grampian:

Services:

- Accident & Emergency Services provided in a hospital;
- Inpatient hospital services relating to: general medicine, geriatric medicine, rehabilitation medicine, respiratory medicine and psychiatry of learning disability; and
- Palliative Care services provided in a hospital.

In so far as they are provided within the following hospitals:

- Hospitals at the Foresterhill Site, Aberdeen (which includes Aberdeen Royal Infirmary, Royal Aberdeen Childrens Hospital and Aberdeen Maternity Hospital)
- Hospitals in Elgin (which includes Dr Gray's Hospital)

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 30 SEPTEMBER 2021**

SUBJECT: **THE INDEPENDENT REVIEW OF ADULT SOCIAL CARE & NATIONAL CARE SERVICE CONSULTATION**

BY: **NEIL STRACHAN, LEAD FOR STRATEGY & PERFORMANCE & DEPUTY CHIEF OFFICER**

1. REASON FOR REPORT

1.1. To update the Moray Integration Joint Board (MIJB) in relation to the Independent Review of Adult Social Care (IRASC), the current consultation period on establishing a National Care Service (NCS) and proposals for developing a MIJB response.

2. RECOMMENDATION

2.1 It is recommended that the MIJB:

i) consider and note the content of this report on the IRASC and NCS consultation, and;

ii) endorse the completion of a MIJB response, for approval by the Chair prior to submission.

3. BACKGROUND

3.1. A report was submitted to the MIJB on 24 June 2021 (para 11 refers) advising of the publication, content and focus of the IRASC which was released in early February 2021. The review was commissioned by the Scottish Government and was independently chaired by Derek Feeley, supported by an expert panel and is available at https://www.gov.scot/groups/independent-review-of-adult-social-care/

3.2. The review sets out an ambitious vision that, if fully implemented, has the potential to transform the lives of people with social care needs, unpaid carers and the wider adult social care sector. Implementation of the review recommendations will form part of the programme for government for the next election term.

3.3. A key recommendation in the IRASC is the formation of a National Care Service for Scotland (NCS). Widespread consultation has now commenced in relation to the creation of the NCS. The consultation period lasts until 2 November 2021 and a dedicated Scottish Government online area has been created at https://consult.gov.scot/health-and-social-care/a-national-care-service-for-scotland/

4. KEY MATTERS RELEVANT TO RECOMMENDATION

A National Care Service for Scotland

4.1 One of the most significant changes recommended by the IRASC is the development of a National Care Service (NCS). This would operate as a new body to oversee social care, similar to how the National Health Service oversees health, described as enabling social care to have a more equal footing with health care. As part of this proposed new structure responsibilities would shift from local authorities to national government, with a new Minister being appointed to oversee social care. The role of the NCS would include:

- Overseeing commissioning and procurement. The review recommends that the NCS should set national standards while Integration Authorities should be responsible for commissioning and procurement at a local level, as well as being responsible for GP contracts;
- The NCS would lead on workforce development, including improvement programmes to raise standards;
- For people whose needs are highly complex, their social care provision would be overseen by the NCS;
- The NCS and NHS would both develop a set of joint outcome measures, which would set the standards for health and social care;
- The Care Inspectorate and Scottish Social Services Council would to be part of the NCS, allowing the NCS to play a role in the inspection of services and the regulation of the social care workforce;
- The NCS would address gaps in social care in relation to workforce planning, data and research, IT and service planning.

Consultation on establishing a National Care Service (NCS)

4.2 The Scottish Government has commenced a widespread consultation into the development of the NCS, running from 9 August until 2 November 2021. The consultation document goes into areas which the IRASC didn't cover in terms of the future development of IJBs and the delegation of services. For example, it asserts that all children's and justice services should be delegated and delivered as part of the NCS.

4.3 The consultation document is lengthy and contains approximately 100 questions, seeking feedback in relation to the following themes (each reflecting a chapter in the document):

- Improving care for people
- The National Care Service

- The scope of the NCS
- Reformed Integration Boards
- Commissioning of Services
- Regulation
- Valuing people who work in Social Care

Community Health and Social Care Boards

4.4 The IRASC recommends that Integration Authorities, created under the Public Bodies (Joint Working) (Scotland) Act 2014, should be reformed to take full responsibility for the commissioning and procurement of adult social care support locally, accountable directly to the Scottish Government as part of the National Care Service.

4.5 A further development in the consultation document is the proposal that IJBs should reform into Community Health and Social Care Boards (CHSCBs) which would become the sole local delivery bodies for health and social care. CHSCBs would be accountable directly to ministers, funded by the NCS and aligned with local authority boundaries. The consultation document asks for consideration that CHSCBs become employing authorities, with the Chief Officer roles becoming Chief Executives in their own right, reporting to the Chief Executive of the NCS). As well as authority for planning, commissioning and procurement, it is proposed that management of the GP contract also sits with CHCBs.

Developing a local MIJB response

4.6 On the 16 September a MIJB development session was held along with Health and Social Care Moray (HSCM) leaders in order to inform a MIJB response to the consultation. The session involved the use of facilitated breakout sessions to encourage a wide contribution to the consultation themes.

4.7 A draft response will be prepared following this session. This response will very likely require to note and accept diverse views and opinions. It is not intended that a single, shared set of responses be elicited. It is proposed that a draft response is collated, shared and approved on behalf of the MIJB by the Chair/Vice Chair. In addition, a request has been made to facilitate a similar session for all elected members, which will be arranged within the timescales of the consultation.

4.8 In addition to contributing to the proposed response, individuals, groups or teams are free to respond to the consultation as they see fit via the links and resources at https://consult.gov.scot/health-and-social-care/a-national-care-service-for-scotland/

Early reactions

4.9 How has the IRASC report landed?

- COSLA and SOLACE endorse principles of empowering people, valuing the workforce and embedding a human rights approach to social care.

- Concern at the recommendation to remove accountability for social care from local government and give to Scottish Ministers
- Review is strongly supported by Disability Groups, Carers organisations, third sector providers and Scottish Care – including creation of NCS.
- Health and Social Care Scotland (Chief Officers' network) agreed to work collaboratively to work on areas of 'common ground', though some areas have expressed a degree of concern as to how certain aspects of the review findings will sit alongside a locally governed approach.

4.10 Further reaction since the consultation launch:

- COSLA has released a strong response and expressed concerns over implications of the NCS consultation focus, describing it as being significantly at odds with how local government functions in Scotland. Concern was expressed by COSLA in relation to 'departures' from the IRASC itself in relation to elements of the consultation document which were not features of the IRASC report.
- Concerns have been expressed as to the length of time available to consult, which although now slightly extended, is a shorter time frame than the Scottish Government's own guidelines in relation to consultation on major service change.

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"

This links to Outcome 7 of the Strategic Commissioning Plan "Partners in Care" – People using health and social care services are safe from harm.

(b) Policy and Legal

Social Work (Scotland) Act 1968; Carers (Scotland) Act 2016

(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

There is no requirement for an equality impact assessment because there is no change to policy required as a result of this report.

(h) Consultations

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

Health & Social Care Moray Senior Management Team
Tracey Sutherland, Committee Services Officer, Moray Council

6. CONCLUSION

6.1. The Adult Social Care Review proposed complex change for adult social care. The early indicators are that many aspects have widespread support however there is much detail to be worked through with multiple stakeholders.

6.2. The consultation in relation to the formation of a National Care Service is eliciting strong and diverse opinion, and widespread engagement with the consultation is encouraged in order to convey the range and volume of feedback being generated.

Authors of Report: N Strachan, Lead for Strategy & Performance & Deputy Chief Officer
Background Papers:
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 30 SEPTEMBER 2021**

SUBJECT: **OUTCOME BASED CARE AT HOME**

BY: **CHIEF SOCIAL WORK OFFICER**

1. REASON FOR REPORT

1.1. To provide the Board with a progress update in relation to 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) consider and note the content of this report.

3. BACKGROUND

3.1 The Independent Review of Adult Social Care in Scotland recommended a range of changes needed in commissioning, the report can be found here: https://www.gov.scot/groups/independent-review-of-adult-social-care/ 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.

3.2 Nationally and locally, the homecare sector is fragile with significant concerns in workforce and provider sustainability as well as increasing demands and costs. Demand for Care at Home in Moray has increased year on year. This is a strain on the care at home providers across Moray to deliver on increasing demand. Health and Social Care Moray (HSCM) long term contract arrangements for care at home expire on 1 November 2021 allowing for a change in commissioning, to tender for flexible and good quality outcome focused care.

3.3 At a meeting of the Board on 25 March 2021 (para 11 of the minutes refer), the Board agreed to note the new model of Care at Home commissioning tender, which involved HSCM working with one care at home external partner to jointly deliver an outcome based care at home service across Moray.

Tender Process

3.4 The care at home project team, including a Senior Commissioning Officer and Procurement Officer, led on the procurement of the new service from tender submission and evaluation, to contract award and the Commissioning Team will take on the contract management role.

3.5 New providers were given the opportunity to engage directly with the Commissioning Officers to fully understand the tender requirements, which involves the successful applicant working with HSCM internal homecare service as equal partners and moving away from time and task allocations.

National Flexible Framework

3.6 Providers were also given the opportunity and support from Commissioning Officers to join the Scotland Excel Care and Support Framework, which offers an alternative mechanism to continue to delivering care and support across Moray.

3.7 This flexible framework is a collaborative agreement for the provision of care and support services (care at home and supported living/housing support services) in Scotland. It is the first framework approach for Care and Support services on nationally agreed terms and conditions, service delivery and quality standards.

3.8 Within the national flexible framework, organisations can apply to be on the framework at set points (quarterly) during the life of the contract. Organisations can register for the services they provide and can add or remove services as their business changes; this offers flexibility to respond to market changes.

3.9 The overarching aim of the flexible framework is to increase choice for people using services and deliver value for money in terms of price, service and quality. It will also increase transparency in the market and an improved understanding of the cost of Care and Support services. It also seeks to drive innovation and best practice on a national level.

Service User Involvement

3.10 To support user involvement in commissioning the new service, in May 2021 a questionnaire was sent to all individuals in receipt of an external care at home service to help identify priority service outcomes.

3.11 171 service users and carers returned their questionnaire, giving a response rate of 47%.

3.12 In terms of assurance that the Health and Social Care Standards were being met by external services, the survey found that:

- 83% experienced high quality care and support that was right for them.
- 75% were involved in decisions about their care and support.
- 90% had confidence in the people who supported and cared for them.

- 71% had confidence in the organisation providing their care and support.
- Almost everyone (95%) indicated they were treated with dignity and respect.
- The vast majority (95%) agreed their service helped them to feel safe at home.
- 88% indicated they felt able to live more independently as a result of the support from their home carers.

3.13 Respondents to the survey were invited to indicate their interest in being involved in the procurement process to ensure it reflected the results of the wider service user and carer engagement.

3.14 Five people agreed to form a lived experience tender panel to support the decision making process of commissioning an outcomes focused care at home partner. The scoring from the lived experience evaluation panel contributed to the overall tender scoring process. The full engagement report can be found in **Appendix 1**.

3.15 In line with the Independent Review of Adult Social Care and Self Directed Support (SDS) standards, service users and carers will continue to be engaged in the ongoing monitoring of the new service.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 There were five submissions received for the care at home contract. Following due process, the contract was awarded to Allied Healthcare with a contract start date of 1 Nov 2021. The contract has been awarded for a 3 year period with an option to extend by 2 x 12 month extensions.

4.2 The Regional Director for Allied Healthcare stated “this was a fantastic opportunity to work alongside HSCM as an extended arm of the Council’s care at home service”. These are exciting times for Allied Healthcare, we are entering into a partnership with a priority on providing quality outcome focused care and support for all across Moray, and I am confident that we are more than ready for this challenge”.

4.3 The underpinning joint transitional project plan aims to ensure collaboratively 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 transition plan includes the following joint workstreams:

- **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 two-month development period.

4.4 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

The contract was awarded to Allied who returned an hourly rate below the national average but an increase to their previous rate. The actual financial pressure arising from this contract award will be dependent on take up and the timing of individuals moving over. The Chief Financial Officer will retain close observation on how this progresses, adjusting any previous budget pressures allowed for as appropriate.

(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 and the national flexible framework.

(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 Commissioning Officer; Service Manager Internal Services, Internal Home Care Managers, Equal Opportunities Officer, Corporate Manager, Tracey Sutherland, Committee Services Officer; have been consulted and comments incorporate for their areas of responsibility

6. CONCLUSION

6.1. The Board are asked to note the progress towards 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 unique partnership to deliver care across Moray.

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

Care at home external services engagement report

The experiences of people who receive a service and their unpaid carers

June 2021

Contents

1. About the report

This report presents the findings from the care at home engagement survey carried out during May 2021 in support of the commissioning of a new outcome-focused service from a single external provider from 01 November 2021.

The purpose of the survey was to monitor levels of satisfaction with current services and how well the Health and Social Care Standards were being met by providers. It also aimed to improve understanding of the aspects of care that matter most to people through highlighting needs, issues and opportunities for improvement.

The survey was conducted as a postal survey where a paper questionnaire was sent to all persons identified on CareFirst as being in receipt of a care at home service from an externally commissioned provider during week commencing 12 April 2021.

A total of 361 questionnaires were issued and 171 returned, giving a response rate of 47%.

2. Key findings

In terms of assurance that the Health and Social Care Standards are being met by external services, the survey found that:

- 83% experienced high quality care and support that was right for them.
- 75% were involved in decisions about their care and support.
- 90% had confidence in the people who supported and cared for them.
- 71% had confidence in the organisation providing their care and support.

Outcomes:

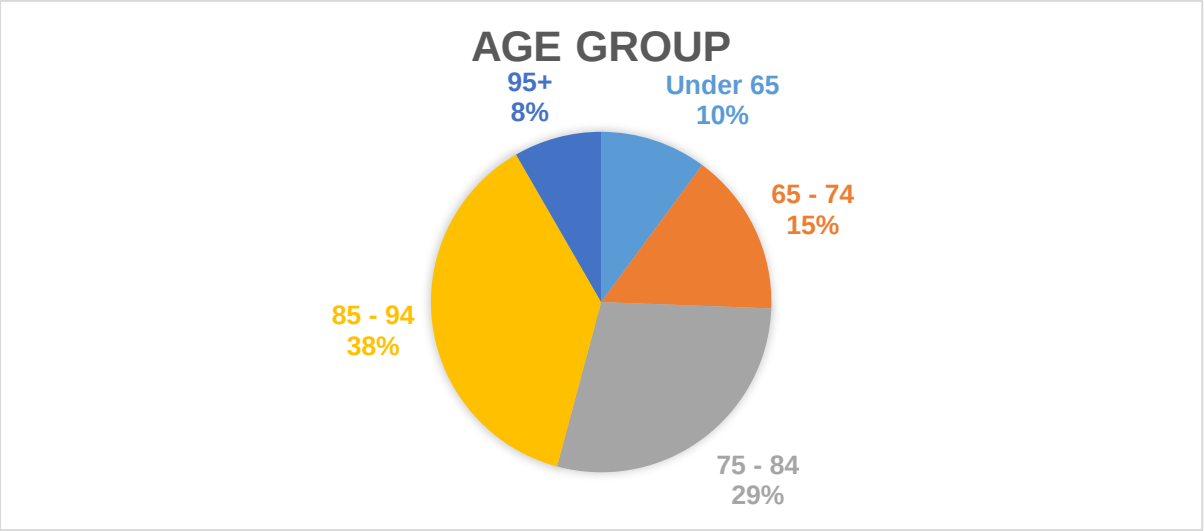
- Almost everyone (95%) indicated they were treated with dignity and respect.
- The vast majority (95%) agreed their service helped them to feel safe at home.
- 88% indicated they felt able to live more independently as a result of the support from their home carers.

Service delivery:

- More than eight in ten respondents (82%) rated the service they received as either very good (42%) or good (40%).
- 89% rated the staff who provide their care and support as very good (57%) or good (32%). Almost three-quarters (74%) of people reported they always or usually saw the same carers
- Less than half (48%) were given a choice of when carers would visit and fewer than a third (29%) had a choice over how long visits would be, however 76% reported their carers always or usually visited at the times they wanted
- 88% said their carers helped them with the things that were most important to them, but almost a quarter (24%) felt carers didn't always have enough time.

3. Who responded

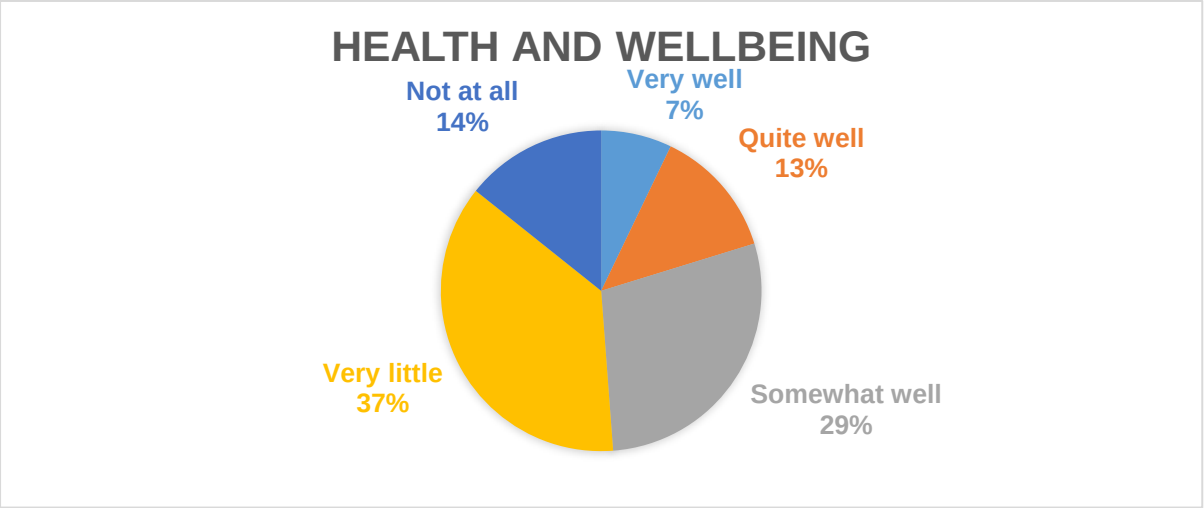
- 171 people
- 40% (67) male, 59% (100) female, 1% (2) preferred not to say.
- 44% (73) were the person receiving the care, 56% (94) were completing the response on their behalf



Age group	Under 65	65 - 74	75 - 84	85 - 94	95+	Base number
Total	17	26	48	63	14	168

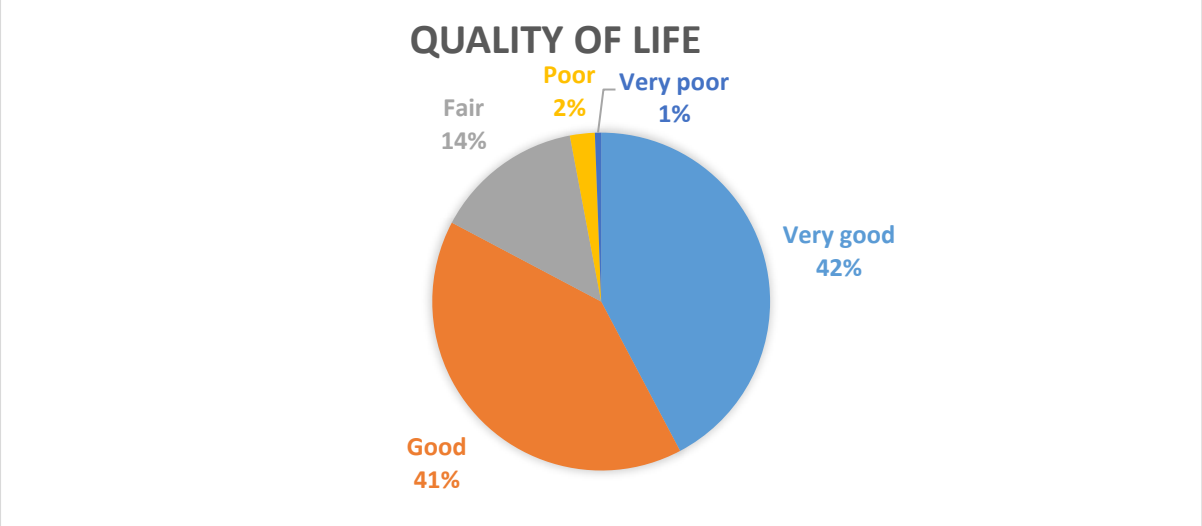
Health and wellbeing and quality of life

Q: In general, how well are you able to look after your health and wellbeing?



Answer choices	Very well	Quite well	Somewhat well	Very little	Not at all	Base number
Total	12	22	48	62	24	168

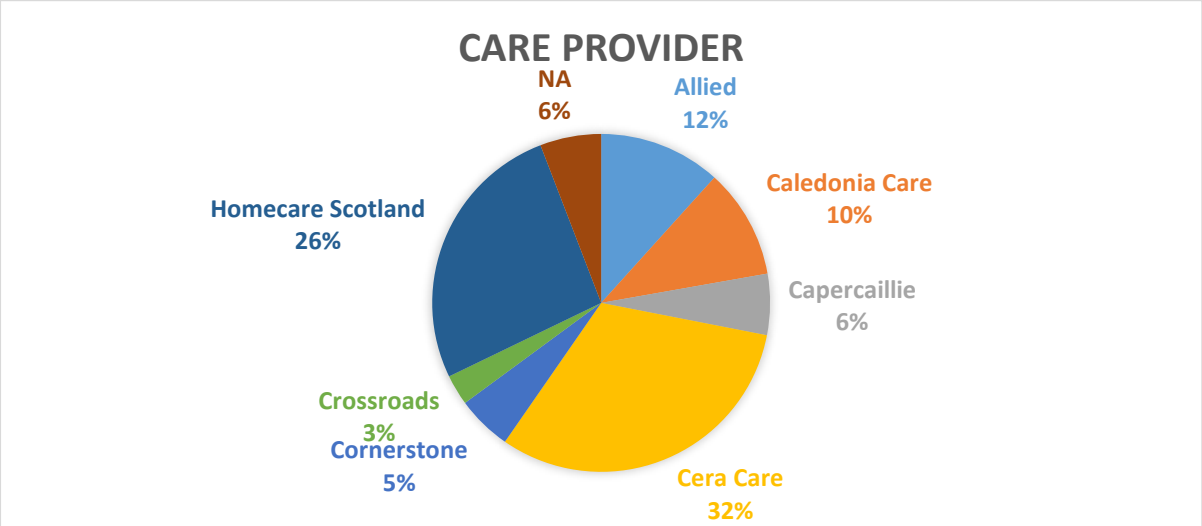
Q: Thinking about the good and bad things that make up your life, how would you rate your quality of life as a whole?



Answer choices	Very good	Good	Fair	Poor	Very poor	Base number
Total	71	68	24	4	1	168

Care provider

- Almost a third of people (32%) received their service from Cera Care



Provider	Allied	Caledonia	Capercaillie	Cera	Cornerstone	Crossroads	Homecare Scotland	NA	Base
Total	20	18	10	54	9	5	45	10	171

4. What people told us about their experiences, needs and aspirations

We asked people a number of open questions to gather feedback on their experiences, needs and aspirations

Q: Looking ahead, what matters most to you about your future care at home service?

People told us they want to continue living independently at home for as long as possible and that care at home was essential to this, particularly as their health declined and their support needs increased. The service helped them to feel safe and also gave reassurance to their families.

"My carers support me so well and adapt to my needs allowing me to remain in my own home."

"I would like my care at home service to continue and increase as I get older and need more support in being able to live independently in my own home."

"It makes me feel more secure and safe knowing I have carer arriving as I have had many falls and feel more safe."

"Carers coming in morning and evening ensures that my family can be informed if there are any problems."

People want a service they can rely on. Having a consistent team of carers allows positive relationship to form and improves person-centred care. People want to have staff rotas in advance and carers who come at the agreed times. Late and missed visits were a particular issue when medication had to be taken at regular times. Good communication with the provider organisation and between the provider and its own staff was highlighted as being important.

"Having consistency in carers is a huge help as they know him."

"Carer visits need to be at consistent times. At the moment it varies from 9.30-11.30am. A few occasions it's been PM."

"The rota weekly sheets should come in time to be useful."

"Having someone at the carers' office who is approachable when problems arise."

"There is no way of contacting the carers directly to pass on important information such as about medication. When you phone the office they do not pass information on to the carers at all."

People told us the carers who support them should be caring, compassionate and skilled to enable good relationships to be formed and to ensure they feel confident that their needs will be met in the right way. Being treated with dignity and respect and being listened to remain important.

"I feel confident with my care team. It helps when I worry about getting frailer. I know my carers are capable and kindly. They don't get paid enough for their skills and hard work."

"The kindest person in the world is not going to be useful as a Carer unless they are trained properly."

Looking ahead, people highlighted the need for their support to be flexible, particularly around the times of visits, and responsive to their changing needs with longer or additional visits as required. Increasing care needs should be anticipated.

"Would like care provider to be more flexible and provide care at times that suit me most."

"What matters, thinking ahead, is having the option to request extra visits when needed at short time without having the long wait for feedback from the social work team."

Q: What improvements would you like to see?

People want to have a regular team of carers and to know who to expect in order to build trusting relationships. It is important to them that they receive copies of the staffing rotas in advance. This is particularly important to them when their regular carers are on annual leave.

They want to be able to able to depend on their carers; that they will arrive at or as close as possible to the time they are expected and if there is a change, that this is communicated to them by the provider as soon as possible. Carers attending at the right time was a concern for those who needed to take medication at regular intervals.

"I would like to be informed as to what time and who will be coming in when my regular carers are off."

"Consistent carers. Carers to be aware of information on care plan."

"More continuity of care (seeing the same person more regularly). Weekend times all over the place. I would like to see this improve."

There was a call for better organisation of rotas to reduce the pressure on carers which also impacted on service users.

"Carers have been good. Poor management. Rotas need to be better organised so carers are not rushing off to see next client (often at other side of area)."

People would like to see a more flexible and responsive care at home service. Many told us they would wish to change the times of their visits or to have longer visits. People highlighted improvements they want to their personal care. As their care and support needs increase, reviews need to be more frequent and the service must be able to respond. Care at home services should support unpaid carers as equal and valued partners.

"Basically more time, especially flexible, negotiable time."

"More time for each visit as each timed visit does not leave any spare for extras. As I am very frail this would be most helpful."

It was very important to people that they were listened to.

"More personal power. To see in action what I want, not what others decide I need."

It would make a difference to people if their carers could do more in terms of meal preparation and housework, or even just more time to keep them company.

For new carers, training was felt to be an area for improvement on how to support people with dementia and in the use of equipment. Carers also need to be able to listen and to treat people with dignity and respect.

"Some carers don't know how to use some of the equipment they use for the people they care."

"New carers could be trained longer before doing the job independently."

"Better medical training, or when to see when it is required. Better training in how to persuade clients if they are unwilling to co-operate (e.g. washing etc.)."

Q: Are there any areas of concern you have?

A significant concern was around medication management.

"Often the carers are running very late and I miss out on my morning tablets. Lately they are so late in the morning that I have to dress myself without getting a wash."

"Mum being left without medication which has happened on more than one occasion. One week mum wasn't getting her pain medication until 11am, despite being up for 8am and being in pain."

"Mix up on meds several times."

"No pain medication when needed."

Some concern was expressed over the financial aspects of the recommissioning process and the move to a single external provider. People were worried about a change of provider and whether this would lead to a poorer experience. Many told us that losing their regular carers would be difficult for them.

"My concerns revolve around change just like many other people. It is something I find difficult to come to terms with. Crossroads has supplied my care for 18 years and my Mother's also before her death."

"Only concern is my provider changing as this would cause distress."

"The continuity if the care provided is very important to me as I have a lot of confidence in the carers who provide my care at home service."

Many of the areas previously highlighted as requiring improvement were mentioned. These included carers running late, variations in the standard of care and poor

communication, particularly around rotas and which carers to expect and how concerns can be raised and acted on.

"The care given varies by carers - quality control required re how the individual carers are doing."

"If not usual carers do not carry out my care plan if shower on it. Say mine can do it when they come back."

"Sometimes when you phone late afternoon to cancel carer or try to speak to someone you don't get a reply as they have switched over phones early to on-call. On call doesn't start till 5pm. I have phoned at back of 4 on a Friday and it's already been switched over so there is no cover."

Many of the concerns centred on people's declining health, increasing frailty and growing support need. People worried about have their support reduced and their carers being rushed.

Q: Is there anything else you want to tell us?

Many people expressed high levels of satisfaction with their current service and told us much they valued their carers.

"Although initially apprehensive about having carers, the current two ladies attending to my needs have become like friends and a great rapport has been built between us. I have a huge amount of confidence in them both."

Some respondents detailed issued they have had with the current external providers, including staffing levels, poor communication, poor quality of care and reliability. They called for better training and understanding of people's conditions and a more flexible and responsive service which supports people towards the outcomes they set for themselves.

Full responses made to all the questions are included at the end of the report.

Engagement in the procurement process

The survey was also used as an opportunity to invite people to be more directly involved in specific decisions about who provides the future care at home service.

17 people – a mix of those who receive a service and family members – expressed an interest in participating in a decision-making panel.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 30 SEPTEMBER 2021**

SUBJECT: **MORAY COAST MEDICAL PRACTICE**

BY: **IAIN MACDONALD, LOCALITY MANAGER**

1. REASON FOR REPORT

1.1. To inform the Moray Integration Joint Board (MIJB) on the proposal to undertake a community engagement and public consultation exercise in relation to the development of health and wellbeing services within the Lossiemouth locality.

2. RECOMMENDATION

2.1. It is recommended that the MIJB:

i) approve the undertaking of a public engagement and subsequent community consultation with Moray Coast Medical Practice patients in relation to the development of health and wellbeing services within the Lossiemouth locality and encompassing reference to 2.1 (ii) and (iii) below;

ii) note the requirement to increase available clinic space within the Moray Coast Medical Centre building in Lossiemouth and the potential to do this through the refurbishment of the vacated Laich Dental Suite;

iii) note the requirement to reach a decision on the future of the Burghead and Hopeman Branch Surgeries;

iv) note that a further report will be submitted to the MIJB in January 2022 outlining the outcome of the engagement process and proposing the detail of the public consultation; and

v) note that a final report will be submitted to the MIJB on 27 March 2022 summarising the outcomes of the public consultation and seeking agreement to proceed with the recommendations.

3. BACKGROUND

3.1. Discussion in relation to the Health and Social Care provision within the Lossiemouth locality has been ongoing for several years, at a community and strategic level. In the main these discussions have focused on the requirement for increased clinical space within the main surgery building in Lossiemouth and

the future of the two branch surgeries in Burghead and Hopeman. However no conclusive decision has, as yet, been reached. Various factors such as Covid-19, imminent renewal of building leases and the currently vacant Laich Dental Suite have led to a decision now requiring to be made. Such a decision requires to be made within the broader context of health and wellbeing provision within the Lossiemouth locality, in line with good practice and following a meaningful engagement and consultation process with all key stakeholders.

3.2. A survey conducted in 2017, concluded that Laich Dental Suite would be suitable for renovating into additional work and clinic space that Moray Coast Medical Practice necessitated at that time. As an outcome of that survey, it was decided that Moray Public Dental Service (PDS) would vacate the premises and this was accomplished in November 2017 following staff consultations. When the Laich Dental suite was vacated in 2017 the bulk of the patients were reassigned to Spynie Dental Centre, Elgin and the remainder registered with a General Dental Practitioner in the Moray area. Staff were transferred, via organisation change to other PDS practice located in Elgin. The vacated space was never formally transferred across to the Moray Coast Medical Practice and Moray PDS continue to pay the rent on the premises. However during Covid-19 the rooms at Moray Coast Medical Practice have been fully used to capacity, and as a result the practice have been reliant on the space within the vacated Laich Dental Suite, to manage services. PDS have no plans to re-occupy Laich Dental Suite.

3.3. Most recently a paper was presented to the NHS Grampian (NHSG) Premises Group on 17 February 2021 (para 3.d of the minute refers) and subsequently to the NHSG Asset Management Group on 30 June 2021 (para 4.6 of the minute refers) seeking agreement in principle to carry out the refurbishment work on the Laich Dental Suite to create 5 additional clinic rooms and a waiting room area. The Asset Management Group approved this in principle dependent on funding being identified, and a public consultation being undertaken along with the completion of relevant Equality Impact Assessments.

3.4. There are financial and service provision risks in allowing the current situation to continue. The proposal is therefore to undertake a community engagement exercise with the patient population of the Moray Coast Medical Practice and all relevant stakeholders. This would include the completion of Equality Impact Assessments for groups adversely impacted by any proposal. A further report would then be submitted to the MIJB on 27 January 2022 outlining the outcome of the engagement process and proposing the detail of the public consultation. A final report would then be submitted to the MIJB on 27 March 2022 summarising the outcome of the public consultation and seeking approval to proceed with the recommendations included therein.

3.5. Within Moray the Covid-19 pandemic has encouraged the adoption of digital technologies and has also illustrated how effective the Third Sector and local community groups can be in supporting vulnerable people within a locality. Nationally there has been a number of creative and innovative approaches to increase the accessibility of local services within rural communities utilising community resources and digital technology. A review of health and wellbeing services within the Lossiemouth locality offers the opportunity to meaningfully

engage with all stakeholder groups to shape the future model of provision. A community engagement and public consultation would aim to take a holistic view of health and wellbeing services within the locality and not focus on the future of the buildings alone.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. Patients who live in Lossiemouth, Burghead, Hopeman and the surrounding area have the option of registering with the Moray Coast Medical Practice or at one of the local Elgin practices. The Moray Coast Medical Practice Lossiemouth premises was built using land from the RAF with considerable NHSG and private investment funding with a 25 year lease which is due to expire in 2033. The Moray Coast Medical Practice building in Lossiemouth is in good state of repair and is fit for purpose although experiencing increased infrastructure difficulties; predominantly from a capacity perspective. The absence of adequate premises, which are essential for service delivery, is causing the practice concern and it is anticipated that this will exacerbate as services and clinics are remobilised which will result in further strain on capacity at the site. The practice therefore requires an increase in clinic space to provide current and improved levels of patient care; to cater for projected growth in patient numbers; and accommodating Health and Social Care staff.

4.2. Patients registered with Moray Coast Medical Practice are also served by two branch surgeries in Hopeman and Burghead respectively. Both of these branch surgeries have been closed since the start of the Covid-19 pandemic, due to inadequate space to allow social distancing and inability to meet other risk mitigation measures. Burghead is a rental property, from a third party landlord, with a lease due to expire in 2023. Burghead branch surgery is 7.8 miles from the main branch surgery in Lossiemouth. Hopeman is a GP owned property which is 5.5 miles from the main branch surgery in Lossiemouth. NHSG Facilities and Estates indicate that neither Burghead nor Hopeman Branch Surgeries are currently fit for purpose. Any refurbishment of the branch surgeries would require to be completed in accordance with health care premises regulations; NHSG Facilities and Estates indicate that these premises would not meet health care premises regulations irrespective of any investment as the buildings are too small with no, or limited, space for extension.

4.3 In April 2008, with the opening of the new building in Lossiemouth, the patient population for Moray Coast Medical Practice was 6984 and this has increased to 10,190 as of May 2021. It continues to increase at a rate of 20-30 patients per month and anecdotally these patients are not associated to the RAF. It is anticipated the patient population will increase further following the closure of Elgin Community Surgery as a portion of these patients live within Moray Coast Medical Practice catchment area.

4.4 The Moray Local Development Plan, has projected over 1,000 potential additional patients for Moray Coast Medical Practice. There are significant building plans evolving in the Moray Coast catchment area: a housing development opposite Moray Coast Medical Practice, currently 40 houses, with plans for an additional 220 houses; building plans for Elgin, the Findrassie development, which indicates a further 1500 houses and a further smaller development at Inchbroom, all anticipated to impact on the patient population

projections. Recent announcements confirming additional civilian jobs at RAF Lossiemouth, together with an increase of serving personnel will also bring additional families to the area.
Innovative use of digital technology, ongoing developments in community nursing, closer working relationships with third sector providers and community groups will all help meet the health and wellbeing needs of this growing population.

4.5 The Lossiemouth Locality has a very active and effective Health and Social Care Multi-Disciplinary Team (MDT). The Lossiemouth premises is fortunate to house the MDT including District Nurses, Health Visitors, School Nurses, Pharmacists, Pharmacy Technicians, First Contact Physiotherapy, Minor Surgery Services, Family Planning Services including Cervical Screening, ECGs (routine and acute), Health Point Services, Joint Injections, Doppler examinations, Bladder and Catheter changes, PIC line Maintenance, Dementia Nurse Specialist and many other procedures.
Visiting services include; Midwife/Antenatal and Postnatal Clinics, Baby Clinics, Baby Massage sessions, CPN, Drug and Alcohol Counsellors, and Retinal Screening. None of this can currently be provided within the local communities due to lack of space/facilities.
The Moray Coast Medical Practice feels patients being seen at branch surgeries have always been disadvantaged due to lack of service provision available on site and patients have always had to travel into Lossiemouth to access these services/procedures. The community engagement process would aim to explore new and innovative ways of addressing this.

4.6 During the Covid-19 pandemic the Moray Coast Medical Practice, has delivered its services by embracing technology such as ‘near-me’, through remote working with the extended use of phone and video conferencing. The GPs/Advanced Nurse Practitioners were able to manage 95% of their workload over the phone and/or VC. Nurses continued to require to see many of their patients face-to-face for ‘tasks’ such as bloods and dressings. This use of digital technology offers one potential option as to how we support patients in a future health and wellbeing model. However it is only one component part of the overall solution.

4.7 The remobilisation of services at Moray Coast Medical is proving difficult to manage:

- A population increase of greater than 25% in the last 13 years.
- Increase in GP and nurse work with additional services traditionally done within hospitals moving from secondary care to primary care.
- A larger MDT bringing improved patient care to the Lossiemouth Locality.
- At this time GP partners work 54 sessions/week, 6 locum sessions/week, ANPs 20 sessions/week, nurses 32 sessions/week, pharmacist 10 sessions/week. On top of this Moray Coast is a training practice and currently has 14 sessions a week of GP trainee time: a total of 136 clinical sessions a week of practice-based staff and this does not account for any other MDT specialists necessitating space for example: CPN, medical students, physiotherapist, drug and alcohol nurse, psychiatrist etc.

- 15 clinical rooms, operational over 5 days per week giving a total of 150 traditional 1/2 day sessions per week, however 2 rooms are not suitable for face-to-face patients so can only be timetabled for non-face-to-face work, and 136 regular clinical sessions plus all the extras rooms needed by extended MDT team it is easy to see room space is at a critical point.

4.8 There is therefore a requirement for more clinical space within the Moray Coast Medical Practice Lossiemouth premises.

4.9 The space vacated by Laich Dental suite continues to offer the potential for additional clinic space within the Lossiemouth building to meet the growing patient population.

4.10 The refurbishment of the Laich Dental suite into 5 clinic rooms and additional waiting room space has been costed at an estimated £169,700 inclusive of VAT. Various options exist to fund the refurbishment work:

a. That the current landlord of the Moray Coast premises pay for all the necessary work required at the site. However this would have implications for the lease, as this would need to be renegotiated. This funding option would also prevent the use of developer obligations.
b. That the work be fully funded by NHSG through Capital allocation.
c. That the cost of the works be covered by improvement grants and developer obligations. Developer's obligation currently being held by Moray Council totals £52k, as detailed below. However this only equates to a percentage of the total costs. As the premises at Moray Coast are not NHSG owned a fall back obligation needs to be factored in.

Location	Developer Obligations
Moray Coast (Burghead)	£464.40
Moray Coast (Hopeman)	£18,582.40
Moray Coast (Lossiemouth)	£32,935.16
Total	£51,981.96

4.11 Understandably the future of the Moray Coast Medical Practice building in Lossiemouth and the two branch surgery buildings in Burghead and Hopeman will be at the forefront of community members' minds. The engagement and consultation process offers the potential to explore the options for these buildings whilst also looking at the opportunity to develop a model of service provision for the future. Community members have already been actively engaged in proposing potential ideas for a future model such as:

- Utilising community resources within Burghead, Hopeman and indeed surrounding areas for specific clinics i.e. vaccinations – for example through the use of libraries/town halls/community facilities. This could actually result in an increased number of patients receiving appointments within their community.
- Developing the capacity for community buildings to offer 'virtual' communication facilities and associated technical supports.
- Develop further links with health care providers within each community i.e. pharmacies – both villages have an excellent pharmacy service supported

by a prescribing pharmacist. Pharmacy First allows community pharmacies to provide expert help to treat a range of conditions.

- Utilising a mobile unit to cover a range of health provision needs. This could allow greater access to rural communities across the Lossiemouth locality. Such a unit would require to operate on a Moray-wide basis to be financially viable.
- A review of transport options – bus, community group vehicles, and volunteer drivers.
- Consider broader plans to support at risk groups and the broader population. Prevention and Self-Management approaches, health improvement activity, social prescribing etc. Projects of this nature have proved very effective in supporting people living within rural communities.

4.12 The community engagement and public consultation would be led by Iain Macdonald, Locality Manager, Health and Social Care Moray, supported by:

- Community Representatives x 2 (identified at the outset of the engagement activity).
- Third Sector Representative.
- Alison Frankland, Practice Manager, Moray Coast Medical Practice.
- Jess Ledingham, GP, Moray Coast Medical Practice.
- Fiona McPherson, Public Involvement Officer, Health and Social Care Moray
- Claire Powers, Locality Manager – Primary Care Lead, Health and Social Care Moray.
- Rosemary Reeve, Project Manager, Health and Social Care Moray.
- Peter Maclean, Service Manager – Primary Care Contracts, NHSG.

4.13 A description and timeline of the community engagement and public consultation process is contained within **Appendix 1**. The strengths and weaknesses of the current community based provision is included in **Appendix 2**.

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"
The policy and approach set out in this report is consistent with the ambitions of the MIJB Strategic Plan in providing care at home or close to home with a particular emphasis on the needs of older people. This locality approach is also consistent with the ambition of the LOIP in Moray.

(b) Policy and Legal
This approach supports national policy and the integration principles set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

(c) Financial implications

There are potential budget implications in relation to this interim report as outlined in sections 3 and 4 above. These will be brought back before the Board as appropriate. The mail out relating to the engagement and consultation exercise will cost approximately £4,500.

(d) Risk Implications and Mitigation

Risks will be mitigated through a robust public consultation process and the completion of Equality Impact Assessment prior to the submission of a further report to the MIJB.

(e) Staffing Implications

There are no staffing implications in relation to this report.

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(f) Property

There are potential property implications in relation to this report as outlined in sections 3 and 4 above.

(g) Equalities/Socio Economic Impact

An Equalities Impact Assessment will require to be carried to ensure that any proposals are not inadvertently discriminating against any protected group.

(h) Consultations

Alison Frankland, Practice Manager, Moray Coast Medical Practice
Fiona McPherson, Public Involvement Officer, Health and Social Care Moray
Simon Boker-Ingram, Chief Officer, Health and Social Care Moray
Sean Coady, Head of Service, Health and Social Care Moray
Tracey Abdy, Chief Financial Officer, Health and Social Care Moray
Lewis Walker, Clinical Lead, Health and Social Care Moray
Claire Powers, Locality Manager, Health and Social Care Moray
Rosemary Reeve, Project Manager, Health and Social Care Moray
Peter Maclean, Service Manager-Primary Care Contracts, NHS Grampian
Andrew McArdle, Interim Infrastructure Manager, Health and Social Care Moray
Allan Robertson, Property Planning Manager, NHS Grampian
Sheila Roberts, Primary Care Resources Manager, NHS Grampian
Jeanette Netherwood, Corporate Manager, Health and Social Care Moray
Tracey Sutherland, Committee Services Officer, Moray Council

Who are in agreement with the contents of this report as regards their respective responsibilities.

6. CONCLUSION

6.1 That the MIJB note the content of the report.

6.2 That the MIJB approve the undertaking of a community engagement and subsequent public consultation event involving all key stakeholders within the Lossiemouth Locality.

Author of Report:	Iain Macdonald, Locality Manager
Background Papers:	None
Ref:	

Appendix 1

Community Engagement and Public Consultation Regards the Potential Closure of Burghead and Hopeman Branch Surgeries

September 2021

- Letter to all patients of the Moray Coast Medical Practice confirming the current status of the Burghead and Hopeman branch surgeries and indicating the intention to request approval from the Moray IJB to undertake an Engagement and Consultation process regarding the provision of Health and Social Care within the Lossiemouth locality
- A formal briefing to local Councillors, MSP and MP regarding the intention to request approval from the Moray IJB to undertake an Engagement and Consultation process regarding the provision of Health and Social Care within the Lossiemouth locality
- Analysis of Moray Coast Medical Practice patient demographic
- Formal submission of a paper to the Moray IJB requesting approval from the Moray IJB to undertake an Engagement and Consultation process regarding the provision of Health and Social Care within the Lossiemouth locality

October 2021 - December 2021

Community Engagement

- Public information campaign utilising local press and social media. Providing outline information and encouraging individuals to participate in the Engagement and Consultation process
- Online and Postal Survey for all key stakeholders
- Engagement events within the local communities
- Focus Groups in each local community
- Individual appointments in each local community
- Discussion with Transport Providers
- Completion of Equality Impact Assessments
- Establish a stakeholder steering group to review outcome of Community Engagement and to compile a draft Public Consultation document.

January 2022

- Present a paper to the Moray IJB outlining the findings of the Community Engagement process and the draft outline of the Public Consultation document.
- Finalise the Public Consultation document

February 2022

- Press and social media release regarding the distribution and content of the Public Consultation document
- Launch the Public Consultation
- Compile the findings of the Public Consultation

March 2022

- Present a paper to the Moray IJB outlining the findings of the Public Consultation, and seek approval to proceed where appropriate
- Press and social media release regarding the outcome of the Public Consultation and subsequent decisions of the Moray IJB

Ongoing meaningful engagement with the communities regarding the development of Health and Social Care Services with the Lossiemouth Locality.

Appendix 2

Burghead and Hopeman Branch Surgeries

Strengths:

The branch surgeries are local; they are within walking distance for the majority of the village patients who are fit enough to walk. They are therefore very convenient for the village population.

Both are small branch surgeries so patients have a feeling of knowing everyone.

Both villages have a pharmacy with a prescribing pharmacist.

Both villages have access to the P&J sponsored minibus, both have access to dial a bus service.

Weaknesses:

Burghead branch – a rental property with a lease due to expire in 2023. These premises would not meet health care premises regulations irrespective of investment. These premises are currently owned by BH Pharmacy and are leased by NHS Grampian at a rate of £5847.00 per annum.

Hopeman branch – is a GP owned property in Hopeman, similarly these premises would not meet current health care premises regulations and would require extensive work to be undertaken including an extension to convert the facility into a usable clinical and/or office space.

When previously operational both branch surgeries were utilised part time with limited GP/nurse clinics - both work only 3 sessions per week per site. 57 patients were seen per week on average at each branch surgery versus 1500 per week at the surgery in Lossiemouth.

All 'urgent' calls require to be dealt with in Lossiemouth.

There is reduced access to the broader multi-disciplinary team (MDT) within the local communities, the vast majority of patients needing a follow up appointment require to be seen in Lossiemouth.

Poorly patients needing interventions such as PIC lines/catheters etc. still need to come into Lossiemouth or receive a home visit from the nursing team, therefore branch surgeries only used for 'fitter' patients.

Stagecoach bus service does not run along the coast road to Lossiemouth so reliant on own transport or the two excellent voluntary bus services. The only option on public transport is to go into Elgin, change bus and then back out to Lossiemouth - around an hour's journey for less than an eight mile direct trip.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 30 SEPTEMBER 2021**

SUBJECT: **HOME FIRST IN MORAY**

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

1. REASON FOR REPORT

1.1. The purpose of this report is to provide an update to the Moray Integration Joint Board (MIJB) on the current status and priorities for Home First in Moray.

2. RECOMMENDATION

2.1 It is recommended that the MIJB:

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

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

3. BACKGROUND

3.1. Operation Home First was launched in June 2020 as part of the Grampian wide health & social care response to the 'living with COVID' phase of the pandemic. All three Health & Social Care Partnerships (HSCPs) in Grampian are working together with the Acute services sector of NHS Grampian to break down barriers between primary and secondary care and to deliver more services in people's homes or close to people's homes. It is known that outcomes for people who are cared for closer to home are better and it is believed that expanding the range of services available to people at home will be of immense benefit to individuals, their families and the wider community.

3.2. The ambition of Operation Home First is to maintain people safely at home, avoiding unnecessary hospital attendance or admission, and to support early discharge back home after essential specialist care.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. Following a previous update at January 2021 (para 10 of the minute refers) a number of Home First work streams have seen progress. More detail on all these programmes is obtained in the attached project sheets (see **Appendix 1**).

Discharge to Assess (D2A)

4.2 Discharge to assess is an intermediate care approach for hospital in-patients who are medically stable and do not require acute hospital care but may still require rehabilitation. They are discharged home with short-term support to be fully assessed for longer-term needs in their own home.

4.3 Following a successful 6 month pilot from October 2020 to March 2021 the MIJB has approved funding at its meeting of March 2021, (Para 10 of the minute refers) allowing the project to progress to full implementation. A new team, including both Allied Health Professional's (AHP's), nursing and support work staff, have been fully recruited. The service re-launched on 2 August 2021 and has already seen 17 patients, with 10 being discharged, as at the time of this report. A progress update report is due to go to the MIJB in January 2022.

Hospital at Home (H@H)

4.4 Hospital at Home (H@H) is a short-term targeted intervention that provides a level of acute hospital care in an individual's own home equivalent to that provided within a hospital.

4.5 Awarded temporary funding by the Scottish Government in July 2021 the programme is at scoping stage with a planning group meeting in early September. Consideration needs to be given on how H@H will work in Moray, taking into account the rurality of the region. Funding received will be used to establish temporary staffing resource in-line with the funding.

4.6 Healthcare Improvement Scotland (HIS), a public body working in behalf of NHS Scotland, is providing project management support via networking sessions which the project team has been attending. As part of the funding agreement regular progress reporting must be made to HIS.

Prevention and Self-Management – Respiratory Conditions

4.7 This programme aims to provide opportunities for individuals to self-monitor their health and wellbeing, enable professionals to access information and training so they can best support individuals and promote and develop community support and resilience. The programme offered both face-to-face and virtual sessions.

4.8 Now on its fifth cohort the programme has been working in partnership with Moray Council who have recently appointed a Health and Wellbeing Officer. This post will now take the lead on the leisure pathway work.

4.9 The project team will now concentrate its efforts on expanding the programme, with its next focus being to explore social prescribing (connecting people to

non-medical support or resources within their community) and further funding opportunities

Third Sector Involvement

4.10 A short life Third Sector Action Group was established to scope and make recommendations as to how the Third Sector could support Home First in Moray. Now disbanded, the group produced a 'Golden Thread' thread report that identified where and how the third sector can support the Home First work streams and recommendations on what would be required to support this. One such recommendation is based around what additional resource HSCM would require to work in partnership with the Third Sector and is dependent on the outcomes from a pilot project the Third Sector Interface Moray (tsiMORAY) are being funded to deliver.

4.11 In August this year, tsiMORAY were successful in a funding bid from NHS Endowments to run a 2 year pilot to support hospital discharges and Home First. With these funds they have recently appointed a new Community Support Co-Ordinator (2 year contract) whose main role is to support and encourage Third Sector (including local community groups) in providing support to people coming out of hospital and to align with many of our Home First work streams. HSCM have supported the recruitment and are participating in the induction of this Coordinator, who will continue to work closely with HSCM identifying how and where the Third Sector could support hospital discharges and Home First. This role, whilst initially working in Aberlour, Forres and Lossiemouth, will begin to scope opportunities and identify gaps as well as continue on from the work in the 'Golden Thread' report.

Delayed Discharges

4.12 The delayed discharges transformation programme has required a whole system approach as discharge is a complex process. It involves many different members of staff and the components of the discharge process cover a number of different services. The focus of this work is on the following four parts of the system - admission avoidance; discharge planning/process; community hospital transfers; and provision of care in the community.

4.13 To date a further two Delayed Discharge Co-ordinators have been recruited and a new pilot is about to launch in September. The pilot takes into consideration new obligations put in place by The Carers (Scotland) Act 2016 and will look at how HSCM is currently performing.

4.14 Work is also on-going to support unpaid carers. This will look at how unpaid carers can be involved in every stage of discharge. Further information will be provided as this progresses.

5. CHALLENGES

Recruitment and retention

5.1 Recruitment and retention across the NHS has resulted in progress in Home First work streams being slower than anticipated. This is being exacerbated by

covid restriction, EU/Brexit changes and an overall national shortage in some clinical posts.

5.2 In addition, management also recognises that some Home First work streams have recruited staff from existing services and that is may be creating issues in those areas.

5.3 Work streams currently, and likely to be, affected by recruitment issues include:

- Ambulatory care
- Palliative care
- Delayed discharges
- Hospital at Home

5.4 Management and project leads are addressing this by both national recruitment as well as model adaptation where possible i.e. using different disciplines.

5.5 Work is also being done to ensure that staff are working to the top of their license, identifying opportunities for upskilling and looking at the transformation of nursing roles. Equally important is ensuring that where internal recruitment is to be used that discussions are had to put in place adequate succession planning in order to reduce service impact.

5.6 Efforts are also being made to monitor the well-being of staff. Recognition of the on-going pressures and work load over the last 18 months is important and staff are being encouraged to look after their mental health i.e. ensuring they utilise their annual leave for sufficient breaks.

6. EVALUATION

6.1. The Evaluation Working Group delivered their final "Operation Home First – Portfolio Evaluation Report" in June 2021. The primary aim of this evaluation was to demonstrate the impact of the Operation Home First (OHF) priorities against the three aims. The report also sought to address, as far as reasonably possible, further questions that were posed to the Evaluation Working Group which included dimensions around system costs and health inequalities.

6.2. Whilst there is currently some uncertainty around where the Operation Home First Steering Group sits due to transformational change in the system, the Evaluation Working Group continues to meet on a weekly basis and provide ongoing support to a number of programmes of work that were instigated during the initial phase of OHF. This includes deeper exploration of the impact of Moray's Discharge to Assess project, development of business cases for a number of Respiratory projects and continuing the evaluation of the Redesign of Urgent Care.

7. GOING FORWARD

Hospital without Walls

7.1 A new model involving all aspects of Home First, unscheduled care, primary/secondary care and acute services is being brought together under the umbrella of 'Hospital without Walls'. This whole system model is still in its infancy and will be the catalyst for driving forward the Home First work streams

but considers elderly medicine as its top priority. The project is reliant on the successful recruitment of key clinical staff, however alterative recruitment options are also being considered at this time.

8. 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"

The aims of Home First have significant alignment to the themes of the MIJB strategic plan and in particular to the Home First theme.

b) Policy and Legal

None directly associated with this report

c) Financial implications

Funding has been made available on a short-term basis to enable progression of the programmes of transformation. This is being kept under review, accepting that any long term implications are required to be met within existing budget where relevant, financial implications have been highlighted in this report.

d) Risk Implications and Mitigation

The risks around being unable to successfully embed a Home First approach in our culture and system will be identified on a project by project basis and mitigations identified accordingly.

There is a risk of projects not being able to proceed within desired timescales due to the lack of suitably qualified and experienced staff being available due to the ongoing impact of the Covid pandemic on recruitment and retention.

e) Staffing Implications

As the modelling for change in service delivery progresses the staffing implications will be identified and taken forward following the appropriate policies. Short term funding has been allocated to the transformation programmes to allow them to move to pilot phase. This has facilitated some additional staff resource to be identified and attached to the programmes.

f) Property

There are no property implications to this report.

g) Equalities/Socio Economic Impact

There are no changes to policy as a result of this report.

h) Consultations

Consultations have taken place with the Home First Delivery Group, Chief Officer, Chief Financial Officer, Clinical Lead, Head of Service, Corporate Manager, and Tracey Sutherland, committee officer, Moray Council and comments incorporated regarding their respective areas of responsibility.

9. CONCLUSION

9.1 Home First is the right approach to driving forward sustainable change to provide the maximum benefit to the health and wellbeing of the population in Moray.

9.2 By taking a whole system approach we can plan our services to deliver the maximum benefits to residents.

9.3 Home First will drive the changes needed to continue the shift of health and social care systems to offer more person-centred alternatives to hospital.

Author of Report: Jamie Fraser, Project Manager

Background Papers:

Ref:

APPENDIX 1

Key Ambitions of Operation Home First

To maintain people safely at home

To avoid unnecessary hospital admission or attendance

To support early discharge back home after essential specialist care

HSCM HOME FIRST-DISCHARGE TO ASSESS

Report Date:	30/09/2021
RAG Status:	

Project Ref : HF1 **Project Lead**: Dawn Duncan **SRO:** Sean Coady

Key Aims

- 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
- 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

Primary Objectives

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

Scope

- #endpjparalysis/Care in Between
- Delayed Discharges/Hospital @ Home
- Care of the Elderly/Living Longer Living Better in Moray
- Moray Partners in Care/6 Essential Actions for Unscheduled Care
- Active & Independent Living Programme Ambitions for AHPs.

Achievements

- This project has successfully completed a test of change (July/Aug 2020), providing the system with enough assurance to allow it to progress to pilot phase and allocate funding accordingly – 5Oct to 31 March 2021.
- Staff Q&A session December 2020
- Forensic mapping of 12 patient journeys
- Report presented to SMT and then to IJB development session was favourably received and then permanent funding approved on 25 March 2021 for full implementation.

Programme Workstreams Progress

Activities in current period

July	One and half Band 7 starts Monday 14 June Band 6 OT and Occupational Therapist starts 28 June 7 HSCW (6 WTE) appointed and started 13 July	
August	Discharge to Assess goes live 2 August. Performance measures established.	

Future Actions/Milestones

Action	Timescale	RAG
Progress update on service delivery to Home First then SMT	January 2022	

Key Risks/Issues

- Failure to demonstrate value within D2A and establish long term sustainability
- Failure to embed pathway in the systems.
- Impact of relocation from Dr Grays at short notice to temporary accommodation results in lack of accommodation for new starts.

Dependencies

Finance

- £500,000 funding secured for 2021/22

Performance

- Measurements for success needed and criteria established.
- Real time measurements as well as potential future aims.
- Established trends noticed.

HSCM HOME FIRST-DELAYED DISCHARGES

Report Date:	30/09/2021
RAG Status:	

Project Ref : HF2 **Project Lead**: Lesley Attridge **SRO:** Sean Coady

Key Aims

Whole system approach to discharge

Primary Objectives

There are four components to this work stream: Admission Avoidance, Discharge Planning Process, Community Hospital Transfers and Provision of Care in the Community

Scope

To identify and implement changes to the discharge process. This a complex piece of work involving all teams across the system.
The aim is to ensure there is sustainable processes in place to support early discharge home and reduce delayed discharge bed days.
Scope, plan and deliver a whole system approach for discharge in Moray that is safe, properly resourced and is sustainable.

Achievements

Ongoing areas of improvement are:
Communication – weekly meetings to review patients on Community Hospital waiting list; weekly meetings to review operational issues/concerns; Locality Managers attend weekly meetings with commissioning and providers; Weekly/daily Multidisciplinary team meetings; Mental Health staff attend senior charge nurse meetings; key information summary available to members of the multidisciplinary team; Out of hours Social Work contact details given to Emergency Department.
Improvements in pathway work - Community Response Team (CRT) pathway circulated; Contracts with new external providers in place; Discharge Coordinator in position; Implementation of Social Work screening tool and Implementation of traffic light system across both acute & community hospitals.
Recruitment – Appointed 2x Care at Home Assessors

Programme Workstreams Progress

Activities in current period

August	Intermediate care options being reviewed including current provider provision and long term provision – includes both Loxa Court and Jubilee Cottages.	
September	Launch of new pilot to look at obligations put in place through the Carers Act. Will look at how unpaid carer can be involved in each stage of the discharge process.	

Action	Timescale	RAG
Review of OOHS provision of 24/7 community nursing model	TBC	
Overview of Surge and Flow Discharge work (to have a consistent process across NHSG), links with process mapping, all being led by Acute improvement team	TBC	
Planned Date of Discharge – embed surge and flow process across Moray system, incorporating MDT and traffic light system. Define approach Implement and communicate	TBC	

Dependencies

Communications
Recruitment
Funding

Finance

Funding for extra posts

Performance

Measurements criteria established.
Real time measurements as well as potential future aims.
Established trends noticed.

Key Risks/Issues

- Staffing issues:-
  - Delays in the recruitment process and appointment of Care at Home assessors is impacting on progress. Short of staffing in some areas – may be as a result of model but requires investigation;
  - Delays in recruitment process may temporarily result, in the loss of an Experienced Discharge Coordinator. Work is ongoing to avert this.
  - Seeking maternity cover for Social work post.
- Number of Acute patients in hospital has increased and has caused an impact on the Hospital discharge team. These patients are more poorly than previously experienced.
- SDS, 3 Conversation model, Adult Social Care review- impact of potential changes to approaches is not yet know.
- Lack of understanding of ADP across sector – communication being progressed for cascading to staff

HSCM HOME FIRST-HOSPITAL AT HOME

Report Date:	30/09/2021
RAG Status:	

Project Ref : HF3 **Project Lead**: Sam Thomas **SRO:** Sean Coady

Key Aims

- Older people with frailty are at particular risk of being affected by institutionalisation and delirium. Some 30 to 56% have been shown to experience a reduction in their functional ability between admission to hospital and discharge.
- Hospital at Home is a short-term, targeted intervention that provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital.
- Hospital at Home works best when it is part of an integrated acute and community-based service model to meet local population need.
- Creating the environment to support Integration Authorities, NHS Boards and Local Authorities to effect transformation and introduce services such as hospital at home will require close collaboration and robust strategic planning and commissioning across sectors.
- Timescales are driven by SG

Primary Objectives

- A short-term, targeted intervention that provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital.
- It differs from other community services by enabling the management of more severe conditions, such as sepsis and pulmonary embolism.
- It provides urgent access to hospital-level diagnostics, such as endoscopy, radiology and cardiology, and access to interventions such as intravenous fluids and oxygen.
- Care is delivered by multi-disciplinary teams of healthcare professionals and is Consultant led, complying with current acute standards of care.

Scope

Programme Workstreams Progress

Activities in current period

July	Bid approved from Scottish Government at £207k. Funding for 8A (or maybe 7) and 2 Band 6.	
August	Band 8A and band 6 Job descriptions are being drawn up for recruitment. It is expected to be a secondment opportunity.	
July	Attendance at a number of Scottish Government/Health Improvement Scotland meetings will be required to report on performance. First meeting 25 July.	

Future Actions/Milestones

Action	Timescale	RAG
Process map and draw together appropriate team, incorporating governance and clinician buy in. A small cohort of patients will be trialled in the first instance. Grampian wide model.	TBC	
Staffing training , measurement and equipment Remote consultation via telephone and Near Me effectively utilising resources.	TBC	
Process will then go to SMT/IJB for appropriate timeline.	TBC	

Key Risks/Issues

- Failure to establish permanent staff/ failure to embed pathway in the systems/ SG criteria may not fit with Moray picture/ whole system approach/ rurality, limited HSCM model, recruitment issues in general and equipment infrastructure are ongoing issues. Geriatric pathway is ongoing concern Continued inappropriate admissions· Loss of independence
- · Increased morbidity/mortality through unnecessary hospital admissions· Increase in Delayed Discharges and decreased availability of medical beds for acute unstable admissions
- · Continued "silo management" and failure of integrated working

Dependencies

- Funding
- Staffing

Finance

- Funding of £207,000 received from SG

Performance

- Specific Targets/Measures need to be further elucidated/ identified through QI methodologies applied to
- multi-professional SLWG's in line with current modern clinical practice
- · It is important that both patients, relatives, carers and "staff at the coal face" are involved in the co-
- production of targets and measures in line with Realistic Medicine

Achievements to date

- HSCM has been approved to take part in an Improvement Programme with Health Improvement Scotland to help develop and implement the Hospital @ Home model
- D2A set up as a key foundation plank
- Meetings held encompassing multi-disciplinary approach including acute, geriatrician, AHP and GP support

HSCM HOME FIRST-Prevention& Self Management/ Respiratory Conditions

Report Date:	30/09/2021
RAG Status:	

Project Ref : HF4 **Project Lead**: Iain MacDonald **SRO:** Sean Coady

Key Aims

To improve the health and wellbeing of those individuals with respiratory conditions, through the promotion of self -management strategies and tools. The three primary drivers to achieve this are:

- Provide the opportunity for individuals to self-monitor their health and wellbeing within their home and local communities.
- Enable professionals access to information and training to ensure they can best support individuals within their own homes and local communities.
- Promote and develop community support and resilience opportunities to support individuals within their local communities.

Primary Objectives

- Improving individuals digital connectivity
- Improving access to information
- Improving peer and community supports
- Increasing access to Weather Alerts
- Increasing access to My COPD App
- Increasing access and attendance at exercise programmes
- Increasing attendance at pulmonary rehabilitation programmes

Achievements

- Test of change completed with COPD patient cohort Oct to Dec 2020
- COPD Information for individuals/patient updated
- Community resources identified and actioned to support individuals becoming digitally connected.
- Virtual Pulmonary Rehab Programme provided for two patient cohorts Jan to March 2021.
- Virtual Exercise Programme provided for two respiratory conditions patient cohorts Jan to March 2021.
- Funding identified and26 ICT devices purchased to enable individuals/patients to access information/virtual classes
- Instructors now trained to Level 3 and available to facilitate virtual and face to face sessions.
- Partnership working between Physio staff and Exercise Instructors.

Programme Workstreams Progress

Activities in current period

July 2021	Fifth Cohort of Exercise Programme underway.	
July 2021	Health and Wellbeing Officer post approved at Moray Council. This post will lead on leisure pathway work in the future.	
July 2021	Programme now broadened to encompass all Long Term Conditions.	
July 2021	Pulmonary Rehab and Exercise pathways now established and in the process of being incorporated into mainstream provision.	
July 2021	Reintroduction of face to face classes whilst maintaining virtual programmes	

Future Actions/Milestones

Action	Timescale	RAG
Explore social prescribing. Including establishing group membership and priorities activities.	September 2021 onwards	
Promote a locality perspective to developing Prevention and Self Management incorporating local 3rd sector & volunteer organisations.	On-going	
Seek additional funding for Pulmonary Rehab activity programme	September 2021 onwards	
Introduction on MYCOPD app.	September 2021 onwards	

Key Risks/Issues

- Sustainability of funding to maintain and develop programmes.

Dependencies

- Staffing and Resources

Finance

- Further funding investment to maintain provision of programmes

Performance

- Work completed at a Grampian level to ensure robust evaluation of programmes provision. Evaluation on going.

Data collected and evaluated includes:

- Before and after questionnaires for participants and staff
- Measurement of EQ 5D improvement in wellbeing scores
- Participant case studies
- Quantitative data

Participant Feedback:

"Prior to the programme I felt that I had no energy & lethargic and quite depressed. I was missing social interaction with people due to COVID-19 and having to shield."

"I think the programme has helped my physical health because my strength in my arms and legs has improved and my stamina has also improved."

HSCM HOME FIRST-Green Shielded Hub / Moray Resource Centre

Report Date:	30/09/2021
RAG Status:	

Project Ref : HF5 **Project Lead**: Claire Power / Andrew McArdle **SRO:** Sean Coady

Key Aims

- Initial objective was to identify a 'green' location where the shielded population could receive treatment in a safe environment outwith GP practice.

Primary Objectives

- As the acute sector begin the remobilisation of services post covid there is an increasing workload from secondary care relocating to the community. GP practice are unable to support the additional workload.

- There is a requirement to identify a 'third space' that could be utilised for a variety of work including:
- Elective care
- Paediatric
- Community assessment centre
- Secondary care bloods
- Shielding population
- CTAC (Community Treatment and Care Centre)
- Flu and Immunisations

Priority shift to secondary care hub rather than green shielding.

Scope

- Establishment of a safe clinical treatment space for Shielded patients for:- essential blood testing, management of dressings, ECGs, administration of injectable treatments, other essential treatment room tasks.
- Cervical screening (funding provided)
- Longer term – relocate clinics where patients currently attend acute hospital setting that could be carried out in community ie secondary care bloods, catheter care, haematology services, CTAC services etc

Achievements

- Moray Resource centre identified and funding approved (£42k)

Programme Workstreams Progress

Activities in current period

July	Voice Comms installed ICT Procurement underway Furniture and peripherals identified ordering to be done	
August	Working to resolve capacity issues as MSK Physio staff still placed at MRC. May be there until end of 2021.	

Future Actions/Milestones

Action	Timescale	RAG
Relocation/ dual location of previous assets/ services at MRC for NHSG clinics	TBC	
Progress communications/engagement with users of MRC (past and future)	TBC	

Key Risks/Issues

- Long term plans for services recommencing is not yet known
- Availability of budget for upfront one off revenue costs
- No budget for ongoing revenue costs
- No staffing budget e.g. Domestic staff
- Change in use agreement with MC
- Reciprocal arrangements and potential outcomes with MC (TBC)

Dependencies

- Joint working - Flexibility in approach to shared use of building from Day Services and Clinical services.

Finance

- Capital funding secured for clinical treatment rooms from NHSG £42k and £2.5k for IT
- Majority equipment required to be transferred from existing premises
- Funding for cervical screening

Performance

Will look at patients numbers treated, patient experiences, what services moved from acute (patient footfall transferred) etc

HSCM HOME FIRST-Ambulatory Care/community hospitals

Report Date:	30/09/2021
RAG Status:	On hold

Project Ref : HF6 **Project Lead**: Cheryl St Hilaire **SRO:** Sean Coady

Key Aims

Ambulatory Care – Venesections
Provide this service out with Dr Grays Hospital (DGH)

Primary Objectives

- Improve Service
- Reduce waiting times
- Make service more accessible to patients
- Improve patient experience

Scope

To cover whole of Moray
Potential to use Community Hospitals and Hubs in the East, with potential use of Moray Resource Centre for the West.

Achievements

Haematology in ARI are now supporting this service and all patients will be registered with them to enable remote monitoring and appointments being made only as needed. This has reduced waiting lists and patients only attending appointments when needed instead of being issued "just in case" appointments.

Appointments re currently held on a Friday and DGH and facilitated by ANP's

Programme Workstreams Progress

Activities in current period

	On hold	

Future Actions/Milestones

Action	Timescale	RAG
Identification of suitable premises in East and West of Moray – Moray Resource Centre check??		
Identify and train staff to deliver the service across the community		

Key Risks/Issues

Dependencies

Staff availability from DGH to enable service delivery in the Community

Finance

None identified at this point

Performance

Number of venesections being delivered in the Community

Patient satisfaction

HSCM HOME FIRST- Palliative Care

Report Date:	30/09/2021
RAG Status:	

Project Ref : HF7 **Project Lead**: Lesley Attridge **SRO:** Sean Coady

Key Aims

Provide support to those people in Moray with palliative diagnosis through a person centred approach.

Primary Objectives

- To remobilise palliative care services at the Oaks
- To develop a model for sustainable service, covering a wide variety of disciplines, to provide support to those with a palliative diagnosis
- To coordinate the in reach and out reach services in the model to ensure appropriate and equitable access to all those with a need.

Scope

To provide support to anyone with palliative support needs within Moray through maximising the services that can be offered through a co-ordinated approach.

Achievements

"Virtual Day" sessions – 6 individuals supported at a time – one full programme completed. Evaluation now under way.

Provision of Occupational Therapy and Physio service for rehabilitation for palliative care patients across Moray in place via phone, video call or home visiting as required.

Confirmation that the McGill QOL to be used for evaluation of the programme at the Oaks

Programme Workstreams Progress

Activities in current period

Sept 2021	Band 6 post has now been advertised as a secondment and interviews happening soon.	

Future Actions/Milestones

Action	Timescale	RAG
Face to face session (6 per session)	When Govt Guidelines allow	
Development of Model of in reach and outreach support	September 2021	
Meeting of Oaks group – expand membership	TBC	
Consultant led sessions recommence	TBC	

Key Risks/Issues

- Lack of staff resource:-
  - Recruitment of Band 6 nurse, held up in recruitment process out with HSCM control, is progressing now but delay is impacting in progress.
  - Long term sick of Band 5 post
- Health Care support worker – held up in recruitment

Need these posts to provide the clinical support to the delivery of the model.

Dependencies

Oaks Volunteer co-ordination – Angela Stewart
Clinical support – Flora Watson

Grampian wide strategic framework to be ratified.

Finance

No additional request to the existing budget

Performance

Feedback from participants (in development)

Participant numbers

HSCM HOME FIRST- Third Sector Action Group

Report Date:	30/09/21
RAG Status:	

Project Ref : HF8 **Project Lead**: Cheryl St Hilaire **SRO:** Sean Coady

Key Aims

To facilitate engagement and identify opportunities for greater reach for third sector involvement in supporting the objectives of Home First

Primary Objectives

- Form a short life working group with key members of the third sector in Moray.
- Explore where and how the third sector (community groups and charities) could align with Home First work streams.
- Produce information for the Home First Group on findings of where and how the third Sector does and could align with Home First work streams.
- Make recommendations based on findings as to what Home First need to have, consider and/or implement to enable third sector involvement in Home First.

Scope

Involvement across the whole of Moray

Identifying ways and means of complimenting the full circle of a patient's journey and preventative intervention through the third sector who can provide support out with health and social cares remit

Achievements

A paper was produced and presented to the Home First Group identifying the 'Golden Thread' – where and how the third sector can, is and could support Home First, along with a brief which gave recommendations.

Programme Workstreams Progress

Activities in current period

August 2021	TSI funding application from Endowment fund was successful and a Community Support Co-ordinator has now been employed on a 2 year contract	

Future Actions/Milestones

Action	Timescale	RAG
Scope opportunities and identify gaps – produced the Golden Thread	October 2021	
Design plan to communicate and engage	October 2021	
Implementation of plan to increase volunteers supporting delivery of home first projects	October 2021	

Key Risks/Issues

- Potential lack of capacity of Third sector and volunteers to be able to engage with meetings
- An uncoordinated approach to involving the third sector and damaging relations and potential collaborative working opportunities.
- Home First Work streams being not able to refer appropriately and sign post into third sector without a dedicated resource to support and monitor.
- Third sector being unable to meet all the needs of Home First (our own volunteers would counteract this).

Dependencies

Finance

Volunteer infrastructure fit for the future TBC

Resource in HSCP Moray to manage referrals/signposting TBC

Performance

Increase in numbers of people volunteering

Feedback from individuals receiving support

HSCM HOME FIRST-Mental Health

Project Ref : HF10 **Project Lead**: Pamela Cremin **SRO:** Sean Coady

Report Date:	30/09/2021
RAG Status:	

Key Aims

Primary Objectives

- Safe, equitable secondary care mental health services; Access
- Recovery focussed secondary care Moray mental health services
- Community based mental health services
- Reducing Drug and Alcohol related harms
- A move away from traditional service age boundaries; upstream intervention and prevention. Improved transitions – mental health and well being services for young people up to age of 25
- Suicide Prevention
- Improving people's experience of care
- Peer and Carer involvement

Scope

- Delivery of Good Mental Health for All Moray Strategy 2016-26; and NHS Scotland Mental Health Strategy 2017-2027 - Action 15
- Unscheduled Care and Distress Brief Interventions
- Strategic Commissioning
- Trauma Informed Workforce
- Primary Care Mental Health: service and workforce development
- Forthcoming Mental Health Transition and Renewal Plan and funding

Achievements

- Mental health Services fully remobilised and responsive
- Technology enabled service and practitioner uptake of Near Me
- Referral Criteria for secondary care updated
- Improved Adult Psychology waiting times – achieved 18RTT standard in November 2020 and sustained as of April 2021

Programme Workstreams Progress

Activities in current period

	Redesign of Moray secondary care Psychological Therapies and re-establishing Groups	
	New Primary Care Psychological Therapies Service commenced on 1st April 2021	

Future Actions/Milestones

Action	Timescale	RAG
Develop Mental Health First Response in GP Practices to replace GP Link Worker Service	As soon as possible – current service gap	Specific to Primary Care. Alternative Tier 1& 2 pathway in place to support
Trauma Informed Workforce – training and development for all H&SC Moray and partner agency workforce	In progress	
Strategic Commissioning: • Wellness Service • Direct Access for Drug and Alcohol	In progress	

Key Risks/Issues

- Bed spacing and reduced admission capacity across NHS Grampian for mental health in patient care
- 3rd Sector remobilisation in terms of supporting and working with people in their own homes to manage their mental health
- Workforce availability – some mental health posts difficult to recruit to. Band 5 nurses; Psychologists; Medical Locum insitu for Older Adult Mental Health; Mental Health Officers
- IT Platform for group therapy requires expansion to meet NHS G demand
- On going high risk drug and alcohol related harms; and deaths – plans in place to risk manage and mitigate against these,

Dependencies

- Integrated and multi agency working and collective risk and case management.
- Care and treatment pathway access and service delivery across Tier models
- Closer working between adult mental health and children and young people; drug and alcohol services and community justice services.

Finance

- Mental Health Budget has no budget pressures. Core budget uplift announced by Scottish Government for 2021/22
- Increased funding for Moray Drug and Alcohol Service (MIDAS) from Moray Alcohol and Drugs Partnership (MADP)
- Significant new and future financial investment by Scottish Government for mental health care and treatment and for drug and alcohol services – across all population age range

Performance

- Ongoing service performance and measurement of KPIs
- Performance monitoring of third sector commissioned contracts for mental health and drug and alcohol services

REPORT TO: **MEETING OF THE MORAY INTEGRATION JOINT BOARD ON 30 SEPTEMBER 2021**

SUBJECT: **ANNUAL PERFORMANCE REPORT 2020/21**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To request the Board considers and approves the draft Annual Performance Report 2020/21

2. RECOMMENDATION

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

i) note the approach taken to produce the 2020/21 Annual Performance Report; and

ii) approve the report at APPENDIX 1 for publication by 1 October 2021.

3. BACKGROUND

3.1 The Scottish Government have advised that the Coronavirus Scotland Act (2020) has been extended to 30 September 2021. Subsequently, Integration Authorities can delay the release of their Annual Performance Report until November 2021 using the same mechanisms as last year and as laid out in Coronavirus Scotland Act (2020), Schedule 6, Part 3. Public Health Scotland (PHS) have also issued guidance to Integration Authorities for 2020/21 Annual Performance Reports in relation to which release of Core Suite Integration Indicators to be referred to.

3.2 The Annual Performance Report must meet the required content as described in the national reporting guidance. It must demonstrate how Health and Social Care Moray (HSCM) has performed against the National Health and Wellbeing Outcomes, within the context of the Strategic Plan and Financial Statement as presented within the report. To support this, a set of Core Integration Indicators have been developed by the Scottish Government and the Board is expected to report upon performance using these and other locally specified indicators. The report is required to include a comparison of performance in previous years. The MIJB Annual Performance Report includes a comparison during the period since establishment, that being 1 April 2016.

3.3 A summary of financial performance for the 2020/21 reporting year, along with comparisons for the previous years, that include the total spend by service, details of any underspend/overspends and the reasons for these.

3.4 An assessment of performance in relation to best value.

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

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

3.7 A report to the Audit, Performance and Risk Committee on 26 August 2021 (para 9 of the draft minute refers) provided members with an opportunity to comment on the Draft Annual Performance Report. The Committee agreed the report be submitted to the MIJB on 30 September 2021 to approve for publication.

3.8 The previous Annual Performance Report can be viewed at the following link: https://hscmoray.co.uk/uploads/1/0/8/1/108104703/moray_ijb_annual_performance_report_2019-20.pdf

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 This report covers performance across HSCM, and highlights specific pieces of work to demonstrate positive performance against a variety of objectives and performance indicators. These include:-

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

4.2 There is a large amount of performance data available to support the report, however it is not possible to include it all within the public facing report so specific highlights have been chosen which reflect areas that have been of particular focus.

4.3 The items for focus were identified by staff and managers following a call for submissions. There is a continued effort to strengthen the links between the Strategic Plan, implementation plans and related performance monitoring reports, to facilitate production of future Annual Performance reports. This

matter will be taken forward as part of the process for the refresh of the Strategic Plan.

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 and meeting the strategic aims contained within the MIJB Strategic Plan; Moray Partners in Care 2019-2029

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

(b) Policy and Legal

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

(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 there are no changes to policy arising from this report and therefore there will be no differential impact on people with protected characteristics.

(h) Consultations

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

- Tracey Sutherland, Committee Services Officer
- Chief Financial Officer, MIJB
- Senior Management Team
- System Leadership Group

6. CONCLUSION

6.1. This report recommends the Board approves the Draft Annual Performance Report 2020/21 for publication by 1 October 2021

Author of Report: Isla Whyte, Interim Support Manager
Background papers: with author
Ref:

HEALTH & SOCIAL CARE MORAY

ANNUAL PERFORMANCE REPORT

2020/21

Working for and with the communities of Moray

Contents

In line with the Coronavirus (Scotland) Act, and with the approval of the Moray Integration Joint Board, the decision was made to postpone publication of the Health & Social Care 2020-21 Annual Performance Report until 01 October 2021.

It will be available thereafter on the HSCP website at www.hscmoray.co.uk. Printed copies will be available on request by contacting involvement@moray.gov.uk or calling 01343 567187.

Foreword from our Chair and Vice-chair

Welcome to the fifth Health & Social Care Moray Annual Performance Report.

The report shows how the resources available to Health & Social Care Moray have been used by the partnership to deliver health and social care services for the people of Moray between April 2020 and March 2021, how performance compares with previous years and with Scotland.

Normally, our report would also celebrate what we have achieved during the past 12 months. This doesn't feel appropriate this year, so instead we have used the opportunity to reflect on what has been anything but a normal year and focus on the response, recovery and renewal work undertaken.

The word that defined the year was pandemic which literally means "affecting everyone" and it is clear Coronavirus has touched and changed every aspect of our lives, testing us all.

We saw the devastating effects of Covid-19 on people around the world. We feared for the fate of the most vulnerable in our society. We learnt that the simple act of hand washing or sanitising was critical in preventing the spread of the virus. We discovered what it meant to be stuck at home, reliant on technology to keep in contact with the outside world and to continue working and learning. We got into the habit of never leaving the house without a face mask.

Councillor Shona Morrison
Chair, Moray Integration Joint Board

Dennis Robertson
Vice-chair, Moray Integration Joint Board

One of the toughest rules to follow was surely being told we had to keep our distance from loved ones. Yet even when we had to physically stay apart, we still came together as the community of Moray to care for and support one another.

Vaccines offered a much-needed ray of hope. December 2020 saw the arrival of the first batch of vaccine in Moray and the start of the biggest vaccination programme ever undertaken. People came forward in numbers we could hardly have imagined to take up their offer of a vaccine to protect themselves, their loved ones and their communities.

Colleagues in health and social care continued to be a presence in our communities and on the frontline, delivering essential services and providing safe and effective support and care for those with the greatest needs. Others moved from offices and bases to bedrooms, living rooms and kitchens to keep working. Many took on new or adapted roles to ensure services were there for those who needed them.

To all colleagues in all sectors across the health and care system - whether you have been working on the frontline, providing essential support from a base or while working from home – we want to say thank you for your hard work and unwavering commitment which has made a huge impact on the lives of people across Moray.

The Moray Integration Joint Board is immensely proud of this partnership and the individual and collective determination and innovation of each and every one to keep essential services going and continuing caring for and supporting our citizens.

We would also like to take this opportunity to recognise and thank all of Moray's unpaid carers for the unparalleled support they have provided throughout the crisis. While we have sought to minimise the disruption to services and supports throughout and continue to do so, the individuals who rely on our services and their carers have displayed remarkable levels of fortitude and understanding of the difficulties we face.

While challenging, our experiences during the year have also been inspiring and uplifting, showing us all how much we can achieve when we pull together. We have been awed by the way our communities rolled up their sleeves to support one another - particularly during the challenges of lockdown - by volunteering and carrying out heart-warming acts of kindness. Their dedication and hard work has been essential to the response efforts.

We continue to have a great deal of work to do to recover and renew as an organisation and have much learning to take stock of. The last year has brought into sharp relief opportunities to transform services to better meet the needs of individuals and communities, and as we continue to build back and redesign while learning to live with Covid-19, we strongly believe Moray has the will, skill and

drive to come out of this stronger than before.

We recognise we are stronger when working together. We will build on the strong partnerships forged during the pandemic across the public, independent, voluntary and community sectors, work alongside our local communities and learn lessons from the lived experience people share with us as we continue on our journey to ensure people have access to the services and support they need to experience improved health and wellbeing outcomes.

Chief Officer's introduction

It is something of an understatement to say that the past year has been the most challenging we have ever faced in health and social care – and in every other sector.

Throughout the response to Covid-19, and our recovery and remobilisation phases, we have continued to use the strength of the partnership of Health & Social Care Moray to work together for the good of the people and communities who need our services.

Simon Bokor-Ingram
Chief Officer, Health & Social Care Moray

Dedication and commitment

It has without doubt been challenging navigating through the usual demands and pressures on our health and care system with the added complexity of Covid-19 infections, precautions and restrictions while maintaining our services as far as possible and establishing new ways to care for our residents and support our communities and partners.

I want to start by acknowledging the huge efforts of colleagues across the health and care system. For more than a year now, folk have been going above and beyond, day after day, to respond to the ongoing coronavirus situation. Their dedication and commitment has been remarkable.

Colleagues on the frontline led on protecting people from harm, ensuring person-centred care and providing the best possible services to our citizens with the restrictions and challenges that Covid-19 created. This was amid much early uncertainty about the virus and despite fears to their own health and the health of those they live with. They had to make rapid adjustments in an ever-changing environment, working in full personal protective equipment (PPE), adhering to strict infection prevention and control measures and carrying out regular testing.

Responding to the pandemic

From the start, the partnership refocussed and reorganised its resources to protect key areas of operation. A large number of rapid changes had to be made to working practices. Changes that would have previously taken months to design and implement were accomplished in days or weeks. The changes also brought about service improvements which ensured we could continue to deliver quality health and care services in a safe manner for those that needed them at home, in care settings and in hospital.

The demands on care homes during the pandemic have been enormous. It is recognised that adults living in care homes often have multiple health and care needs and are frail with varying levels of dependence. Many are inevitably at greater risk of a poor outcome if they were to contract Covid-19. We have worked in real partnership with the owners and managers of Moray's care homes to protect residents and staff.

We worked hard to keep our patients, clients and staff safe, changing working practices in line with national guidance and ensuring people had access to personal protective equipment (PPE). We moved to remote working and service delivery where appropriate to minimise footfall in buildings and face-to-face contacts. This has improved access for many patients and clients, although we recognise that this has been a difficult change for some folk.

Our Covid-19 vaccination programme has been a really successful example of partnership working across staff groups and with our communities. There was a significant response to our call for help, including folk who had retired or left health work, who returned to help vaccinate, making a huge difference to how quickly we responded when vaccines became available. The uptake rates of the vaccine are high, and the community have worked with us to make that happen.

Command structures were established to enable strategic, tactical and operational decision making across the wider system. Staff wellbeing was prioritised as we moved from response to remobilisation and recovery. Our plans focused on living with the risks of Covid-19 through delivery of the testing and vaccination programmes and supporting the safe return of suspended services.

The National Day of Reflection on 23 March 2021 marked the anniversary of the first lockdown and we paused to think about those we had lost during

the year, whatever their cause of death, and to acknowledge the sacrifices so many have endured over the past 12 months. It was an opportunity to look back over the 12 months, acknowledge how far we had come, the sacrifices we have made and to start looking ahead to better times to come.

Working in partnership

We are fortunate that the good work taken forward by the partnership in previous years meant we were in a strong place to respond to the challenges we experienced and continue to experience. Of course, the pandemic has inevitably impacted on our service planning, delivery and performance this year while we worked in an agile and rapid manner to redesign services at pace and scale and create new and innovative ways to deliver them.

During the pandemic we had to stop doing some of the things we routinely did. As we moved into recovery and remobilisation we needed to consider whether we re-started and returned to these again in the same way or perhaps continued to take a different approach to what we did before. Out of necessity we also found ways of doing things differently. We have learnt a lot as we continue to assess the practicality and effects of the new working practices and to identify, refine and embed those which have delivered real benefits.

I look forward now to leading the partnership as we emerge from the pandemic, working together to shape what that future looks like as we strive to achieve the best health and care system which offers high quality, person-centred, safe and sustainable services which enable our communities to enjoy better health and wellbeing.

Our key objectives set out in the Strategic Plan for the Integration Joint Board have not changed. The pace of meeting those objectives has quickened, and as we emerge from the pandemic we must keep up that pace to meet the new challenges we face.

Background to health and social care integration

National Context

The way in which health and social care services are managed changed in 2016 when legislation brought together health and social care in to a single integrated system.

The legislation created 31 integration authorities in Scotland which now have responsibility for the budget, strategic planning and commissioning of services which were previously managed separately by NHS Boards and Local Authorities.

Integration aims to improve care and support for people who use services, their carers and their families by ensuring services:

- ✓ Are joined up and easy for people to access
- ✓ Take account of people's individual needs
- ✓ Take account of the particular characteristics and circumstances of different service users in different parts of the city
- ✓ Respect the rights and dignity of service users
- ✓ Take account of the participation by service users in the community in which service users live
- ✓ Protect and improve the safety of service users
- ✓ Improves the quality of the service
- ✓ Are planned and led locally for the benefit of service users, people who look after service users and the people who provide health or social care services
- ✓ Anticipate people's needs and prevent them arising
- ✓ Make the best use of facilities, people and resources

Local context

NHS Grampian and Moray Council agreed to integrate all community-based adult health and social care services and some hospital-based services. Responsibility for these services was delegated to a new body, the Moray Integration Joint Board (IJB) which was established in 2016.

The services which have been integrated and now come under the Moray IJB include:

Adult Care Services	Community Health Services
• Social Work Services for adults and older people; • Services and support for adults with physical disabilities and learning disabilities; • Mental Health Services; • Drug and Alcohol Services; • Care at Home and Community Support • Carers support services; • Respite provision • Social Care Assessment • Equipment and telecare; • Day services/opportunities • Occupational Therapy services • Aspects of housing support including aids and adaptations.	• District Nursing; • Primary Medical Services (GP practices); • Out of Hours Primary Medical Services; • Public Dental Services; • Ophthalmic Services; • Community Pharmacy Services; • Community Geriatric Services; • Community Learning Disability Services; • Community Mental Health Services including inpatient beds; • Community Drug and Alcohol Services • Community Palliative Care; • Allied Health Professional Services.

There are six services, based within the acute sector, which are delegated to the three Grampian Integration Joint Boards for the purpose of Strategic Planning as they are the specialties with the highest levels of unscheduled care. . These services are:

1. Accident and Emergency services provided within hospitals;
2. Palliative care;
3. Care of the elderly;
4. Respiratory medicine;
5. General medicine;
6. Emergency Department.

Community Services 'hosted' by Moray on behalf of the NHS Grampian Boards are:

- Primary Care Contracts
- Out of Hours Service Primary Care (GMED)

Children and Families Health Services are 'hosted' by the Moray IJB. The full list of delegated services can be found in the Scheme of Integration.

The Moray Integration Joint Board and Health & Social Care Moray

The Moray IJB is made up of voting and non-voting members:

- Voting members: three Elected Members of Moray Council and three Members of the Board of NHS Grampian.
- Non-voting members: professional advisors including the Chief Officer, Chief Finance Officer, Chief Social Work Officer and Clinical Leads, and also stakeholder members representing patients and service users, unpaid carers, the Third Sector and staff.

There were a number of changes to the Moray IJB membership during the year.

Jonathan Passmore, Chair of the Board, and Councillor Tim Eagle both stepped down from the IJB. They were replaced by Professor Nick Fluck, Executive Member of the NHS Grampian Board and Councillor Frank Brown, elected member of Moray Council. Dennis Robertson became Chair in September 2020.

Pamela Dudek, Chief Officer, took up a secondment to NHS Highland in April 2020 and was then appointed to the post of Chief Executive in August 2020. Simon Bokor-Ingram arrived on secondment from his post as Director of Community Health and Social Care and Chief Officer of the Shetland Islands IJB. He was appointed to the Chief Officer post in Moray in January 2021.

Dr Graham Taylor stepped down as joint Clinical Lead in September 2020. Jane Ewen, Nurse Director Excellence and Innovation, NHS Grampian, replaced Dr June Brown as a professional adviser to the Board

Governance

The Board continued to operate in an open and transparent manner during the pandemic. Due to rapid advancement in digital technology availability, the Board was able to establish online meetings immediately and the original timetable was fulfilled. The March 2021 meeting was the first to be webcast.

All but one of the scheduled Audit Performance and Risk Committee meetings were held as timetabled during 2020/21. An interim arrangement was agreed for the operation of the Clinical and Care Governance Committee whereby the Chair of the Committee received monthly updates on the key issues arising during the pandemic response.

Decisions taken by the Board during the year included:

March 2020	The Chief Officer (or Interim Chief Officer) was granted delegated authority to take decisions in respect of matters that would normally require Board approval, if the Board was unable to meet.
July 2020	The Annual Performance Report for 2019/20 was approved.
September 2020	The temporary suspension of care packages was ended and the eligibility criteria reverted to meeting both critical and substantial need. The Standards Officer and Depute were re-appointed. The delegated authority granted to the Chief Officer was revoked.
November 2020	The Audited Annual Accounts for the financial year 2019/20 were approved. The Public Sector Climate Change Duties Report was submitted to Sustainable Scotland Network. Charges for services for 2021/22 were approved and recommended to Moray Council for approval and inclusion in the budget setting processes.
January 2021	An increase to the voting membership was approved, subject to consultation and ratification by the Scottish Government. The updated Learning Disability Strategy was approved along with proposed housing projects for people with a learning disability. The governance framework was approved. The Annual Report of the Chief Social Work Officer 2019-2020 was accepted.
March 2021	Funding was approved to scale up the Discharge 2 Assess Team on a permanent basis. Commissioning of an outcomes-based care at home service was agreed. An implementation plan for the National Whistleblowing Standards was approved.

Agendas, reports and minutes for the Moray Integration Joint Board and its two committees (Audit, Performance and Risk, and Clinical and Care Governance) are available using the website link below.

https://moray.cmis.uk.com/moray/CouncilandGovernance/Committees.aspx

The Strategic Plan 2019-2029

The Moray IJB's second Strategic Plan, Partners in Care, was developed in partnership with our stakeholders and published in 2019. It sets out the vision for a Moray where:

"We come together as equal and valued partners in care to achieve the best health and wellbeing possible."

The Strategic Plan sets out the high-level priorities for the health and social care partnership to focus on for the next 10 years to deliver improved health and wellbeing outcomes. These are:

- **Building Resilience**

Enabling people to take greater responsibility for their own health and wellbeing

There is a commitment to improve overall health and wellbeing and prevent ill health of the people of Moray. Positive health and wellbeing, prevention, early intervention and harm reduction will continue to be promoted. People need to get the right levels of information, advice and support to maintain their independence and reduce the instances of them having to engage with services at points of crisis in their life.

- **Home First**

Supporting people to live as independently as possible at home or in a homely setting

There is a commitment to continue to invest in communities for services to be delivered locally and support people to be maintained safely at home, avoid unnecessary hospital attendance or admission, and to be supported with early discharge back home after essential specialist care.

- **Partners in Care**

Enabling people to have greater choice and control over decisions affecting their care and support

There is a commitment to ensure patients, people who receive services and their carers are supported and empowered to make their own choices about how they will live their lives and what outcomes they want to achieve.

Health & Social Care Moray

Through our strategic priorities, our ambition is to create a health and social care system that is accessible, caring, person centred, safe and sustainable. We need to ensure we can continue to provide health and social services to those who need them most, at the appropriate time, in the appropriate place. We want to transform the way we do things so that more people can access the support they need to live healthy, independent lives.

The Strategic Plan drives the work of the partnership of Health & Social Care Moray. This is the delivery arm of the Integration Joint Board with Moray Council and NHS Grampian employees work together with organisations across the Third and Independent Sectors to deliver integrated services.

Responding to the challenges of Covid-19 has resulted in the opportunity to accelerate work to achieve the Moray IJB's ambitions as set out in the Strategic Plan, particularly around the Home First agenda.

Health & Social Care Moray works to achieve improved health and wellbeing outcomes for individuals and communities, and achieve the core aims of integration to:

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

The Chief Officer is supported by the Senior Management Team and wider System Leadership Group Team.

The partnership reports quarterly to the Moray IJB on a range of performance measures to highlight areas of good performance and areas where improvement action is required.

About the Annual Performance Report

Integration Authorities are required by legislation to report on the Core Suite of Integration Indicators within their Annual Performance Reports. These national indicators are intended for consideration within the wider context of health and social care and identify areas for improvement to aid strategic planning.

The Annual Performance Report describes our performance in a number of different ways, recognising that information is used and understood differently by different audiences. It presents how the Partnership has:

- Worked towards delivering against our three strategic priorities by highlighting areas of key activity and good practice
- Performed in relation to the nine National Health and Wellbeing Outcomes
- Performed in relation to the National and Local Indicators
- Performed financially

The National Health and Wellbeing Outcomes

There are nine National Health and Wellbeing Outcomes that seek to measure the impact that integration is having on people's lives.

They are high level statements of what health and social care partners are striving to achieve through integration, and ultimately through improvement across health and social care.

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

National and Local Indicators

We present a range of key performance indicators to evidence our progress during 2020/21:

- National Core Integration Indicators;
- National and Local Indicators;
- Ministerial Strategic Group (MSG) Indicators.

The indicators have been developed from national data sources to enable comparisons between Integration Authority areas and with Scotland. There are 23 indicators in total.

There are nine indicators based on the Health and Care Experience Survey and 10 other measures mainly using health activity, community and deaths information. The remaining four indicators cannot be reported as national data is not available or there is not yet a nationally agreed definition. Each indicator acts as a measure of progress against at least one outcome.

Financial Performance

We have set out an overview of our financial performance for 2020/21 and by comparison with the preceding year as trend data.

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

Locality Planning

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

The Partnership has appointed four Locality Managers who will lead on the development of Locality Plans with partners including patients, service users, carers and the third and independent sectors. Each Locality Plan will be updated annually to show how the Strategic Plan is being implemented locally to ensure services and any redesign work reflects local priorities, needs and community issues.

Inspections

Health and Social Care services delivered by statutory and non-statutory providers in Moray are monitored and inspected in a range of ways to give assurance about the quality of people's care.

The Partnership's commissioning officers apply contract monitoring processes to services commissioned to deliver health and social care while Service Managers monitor internal service delivery. This work is reported through the Board's Clinical and Care Governance Committee.

Normal programmes of inspection by external bodies were suspended during the pandemic but they continued to carry out scrutiny. The type of scrutiny was based on risk or intelligence, taking the form of self-evaluation, virtual scrutiny and on-site inspection.

Our response to Covid-19

The national situation

In January 2020, the World Health Organisation (WHO) announced that a new respiratory illness in Wuhan, China, was associated with a novel (new) coronavirus called Covid-19.

As the virus spread around the world and reached Europe, it became clear that mortality varied across age groups with the elderly appearing to be at particular risk as were those with certain health conditions.

Scotland confirmed its first case in early March 2020 and by 23 March - the start of the first national lockdown - the deaths of 16 people had been linked to the virus. In the year since, more than 9,800 deaths where coronavirus was mentioned on the death certificate had been recorded.

Lockdown placed stringent restrictions on every day activity. People were required to stay at home unless they had a key role (which included many NHS and Social Care staff) or for essential purposes, such as shopping and once a day exercise. Legislation allowed for enforcement and fines for non-compliance.

Scotland began the first of four phases to exit lockdown at the end of May when an initial easing of lockdown restrictions began.

Coronavirus remained a significant threat to public health and measures to limit its spread continued, including requirements to observe social/physical distancing and avoid crowds, to adopt strict hand washing, to wear a face covering unless exempt, and to self-isolate and book a test if experiencing symptoms.

In November 2020 a new five-tier local lockdown levels system was put in place, based largely on the prevalence of the virus, including the number of positive cases. Due to concerns around the emergence of a new, more transmissible variant of the virus, from Boxing Day the country moved into the tightest Level 4 restrictions, which included the closure of non-essential retail and hospitality. Scotland moved into its second lockdown on 5 January 2021.

The Scottish Government published an updated strategic framework in February 2021 setting out the plan to restore, in a phased way, a return to a more normal life for the country while at the same time suppressing the virus to the lowest level possible and keeping it there.

The picture in Moray

For much of 2020, Moray had the third lowest infection rate of any Scottish local authority and typically recorded 6-8 cases per week, per 100,000 of population. As a result, Moray was placed in Level 1 in the first review of Scotland's Covid-19 alert system in November.

In early 2021, however, Moray began to experience a significant increase in cases. To drive down transmission, in February, community testing began of people who experienced no symptoms to identify those with virus who had the potential to infect others.

The initial response

Following direction from the Scottish Government, in March 2020 Health & Social Care Moray started its emergency response to the pandemic. Many planned services were suspended whilst others rapidly changed their delivery model and huge numbers of staff began working from home. Many members of the workforce were redeployed to assist with anticipated high levels of demand and activity.

The command and control structure was embedded. To meet the requirement for robust and continuous planning, the HSCM Covid Response Group of service managers and system leads met daily and linked directly to Local Authority and NHS arrangements to ensure a co-ordinated tactical and operational multi-agency response for Moray and Grampian.

In the emergency response phase, there were a number of key priorities to be addressed.

- **Ensuring the most vulnerable residents with critical care and support needs stayed safe and well in the community**
- **Supporting those in the community who were shielding, self-isolating or vulnerable**
- **Supporting the workforce to continue to safely deliver essential services**
- **Supporting those in the community effected by coronavirus**

Actions in relation to these areas of priority is reported from Page 22 in relation to our progress against the National Outcomes.

Recovery and Re-mobilisation

The Re-mobilisation Plan developed by the Moray, Aberdeenshire and Aberdeen City Health & Social Care Partnerships and NHS Grampian, set out a whole-system approach to safely restarting services whilst living with Covid-19.

The plan drew on learning from the innovation and reform accelerated during the initial response phase to support the priorities of keeping residents safe through work with statutory, third sector and independent sector partners.

The partnership remained focused on strategic priority of Home First. The approach of aiming to avoid hospital admissions where appropriate and minimise hospital delayed discharge, was key to creating the capacity and pathways required to sustain care delivery through winter, including the prospect of further waves of Covid-19.

Our progress against the National Outcomes

Community health and wellbeing

National Health and Wellbeing Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.

Strategic priority: Building Resilience: Supporting people to take greater responsibility for their own health and wellbeing

Covid priorities: Supporting those in the community who were shielding, self-isolating or vulnerable; and supporting those in the community effected by coronavirus

The health and wellbeing of the people of Moray is central to the work of the health and social care partnership. One of the priorities of the Moray Integration Joint Board's Strategic Plan is to work collaboratively with partners and communities to progress approaches which enables individuals to take greater responsibility for their own health and wellbeing. This will support them to live longer and healthier lives.

Living through a global pandemic has had a huge impact on the health and wellbeing of Moray's citizens. The resilience of individuals, households and communities will determine how well we recover from the wide range of impacts, and the length of time this will take, and ongoing work is required to fully understand the long-term impacts.

Everyone had to adapt their lives and follow the national restrictions put in place to reduce the devastating spread of Covid-19. We have all had to change our behaviour, such as wearing a face covering whilst shopping and keeping our distance from others.

As the number of people with Covid-19 symptoms in Scotland grew, Health Boards were asked to set up community clinical hubs and assessment centres as part of a comprehensive front line community response for people struggling to manage their symptoms at home.

Grampian Covid-19 Hub has been set up by the Out of Hours Primary Care (GMED) Service with support from management and clinical lead teams from three partnerships and continues to be staffed by clinicians from across the system. Calls made day or night to NHS 24 by members of the public whose symptoms failed to improve, were initially assessed and information forwarded to the hub using existing

infrastructure. Staff at the hub then contacted the individuals by phone and provided advice on how best to manage their symptoms and continue to self-isolate at home, gave an appointment to attend the centre for further assessment or arranged a GMED home visit. The initial telephone assessment was complemented by the NHS Near Me video consulting platform when required.

During an 11-month period, the **Community Response Team** (CRT) carried out 72 rapid response assessments (completed within a 2-hour timeframe) for patients too unwell to attend the centre, which was based at The Oaks in Elgin, enabling it to dovetail with the CRT, the Out of Hours Primary Care Service (GMED) and Grampian Covid Hub. The team also undertook training in relation to providing care and support to Covid-19 end of life patients at home.

The adult seasonal flu immunisation programme had a key role in preventing ill health in the population and minimising further impact on NHS and social care services. Flu vaccinations in Grampian moved away from a model based on GP delivery to delivery through dedicated teams. The **Moray Immunisation Team** developed and delivered the core programme to all eligible groups with particularly focus of those aged 65 years and over, those aged 18-64 in clinical risk groups and pregnant women. The extended programme offered vaccination to frontline health and social care workers, including Independent Contractors, unpaid and young carers.

The national Covid-19 vaccination programme is the biggest in history. It represented a huge logistical challenge requiring scaling up the workforce, inviting large numbers to get vaccinated safely, transportation and storage of the vaccines.

Since early December 2020, when the Covid-19 vaccine first became available in Grampian, the **Vaccination Team** – including

nursing and medical staff, care workers, GPs, returning workers, admin staff and volunteers – have worked together to protect people in Moray from the virus.

The roll-out of the programme prioritised those most at risk, beginning with the first of two doses to care home residents and staff and frontline health and care workers to lower the risk of them getting Covid-19 or transmitting it to the people they care for and support. Teams from general practice and community nursing led the vaccination effort for the over 80s and people who were housebound.

January saw the first appointments offered at newly opened mass vaccination centre in Elgin. The Fiona Elcock Centre is named in memory of a much-missed and valued colleague who was an immunisation nurse and died very suddenly at the end of 2020. The delivery of first and second doses has continued into 2021/22.

Moray's first mobile community testing site opened in Keith in February to provide free testing for members of the public with no symptoms associated with Covid-19 but who could be infectious and spreading the virus without knowing it. This pop-up testing unit will moved between Moray towns in an effort to drive down community transmission.

Amidst all the challenges, there have been many positives, most notably the response from the people of Moray. Since March 2020 there has been an unprecedented movement in community resilience and increase in community capacity. Neighbours connected and looked out for one another more than usual and informal groups in local areas mobilised to use community-centred approaches to identify and support individuals and families in need, particularly the isolated and excluded.

Much of this work was co-ordinated by community planning partners including the partnership's community development team, Moray Council's community support unit and tsiMORAY, which included support for the **Grampian Humanitarian Assistance Centre** (HAC). It began operation to coordinate resilience partnership, third sector and community resources for people on the shielded patients list (the extremely vulnerable at higher risk) and for members of the wider public experiencing difficulties due to the Covid-19 restrictions such as collecting shopping and medications. In its first week, the helpline responded to over 600 people across Grampian and connected them to appropriate support.

Our **Volunteer Service** experienced increased interest in volunteering, including a number of people furloughed from their jobs, to support people known to health and social care services. During the year, 131 volunteers were matched with clients to take the number of current volunteers to 183. They supported 291 clients – 170 who were in need of a social buddy and 121 who required one or more volunteer to act as their community alarm responder.

All volunteers were provided with national Covid-19 guidance, PPE and guidance cards for safe procedures during community alarm call outs as appropriate. Training moved online which gave greater accessibility and reduced travel time and costs.

The team had to find different ways to meet 77 potential volunteers and used video calls and outdoor meetings to get to know people and explore volunteering opportunities. Adapting the buddy roles was a challenge due to restrictions on face to face visits, most of the clients and their buddies maintained contact by phone in the early stages. As some restrictions were lifted in the summer of 2020 over 50% were able to visit clients in gardens and outside spaces.

There was a marked increase in the number of community alarm responder referrals, including via the Home from Hospital Team based at Dr Gray's Hospital. The rise may in part have been due to neighbours, friends or family who would normally have filled the role having to shield.

We continued our work to promote healthier lifestyles and active ageing. Community health and wellbeing groups supported by the partnership including **Be Active Life Long** (BALL) Groups for older people, **Baby Steps** for pregnant women and new parents, and **Walk Moray** which deliver health walks in communities across Moray, had to suspend or adapt activities in line with the Covid-19

restrictions, with online sessions helping to combat social isolation and promote physical activity.

The **Community Development Team** supported 80 people to access digital devices and training, to enable them to make use of digital services and video consultations. Devices have also been supplied to care homes.

The Bow community café in Elgin run by Arrows, a Quarriers support service which provides a resource of practical help for individuals and their families dealing with substance or alcohol misuse in Moray. The service receives funding from the Moray Alcohol and Drug Partnership.

The café is supported by volunteers and Moray Food Plus who facilitate donations from local supermarkets. The food recovery initiative allows the café to prepare and provide quality meals and fresh baking to customers. While the café was closed, volunteers, staff and catering colleagues redeployed by Moray Council worked together and between April and September provided 6,970 three course meals to families, people who were shielding, older people, single person households, people who were experiencing physical and/or mental health difficulties and people who found themselves in financial hardship.

The **Hopeman Community Minibus** was a lockdown lifeline to locals with medical appointments and then began supporting vaccination runs. Community members from Burghead, Cummingston and Hopeman joined forces last August to form a new committee in response to the transport issues experienced by coastal residents following the temporary closure of the GP surgeries in Burghead and Hopeman and reductions to the already limited public transport timetable.

They made use of an underused mini bus to establish a volunteer-led door-to-door service which enabled people to continue accessing their health centre, hospital, and optometrist and podiatrist appointments. Additional funding was secured through Health & Social Care Moray's Health Improvement Fund to meet growing demand for the service and the committee has worked closely with the medical practice to co-ordinate appointment times.

The NHS Grampian virtual **Psychological Resilience Hub** launched just days after the first lockdown was imposed and was the first of its kind in Scotland. Members of the public and health and care staff from all sectors who were struggling with the impact of the pandemic on their mental health could refer themselves to the hub. Clinicians and trained volunteers provided psychological first aid aimed at reducing distress, preventing further psychological

harm and reducing presentations to front line services

Primary care services are often the first point of contact in the healthcare system. The primary care services of general practice (GP), community pharmacy, dental, and optometry (eye health) all had to adapt ways of working during the year.

Since the end of June 2020, **Community Optometry** has worked hard to remobilise whilst adapting to a new world of PPE and more stringent hygiene and infection control and prevention measures. Initially permitted to only deal with emergency and essential eye care, the scope of services was expanded to review routine eye care patients as well.

Early on in the response to Covid-19, **Community Pharmacies** quickly implemented systems to remain open for face-to-face services, working hard to complement system transformation and ensure patients received their medication. Community pharmacies were also key in delivering the flu vaccination programme.

With many services suspended and venues temporarily changed, technology was used to support conversations with individuals in making positive changes in their health-behaviour and lifestyle, such as smoking, diet, alcohol consumption and physical activity.

General Practice was never stood down but delivery methods rapidly changed to maintain infection control in GP practices, keeping patients and staff safe, and allowing general practice staff to continue delivering care should they need to self-isolate.

The majority of consultations were delivered remotely by telephone or using two emerging platforms unless it was clinically appropriate for the patient to be seen face-to-face. These were the secure NHS video calling platform **Near Me** and eConsult, a form-based online consultation platform that the collects the patient's medical or administrative request and sends it through to their GP practice to triage and decide on the right care for the patient.

2020/21 saw a full take-up and scale-up of Near Me video calling by all GP practices in Moray with a 915% increase in consultations from the previous year (459 to 4200) and a 1173% rise in consultation hours delivered using the platform (58,000 to 690,200).

Person-centred approaches to independent living and building a good life

National Health and Wellbeing Outcome 2 - People, including those with disabilities or long term conditions, or who are frail, are able to live as independently as possible at home or in a homely setting in the community

National Health and Wellbeing Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected

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

Strategic Priority: Home First – Supporting people to live as independently as possible at home or in a homely setting

Strategic Priority: Choice & Control – Supporting people to make choices and take control over decisions affecting their care and support

Covid priority: Supporting those in the community effected by coronavirus

We have presented Outcomes 2-4 collectively as they underpin the way in which we plan, design and deliver our services.

Lockdown was a particularly difficult and isolating time for those with health and care needs and their families as their usual services were suspended, community facilities closed their doors and support from those out with their household was restricted. Carers had little to no respite from their role.

Business continuity plans were enacted within all services as health and social care moved to critical function in response to Covid-19.

The **Access Team** continued to provide a single point of contact for all initial requests for care and support. Daily duty social work systems, out of hour's services and Adult Protection responses were all maintained.

Mental Health Services in Moray remained open during the pandemic to ensure people in crisis had access to mental health assessment, care and treatment. Emergency (seen same day) and urgent (seen within 7 days) referrals were triaged and prioritised by a newly-formed Urgent Care Team. The in-patient wards - Ward

4 at Dr Gray's Hospital and Muirton at Seafield Hospital - continued to provide services.

An **Enhanced Discharge Hub** was set up to focus efforts to free up hospital beds and arrange care at home or a homely setting for older people and others in need of support.

Members of the Hospital Discharge, Reablement, Care at Home and Commissioning teams worked together to support the care system to adapt to the increased pressure placed on it by Covid-19, with many people requiring continued support for daily living even if they had not contracted the virus.

To increase capacity in care at home services, Social Work teams worked with service users and their families to review low-level packages of care and seek agreement for temporary variations. The process of assessment and reassessment was overseen by Consultant Social Work Practitioners. Any variation to a package of care was reassessed in a maximum timescale of 12 weeks or sooner if triggered by the service user or the team.

The adjustment in packages ensured HSCM maintained an ability to meet all critical needs whilst having the capacity to continue with hospital admission avoidance and early hospital discharge in order to protect the acute hospital bed capacity.

Additional bed capacity was created with the opening of **Duffus Wing** – an unused section of Spynie Care Home in Elgin – to support the discharge of individuals who no longer required acute care but were not in a position to return home. The17-bed intermediate social care facility was staffed by teams deployed from the council and NHS working in partnership with staff from local providers Cornerstone and Mears. The wing was operated by Health & Social Care Moray from April until the end of September.

While the majority of building-based day services had to close temporarily, the **Burnie Day Centre** in Buckie continued to provide a critical service for adults with learning disabilities, with staff making adaptions to the service to ensure the provision of excellent day care and support that was safe, fun and meaningful.

We engaged with providers of services and supported them to continue to offer virtual day opportunities using online platforms. The options to provide support and services online have opened up the opportunity to increase choice to people who may not want to attend a traditional building-based service.

To encourage people to approach meeting their outcomes in creative ways following the suspension of their usual services, Social Work reviews were undertaken with a focus on the full range of **self-directed support** (SDS) options discussions to promote greater choice and control.

The SDS Team developed 'Talking Heads' videos where people spoke about their experience of using SDS creatively. These included the purchase of a greenhouse to meet an unpaid carer's outcome of having a break from caring for her family member; the purchase of a laptop to enable an individual to continue with online yoga and music sessions; and the purchase of gym equipment to continue with at-home fitness sessions while gyms were closed.

Many other services continued to be delivered face-to-face such as care at home and community nursing, and in supported living and residential care settings.

Enhanced support was provided to commissioned services with a particular focus on care homes. Care homes have a vital role to play in providing a safe, caring environment for people to live, but are a high risk setting for coronavirus due to the vulnerability of residents and the institutional setting.

From March, a range of structures and processes were put in place to support and maintain good engagement with care home providers in Moray and to offer assurance to the partnership around care homes' ability to cope with additional pressures placed on them. This included the establishment of a multi-disciplinary oversight group.

The collaborative approach including daily contact with the commissioning team to monitor PPE supplies and staffing levels and to signpost to updated national guidance and legislation. There were open lines of communication with the Chief Nurse to offer clinical guidance and support on areas including use of PPE and educational needs. A consultant social work practitioner and lead nurse were seconded to provide support and carry out onsite visits. Weekly information returns were made to the Scottish Government.

Building on the success of delivering virtual consultations during the Covid-19 pandemic, systems and processes are being established to ensure this method of service delivery is embedded, sustained and used widely across our health and social care partnership.

Since January 2021, a core group of early adopter social workers have been using **Near Me**. The primary driver was to reduce the backlog of outstanding reviews with residents in care homes, which could not be held face to face due to restrictions on entering the homes. This group has also been starting to use video calling for other social work interactions and the work has informed processes to embed Near Me as an additional tool which affords a more personal approach than being undertaken by telephone.

Social workers have so far reported that the experiences have mostly been positive for all parties. One of the most positive aspects reported so far has been the ability to include other participants such as family members who do not live locally or are unable to travel due to restrictions as well as the ability to review out-of-area placements as far away as England. In the first three months of use around 1800 miles of travelling has been saved.

Transformation work is being progressed under the Home First programme working to maintain people safely at home, avoiding unnecessary hospital attendance or admission, and supporting early discharge back home after essential specialist care.

There is wide recognition that outcomes for people who are cared for closer to home are better and we believe that expanding the range of services available to people at home will be of immense benefit to individuals, their families and the wider community.

Home First was launched in June 2020 as part of the Grampian-wide health and social care response to the 'living with COVID' phase of the pandemic. All three Health & Social Care Partnerships are working together with the acute services sector of NHS Grampian to break down barriers between primary and secondary care and to deliver more services in people's homes or close to people's homes.

In support of a whole system approach to reducing the number of people delayed in hospital when they are clinically ready to leave, the Discharge to Assess workstream was successfully taken forward into a six-month pilot project.

Discharge to Assess supports the rapid discharge of patients who are medically ready to leave hospital and appropriate to have their functional needs assessed among the familiar surroundings of their own home. People are supported through

comprehensive physiotherapy and occupational therapy assessment and the provision of timely rehabilitation to maximise their independent living skills.

An element of the Discharge to Assess project was to review the pathway to enable early identification of people for whom discharge to assess would be appropriate so that admission could be avoided and people could return home with appropriate support.

The targeted functional approach results in more people remaining independent after a hospital admission or attendance, and a reduced dependency on formal care services. During the six-month test, 48 patients aged between 64 and 96 were supported by the team to return home to continue their recovery. All 48 recorded improved assessment scores in their gait, balance and mobility leading to a reduced risk of falls. 88% of patients agreed their functional performance had improved.

Funding was approved to scale up the project to full implementation from August 2021.

The **Delayed Discharge** programme has required a whole system approach as discharge is a complex process. It involves many different members of staff and the components of the discharge process cover a number of different services.

The focus of this work is on the following four parts of the system: admission avoidance; discharge planning/process; community hospital transfers; and provision of care in the community.

A Delayed Discharge Focus Group has been meeting regularly to address these issues by identifying and progressing actions. Since the action group began meeting in October 2020 there has been a sustained reduction in the number of delayed discharges in Moray.

Hospital at Home is a short-term targeted intervention that provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital. The Moray programme is at the scoping stage and meetings are taking

place with clinicians and Service Managers to agree and identify components of a hospital at home model that takes in to account the remote and rural aspects of service delivery in Moray.

Health improvement approach to Respiratory Conditions is a programme providing the opportunity for individuals to self-monitor their health and wellbeing within their home and local communities. It enables professionals to access information and training so they can best support individuals within their own home and local community, and promotes and develops community support and resilience to support individuals within their local communities.

Two initial tests of change were completed with patient cohorts from Forres and Buckie. Where appropriate the patients were given further information on how to self-manage their condition and have been referred on to one of the established respiratory pathways.

Health & Social Care Moray worked in partnership with Moray Council Sport and Leisure Service to launch a new Respiratory Programme dedicated to those living with or at risk of respiratory disease. Based on physical activity and behavioural change, healthcare professionals were able to refer patients to either the core Pulmonary Rehabilitation Programme or to a new Physical Activity Programme.

Reducing Inequalities

National Health and Wellbeing Outcome 5 - Health and social care services contribute to reducing health inequalities

Whilst the last year has required a concerted focus on meeting the challenges of a pandemic, positive steps have continued to be taken to incorporate and further develop equalities into our policies and processes, and our teams have actively engaged in meeting the needs of people with protected characteristics despite the complexities that Covid has created.

The Equality Act 2010 introduced a Public Sector Equality Duty, which requires us to pay due regard to the need to eliminate discrimination, harassment and victimisation; advance equality of opportunity; and foster good relations between people with one or more protected characteristics, both in relation to our commissioning responsibilities and our workforce. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership (only with regards to eliminate discrimination), pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Moray Council and NHS Grampian recognise their responsibility as community planning partners, service providers and employers to encourage the fair treatment of all and are committed to the principle of equality of opportunity.

We recognise that due to a range of dimensions - including personal characteristics; lifestyle factors; social networks; living and working conditions; and socio-economic and environmental conditions - some communities experience health inequalities. Health inequalities are the avoidable and unjust differences in health between people or groups of people.

The pandemic and the necessary lockdown restrictions to control its spread, have had an impact on our health, the economy and how we function as a society, with everyone being affected in some way. This has replicated existing health inequalities with the burden falling on the most vulnerable, the most deprived and the more marginalised, and, in some cases, has increased them.

These determinants of health require to be addressed in line with national public health priorities as part of wider Community Planning Partnership activities that focus on prevention and inequality in order to protect and improve the health and wellbeing of Moray residents.

A short life working group was established in early 2021 to review and refine the partnership's **Equality and Mainstreaming Outcomes** and provide a basis for

reporting performance and demonstrating implementation across the partnership's services. The refocused outcomes are:

1. Everyone across Moray (including those who share a protected characteristic and those who do not) has the opportunity for good health and wellbeing across their lifespan.

This outcome seeks to empower individuals to take charge of their own health and wellbeing; be active, make positive choice and feel connected within their communities. It also recognises that wider inequalities that effect health and wellbeing as well as the need for prevention and early intervention to mitigate health consequences.

2. Everyone across Moray (including those who share a protected characteristic and those who do not) has equitable access to Health and Social Care services and are supported to live as independently as possible.

This outcomes will support people to have access to person-led health and social care services and the help they need to make informed decisions about their care and support so they can feel more in control of their lives.

3. Health and Social Care staff understand the needs of people with different protected characteristics, are able to support them and promote diversity in the work they do.

This outcome focuses on workforce development. Awareness will be raised among staff of issues affecting health equalities and they will receive training appropriate for their roles. Opportunities for personal well-being, development and learning are to be developed for all employees.

In delivering on the Strategic Plan, we work to take account of the particular needs of different service users; the particular needs of service-users in different parts of the area in which the service is being provided; and the particular characteristics and circumstances of different service-users.

Through our 'planning with people' engagement work, we are proactive in ensuring that equality, diversity and inclusion are a priority when we are designing, planning and commissioning services and respect the voices of the diverse communities we serve.

Supporting Carers

National Health and Wellbeing Outcome 6 - People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.

Three in five of us will be carers at some point in our lives, supporting family members, friends or neighbours whose lives are affected by disability, physical or mental ill-health, addiction or frailty.

Unpaid carers in Scotland represent a larger workforce than the paid health and social care support workforces combined. They are among our key partners in care and contribute significantly to achieving the ambitions of our Strategic Plan. Recognition of the value they bring and representation of their experiences and views are central to the planning and delivery of services and supports for carers and those they care for.

During the Covid-19 pandemic, the responsibilities of unpaid carers have increased considerably. There are more unpaid carers than ever before, and most of those who provided unpaid care before the pandemic are now spending more time providing care for another person.

Carers who took part in a series of engagement sessions during January and February 2021 led by Health & Social Care Moray and supported by Quarriers Carers Support Service (Moray), reflected on the significant impact the role continues to have on their own health and wellbeing.

As well as their caring situation, they were also dealing with anxieties resulting from Covid-19 such as transmission and finances. Restrictions and shielding had stripped away the support networks carers normally have, leaving many feeling even more lonely and isolated. The closure of community facilities and suspension of social care services amplified the pressure on carers by increasing the hours they spent in a caring role and in many cases leaving them without any respite from their responsibilities.

Advice and guidance which detailed the situations in which unpaid carers may require personal protective equipment (PPE) was published by the Scottish Government and promoted by the partnership. A local **PPE Hub** was set up to support unpaid carers to access supplies of PPE if their normal supply routes were unavailable.

Unpaid carers aged 16 to 64 were invited to come forward for the Covid-19 vaccination as part of priority group 6. Letters were sent out in February 2020 to those registered with their GP as an unpaid carer or in receipt of carers' benefits. There was also the opportunity to self-register via an online portal or through the Covid-19 Vaccination Helpline.

Carers support service

Quarriers Carer Support Service (Moray) – the commissioned carers support service – focused on continuing to provide information and support, achieving a seamless transition from office to home working, and introducing a range of remote supports and activities to stay in touch with carers.

The staff team called registered carers to let them know they were not alone and reassure them of the service's ongoing availability. They targeted carers considered to be most vulnerable, offering additional support where possible.

Quarriers secured significant additional funding for emergency responses to carers' need for breaks, financial support, shopping and wellbeing. Funding was also secured to accelerate the service's IT development plan and equipped workers with the devices and software packages needed to work effectively from home.

Quarriers moved to greater reliance on IT, doorstep visits, outdoor meetings and walks, and completed Adult Carer Support Plans over the phone or by video call. Carer support activities moved online and new creative options were introduced to keep carers connected, with learning, social, craft and networking opportunities available.

The service increased information flow to and from Health and Social Care Moray, keeping the service and carers updated with developments, and reporting on the impact on carers of the pandemic.

Quarriers has worked closely with Health and Social Care Moray to create an Adult Carer Support Plan providing an overview of a carer's life and the impact of their caring role. During 2020/21, completing support plans was a challenge and there has been backlogs in assessing carer eligibility for additional supports and a lack of service availability to meet carers' outcomes.

During the reporting period:

- 248 new referrals were received
- Over 14,000 contacts were made
- 1068 carers were supported
- 332 Adult Carer Support Plans were offered and 102 were completed
- 255 counselling session were delivered
- 55 Adult Short Breaks were awarded
- 40 Adult Respite Awards were made
- 17 online sessions were delivered to 63 participants
- 142 people took part in the Open Doors activity programme
- 4000 newsletters were distributed, 22,500 e-newsletters and 2000 Covid-19 fact sheets.

Safe Services

National Health and Wellbeing Outcome 7 - People using health and social care services are safe from harm.

One of the principles for Moray's integrated health and social care system is to protect and improve the safety of people who make use of services. Staff are focused on ensuring people are kept safe from harm.

All areas of service are linked into the **Clinical and Care Governance Group** which provides a platform to identify and respond to governance issues at a local operational level. The governance group seeks assurance that safe, effective, person centred care is delivered by HSCM by receiving and scrutinising regular reports from all services including hosted services.

It determines any issues which require to be escalated to the Board's Clinical and Care Governance Committee.

During the year, reports were presented on issues including:

- Child and Adult Protection;
- Out of Hours Primary Care Service (GMED) and Grampian Covid Hub;
- Use of Spynie Care Home (Duffus Wing);
- Enhanced oversight of care homes;
- Adverse events and complaints;
- Deaths involving coronavirus

The Clinical Risk Management (CRM) Group continued to meet every two weeks to discuss adverse events, complaints and risks. The group comprises of senior management, clinical leads, chief nurse and relevant service managers/ consultants.

Contract monitoring was conducted virtually by the **Commissioning Team** which monitors externally provided services alongside **Social Work** and **Adult Protection** colleagues and the Care Inspectorate. Performance issues are addressed through jointly negotiated service improvement action plans.

The Partnership directly provides a number of services including care at home, day services and housing which are subject to a rolling programme of internal audit. Independent inspection from the Care Inspectorate was largely paused during the pandemic in order to assess care home arrangements.

Staff and services retain a focused approach to child and adult protection and require to be suitably trained and supported to confidently deliver positive outcomes for those who may be subject to harm.

The partnership has continued preparations for the anticipated Care Inspectorate Adult Support and Protection (ASP) thematic inspection. A self-evaluation exercise was undertaken with members of the **Moray Adult Protection Committee** and representatives of the Moray ASP partner agencies. The findings from this and a case file audit supported the development of an Improvement Action Plan.

Due to competing priorities and the global pandemic, a delay occurred in developing and implementing the improvement plan. Consequently, for the plan to be achievable in line with competing priorities, it was agreed to prioritise improvements in policy, processes and procedures.

Phase 1 of the plan focused on the review of the core ASP process with the aim of ensuring that it adequately reflects multi-agency input and covers the whole ASP process including monitoring and review. Phase 1 also covers NHS Grampian requirements to produce and facilitate a pan Grampian approach for Initial Referral Discussions (IRDs). The outcome is to offer a consistent response across Grampian. This is fully supported by the NHS Grampian Public Protection Officer.

The improvement plan has achieved the milestones of creating a robust screening tool, mapped and developed processes and procedures for ASP across a whole systems approach whilst working in partnership with NHS Grampian to develop a pan Grampian IRD process for Health. These improvements require testing and further reviewing through staff consultation prior to being adopted as business as usual.

To address limited capacity for social work to screen referrals and drive forward the improvements required by the processes in the Access Team, Covid finances have been directed to the recruitment of 3.5 full time equivalent (FTE) social work staff for a nine month period to support the improvement plan.

We are continuing work to further adopt and embed a trauma informed culture across the workforce, supporting staff and partners to embed a trauma informed approach across all services and aspects of the organisation.

Effective Organisation

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

National Health and Wellbeing Outcome 9 - Resources are used effectively and efficiently in the provision of health and social care services

Covid priority: Supporting the workforce to continue to safely deliver essential services

Our workforce has been responsive and flexible, stepping up to the challenges of a global pandemic. Many were redeployed into new roles such as running the PPE Hub, Covid Hub or returned to work to support our existing workforce and the Covid-19 vaccination programme.

The impact of the pandemic on the NHS and Local Authority as employers and on their employees has been far reaching with new ways of working rapidly introduced.

Like many others, staff had to contend with the impact of lockdown and restrictions, home schooling and additional caring responsibilities. While some services were suspended and staff redeployed to support areas of focus, others were stretched beyond capacity in the effort to meet rising demand. Colleagues were tested in terms of functional practices, IT and home-working

In addition, the impact on the physical and mental health of workers has been brought to the fore, with individuals having to cope with new and incredibly difficult challenges. This included the care of people who had or may have had Covid-19 infection, putting them at increased risk of contracting the virus themselves.

In the face of unprecedented demand across the health and social care system, national measures were introduced to maintain an appropriate supply and improve the distribution of masks, aprons, gloves and other crucial items of PPE direct to those on the frontline who needed it.

In Moray, deliveries were received at NHS and Local Authority points for onward distribution and collection. The social care hub was established at a day centre in Elgin where services had been suspended. Redeployed council employees worked to ensure staff across in house services and external providers, along with personal assistants and unpaid carers, had access to PPE through an efficient packing and distribution system.

Staff worked to the national guidance on the use of personal protective equipment (PPE), donning and doffing, cleaning and waste management.

Workforce health and wellbeing has never been more important. NHS Grampian and its partner Health and Social Care Partnerships recognised the importance of prioritising the wellbeing and recovery of staff across the system as the country moved on from the Coronavirus (COVID-19) pandemic.

Protecting the mental health and wellbeing of health and social care staff – whether they worked on site, in the community or from home – was a priority. Enhanced resources promoting physical and psychological wellbeing, self-care and personal resilience were put in place nationally with the launch of the National Wellbeing Hub and We Care website for NHS Grampian and partnership staff. Both offered a wealth of resources for individuals and for managers to help them support their staff through the challenges brought by the pandemic.

A symptomatic key worker testing programme was developed and a drive-through testing facility set up at Linkwood in Elgin, initially staffed by redeployed members of the partnership's Public Health Team. Staff critical to the delivery of frontline services had rapid access to testing, as did members of their immediate household, to allow them to be released from isolation guidance on confirmation of a negative test.

The testing team provided a seven day a week service that included the roll out of testing to residents and staff in care homes reporting a single suspected or confirmed case of Covid-19 and testing of people in the community prior to a planned hospital admission. The **Community Response Team** carried out swabbing of individuals moving from home to residential care.

Partnership workplaces were risk assessed and measures brought in to limit capacity, reduce movement of people and ensure physical distancing. Guidance was provided on infection control measures including hand washing/sanitisation, respiratory hygiene, cleaning and decontamination.

Improved communication was essential during the year. Every effort was made to ensure staff were sighted on and adhered to the latest government guidance which was frequently updated. NHS Grampian issued a daily brief and the partnership a weekly brief, both of which were communicated to staff through the line management structure.

Staff have acknowledged that they have felt empowered to make rapid decisions and implement change with the removal of bureaucracy.

Social media was used to highlight and celebrate the work of staff. The partnership's Facebook page increased its number of 'likes' from 1,613 to 3,570 over the year and followers grew from 1,870 to 4,078.

Staff working in health and social care were touched as each week the public demonstrated their support for keyworkers by gathering on their doorsteps, in their streets and outside workplaces for the **Clap for Carers** national round of applause. For months, people stopped at 8pm on a Thursday to reflect on the lives lost to Covid-19 and also the many lives saved, as well as the contribution of many to keep public services going.

Our staff also received numerous kind donations from generous and thoughtful local businesses, community groups and individuals to help support them through the challenges they faced. From hot meals and drinks to hand cream, sweets, treats to scrubs, the gifts always raised spirits and boosted morale.

International Nurses' Day is celebrated around the world each year on 12 May. In 2020, the day also marked the 200th anniversary of the birth of Florence Nightingale, the founder of modern nursing and pioneer of infection control. It was marked in Moray with deliveries of specially decorated cupcakes to nurses along with a message of thanks and appreciation from Moray and Grampian Nursing Leads.

Health & Social Care Moray joined the international celebrations for World Social Work Day 2021 in March, a day that recognises the achievements of the profession and the contribution social workers make in their communities. Against the backdrop of a constantly developing situation, social work teams have responded with dedication and resilience in order to continue to safeguard the vulnerable from harm and support people with social care needs to experience positive personal outcomes.

Staff awards

Maggie Taylor, Team Leader for the East Moray Older Adult Community Mental Health Nursing Team, was recognised for the dedication, commitment and excellence she brings to her role. She received The Queen's Nursing Institute Scotland (QNIS) Long Service Award that is presented to nurses who have been working in the community for 21 or more years, delivering care to people in a range of settings including their own homes, schools, community hospitals, care homes and GP practices.

Keith Mackay, Senior Charge Nurse at Stephen Hospital in Dufftown, was presented with an award and medal to mark his dedication to his profession after 44 years' service with NHS Grampian. In a letter of congratulations, Professor Amanda Croft, who was then Chief Executive of NHS Grampian, said the long-service milestone marked a lifetime achievement of loyalty, hard work and commitment.

Use of resources

As a public organisation, the partnership has a duty to optimise the use of its resources. These resources include staff, buildings, information and technology.

Our workforce has been responsive and flexible, stepping up to the challenges of a global pandemic. Many were redeployed into new roles such as running the PPE Hub or returned to work to support our existing workforce and the Covid-19 vaccination programme.

In recent years, digital technology has played an increasingly important role within the health and care sector. At the beginning of 20/21, our parent organisations had

the Herculean task of enabling remote and Covid-19-safe working for NHS and Moray Council employees

The partnership's ability to work effectively with much of its workforce based at home, working remotely and conducting business via virtual means, relied on technological capability.

ICT Services mounted an urgent response to enable as many staff as possible to do this, sourcing, building and distributing large volumes of laptops and mobile phones although orders were delayed due to the national demand and supply issues. Virtual meetings were enabled using Microsoft Teams and consultations and reviews via the secure NHS video platform Near Me. ICT service desks dealt with increased volumes of requests from home workers.

Within Moray we have seen increasing demand for our services which has added significant financial challenges across the health and social care sector. In response to this, we have focused on further unlocking the benefits of whole system flow and partnership working which has enabled us to more effectively enhance the efficiency and quality of service provision.

Winter / surge planning is a critical part of operational business to ensure business continuity during a potentially pressured time of the year. It was anticipated that the winter period 2020/21 would bring significant pressure to the health and care system across Grampian.

The **Winter Plan** reflected considerable cross system working on unscheduled care that had accelerated since the spring. It focused on key areas to ensure early prevention and response to minimise potential disruption to services and ensure that we continued to provide safe and effective care for our population. Meetings with sector leads were arranged to review respective plans, key themes, gaps and opportunities to optimise cross-system capacity. Services reviewed their business continuity plans and prioritisation of critical functions.

A **Moray Covid-19 Outbreak Control Plan** was developed which built on existing health protection plans and puts in place measures to contain any outbreak and protect the public's health. The plan set out how Moray Council, NHS Grampian, businesses, voluntary agencies and local communities are working together to prevent, manage, reduce and suppress outbreaks of Covid-19 in Moray.

Moray is fortunate to be an area rich in assets and strengths. We have a vibrant Third sector, which includes charities, social enterprises and voluntary groups, delivers essential services, helps to improve people's wellbeing and contributes to economic growth. During the year it played an even more vital role in supporting communities at a local level.

Financial performance and best value is detailed later in this report.

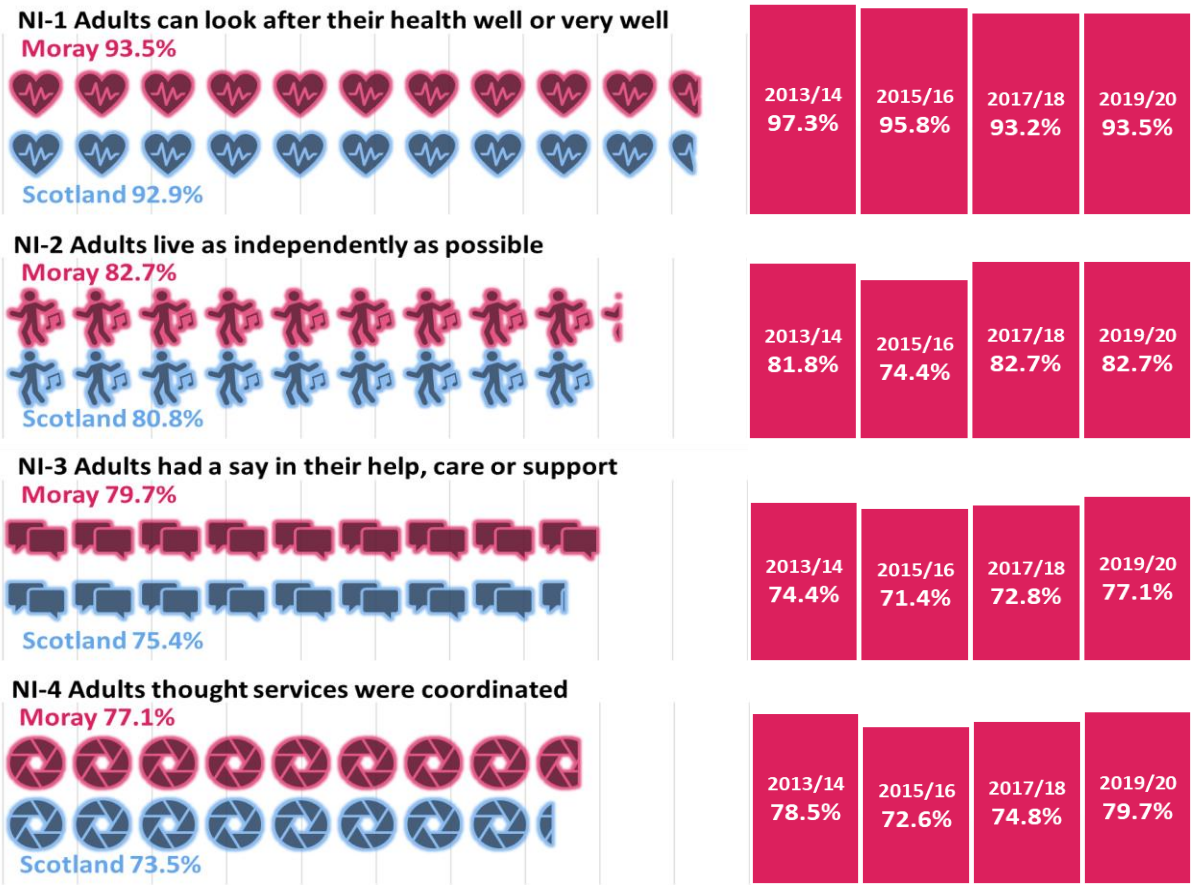
Measuring performance under integration

Source: https://publichealthscotland.scot/publications/core-suite-of-integration-indicators/core-suite-of-integration-indicators-13-july-2021/

The Core Suite of 23 National Integration Indicators were published by the Scottish Government in March 2015 to provide the basis against which Health and Social Care Partnerships can measure their progress in relation to the National Health and Wellbeing outcomes. As these are derived from national data sources, the measurement approach is consistent across all Partnerships.

The Integration Indicators are grouped into two types of measures: 9 Outcome Indicators are based on feedback from the biennial Scottish Health and Care Experience survey (HACE) and 10 Data Indicators are derived from Partnership operational performance data.

Outcome Indicators

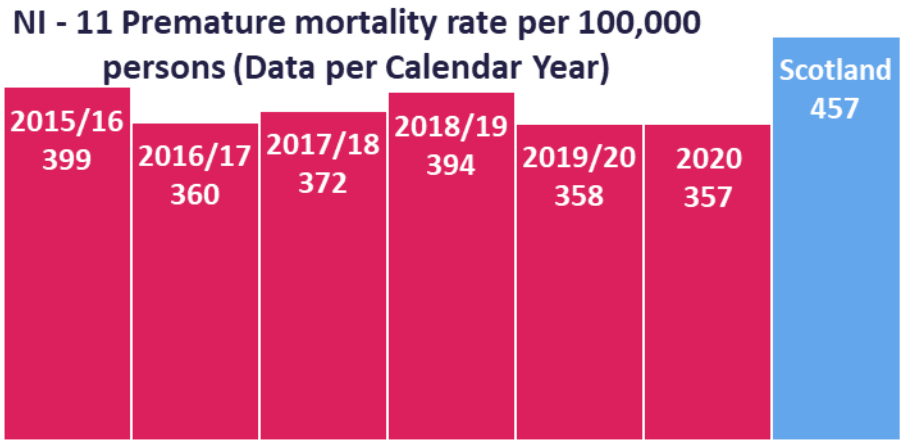


Due to various changes in the 2019/20 HACE survey wording, indicators 2, 3, 4, 5, 7 and 9 are no longer comparable to previous years. Of those Moray has performed close to or above the Scottish average in all but one, NI-9 (Percentage of adults supported at home who agree they felt safe).

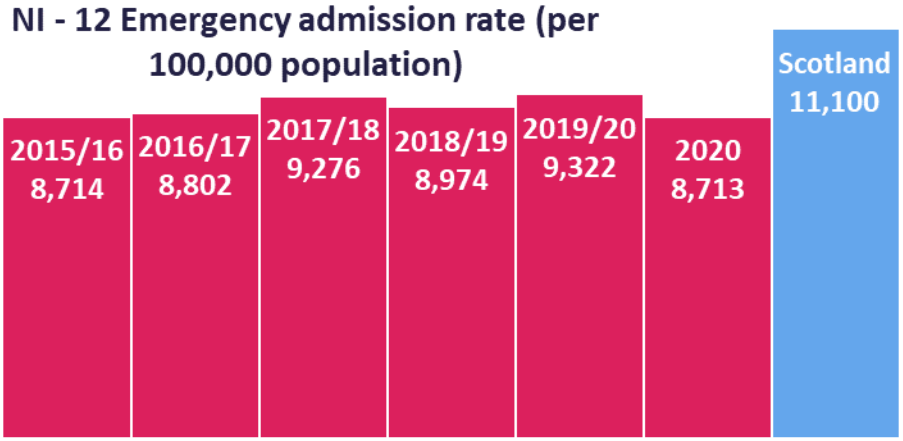
Of those that do have comparable data over the four years, NI-1 (Adults who can look after their health well or quite well) and NI-6 (People with positive experience of care with their GP Practice) are decreasing in line with a wider Scottish trend (NI-1 tracking above average and NI-6 tracking just below average).

NI-8 (Carers who feel supported to continue in their caring role) has decreased 8.8% in Moray. Despite a decreasing trend across Scotland, Moray is now 2.6% below Scottish average, compared to 2.5% above in 2017/18.

Data Indicators



Moray continues to perform well in this measure.



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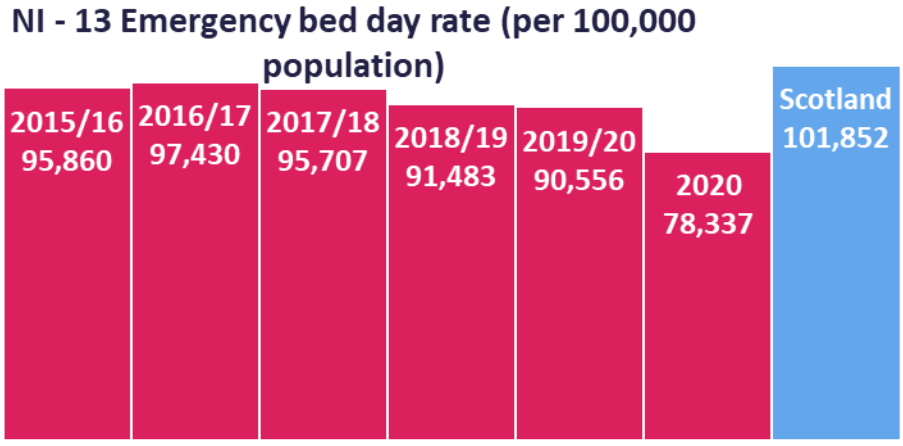
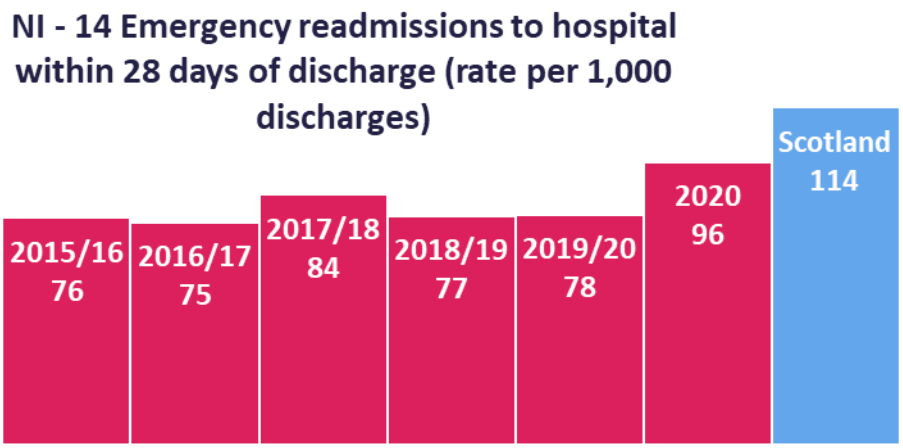
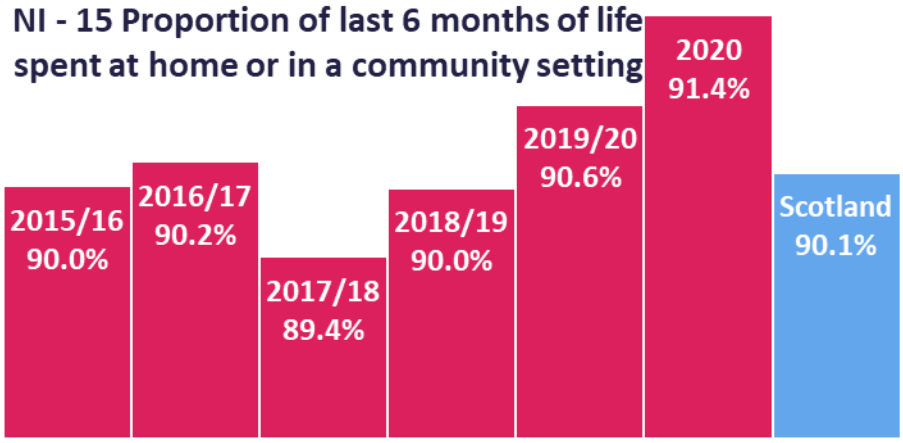


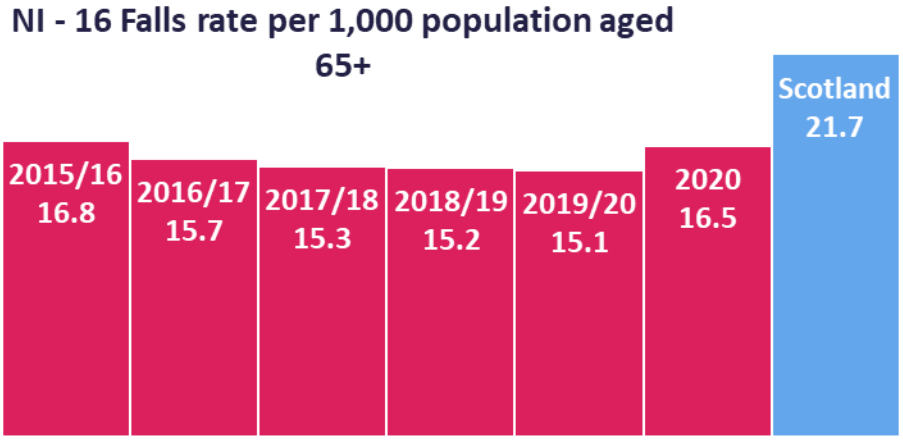
Moray has had a decrease in its Emergency Bed Day rate. Performance in this measure continues to perform well.



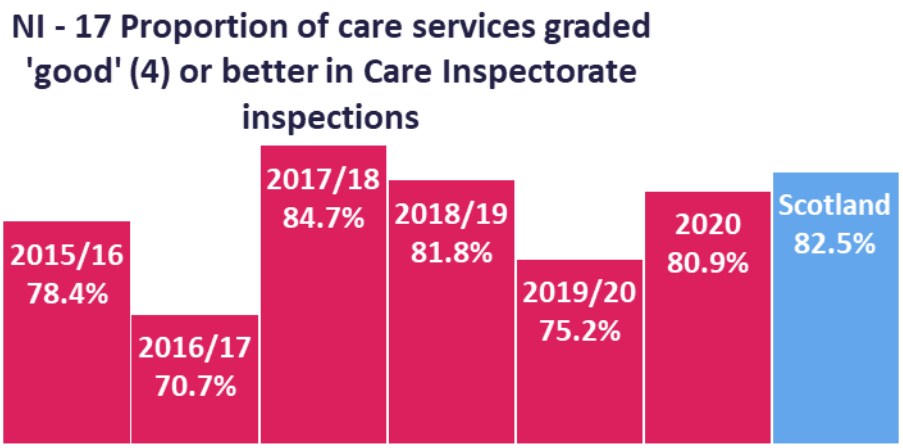
Despite an increase in this measure for Moray, the rate of re-admissions remains within the top quartile across Scotland.



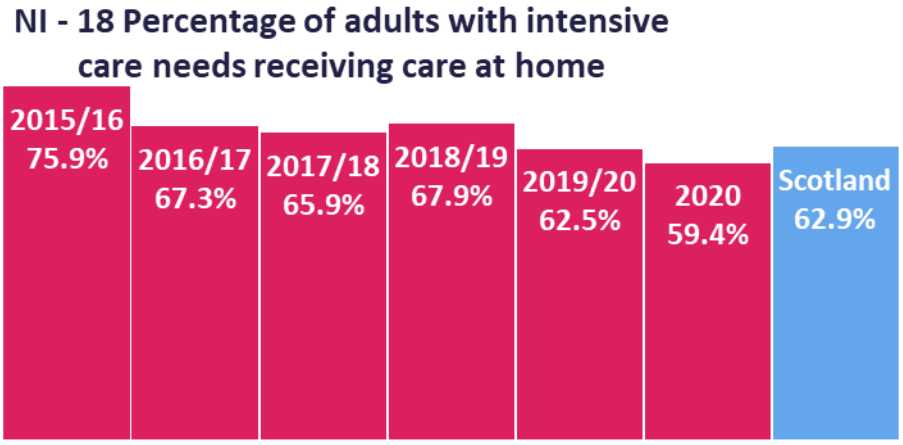
Moray continues to perform very well in this measure.



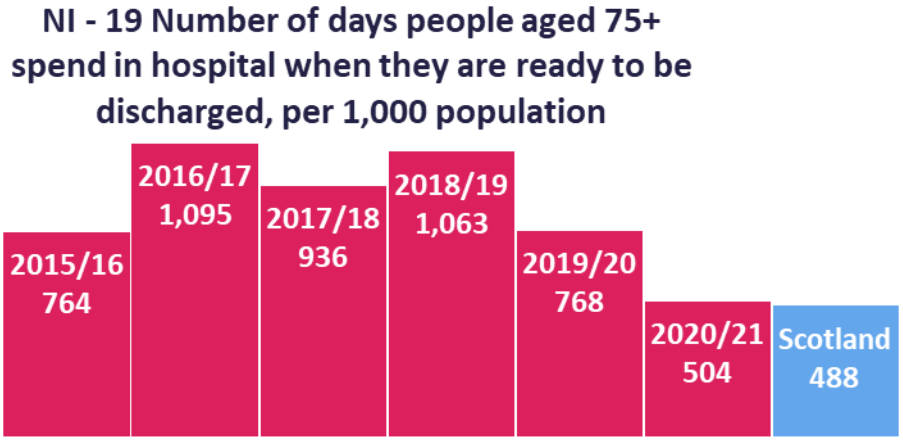
Moray has the third lowest falls rate in Scotland but this measure did have a small increase in 2020.



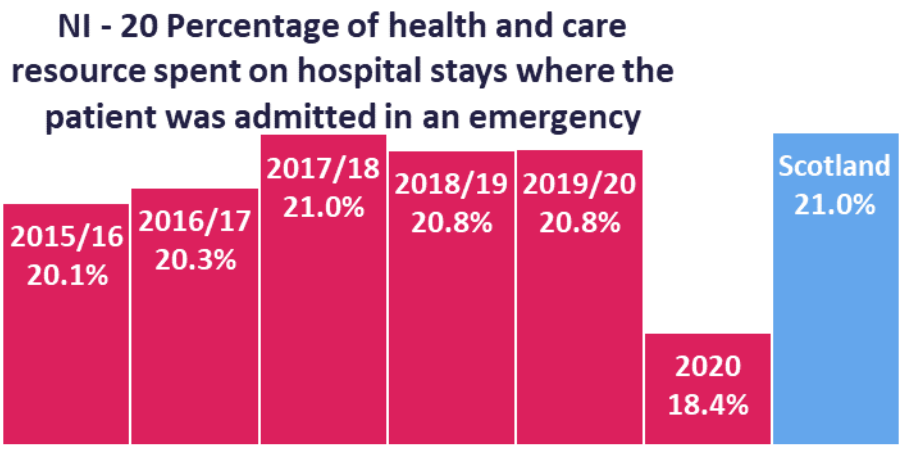
While Moray was below the Scottish average performance in this measure, it has improved significantly from 2019/20.



Moray has had a decreasing trend in this indicator since it was introduced and has now been below the Scottish average for two years in a row.



In the last two years this measure has shown good improvement in Moray.



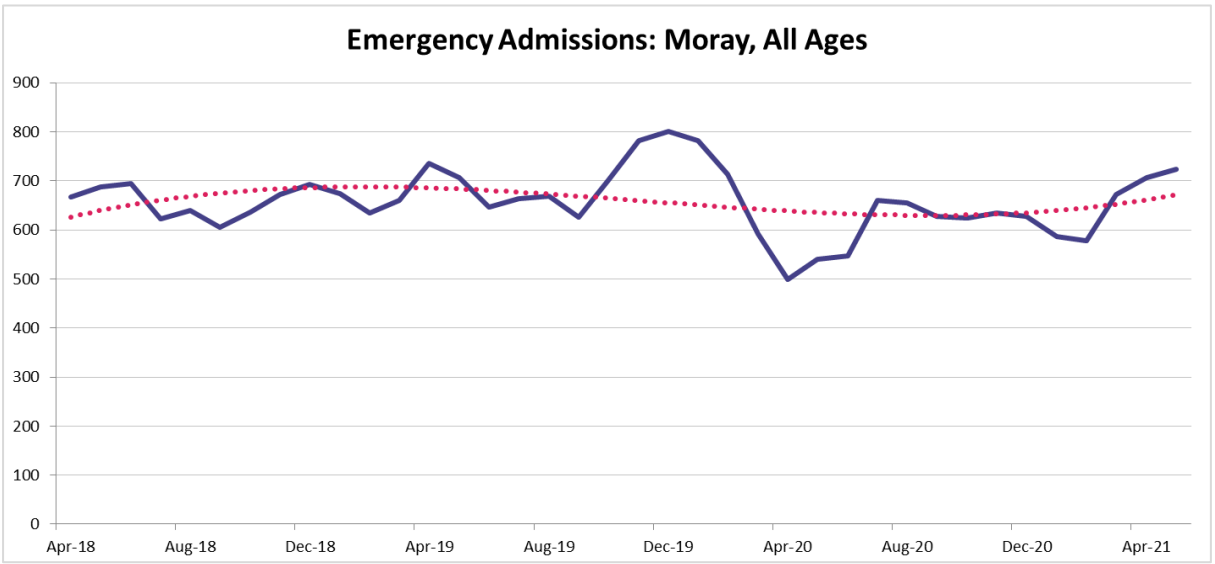
Despite a significant reduction in this measure, Moray continues to track at just under 3% below the Scottish average which it has done since this measure was put in place.

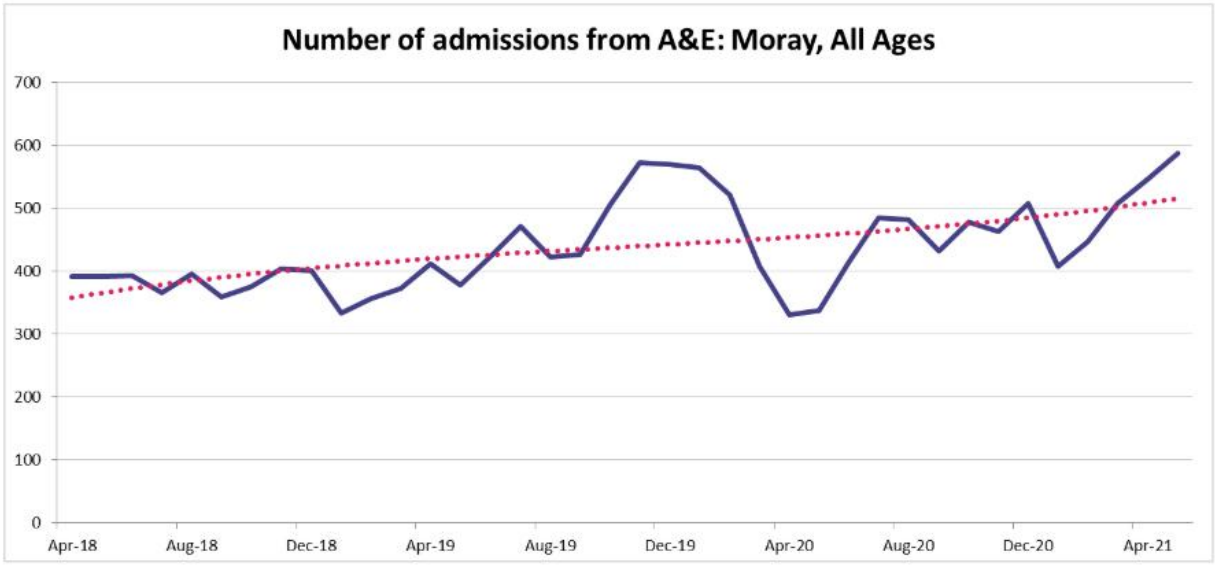
Ministerial Strategic Group (MSG) Indicators

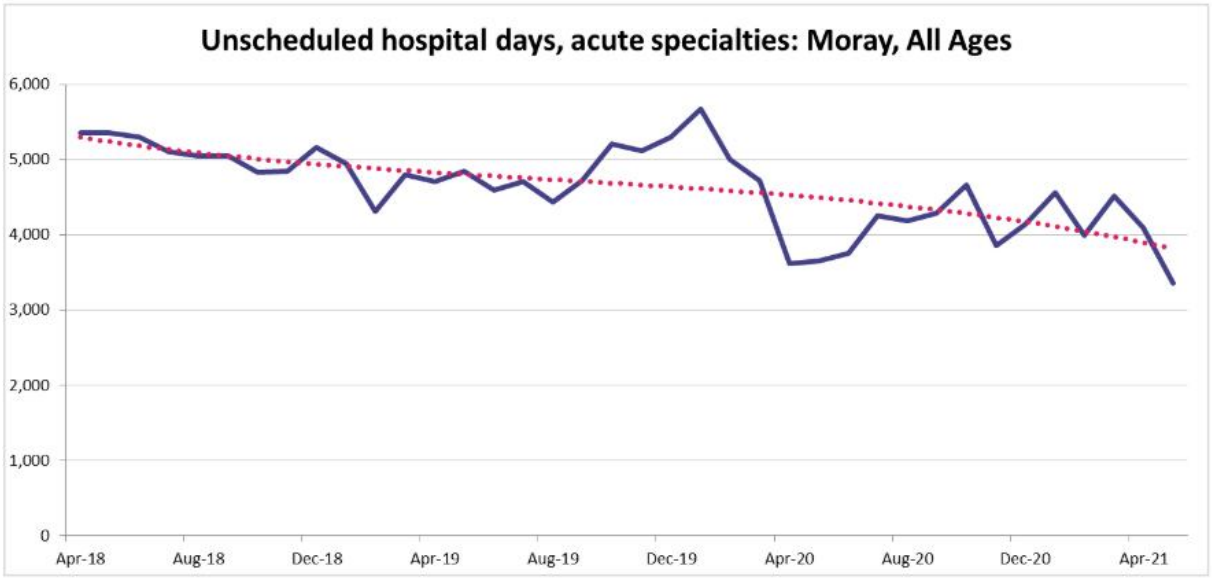
Data Release Note: Some figures have been released ahead of National Statistics publications. Where this occurs data has been used to report the partnership's position, however data cannot be published for peer partnerships / Scotland.

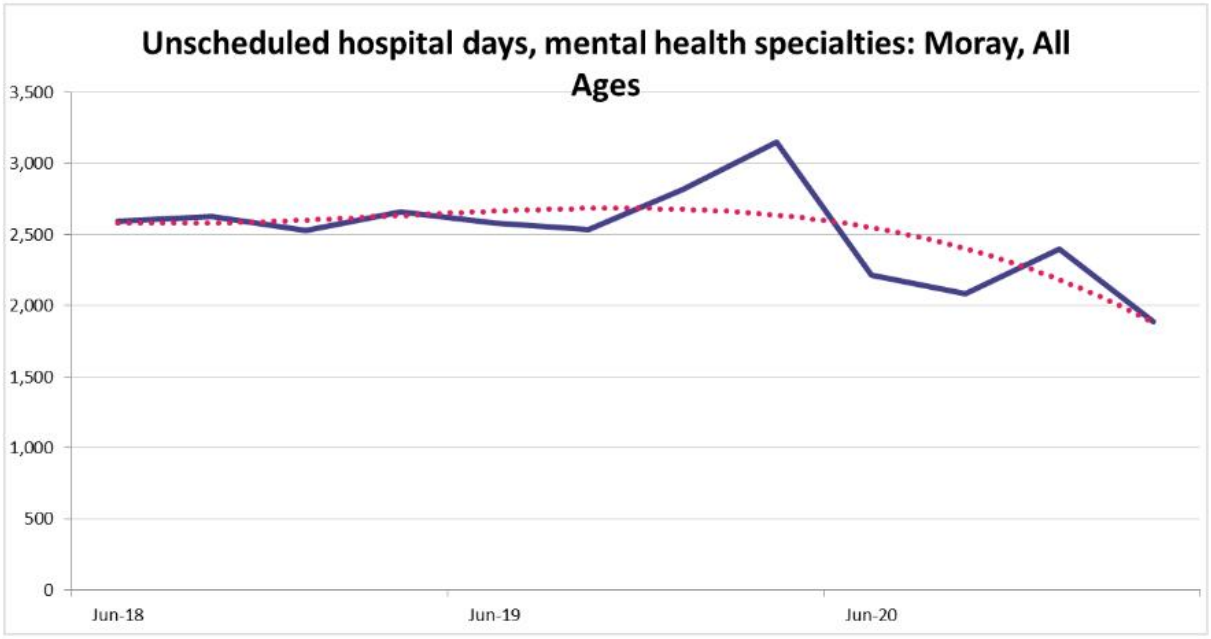
The only measure this does not apply to is the Delayed Discharge Bed Days.

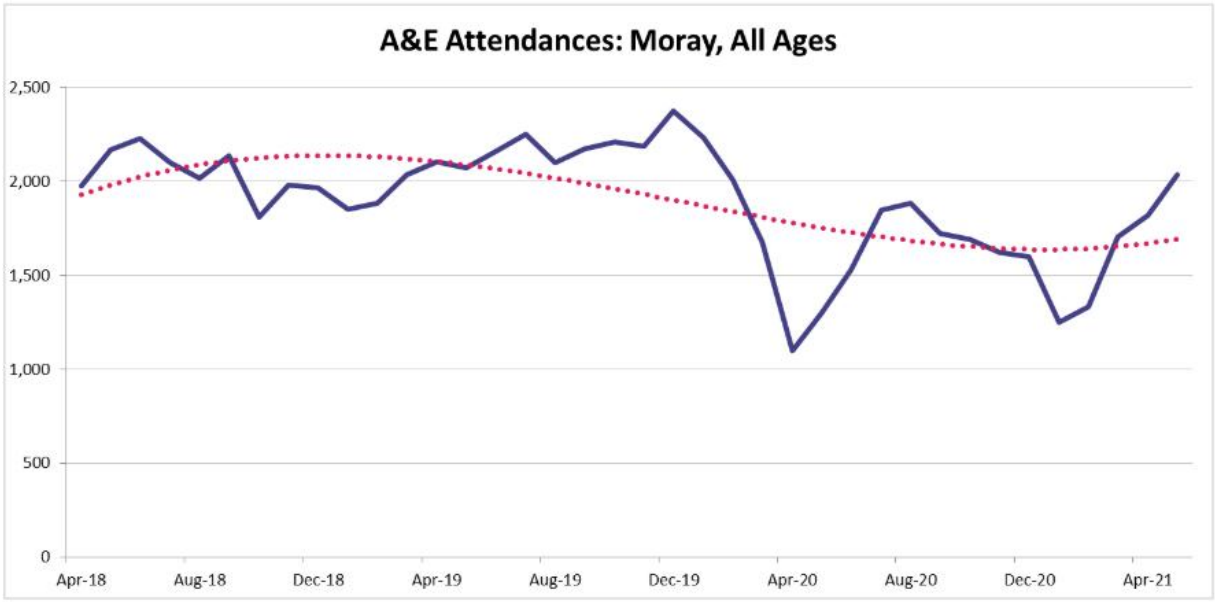
Moray continues to perform well in all MSG measures

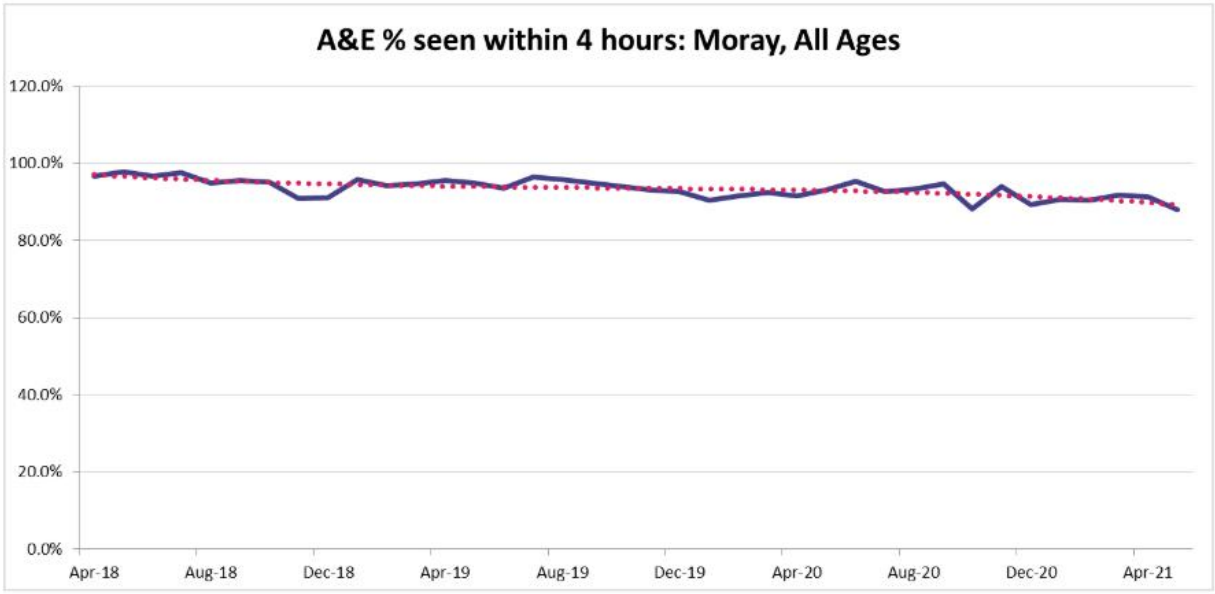


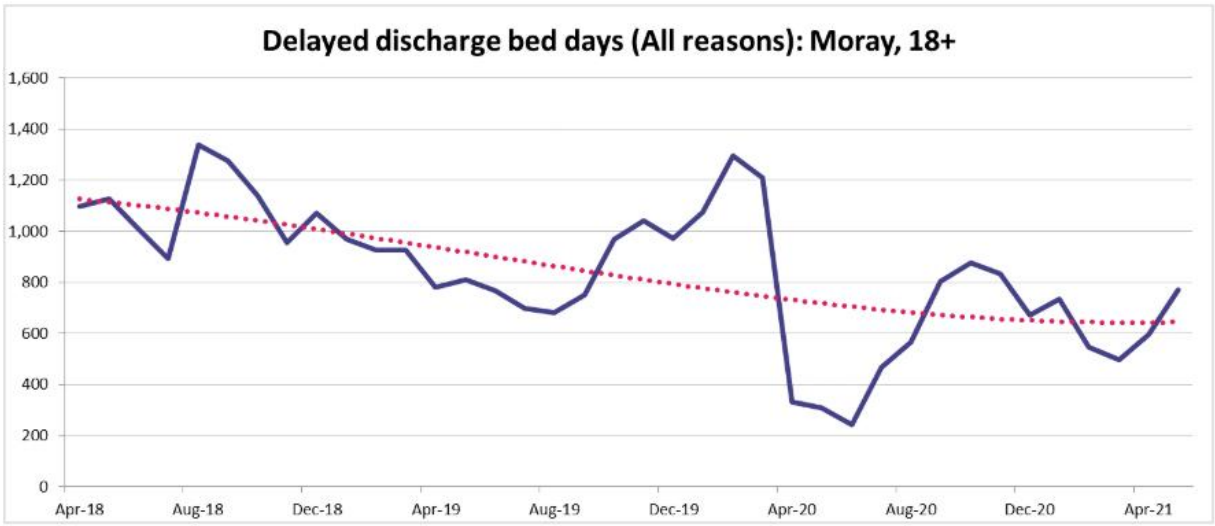

Number of admissions from A&E: Moray, All Ages
700
600
500
400
300
200
100
0
Apr-18
Aug-18
Dec-18
Apr-19
Aug-19
Dec-19
Apr-20
Aug-20
Dec-20
Apr-21

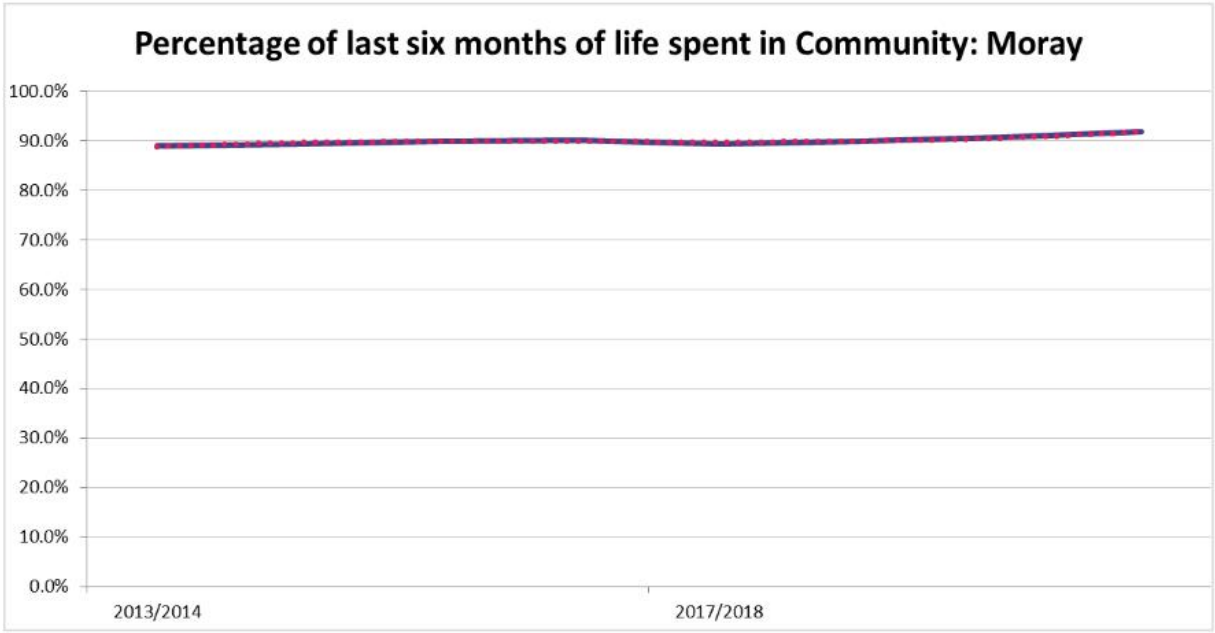

Unscheduled hospital days, acute specialties: Moray, All Ages
6,000
5,000
4,000
3,000
2,000
1,000
0
Apr-18
Aug-18
Dec-18
Apr-19
Aug-19
Dec-19
Apr-20
Aug-20
Dec-20
Apr-21

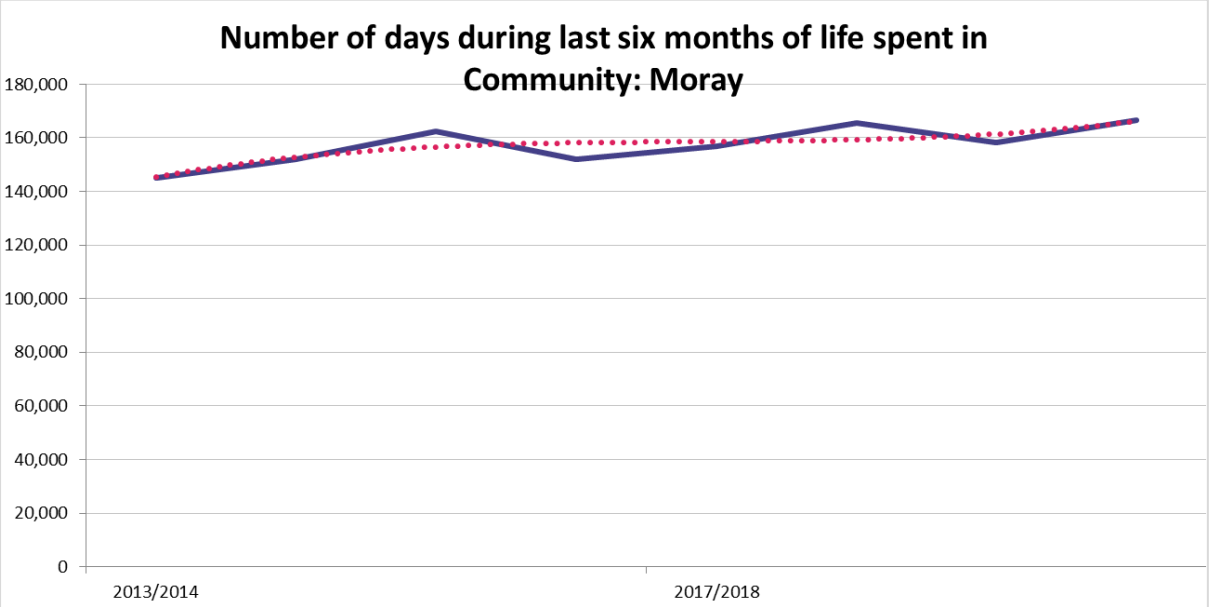

Unscheduled hospital days, mental health specialties: Moray, All Ages
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Jun-18
Jun-19
Jun-20

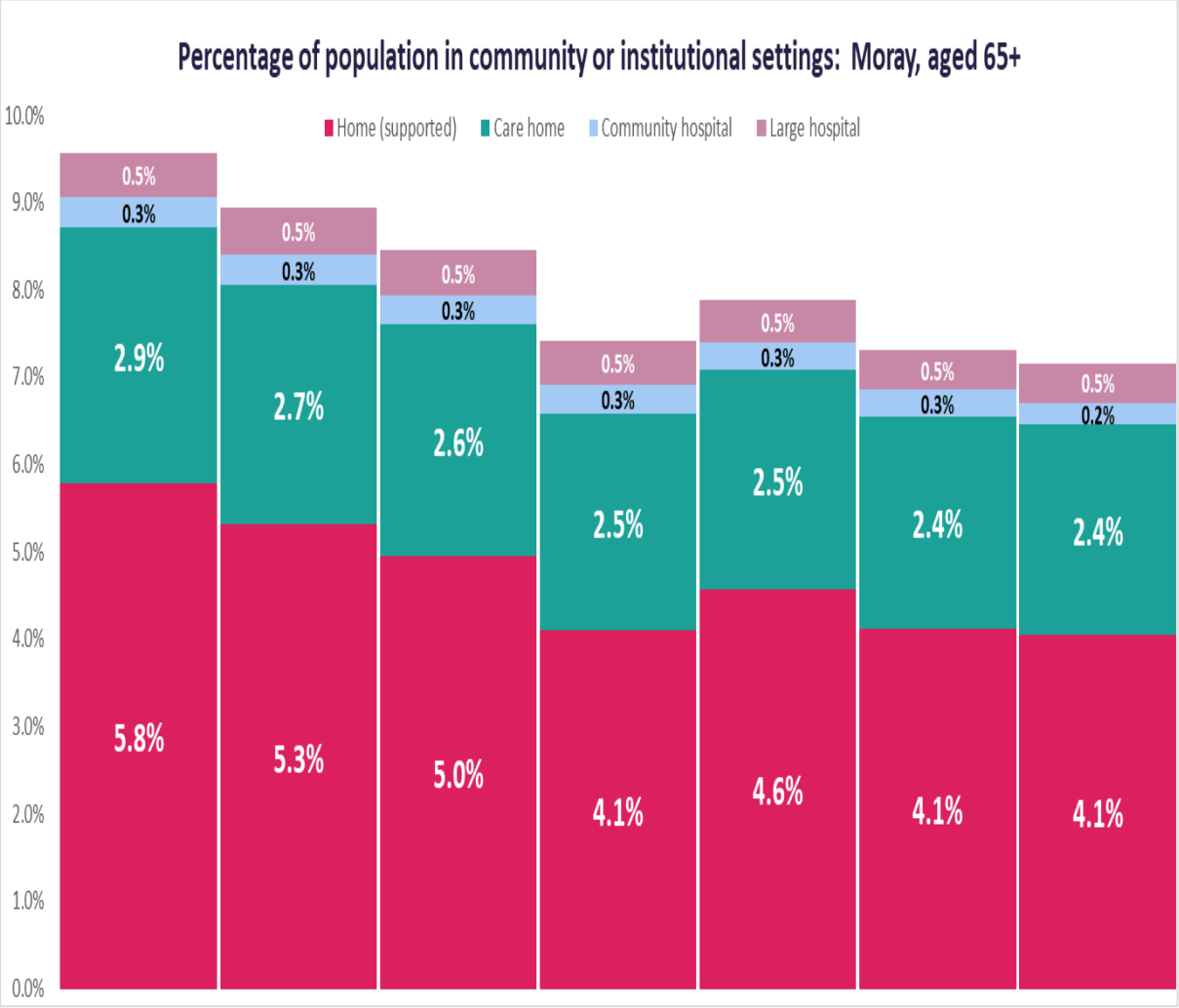

A&E Attendances: Moray, All Ages
2,500
2,000
1,500
1,000
500
0
Apr-18
Aug-18
Dec-18
Apr-19
Aug-19
Dec-19
Apr-20
Aug-20
Dec-20
Apr-21


A&E % seen within 4 hours: Moray, All Ages
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Apr-18
Aug-18
Dec-18
Apr-19
Aug-19
Dec-19
Apr-20
Aug-20
Dec-20
Apr-21


Delayed discharge bed days (All reasons): Moray, 18+
1,600
1,400
1,200
1,000
800
600
400
200
0
Apr-18
Aug-18
Dec-18
Apr-19
Aug-19
Dec-19
Apr-20
Aug-20
Dec-20
Apr-21


Percentage of last six months of life spent in Community: Moray
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2013/2014
2017/2018

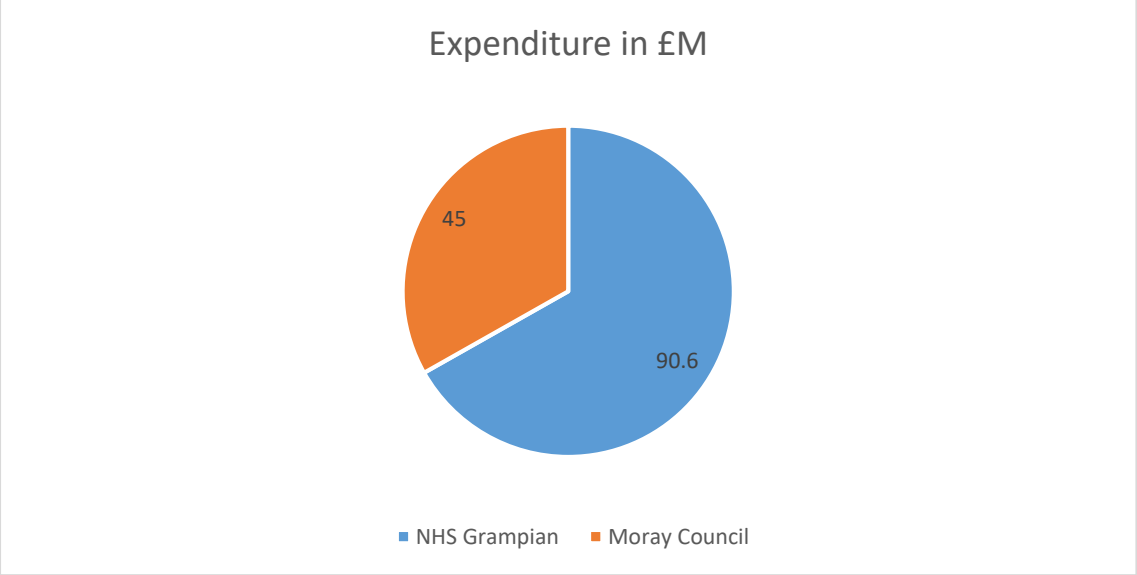

Number of days during last six months of life spent in Community: Moray
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
2013/2014
2017/2018


Percentage of population in community or institutional settings: Moray, aged 65+
Home (supported)
Care home
Community hospital
Large hospital
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
0.5%
0.3%
2.9%
5.8%
0.5%
0.3%
2.7%
5.3%
0.5%
0.3%
2.6%
5.0%
0.5%
0.3%
2.5%
4.1%
0.5%
0.3%
2.5%
4.6%
0.5%
0.3%
2.4%
4.1%
0.5%
0.2%
2.4%
4.1%

Financial Performance and Best Value

Financial Governance

The Moray IJB has a responsibility under the Public Bodies (Joint Working) (Scotland) Act 2014 to set a revenue budget by the 31 March each year. The funding of the Moray IJB revenue budget is provided by NHS Grampian and Moray Council. It is then the responsibility of the Moray IJB to direct the funding in a way that best supports the delivery of the Strategic Plan in accordance with the functions that have been delegated. The total level of funding provided to the Moray IJB at the start of the 2020/21 financial year was £135.6 million. In addition, the Moray IJB had a remaining reserve at the start of the year of £0.187million which was earmarked for the Primary Care Improvement Plan. This reserve is held in line with the Scottish Government Transformation Programme. The split of funding can be analysed as follows:



Financial Performance

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

In March 2020, a balanced revenue budget for the 2020/21 financial year was presented to the Moray IJB supported by a financial recovery plan of £1.9 million to align service delivery with the approved level of funding. The progress against the

recovery plan is reported at quarterly intervals throughout the year as part of the regular financial monitoring process. Through in-year reporting of the recovery/savings plan progress, it was evident that whilst some small elements were delivering according to plan, other areas were falling significantly short and with the impact of the Covid-19 pandemic on expenditure, Scottish Government made available additional funding to support the underachievement of savings totalling £1.4 million. The Moray IJB concluded the financial year in an underspend position due to additional funding being made available for Covid-19 related expenditure and unachieved savings. The additional funding is advance payment and has been carried forward in General Fund Reserves. The level of reserves as at 31 March 2021 is £6.3 million. £4.5 million is required to be earmarked and used for specific purposes and the remaining £1.8 million is a general reserve that will be used to support the 2021/22 revenue budget.

An expenditure summary is provided below:

Service Area	2019/20 Budget	2019/20 Actual		2020/21 Budget	2020/21 Actual	Variance Fav/ (Adverse)
Community Hospitals	5,092	5,466		5,348	5,587	(239)
Community Nursing	4,778	4,738		5,175	4,853	322
Learning Disabilities	7,062	7,481		7,968	8,546	(578)
Mental Health	8,372	8,568		8,680	8,649	31
Drug & Alcohol	1,116	1,048		1,176	1,143	33
Adult Protection & Health Improvement	148	151		151	152	(1)
Care Provided In-House	15,959	15,514		16,397	15,183	1,214
Older People's Services	16,789	18,636		17,930	19,835	(1,905)
Intermediate Care & Occupational Therapy	1,555	1,736		1,510	1,497	13
Externally Provided Care	8,972	9,060		8,413	8,067	346
Community Services	7,860	7,712		8,144	7,725	419
Administration and Management	3,296	2,933		4,363	3,904	459

Service Area	2019/20 Budget	2019/20 Actual		2020/21 Budget	2020/21 Actual	Variance Fav/ (Adverse)
Primary Care Prescribing	16,905	17,573		17,626	17,451	175
Primary Care Services	16,757	16,555		17,669	17,541	128
Hosted Services	4,291	4,671		4,427	4,526	(99)
Out of Area Placements	669	807		669	808	(139)
Improvement Grants	925	933		938	613	325
Total Core Services	120,546	123,582		126,584	126,080	504
Strategic Funds & Other Resources	2,018	1,055		12,540	6,702	5,838
Set Aside	12,252	12,252		12,620	12,620	0
Total Net Expenditure	134,816	136,889		151,744	145,402	6,342

Main reasons for variances against budget 2020/21

Older People Services and Physical & Sensory Disability - This budget was overspent by £1.9m at the end of the year. The final position includes an overspend for domiciliary care in the area teams, which incorporates the Hanover complexes for sheltered housing in Forres and Elgin. The ageing population and local demographics also contributes to this overspend.

Care Services Provided In-House – This budget was underspent by £1.2M at the end of the year. The most significant variance being due to the Care at Home services for all client groups. Supported Living services are also underspent. Staff transport across all the services and client transport under day services are also contributing to the underspend. This was due to Covid-19 and related restrictions

Learning Disabilities – The Learning Disability (LD) service was overspent by £0.6m at the end of 2020-21 where pressures continue to be experienced in supporting people with complex needs and the transition of individuals moving from being cared for by their families to living more independently creates additional costs that have to be met. The whole system transformational change programme in learning disabilities can help ensure that every opportunity for progressing people's potential for independence is taken, and every support plan is scrutinised prior to

authorisation, that expenditure is appropriate to meet a person's outcomes, but it is not possible to remove the need for ongoing support.
Administration & Management – This budget was underspent overall by £0.5m at the end of 2020-21 and refers primarily to an adjustment relating to staffing budgets, meaning staffing underspends were greater than the staff savings target applied.

Other Community Services – Other Community Services was underspent by £0.4m. This relates to underspends in Allied Health Professionals, which includes underspends in Speech and Language Therapy and Podiatry where ongoing difficulties are being experienced in recruitment. This is partially offset by overspends in Occupational Therapy, Dietetics and Physiotherapy. There were also underspends in Community Dental services mainly arising from staffing, Specialist Nursing services and Public Health. The underspends are offset in part by an overspend in Pharmacy which is related to staff costs which are expected to continue.

Financial outlook and best value

One of the major risks that continues to face the Moray IJB and its ability to deliver the services delegated to it within the context of the Strategic Plan is the uncertainty around the funding being made available from the partners and the Scottish Government. This is set against a back-drop of a changing demography which increases the demand and complexity for our health and social care services. In addition, we are faced with a need to rapidly transform services in line with the integration agenda and as we continue to respond to and remobilise through the current pandemic. The balance in continuing to provide services and plan for transformation is a difficult combination; however, the Home First agenda has escalated programmes such as Discharge to Assess during the year with clear support and commitment being provided by the Board. There is an on-going commitment to provide care to those in the greatest need while providing those services within the resource available.

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

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

For the 2021/22 financial year there will be a continued focus on financial recovery that will have to be considered alongside transformational development. Covid-19 continues to impact on delivery of services with work to remobilise being a priority. It is therefore key to ensure consideration of opportunities at every juncture to ensure

the MIJB can remain with the limits of the funding being made available through NHS Grampian and Moray Council.

Financial Reporting on Localities

The financial reporting for 2020/21 is not currently reported at locality level. This continues to be a work in progress and remains a priority for development. A recently implemented management structure has secured 4 Locality Managers who are all now in post and work is underway to align budget responsibility to locality areas.

Looking forward – priorities for 2021/22

Recovery and renewal

Covid-19 has been the biggest challenge the health and care system has faced in living memory. It is essential that lessons continue to be learned from this experience – whether from the extraordinary contributions of staff and volunteers, the rapid progress achieved in digitising and transforming service delivery, or from the shortcomings and inequalities brought sharply into focus.

Demand pressures will continue to extend to all hospital and community services which must respond to the health impacts coronavirus and the care and support needs of those who have experienced a deterioration in their mental and physical health and wellbeing as a result of delayed presentations or gaps in routine care, or as a consequence of social restrictions and lockdown measures.

Concerns remain over new and more transmissible variants of coronavirus and future outbreaks of infection, which could lead to many more cases of long Covid and make catching up with the backlog of routine NHS care even more challenging. Looking ahead to winter, a potential surge in respiratory viruses could cause widespread ill health and put pressure on the NHS which will be operating with fewer beds because of infection control measures. Planning is already advanced for delivery of the 2021/22 adult flu programme.

In Moray we are continuing to build on the whole system, integrated approaches seen during the pandemic. A system leadership and management approach is in place with the senior management team membership for health and social now revised to incorporate community and acute leaders, and is functioning with an integrated approach and a responsibility for the success of the whole Moray health and care system

Comprehensive engagement and collaboration with partners and communities will generate further learning to bring about positive change and renewal as we move towards the new models of care which are central to the Moray IJB's long term strategic intent.

Strategic Planning

The key pieces of work outlined in the Strategic Commissioning Plan published in 2019 remain our priority but the operating models for our services have inevitably changed as a result of the pandemic.

The Strategic Planning and Commissioning Group will refresh, reform and lead the ongoing implementation

of the Strategic Plan. Redesign and transformation will see significant pieces of work taken forward over the coming year, including the requirement for Locality Plans.

Locality Planning

Financial reports are now being produced by locality. These are reviewed regularly by the teams. Improvements continue to be made and regular finance meetings have been established. A Home First and Localities Project Manager has been appointed to support this work further over the next 12 months

Home First

We continue to drive forward our Home First approach to ensure home is always considered first with a range of community-based services offering alternatives to traditional hospital care in order to support people through times of crisis to regain their independence.

We are developing the provision of Hospital at Home services for older people with frailty to provide a short-term, targeted intervention that gives a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital.

Our bed-based services should be available to those who need them most, and be able to provide the right level of care for those who cannot have their care and support needs met in any other environment. Our intermediate care beds should provide targeted, outcome focussed, rehabilitation goals that support and prepare people to return to their home

Following the success of the pilot, Discharge to Assess will be in place from August 2021. This supports the rapid discharge of people who are medically ready to leave hospital and appropriate to have their functional needs assessed among the familiar surroundings of their own home.

Home-based care and support is a key enabler to people remaining as independent as possible at home within their communities. Work is underway to move away from the "time and task" model to help care workers take an outcomes-focused approach to their practices

Social Care Reform

The Independent Review of Adult Social Care, commissioned by the Scottish Government and independently chaired by Derek Feeley, sets out a bold and

ambitious vision that, if fully implemented, has the potential to transform the lives of people with social care needs, unpaid carers and the wider adult social care sector.

The review makes 53 individual recommendations across 8 key themes: a human rights based approach; unpaid carers; the case for and operation of a National Care Service; a new approach to improving outcomes – closing the implementation gap and managing quality; models of care; commissioning for public good; fair work; and, finance.

If fully implemented, the recommendations will have significant implications for Moray IJB and the Health and Social Care Partnership, NHS Grampian, Moray Council and wider community planning partners, and initial assessment of potential implications have been carried out.

Whilst a number of the recommendations require significant legislative and structural change at a national level, some aspects are already being progressed by the IJB and partnership in the short-term such as those relating to further enhancing human-rights, equality and fairness as key aspects of our social care and social work practice.

Unpaid carers

The partnership recognises the essential contribution young and adult carers make to their communities in Moray – even more so throughout the Covid-19 pandemic. They are an important resource that requires the right support and services to be available.

A new Carers Strategy will be developed in 2021/22, which will be informed by the experiences of Moray's carers and the needs and aspirations they identify.

Digital change

There was rapid acceleration of digital change over the pandemic and we will continue to embed and accelerate policy and practice to support digital innovation while recognising the importance of actions to prevent digital technologies entrenching or widening health inequalities.

A significant future challenge will be the analogue to digital switchover. Around for decades, analogue lines are now harder to maintain making them less reliable. By 2025 telephone companies in the UK are switching off analogue telephone services and replacing them with digital internet protocol (IP) technology.

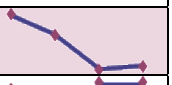
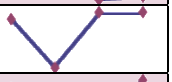
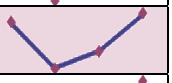
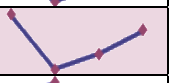
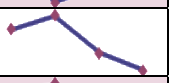
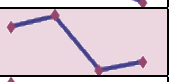
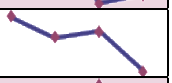
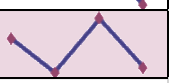
We currently use in-house telephone lines to connect people who receive a telecare service to the alarm receiving centre. All current telecare unit will require to be replaced with ones which will work with the digital phone lines.

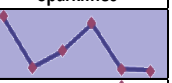
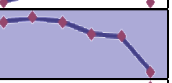
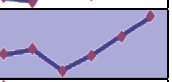
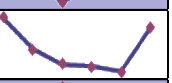
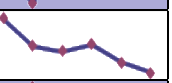
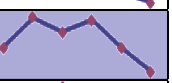
Budget Control

For the 2021/22 financial year there will be a continued focus on financial recovery that will have to be considered alongside transformational development. Covid-19 continues to impact on delivery of services with work to remobilise being a priority.

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 continually review spend, identify additional savings and track progress on transformational redesign so that corrective action and appropriate disinvestment can be supported.

Appendix 1– summary of performance against core suite of integration indicators

	Indicator	Title	2013/14	2015/16	2017/18	2019/20	Scotland	Trend
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	97%	96%	93%	**93%**	93%	
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	82%	74%	83%	**83%**	81%	
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	78%	73%	75%	**80%**	75%	
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	74%	71%	73%	**77%**	74%	
	NI - 5	Percentage of adults receiving any care or support who rate it as excellent or good	81%	79%	80%	**81%**	80%	
	NI - 6	Percentage of people with positive experience of care at their GP practice	84%	86%	80%	**77%**	79%	
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality	82%	83%	79%	**79%**	80%	
	NI - 8	Percentage of carers who feel supported to continue in their caring role	43%	38%	39%	**31%**	34%	
	NI - 9	Percentage of adults supported at home who agreed they felt safe	82%	79%	84%	**79%**	83%	
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	**NA**	*NA*	

	Indicator	Title	2015/16	2016/17	2017/18	2018/19	2019/20	2020	Scotland	Sparklines
Data indicators	NI - 11	Premature mortality rate per 100,000 persons (Data per Calendar Year, Latest 2019)	399	360	372	394	358	**357**	457	
	NI - 12	Emergency admission rate (per 100,000 population)	8714	8802	9276	8974	9322	**8713**	11,100	
	NI - 13	Emergency bed day rate (per 100,000 population)	95860	97430	95707	91483	90556	**78337**	101,852	
	NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	76	75	84	77	78	**96**	114	
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	90.0%	90.2%	89.4%	90.0%	90.6%	**91.4%**	90.1%	
	NI - 16	Falls rate per 1,000 population aged 65+	16.8	15.7	15.3	15.2	15.1	**16.5**	21.7	
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	78.4%	70.7%	84.7%	81.8%	75.2%	**80.9%**	82.5%	
	NI - 18	Percentage of adults with intensive care needs receiving care at home	75.9%	67.3%	65.9%	67.9%	62.5%	**59.4%**	62.9%	
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	764	1,095	936	1,063	768	**504**	488	
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an	20.1%	20.3%	21.0%	20.8%	20.8%	**18.4%**	21.0%	
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care	*NA*	*NA*	*NA*	*NA*	*NA*	***NA***	*NA*	
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	*NA*	*NA*	*NA*	*NA*	*NA*	***NA***	*NA*	
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	*NA*	*NA*	*NA*	*NA*	*NA*	***NA***	*NA*	

Appendix 2 – inspections

To meet the duties placed on it by the Coronavirus (Scotland) (No. 2) Act and subsequent guidance that it must evaluate infection prevention and control and staffing, the Care Inspectorate amended its quality framework for care homes to support this process.

This enabled the Care Inspectorate to conduct targeted inspections that were short, focused and carried out with colleagues from Health Improvement Scotland and Health Protection Scotland, to assess care and support during the Covid-19 pandemic.

All care homes in Moray are independently owned with one run by a charitable trust.

The following information is taken from the fortnightly reports to the Scottish Parliament on Care Inspectorate inspections and the grades published on the website here.

Service name: Cathay nursing home, Forres **Service provider**: Care Concern Limited **Service type**: Care home for older people. Registered to provide care to 41 people			
Date of report	People's health and wellbeing	Infection control practices	Staffing arrangements
12 June 2020	Adequate	Adequate	Adequate
	How good is care and support during the Covid-19 pandemic?		
	Adequate		
01 Apr 2021	Good	Good	Good
	How good is care and support during the Covid-19 pandemic?		
	Good		
	How good is our leadership?		
	Good		

Service name: Spynie (Care Home), Elgin **Service provider**: Intobeige Ltd **Service type:** Care home for older people. Registered to provide care to 56 people			
Date of report	People's health and wellbeing	Infection control practices	Staffing arrangements
28 May 2020	Good	Good	Good
	How good is care and support during the Covid-19 pandemic?		
	Not assessed		

Service name: Lythe Home, Cullen
Service provider: Lythe Home
Service type: Care home for older people. Registered to provide care to 32 people

Date of report	People's health and wellbeing	Infection control practices	Staffing arrangements
28 July 2020	Adequate	Adequate	Adequate
	How good is care and support during the Covid-19 pandemic?		
	Adequate		
04, 08 Feb 2021	Unsatisfactory	Unsatisfactory	Unsatisfactory
	How good is care and support during the Covid-19 pandemic?		
	Unsatisfactory		

Service name: Speyside (Care Home), Aberlour
Service provider: Parklands Group Ltd
Service type: Care home for older people. Registered to provide care to 41 people

Date of report	People's health and wellbeing	Infection control practices	Staffing arrangements
31 Jul 2020	Good	Adequate	Adequate
	How good is care and support during the Covid-19 pandemic?		
	Adequate		

Service name: Weston View Care Home, Keith
Service provider: Craigard Care Ltd
Service type: Care home for older people. Registered to provide care to 40 people

Date of report	People's health and wellbeing	Infection control practices	Staffing arrangements
16 Nov 2020	Adequate	Good	Adequate
	How good is care and support during the Covid-19 pandemic?		
	Adequate		

Service name: Meadowlark, Forres
Service provider: Renaissance Care Ltd
Service type: Care home for older people. Registered to provide care to 57 people

Date of report	People's health and wellbeing	Infection control practices	Staffing arrangements
02 Dec 2020	Good	Adequate	Good
	How good is care and support during the Covid-19 pandemic?		
	Adequate		

Service name: Wakefield House Care Home, Cullen **Service provider**: Craigard Care Ltd **Service type**: Care home for older people. Registered to provide care to 30 people			
Date of report	People's health and wellbeing	Infection control practices	Staffing arrangements
29 Jan 2021	Good	Adequate	Good
	How good is care and support during the Covid-19 pandemic?		
	Adequate		

If you would like a copy of this document in another language or format, or if you require the services of an interpreter, please contact Health & Social Care Moray on XXX or email involvement@moray.gov.uk

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REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 30 SEPTEMBER 2021**

SUBJECT: **ANNUAL COMPLAINTS REPORT 2020/21**

BY: **CORPORATE MANAGER**

1. REASON FOR REPORT

1.1. To inform the Board of the statutory requirements, performance and improvement actions identified in relation to complaints received by Health and Social Care Moray (HSCM) and present the Annual Complaints Report for 2020/21

2. RECOMMENDATION

2.1. It is recommended that the Board;

i) consider and note the statutory requirements in relation to production of performance reporting regarding complaints outlined in this report;

ii) note the approach to be adopted to improve performance; and

iii) consider and approve the annual report for April 2020 to March 2021, attached as Appendix 1 to this report, for publication.

3. BACKGROUND

3.1. The Clinical and Care Committee requested specific information relating to complaints at the meeting on 27 May 2021 (para 6 of the minute refers). The information requested was:-

- explanation of the Statutory obligations and if they were being met
- themes emerging from complaints
- how learning from complaints was collated and actioned

3.2. The Scottish Public Services Ombudsman (SPSO) Act 2002 (as amended) provides the legislative basis for SPSO to public the Model Complaints Handling Procedures (MCHP) for bodies under SPSO's jurisdiction.

3.3. The original MCHPs were first developed by the SPSO in collaboration with complaints handlers and key stakeholders from each sector and were published in 2012. The MCHPs were produced taking account of the Crerar and Sinclair reports that sought to improve the way complaints are handled in the public sector, and within the framework of the SPSO's Guidance on a MCHP. The MCHPs also reflect the SPSO Statement of Complaint Handling Principles approved by the Scottish Parliament in January 2011. Following recommendations from the Scottish Government's social work complaints working group in 2013, a separate MCHP for social work was developed. The 'Public Services Reform (Social Work Complaints Procedure) (Scotland) Order 2016' (the Order) brought social work complaint handling under the remit of the SPSO Act and subsequently the separate documents for Local Authorities (LA) and Social Work sectors were combined into a single document, the LA MCHP.

3.4. The SPSO revised and reissued all the MCHPs (except the NHS) in 2020 under section 16B(5) of the Scottish Public Services Ombudsman Act 2002 on 31 January to give public sector organisations time to implement any changes by April 2021. The NHS was the last public sector to adopt the MCHP on 1 April 2017 and it has not yet been revised since it was first published.

3.5. The Moray Council Model Complaints Handling Procedure states "The *purpose of the Local Authority MCHP is to provide a standardised approach to dealing with customer complaints across the local authority sector in Scotland. The procedural elements tie in very closely with those of the NHS complaints handling procedure (CHP), where social work or care complaints cut across services, they can still be handled in (much) the same way as other complaints. In particular the aim is to implement a standardised and consistent process for customers to follow which makes it simpler to complain, ensures staff and customer confidence in complaints handling and encourages local authorities to make best use of lessons from complaints*".

3.6. The SPSO are in the process of producing guidance documents in relation to key performance indicators for the Model Complaints Handling Procedures which should be published shortly.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The draft mandatory Key Performance Indicators that will be required as a minimum for inclusion in an Annual Complaints Report to be published by the end of September, have been identified by SPSO as:-

Indicator One	**Learning from complaints** *A statement outlining changes or improvements to services or procedures as a result of consideration of complaints*
Indicator Two	**The total number of complaints received** *The sum of the number of complaints received at Stage 1 (this includes escalated complaints as they were first received at Stage 1), and the number of complaints received directly at Stage 2.*

Indicator Three	**The number and percentage of complaints at each stage which were closed in full within the set timescales of five and 20 working days** *The number of complaints closed in full at stage 1, stage 2 and after escalation within MCHP timescales as % of all stage 1, stage 2 and escalated complaints responded to in full*
Indicator Four	**The average time in working days for a full response to complaints at each stage** *The average time in working days to respond at stage 1, stage 2 and after escalation*
Indicator Five	**The outcome of complaints at each stage** *The number of complaints upheld, partially upheld, not upheld and resolved at stage 1, stage 2 and after escalation as % of all complaints closed at stage 1, stage 2 and after escalation*

Information about complaints referred to the Ombudsman will also be included along with any complaints made against the MIJB.

4.2. In addition there are another 3 indicators that are recommended:-

Indicator Six	***Raising awareness*** *A statement to report on the actions taken to identify vulnerable and underrepresented groups and raise awareness of, and access to, the complaints handling process with them.*
Indicator Seven	***Staff training in complaint handling*** *A statement to report on levels of staff awareness and training.*
Indicator Eight	***Customer satisfaction with the complaints process*** *A statement to report customer satisfaction with the complaints service provided*

4.3. With regard to indicator 5 the updated MCHP has provided a definition of "resolving" a complaint. "*A complaint is resolved when both the organisation and the customer agree what action (if any) will be taken to provide full and final resolution for the customer, without making a decision about whether the complaint is upheld or not*". This focusses efforts to, wherever possible and appropriate, resolving complaints to the service user's satisfaction. To do this it is necessary to identify and clarify what outcome the service user wants at the start of the process which maybe a change in process for some people currently involved with complaints. It will also change the number of categories of outcomes for complaints to:-

- Upheld
- Not upheld
- Partially upheld and
- resolved

.

4.4. The MCHP requires reports to be presented to Senior Managers on a quarterly basis outlining the complaints handling performance indicators identified above (indicator 1-5) and the analysis of trends and outcomes of complaints. This will be a change to current practices where complaints are reviewed on a fortnightly basis for progress through the Clinical Risk Management meeting and through quarterly standing agenda items for Practice Governance Board and Clinical and Care Governance Group where there are representations from the senior management team, however in future these reports will also be submitted to the Senior Management Team for scrutiny.

4.5. Service managers discuss complaints with their teams as part of their normal business practices. Some examples of good practice: - within Care at Home services where all frontline resolutions and complaints are looked at by the appropriate team to identify any learning opportunities and this information is fed to the service management team. GMED have a clinical and governance meeting where they review complaints with their partners to gain shared understanding of impacts on people. The Quality and Patient Safety Committee at Seafield Hospital is proving to be a popular forum and a successful platform for shared learning. While still in its infancy, it is planned that as the forum evolves, it will provide an opportunity for joint training events with colleagues from all disciplines. The standing agenda focusses on all governance aspects including Older People in Acute Hospital inspection programme (OPAH) standard compliance and audit, complaints and risk, DATIX and significant event analysis.

4.6. The information from complaints from April 2020 to March 2021 was collated and circulated to Clinical and Care Governance Committee members for comment and forms the basis of the annual report presented in **APPENDIX 1**.

4.7. The analysis of the information for indicator 2 shows that there was a drop in the number of complaints received during 2020/21 however due to the pandemic in 2020 there were many services that were suspended and many others where service delivery was altered in some way to accommodate the requirements for social distancing which may account for the reduction.

4.8. Of the total number of complaints received (indicator 3) there is a much greater proportion of complaints dealt with at early resolution/frontline stage by the Council employed staff then the NHS staff. This maybe down to the differences in recording systems but will be investigated further to ascertain if there is another reason.

4.9. The main causes of complaints (highlighted in indicator 1) related to communication and procedure and a number of actions were undertaken through the year to apply the learning and reduce the likelihood of reoccurrence. These included:-

- an establishment of monthly multi-disciplinary meetings to monitor care packages and provide a forum to discuss and issues raised and development of focussed training for all relevant Social work staff with the aim of improving the consistency and quality of engagement with families both during assessment process and pre-discharge care planning.

- changes to recording of meetings on Carefirst to ensure that resource allocation meetings had the necessary information to ensure appropriateness of referrals.
- Establishment of a short life working group with GMED for the dispatching/caseload allocation based on staff and patient feedback to improve process and information flow.
- Case review was held, when there was a placement of an individual that was handled badly, so that learning could be identified and shared.

4.10. In addition there was other instances of the need for individual learning, where specific members of staff were given additional training in respect of the standards of communications expected, and the protocol for reviewing an individual's care package. An example of this was where there was a meeting with a complainant to explain how the system worked in more detail, which resulted in the complaint being resolved to their satisfaction.

4.11 If appropriate, a service manager, may decide to record an adverse event as a result of a complaint. By recording incidents in this way details can be recalled and referred to in the future and by analysis of incidents enables teams to learn from events, develop and improve services and identify training needs. Staff are encouraged and supported to report all adverse events; all incidents are taken seriously and reporting enables appropriate surveillance and ensure support systems are in place for staff. For example, monthly educational sessions are held for the Grampian Medical Emergency Department (GMED) to learn from adverse events/complaints and build sustainable connections between GMED clinicians and between the service and wider system. These sessions receive positive feedback and are well attended

4.12. It is anticipated that the number of complaints that will be received during 2021 to 2022 has the potential to be significantly greater than previous years due to people being dissatisfied with the length of time they are required to wait for services, or the type of service they are offered. From the data in relation to Indicators 3 and 4 it is clear that HSCM did not meet the targets for responses and the average working days to respond far exceeded the targets. It is recognised that a significant number of complaints were not responded to within the target of 20 days however some of this may be attributed to the fact that, as a direct result of the covid-19 pandemic, staff were advised that the length of time to process complaints could be extended as services struggled to cope with the demands.

4.13. Whilst there might have been a temporary relaxation for time taken to respond to complainants, there is insufficient evidence that people are being kept up to date with progress and improvements need to be made. Furthermore there is a need to ensure that managers are fully aware of the changes that have taken place in relation to the "resolved" classification and the importance of establishing the key focus of the complaint early on to facilitate finding a resolution that is satisfactory to the complainant. To address these issues, following discussion at the Clinical and Care Governance Group, it was decided to hold a workshop in September with managers and staff involved with the complaints process, to:

- Use some examples of recent complaints as case studies to reflect on how they were taken through the process and if there are learning

opportunities to take forward. This would include developing a shared understanding of the recording and reporting of complaints and the flow of information through the system.
- Identification of any opportunities for streamlining processes
- Identify commonly raised questions to see if a "frequently asked questions" document can be produced

4.14. The workshop was held on 16 September 2021 with representation from a wide range of services across HSCM. Following a presentation highlighting the revisions in the complaints handling procedures and setting out the governance processes for complaints, attendees participated in break outs to discuss some scenarios, approaches to be taken, challenges and potential obstacles to achieving a timeous and satisfactory resolution. There was good discussion and some matters identified for further investigation. The output from the workshop is being collated, an action plan will be developed and will be taken forward by the clinical and care governance group.

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"

Feedback from people is important for organisations to listed and respond to. Complaints are one mechanism for feedback and it is essential that they are dealt with appropriately with lessons learn to ensure that we make best use of the engagement to support the delivery of the outcomes in the Moray Integration Joint Board Strategic Plan specifically in relation to;

- People are safe
- The workforce continually improves

(b) Policy and Legal

The processes set out are in accordance with the legislation identified in section 3.

(c) Financial implications

There are no financial implications as a result of this report

(d) Risk Implications and Mitigation

If we do not listen and learn from complaints there is a risk that we repeat the same mistakes which may affect people and their wellbeing negatively or may be wasteful of resources.

(e) Staffing Implications

There are no staffing implications as a result of this report

(f) Property

There are no property implications as a result of this report

(g) Equalities/Socio Economic Impact

There are no equalities/socio economic implications as a direct result of this report

(h) Consultations

Consultations have taken place with Clinical and Care Governance Committee, H&SCM Chief Officer, Chief Financial Officer, Head of Service, John Black, Complaints Officer, Moray Council, NHSG and Tracey Sutherland, Committee Services Officer, Moray Council, and comments incorporated into the report.

6. CONCLUSION

6.1 The governance and monitoring of complaints forms part of core business for teams and services and the provision of a good quality, effective and safe service is a key priority for all. Monitoring and learning from all feedback is an ongoing process and this report sets out the progress to date and the next steps for improvement.

Author of Report: Jeanette Netherwood
Background Papers: With the author
Ref:

Annual Report on

Complaints 2020 – 2021

01/04/20 – 31/03/21

Jeanette Netherwood

Table of Contents

Introduction

This Complaints Handling Annual Report summaries Health and Social Care Moray's (HSCM) performance in terms of handling complaints during 1 April 2020 and 31 March 2021.

There are internal processes for reporting of complaints information, including analysis of complaints trends, however this is HSCM's first published annual complaints performance report. It includes performance statistics, in line with the complaints performance indicators published by the Scottish Public Services Ombudsman (SPSO) and complaints trends and actions that have been or will be taken to improve services as a result.

Background

The original Model Complaints Handling Procedures (MCHPs) were first developed by the SPSO in collaboration with complaints handlers and key stakeholders from each sector and were published in 2012. The MCHPs were produced taking account of the Crerar and Sinclair reports that sought to improve the way complaints are handled in the public sector, and within the framework of the SPSO's Guidance on a MCHP.

The MCHPs also reflect the SPSO Statement of Complaint Handling Principles approved by the Scottish Parliament in January 2011. Following recommendations from the Scottish Government's social work complaints working group in 2013, a separate MCHP for social work was developed. The 'Public Services Reform (Social Work Complaints Procedure) (Scotland) Order 2016' (the Order) brought social work complaint handling under the remit of the SPSO Act and subsequently the separate documents for Local Authorities (LA) and Social Work sectors were combined into a single document, the LA MCHP.

The SPSO revised and reissued all the MCHPs (except the NHS) in 2020 under section 16B(5) of the Scottish Public Services Ombudsman Act 2002 on 31 January to give public sector organisations time to implement any changes by April 2021. The NHS was the last public sector to adopt the MCHP on 1 April 2017 and it has not yet been revised since it was first published.

Upon receipt of a complaint, Health and Social Care Moray staff follow the appropriate MCHP of the partner organisation and are supported by their specialist teams.

Key Performance Indicators

Performance Indicators are measures and targets that help assess and demonstrate how functions are carried out.

The SPSO have published draft mandatory Key Performance Indicators for measuring how public bodies manage complaints, these are:

Indicator One	**Learning from complaints** *A statement outlining changes or improvements to services or procedures as a result of consideration of complaints*
Indicator Two	**The total number of complaints received** *The sum of the number of complaints received at Stage 1 (this includes escalated complaints as they were first received at Stage 1), and the number of complaints received directly at Stage 2.*
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The data detailed in this report is based on these Key Performance Indicators.

There is a challenge for reporting of complaints for HSCM due to the fact that there is a need to use two recording systems which then requires collation and as the systems hold data in slightly different ways. This means that there are differences in how the information is reported for some of the indicators.

Datix is used by NHS Grampian and is therefore accessed by NHS staff, Lagan is used by Moray Council and is used by Council staff.

With regard to Indicator 5 the updated MCHP has provided a definition of "resolving" a complaint. "*A complaint is resolved when both the organisation and the customer agree what action (if any) will be taken to provide full and final resolution for the customer, without making a decision about whether the complaint is upheld or not*". This focusses efforts to, wherever possible and appropriate, resolving complaints to the service user's satisfaction. To do this it is necessary to identify and clarify what outcome the service user wants at the start of the process which maybe a change in process for some people currently involved with complaints. It will also change the number of categories of outcomes for complaints to:-

- Upheld
- Not upheld
- Partially upheld and
- resolved

Summary

Complaints provide valuable information that can be used to continuously improve services, the experiences and satisfaction of people along with their families and carers.

Our Model Complaints Handling Procedure reflects the partnerships commitment to serving the public by valuing complaints.

It seeks to resolve issues through local, early resolution and, where necessary, to conduct thorough, impartial and fair investigations of complaints. This will enable us to address dissatisfaction and should prevent the problems that led to the complaint from occurring again.

Indicator 1 **- Learning from complaints**

Teams and services actively review the outcomes of complaints to see where improvements can be made and learn from the feedback, with a view to reducing the number of complaints in future. The tables 1a, 1b, 2 and graph 1 below set out the stages the complaints were closed and what the complaint was about and what action taken.

Table 1a

Complaints Information Extracted from Datix – Action Taken

	Early resolution	Investigation	Total
Access - Improvements made to service access	0	4	4
Communication - Improvements in communication staff-staff or staff-patient	0	17	17
Education/training of staff	0	5	5
No action required	3	10	13
Policy reviewed	0	1	1
Risk issues identified and passed on	0	1	1
System - Changes to systems	0	2	2
Share lessons with staff/patient/public	0	9	9
Total	3	49	52*

**Figure more than total number of closed complaints as there could be multiple actions taken for each complaint*

Table 1b

Complaints Information Extracted from Lagan – reason for complaint

	Early resolution	Investigation	Total
Complaint against service assessment	2	1	3
Complaint against staff	4		4
Other	5	1	6
Process / Procedure	10	5	15
Total	21	7	28

Actions taken by services as learning outcomes included establishment of monthly multi-disciplinary meetings to monitor care packages and provide a forum to discuss and issues raised and development of focussed training for all relevant Social work staff with the aim of improving the consistency and quality of engagement with families both during assessment process and pre-discharge care planning. There were changes to recording of meetings on Carefirst to ensure that resource allocation meetings had the necessary information to ensure appropriateness of referrals. In addition specific members of staff were given additional training in respect of standards of communications expected, and the protocol for reviewing an individual's care package.

Table 2

Complaints Information Extracted from Datix – Action Taken by Service

	Access - Improvements made to service access	Communication - Improvements in communication staff-staff or staff-patient	Education /training of staff	No action required	Policy reviewed	Risk issues identified and passed on	System - Changes to systems	Share lessons with staff/patient/public	Total
Allied Health Professionals	1	2	1	0	1	0	0	1	6
Community Hospital Nursing	0	1	0	0	0	1	0	2	4
Community Nursing	1	4	0	1	0	0	0	1	7
General Practice	0	0	0	1	0	0	0	0	1
GMED	1	7	4	6	0	0	2	5	25
Mental Health - Adult Mental Health	0	1	0	3	0	0	0	0	4
Mental Health - Child and Adolescent	0	0	0	1	0	0	0	0	1
Mental Health - Old Age Psychiatry	1	2	0	0	0	0	0	0	3
Public Health	0	0	0	1	0	0	0	0	1
Total	4	17	5	13	1	1	2	9	52*

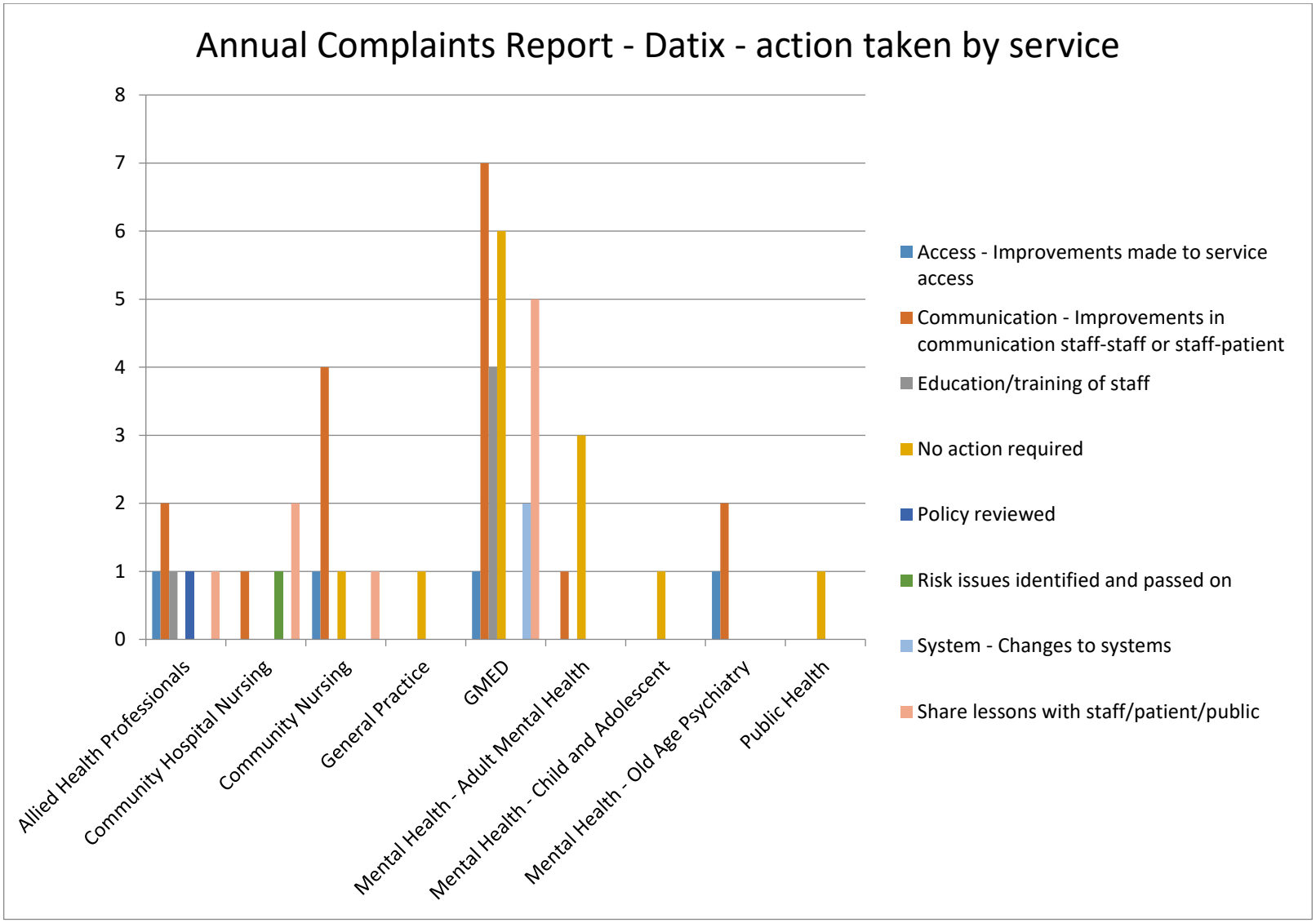
GMED have received the most complaints but that is usual due to the type of service that they provide and they actively review all their complaints on a weekly basis. They established a short life working group to review the dispatching/caseload allocation based on staff and patient feedback to improve process and information flow. They also have established a monthly learning session where topics are discussed that have arisen from complaints or adverse events, that provide a cross-service training opportunity and forms an excellent basis for identification of improvements.

A significant number of the complaints recorded via Datix are related to communication and there has been additional training regarding protocols for how to hold meetings and discussions with people and then the follow up to ensure that there is a shared understanding which should hopefully reduce misunderstandings in future.

Other teams discuss their complaints at their team meetings and discuss any opportunities for improvement or training requirements.

Graph 1

Complaints Information Extracted from Datix – Action Taken by Service



Indicator 2 **- The total number of complaints received**

The sum of the number of complaints received at Stage 1 (this includes escalated complaints as they were first received at Stage 1), and the number of complaints received directly at Stage 2.

Table 3 – total number of complaints

System recorded	Early Resolution / Frontline	Investigation	**Total**
NHS - Datix	3	32	35*
Moray Council - Lagan	25	7	28*
Total	28	39	**67**

**Note - 1 rejected on Datix as for NHS 24 not NHSG but included in total figure (35)*
**Note - 4 complaints received into Lagan but not closed during the period included in early resolution figures*

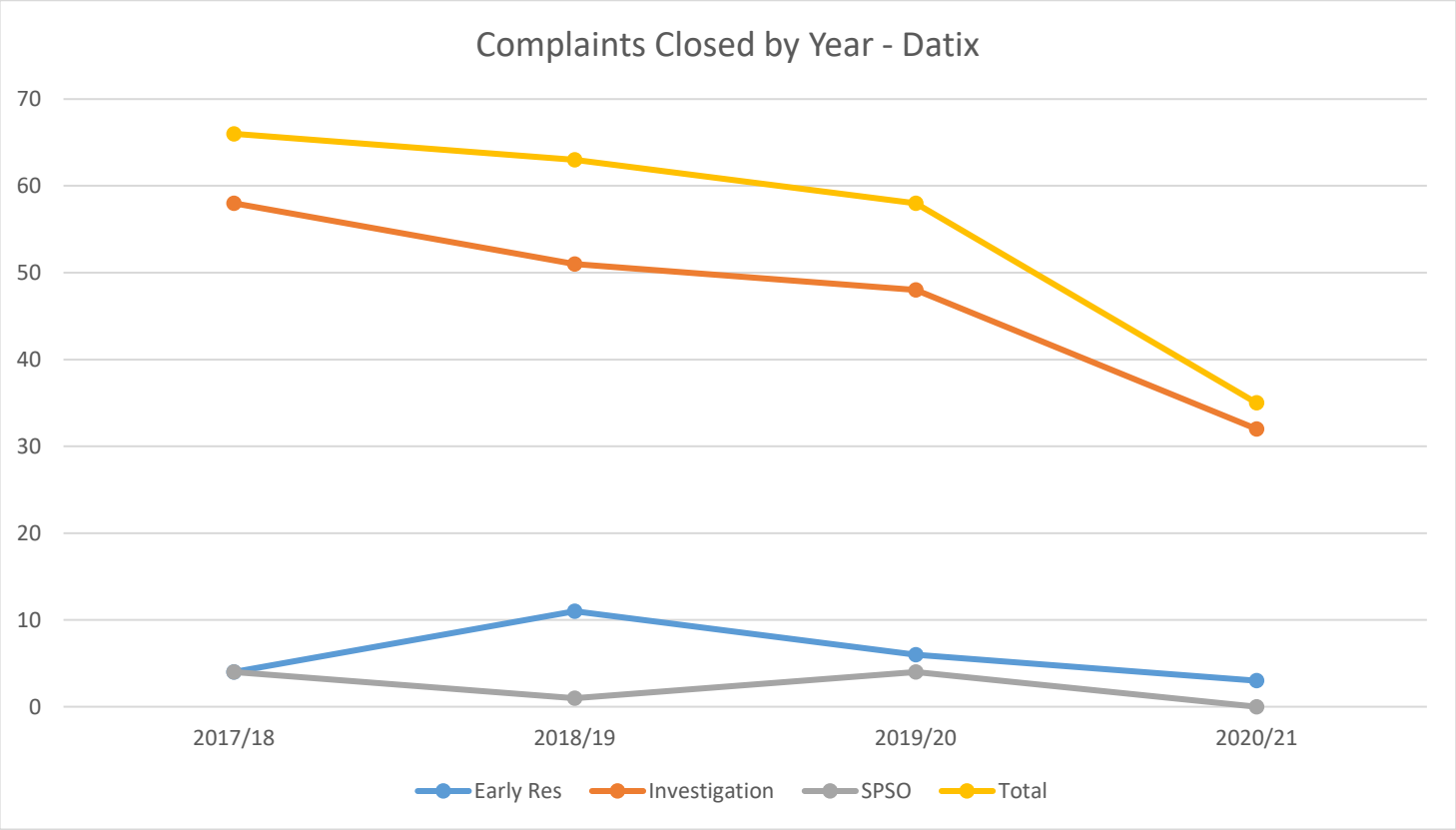
Table 4

	Early resolution	Investigation	Total
Allied Health Professionals	0	2	2
Community Hospital Nursing	0	2	2
Community Nursing	1	4	5
General Practice	0	1	1
GMED	1	15	16
Mental Health - Adult Mental Health	0	5	5
Mental Health - Child and Adolescent	0	1	1
Mental Health - Old Age Psychiatry	0	2	2
Public Health	1	0	1
Access Team	3	0	3
Head of Service	14	3	17
Mental Health – Social Work	1	1	2
Adult Protection	1	0	1
Occupational Therapy	1	0	1
Care at Home	2	1	3
Community Care Finance	2	0	2
Moray East Team – Social work	0	1	1
Moray West Team – Social Work	1	1	2
Total	28	39	67

Datix – Complaints Closed by Year:

Year	Early Resolution	Investigation	Ombudsman	Total
2017/18	4	58	4	66
2018/19	11	51	1	63
2019/20	6	48	4	58
2020/21	3	32	0	35

Graph 2 - Datix – Complaints Closed by Year

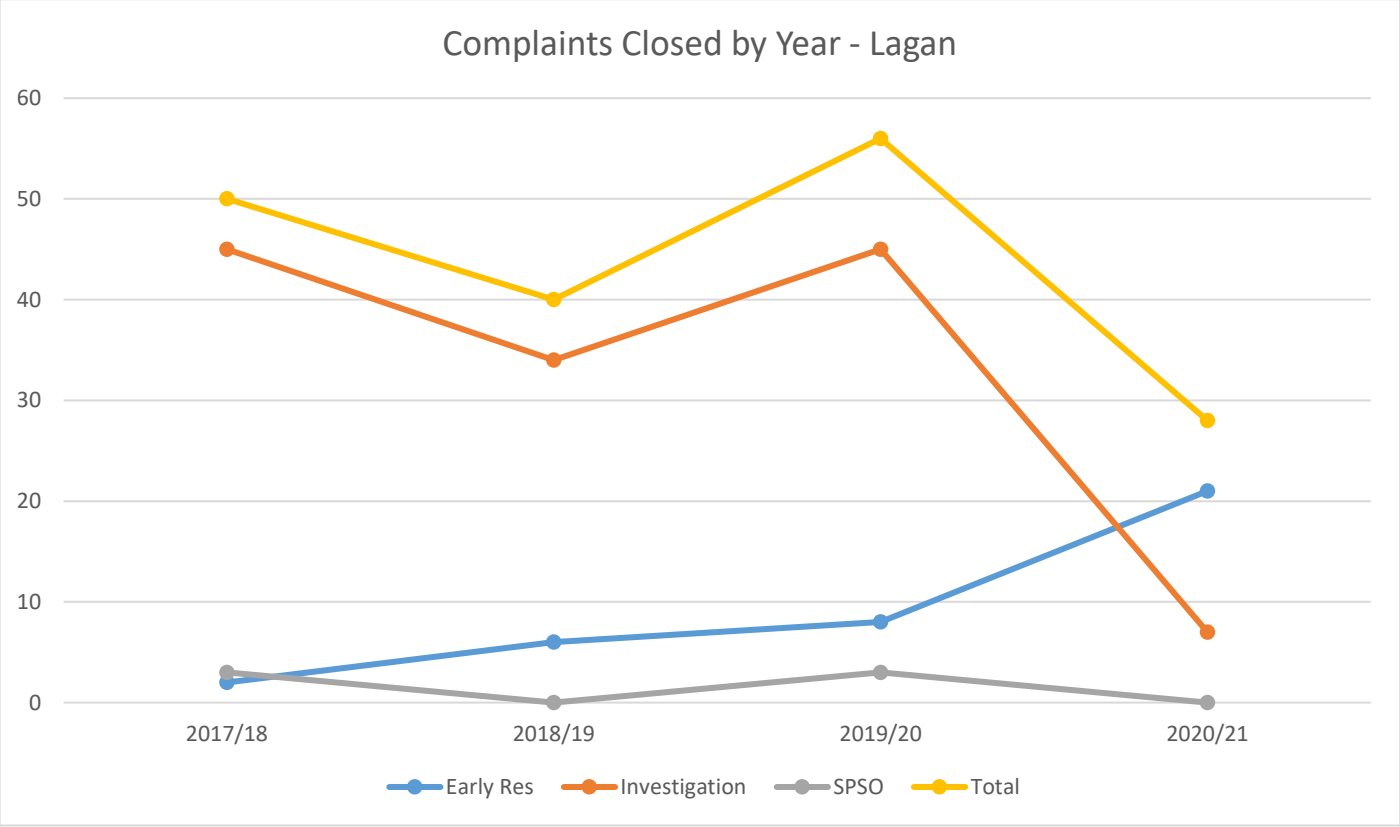


The number of complaints recorded through Datix last year reduce significantly. Due to the pandemic and the impacts and changes to services it is not possible to do a direct comparison to previous years. What is promising is the reduction in the number of complaints that required to be taken to investigation stage although efforts during 2021/22 will be to increase the number of complaints closed and complainants satisfied at early resolution stage.

Lagan - Complaints Closed by Year:

Year	Early Resolution	Investigation	Ombudsman	Total
2017/18	2	45	3	50
2018/19	6	34	0	40
2019/20	8	45	3	56
2020/21	21	7	0	28

Graph 3 - Lagan – Complaints Closed by Year



The number of complaints recorded through Lagan also was half the number in the previous year. What was very promising was the increase in the volume of complaints completed at early resolution stage (circa 60%).

Indicator 3 **- The number and percentage of complaints at each stage which were closed in full within the set timescales of five and 20 working days**

The number of complaints closed in full at stage 1, stage 2 and after escalation within MCHP timescales as % of all stage 1, stage 2 and escalated complaints responded to in full

Table 5 – number and percentage of complaints at each stage closed within timescales

	Early Resolution with timescale	Investigation within timescale
NHS - Datix	1 out of 3 (33%)	8 out of 32 (25%)
Moray Council - Lagan	4 out of 25 (16%)	1 out of 7 (14%)

Complaints received into HSCM are often multi-faceted and include more than one service which can impact on response times due to the level of investigation and coordination required. However during last year we were not able to achieve the targets timescales for responding with over 75% of responses out with target. This may be in part due to the impact of Covid-19 Pandemic as during times of surge, all staff resource was directed on delivering critical functions and responses to communications were not given the same priority. This is a particular target area for improvement and a workshop to review some examples of complaints to conduct case studies was undertaken in September 2021 to identify obstacles preventing and opportunities to improve response times, raise awareness of the need to seek how to resolve matters to the complainants' satisfaction and to streamline processes. The output from this workshop is being collated and actions identified to address the issues raised.

Indicator 4 - **The average time in working days for a full response to complaints at each stage**

Table 6 – average time in working days to respond

	Frontline	Investigative
NHS - Datix	18 working days	55 working days
Moray Council - Lagan	21 working days	35 working days

Whilst there have been significant improvements in seeking early resolutions to the complaints, we are not achieving this within the set timescales and this is an area that needs significant improvement. During the initial phases of the pandemic staff were focussed on delivery of critical services to people and complaint responses were not prioritised to the same extent due to the pressure staff were under. However processing the feedback from people receiving our services is extremely important to establish the learning and to take actions to improve and there are renewed efforts to achieve the timescales because there is a fundamental desire from managers and staff to provide a good service.

Indicator 5 - **The outcome of complaints at each stage**

The number of complaints upheld, partially upheld, not upheld and resolved at stage 1, stage 2 and after escalation as % of all complaints closed at stage 1, stage 2 and after escalation

Table 7 – Stage 1 – Frontline

71% of complaints were not upheld,

Service	Upheld	Partially Upheld	Not Upheld	Grand Total
Access Team	0	1	2	3
Adult Protection	0	0	1	1
Care at Home	0	0	2	2
Community Care Finance	0	0	2	2
Head of Service	1	3	7	11
Mental Health	0	0	1	1
Occupational Therapy	0	1	0	1
Total	1 (5%)	5 (24%)	15 (71%)	**21**

Table 8 – Stage 2 - Investigative

Service	Upheld	Partially Upheld	Not Upheld	Grand Total
Care At Home	0	1	0	1
Head of Service	0	3	0	3
Mental Health	1	0	0	1
Moray East	0	1	0	1
Moray West	0	1	0	1
Total	1 (14%)	6 (86%)	0	**7**

Combined Statistics - Department/Service

Table 9

Service	Upheld	Partially Upheld	Not Upheld	Grand Total
Access Team	0	1	2	3
Adult Protection	0	0	1	1
Care At Home	0	1	2	3
Community Care Finance	0	0	2	2
Head of Service	1	6	7	14
Mental Health	1	0	1	2
Moray East	0	1	0	1
Moray West	0	1	0	1
Occupational Therapy	0	1	0	1
Total	2 (7%)	11 (39%)	15 (54%)	**28**

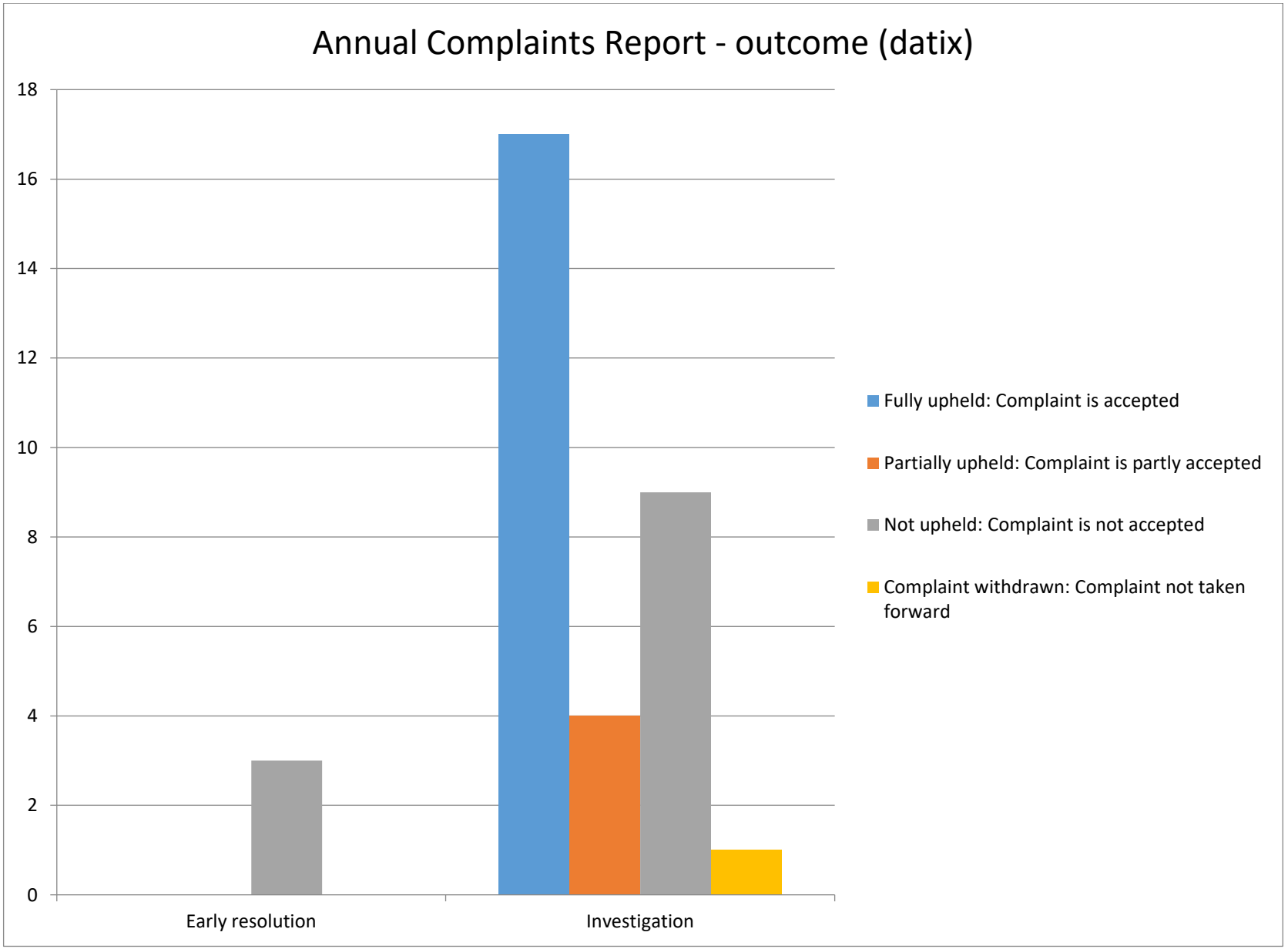
Of the complaints logged in Lagan 7% were upheld, 39% partially upheld and 54% were not upheld overall.
There was a different ratio at the two stages where at stage 1, 71% were not upheld which is positive.
Overall on 2 (7%) out of 28 complaints were upheld although a further 11 were partially upheld.

There were 8 learning outcomes identified and actioned.

It is recognised that there is a need for some refresher training for staff logging complaints on systems to ensure that they complete the necessary fields to facilitate extraction of learning so it can be shared more widely.

Graph 4 below shows the amount of complaints fully upheld as recorded in Datix and whilst the early resolution complaints were not upheld there was a significant proportion 17 (56%) of complaints upheld at investigation stage. The proportion of complaints logged on Datix that are upheld/partially upheld is similar to the complaints upheld/partially upheld that are logged on Lagan.

Graph 4 – complaints by outcome



REPORT TO: MORAY INTEGRATION JOINT BOARD ON 30 SEPTEMBER 2021

SUBJECT: FAST TRACK CITIES

BY: SUSAN THOM, AREA PUBLIC HEALTH COORDINATOR

1. REASON FOR REPORT

1.1 To inform the Moray Integration Joint Board (MIJB) of the work being undertaken within Grampian in relation to the Paris Declaration (2014) [amended November 2019] which pledges support to the Fast Track Cities initiative as part of the global focus on Human Immunodeficiency Virus (HIV), prevention, diagnosis and treatment.

2. RECOMMENDATION

2.1. It is recommended that the MIJB:

i) note the Grampian City Fast Track Cities High Level Action Plan (Draft) at APPENDIX 1;

ii) endorse and promote the Fast Track Cities initiative, and;

iii) approve Moray's involvement in the Grampian Fast Track Cities High Level Action Plan

3. BACKGROUND

3.1 Fast Track Cities is a global partnership and initiative, focussing on developing a network of cities pledged to achieve the commitments in the Declaration of Paris on HIV prevention, diagnosis and treatment[1] Aberdeen was the second City in Scotland to sign the Paris Declaration. HIV care in Grampian is co-ordinated by NHS Grampian and covers a pan Grampian cohort; it is hoped that all Cities in Scotland will eventually be a part of Fast Track Cities.

3.2 In brief, the Paris Declaration has three 90-90-90 (UNAIDS) targets which are:

- To ensure that 90% of people living with HIV know their status
- To improve access to antiretroviral treatment for people living with HIV to 90%
- To increase the proportion of people living with HIV on antiretroviral therapy (ART) with an undetectable viral load to at least 90% and to reduce stigma and discrimination related to HIV to zero and by 2030 achieving:

- Zero new transmissions
- Zero related HIV-deaths
- Zero HIV-related stigma

3.3 It should be noted that in 2018 overall Scotland had already achieved the 90-90-90 (UNAIDS) targets. However, there is still progress to be made in reducing late diagnosis, stigma and ensuring engagement with treatment and support.

3.4 Aberdeen City Health and Social Care Partnership (ACHSCP) initially led on the introduction of Fast Track Cities in Grampian. Since Aberdeen City approval in 2019 the Grampian Fact Track Cities strategic group have worked to establish a Grampian High Level Fast Track Cities (FTC) Action Plan (**Draft – Appendix 1**) and wider partnership approach across the whole of Grampian. The initial high level summary was completed in 2019 with asset mapping, consultation and short term outcomes planned for 2020, this plan was endorsed by the Aberdeen City IJB in January 2020.

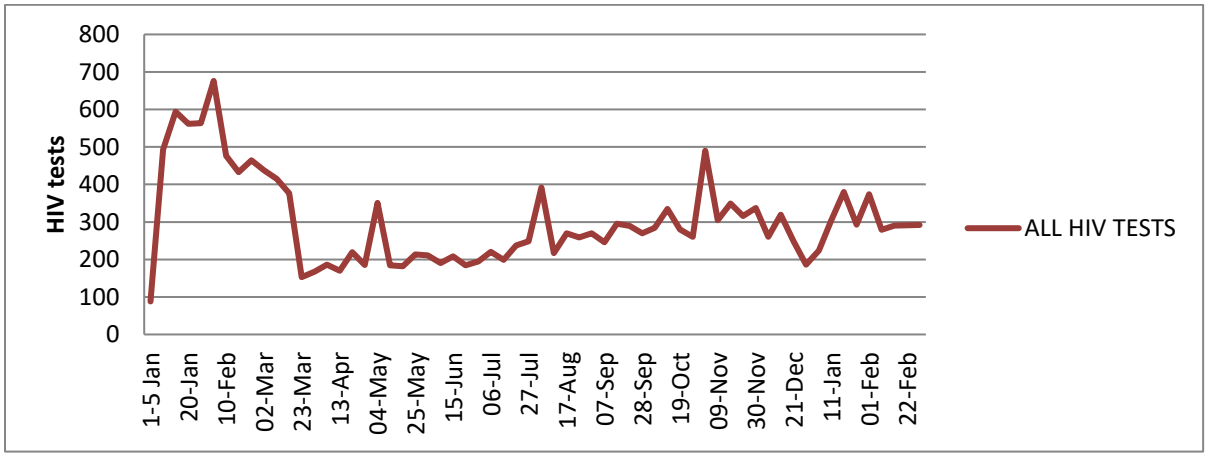
3.5 The opportunity now exists for MIJB and Aberdeenshire IJB to formally endorse and commit to the Grampian Fast Track Cities High Level Action Plan.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 As a result of Covid-19 the main challenges to clinical services have included

- Reduction in workforce capacity due to competing pressure linked to the pandemic especially from public health/data perspective
- Reduced capacity in partner services and competing priorities
- HIV prevention strategies such as HIV Pre-exposure prophylaxis (PrEP) maintained however demand reduced
- HIV care delayed in stable patients with the increasing use of telemedicine. The impact of this on cohort viral load is still awaited.

It also brought a decrease in HIV testing due to reduced demand and limited capacity within face to face services due to service restrictions secondary to Covid-19 and redeployment, and also pressure on laboratory services.



4.3 It has been challenging to work towards zero new transmissions with the drop in testing, yet services and partner organisations have tried to find alternative solutions. In partnership with NHS Boards, HIV Scotland piloted self-testing during the national lockdown (April-September). Although the uptake of tests in Grampian (N=198) is a fraction of tests that would have normally seen during the same period, the importance of offering self-testing was the opportunity for people to seek a test, remove barriers to testing and was seen to engage some people in testing who would otherwise not have. This type of approach should be recognised by the MIJB as a small step towards increasing testing and a continuation of improving the availability of testing (Short-Term Outcome). A full copy of the evaluation published by HIV Scotland can be accessed here: https://www.hiv.scot/Handlers/Download.ashx?IDMF=811ba817-0db2-4f1c-9c58-7743a2d10923

4.4 While undoubtedly Covid-19 has impacted people living with HIV in many ways, there has been an enthusiasm locally to maintain every effort possible to progress Fast Track Cities. The Grampian Fast Track Cities Group are the only group in Scotland to have continually met throughout the pandemic; seeing each other via Microsoft Teams and sharing thoughts, comments, plans and action via Basecamp.

4.5 Throughout 2020 Grampian maintained the 90-90-90 targets with 91% estimated diagnosed, 99% maintained on treatment and 98% undetectable. This should be noted by the MIJB as a real achievement given all the challenges that 2020 presented.

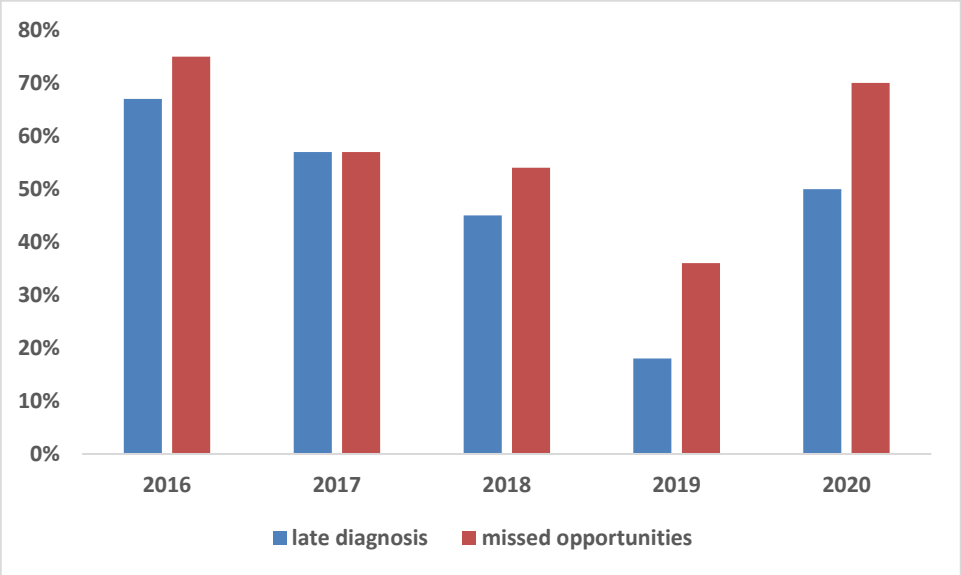
4.6 Grampian Sexual Health Services and NHS Grampian Infection Unit have continued to deliver HIV care along with Our Positive Voice Grampian who have been instrumental in supporting those who are newly diagnosed and/or living with HIV.

4.7 The importance of recognising prevention, particularly in the lead up to World AIDS day is an important calendar event. The MIJB should recognise that there was a significant amount of work completed by the Fast Track Cities group to keep a profile and awareness of HIV in the public domain, via respective organisations (ACHSCP and NHS) and other partner organisations (OPVG, Alcohol and Drugs Action, Alcohol and Drug Partnerships etc.). The symbolic lighting of Marischal College on World AIDs day and several social media posts outlined the importance of awareness of:

- the clinical indicators of HIV
- knowing your HIV status
- how to access Pre and Post-Exposure Prophylaxis
- the anti-stigma message U=U – Undetectable=Untransmittable.

4.8 Going forward it is recommended priorities should include; reducing incidences of late diagnosis, stigma and improving universal access to care, treatment and prevention. When reviewing the patient journey to diagnosis there continues to be missed opportunities for testing, where individuals presented with a clinical

symptom of HIV or a history of potential exposure but were not offered or did not access a test.



4.9 There also remains evidence of HIV stigma within local communities from feedback from people living with HIV and services, as well as the wider community. Stigma is cited as a reason why some clinicians/workers may not offer testing and is a documented factor in reasons for declining a HIV test, as well as disengaging from care. It is essential we tackle stigma within services and beyond for the dignity and human rights of people living with HIV and if we are to achieve the aims of zero transmissions and HIV related deaths.

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"

The policy and approach set out in this report is consistent with the ambitions of the MIJB Strategic Plan in providing care at home or close to home with a particular emphasis on the needs of older people. This locality approach is also consistent with the ambition of the LOIP in Moray.

(b) Policy and Legal

This approach supports national policy and the integration principles set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

(c) Financial implications

There is no specific financial implications as a result of this report. Actions within the plan will be delivered within existing budgets held jointly across

Grampian Sexual Health Services and NHS Grampian (Managed Care Network for Sexual Health and Blood Borne Viruses) [3].

(d) Risk Implications and Mitigation

Risks will be mitigated through a robust public consultation process and the completion of Equality Impact Assessment prior to the submission of a further report to the MIJB.

(e) Staffing Implications

There is no specific staffing implications; support to deliver the plan will be from existing resources.

(f) Property

There are no property implications in relation to this report.

(g) Equalities/Socio Economic Impact

It is anticipated that the continued implementation of this action plan will have a neutral to positive impact on the protected characteristics as defined in the Equality Act (2010). Increased knowledge and awareness of HIV in the general population and within public and private organisations is hoped to create a more positive environment for those living with HIV.

(h) Consultations

Iain Macdonald, Locality Manager, Health and Social Care Moray
Lisa Allerton, Manager of NHS Grampian Managed Care Network for Sexual Health and Blood Borne Viruses
Elaine McConnachie, Area Public Health Coordinator Aberdeen City Health and Social Care partnership
George Rutton, Public health Coordinator Aberdeenshire North
Grampian Fast Track Cities Strategic Group
Tracey Sutherland, Committee Services Officer, Moray Council

Who are in agreement with the contents of this report as regards their respective responsibilities.

6. CONCLUSION:

6.1 That the MIJB note the content of the report.

6.2 That the MIJB approve Moray's involvement in the Grampian Fast Tracked Cities High Level Action Plan

Author of Report: Susan Thom, Area Public Health Coordinator

Background Papers:

1. https://www.unaids.org/sites/default/files/media_asset/20141201_Paris_Declaration_en.pdf
2. Grampian High Level Fast Track Cities (FTC) Action Plan (Draft) attached
3. https://www.hi-netgrampian.org/wp-content/uploads/2018/09/MCNSTRATEGICPLAN.pdf

APPENDIX 1

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

Grampian Fast Track Cities (FTC) High Level Plan

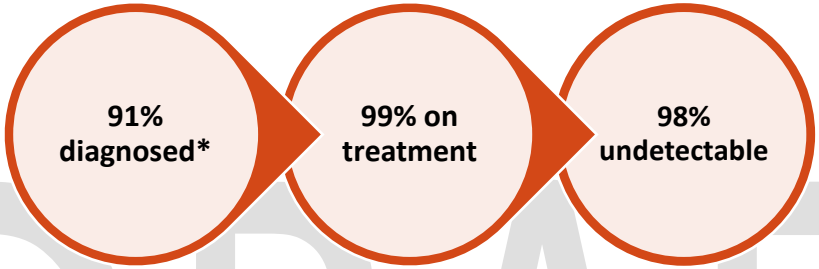
Introduction

There has been significant advance in HIV prevention, treatment and care locally, nationally and internationally over the last 35 years. Scotland and Grampian have achieved the World Health Organisation (WHO) target of 90/90/90 - over 90% of individuals are aware of their diagnosis and of those over 90% are on treatment, with over 90% virally suppressed. Nevertheless despite these advances there continues to be challenges in terms of transmissions, late diagnoses and missed opportunities for testing, as well as ongoing HIV stigma. Our FTC pledge and strategic plan aims to target these challenges with a local lens and pull together our services, partners and communities towards a long term plan for zero HIV transmissions, zero HIV related deaths and zero HIV stigma.

HIV in Grampian

HIV care in Aberdeen is co-ordinated by NHS Grampian and covers a pan Grampian cohort. Clinical care is provided by Grampian Sexual Health and Aberdeen Royal Infirmary Infection Unit and encompasses a clinical team of doctors, nurses, pharmacists and psychologists. The wider team also involves Our Positive Voice (Grampian) forum and peer support group in addition to NHS Grampian public health support for data analysis and prevention, treatment and care local strategy. There is also input from primary care for shared care patients and partners such as Aberdeen Alcohol and Drugs Action and Four Pillars, especially regarding education, testing and support.

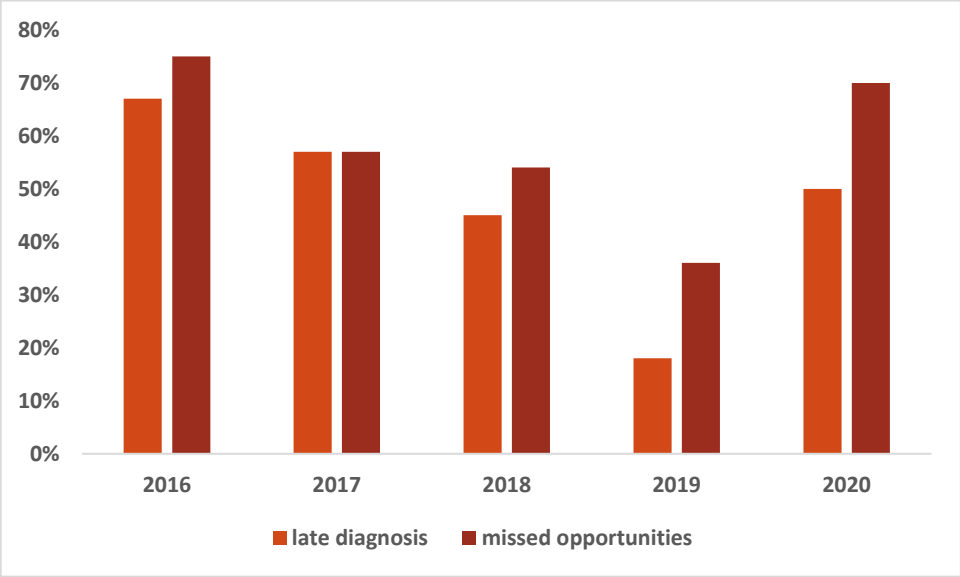
This foundation of multiagency working has allowed to achieve 90-90-90. As of April 2021, there are 421 people diagnosed with HIV who are currently under the care of NHS Grampian, with 99% on treatment and 98% with an undetectable viral load.



*based on Health Protection Scotland prevalence data

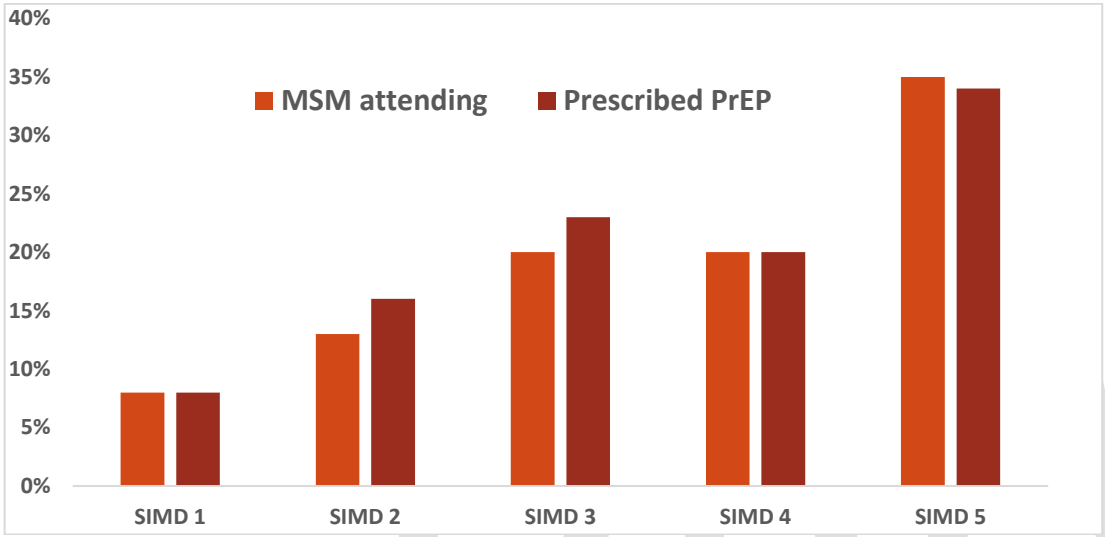
However despite these local partnerships and progress, HIV remains a public health challenge locally. There remains a high rate of late diagnosis, when individuals are diagnosed with a CD4 count of less than 350, indicating impact to the immune system (figure 1). When reviewing the patient journey to diagnosis there continues to be missed opportunities for testing, where individuals presented with a clinical symptom of HIV or a history of potential exposure but were not offered or did not access a test (figure 1). Furthermore, although not currently seen within the local epidemiology in the North East, the central belt of Scotland have seen a significant increase in transmissions in people who inject drugs. Grampian need to be alert to the possibility of this and maintain access to information, prevention and testing.

Figure 1: Late diagnoses and missed opportunities for testing 2016-2020



With regards to prevention, HIV Pre-exposure Prophylaxis (PrEP) has been available locally via Grampian Sexual Health since 2017, with over 600 people being prescribed this prevention method. An audit in 2018 found the uptake in rural areas was equal to urban areas however patients in areas of higher deprivation were less likely to be prescribed PrEP (figure 2). There is a need to increase awareness and access in areas of deprivation, including potentially access for people who inject drugs based on local transmission data.

Figure 2: Proportion of gay, bisexual and men who have sex with men (GBMSM) attending Grampian sexual health service overall and proportion prescribed PrEP as per Scottish Index of Multiple Deprivation in 2017/18



Lastly there sadly remains evidence of HIV stigma within our local communities from feedback from people living with HIV and services, as well as the wider community. Stigma is cited as a reason why some clinicians/workers may not offer testing and is a documented factor in reasons for declining a HIV test, as well as disengaging from care. It is essential we tackle stigma within services and beyond for the dignity and human rights of people living with HIV and if we are to achieve the aims of zero transmissions and HIV related deaths.

Our Strategic Plan: Zero HIV stigma, Zero HIV transmissions, Zero HIV related deaths

Our strategic plan builds on the work already being done locally and nationally. This includes Scotland's Sexual Health and Blood Borne Virus Framework 2015-2020, which is a multiagency strategy with five high level outcomes, addressing HIV prevention, treatment, care and stigma;

1. Fewer newly acquired sexually transmitted infections and blood borne viruses including HIV
2. A reduction in health inequalities experienced by people living with blood borne viruses including HIV
3. People living with blood borne viruses including HIV live longer, healthier lives

4. Sexual relationships are free from coercion and harm
5. We live in a society whereby the attitudes of individuals, the public and professionals, and the media in Scotland towards sexual health and blood born viruses including HIV, are positive, non-stigmatising and supportive.

This has enabled Scotland to achieve the global 90-90-90 HIV targets and is a foundation for our Fast Track Cities aims.

Our strategy is underpinned by 7 principles which we recognise are essential for success.

- **Systems wide working**
- **Communication and engagement at all stages**
- **Education underpinning all outcomes**
- **Prevention and Practice at the centre of the strategy**
- **Access and equity for all**
- **Data that is accurate and timely**
- **Advocacy**

Our high outcomes are shown below with long, medium and short term aims that encompass both individual, community and public health outcomes.

Aim	Outcomes			Measures	Continue
	Long Term	**Medium Term**	**Short Term**		
Zero discrimination & stigma	Zero tolerance of HIV stigma throughout society in Grampian	All employers in Grampian are aware of, and their practices adhere with the legislation (e.g. Equality 2010).	Community Planning Partners are aware of, and their practices adhere with legislation (e.g. Equality 2010).	Reduction in stigma (based on suite of measures): - Reduction in proportion of people living with HIV who decline GP consent - Increase proportion of people living with HIV collecting prescriptions from local pharmacies - Questionnaire on views of clinical staff - Results from Stigma Questionnaire show a downward trend in stigma - Reduction in HIV stigma complaints in Health & Social Care Partnerships, NHS Grampian	Maintain existing good practice
	HIV educated population	All young people, Health Care Professionals and Public Sector workers have access to HIV inclusive education with focus on stigma.	Work with Community Planning Partners to provide inclusive HIV education for their employees with focus on stigma.		
	Positive sexual health is seen as a human right	Policies and strategies are aligned and integrated around HIV and positive sexual health.	Community Planning Partners policies and strategies are aligned and integrated to recognise HIV inequality and stigma.		

				and aligned partners - Evidence that partners are aware of stigma strategy and have signed up to strategic aims	

Systems wide > Communication & Engagement > Education > Prevention & Practice > Access > Data > Advocacy

Aim	Outcomes			Measures	Continue
	Long Term	**Medium Term**	**Short Term**		
Zero new transmissions	100% of people living with HIV knowing their HIV status.	95% of people living with HIV knowing their HIV status.	Maintain 90% of people living with HIV knowing their HIV status.	Increase testing overall with specific aims for - Increasing testing post Covid19 including postal options (self sampling and DBST) - HIV Testing week - Grampian Pride Increase testing in line with current guidelines	Maintain existing good practice
	Identify those who undiagnosed with HIV and link to care timeously.	Ensure HIV testing is widely available in clinical and non-clinical settings - Accessible including online/postal options - Routinely completed in high prevalence areas and for indicator conditions	Continue work to improve availability of testing, - As part of routinely completing testing in high prevalence areas and for indicator conditions		

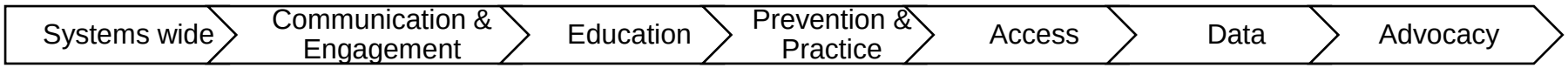
		- Proactively offered to high risk groups using local data trends	- Proactively offering testing in high risk groups using local data trends Accurate and robust data on testing and new diagnosis and associated demographics to inform workplan. Pathways of referral for new diagnosis clear to allow rapid access to treatment	(BASHH/BHIVA) including for clinical indicator conditions Reduction in annual number of new transmissions Reduction in proportion of new diagnoses that have been recently acquired based on avidity data Increase the percentage of people living with HIV who are - Retained in care - On treatment - undetectable	
	Retention in care and viral suppression	Access to requested support services and support networks widely available timeously	Map support services available to support needs of people living with HIV		
		Priority groups (as informed by data) receive targeted support			
	Access to multi-faceted prevention strategies	Formula milk is available to infants without cost where breastfeeding poses a HIV risk	Focus on prevention e.g. ensure that that condom distribution is appropriate and		

			meets the needs of the population		
		Increase PEP/PrEP awareness, access and uptake with access equity for all groups	Map PrEP uptake to deprivation Collate “missed opportunities” for PrEP in new diagnoses		

Systems wide | Communication & Engagement | Education | Prevention & Practice | Access | Data | Advocacy

Aim	Outcomes			Measures	Continue
	Long Term	**Medium Term**	**Short Term**		
Zero HIV related deaths	100% of people who know their HIV-positive status on treatment. 100% of people on treatment with suppressed viral loads.	Reach: - 95% of people who know their HIV-positive status on treatment. - 95% of people on treatment with suppressed viral loads.	Maintain: - 90% of people who know their HIV-positive status on treatment. - >90% of people on treatment with suppressed viral loads.	- Reduction in late diagnosis rate both absolute and proportionate - Reduction in missed opportunities for testing based on clinical indicator conditions and criteria for HIV PrEP	Maintain existing good practice
	Reduced late diagnosis (to 10%) and increase testing for indicator conditions.	Reduced late diagnosis (to 20%) - Screening prompts for clinical indicator conditions	Reduced late diagnosis (to 30%) Monitor late diagnosis/missed		

		- Education to HCPs partners and public re clinical indicator conditions	opportunities and use this data to inform evolving local action plan	- Reduction in AIDS defining illnesses - Reduction in of HIV-related deaths	
	Retention in care	Offer flexible services, patient centred and close to home including telemedicine, including planning for HIV care in older age and management of co-morbidities			
		Cross system approach to data to enable targeted support (while respecting rights of individuals) Protocol for this developed.			
		Improved links across health provision and social work			



Progress so far

The FTC strategic group has built on the existing multi-agency working and achievements in clinical care as well as prevention and work towards reducing stigma. This includes,

- Achieving >98% in terms of treatment and undetectable rates
- Availability of community prescribing of HIV treatment

- Telemedicine and shared care with primary care
- Assessment of support needs of people living with HIV and service recommendations/implementation
- Establishing Our Positive Voice (Grampian) Forum and Peer Support group, instrumental in service development and FTC strategy as well as individual patient support
- Joint working with hepatology and addiction services for testing and referral pathways in high risk groups
- High uptake of HIV pre-exposure prophylaxis
- Establishing HIV clinical database
- Mapping of education in NHS and higher education and delivery of education based on local data
- HIV education and stigma in care homes
- Self-assessment of Healthcare Improvement Scotland and British Association of HIV standards of care

Implementation and challenges

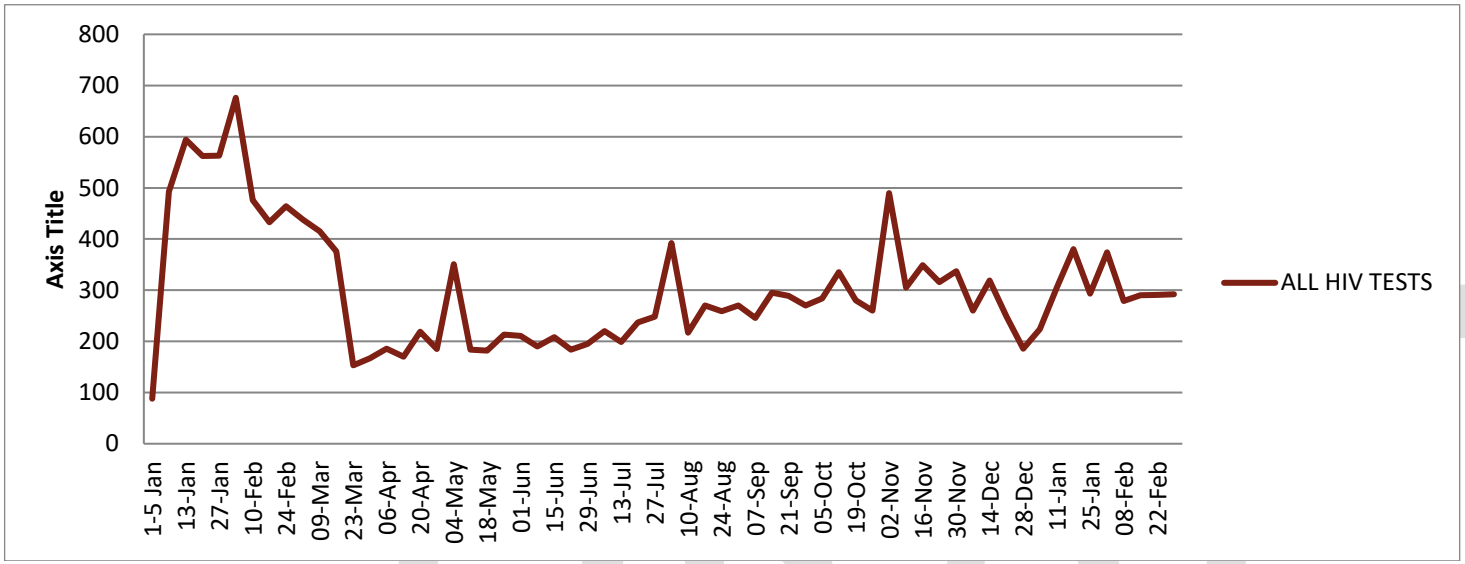
Since local approval in September 2019 the strategic group have worked to establish a strategic plan and wider partnership. The initial high level summary was completed in 2019 with asset mapping, consultation and short term outcomes planned for 2020. The main challenge at this time was limited resources for the work of the group, partner services and organisations time, with contribution on voluntary basis or within existing job plans and funding streams. Since the Covid19 Pandemic further challenges have been recognised, including but not limited to,

- Reduction in workforce capacity due to competing pressure linked to the pandemic especially from public health/data perspective
- Limited availability of partners and competing priorities

Clinically there has also been an impact including,

- Reduction in HIV testing due to a reduction in face to face care and without a high volume postal alternative currently in place (figure 3)
- Reduction in HIV PrEP demand
- HIV care was delayed in stable patients with the increasing use of telemedicine. The impact of this on cohort viral load is still awaited.

Figure 3: HIV testing pan Grampian 2020/2021



Despite these challenges, both pre and post Covid19, the strategic group continued to work throughout the pandemic to focus on awareness and education as work towards a 2021 workplan which will include,

- Impact analysis of Covid19 on FTC high level outcomes
- Consolidating our assets
- Stakeholder engagement and consultation
- Focus on testing access
- Focus on stigma with tangible outcomes

Looking towards 2021 and beyond, the last year has highlighted that in spite of competing pressures and unpredictable landscape, the work to achieve the FTC high level outcomes has to continue and adapt if the vision of HIV elimination, both as an infection and in terms of stigma, is to be realised.

Governance, reporting, monitoring and evaluation

This strategy is endorsed and governed by the FTC strategic group who will monitor the progress towards the targets and identify emerging issues and opportunities for action, this group reports to the Integrated Joint Boards across Grampian.

Stakeholders:

- NHS Grampian
- Four Pillars
- ADA/ ADP
- HIV Scotland
- Our Positive Voice (Grampian) (OPVG)
- ACVO
- Aberdeen City Council (including Education)
- Community Planning Aberdeen
- Waverly Care
- Homeless Collaborative
- Aberdeen Cyrennians
- Aberdeen Foyer
- SACRO
- AHSCP → HMP Grampian
- Activities that have been delivered successfully so far
- ACHSCP (Social Work/ Primary Care)
- Acute
- Aberdeen Chamber of Commerce
- Federation of Small Businesses (FSB)
- Universities/ College
- African Community
- Oil & Gas UK (or similar org)
- (NETRALT) North East Tenants Residents and Landlords Together