Moray Integration Joint Board

Thursday, 29 August 2019

Inkwell Main, Elgin Youth Café

NOTICE IS HEREBY GIVEN that a Meeting of the **Moray Integration Joint Board** is to be held at **Inkwell Main, Elgin Youth Café**, **Francis Place, Elgin, IV30 1LQ** on **Thursday, 29 August 2019** at **09:30** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

MEMBERSHIP

Councillor Shona Morrison (Chair)	Moray Council
Mr Jonathan Passmore (Vice-Chair)	Non-Executive Board Member, NHS Grampian
Councillor Tim Eagle	Moray Council
Councillor Louise Laing	Moray Council
Mr Sandy Riddell	Non-Executive Board Member, NHS Grampian
Mr Dennis Robertson	Non-Executive Board Member, NHS Grampian

NON-VOTING MEMBERS

Ms Tracey Abdy	Chief Financial Officer, Moray Integration Joint Board
Mr Ivan Augustus	Carer Representative
Ms Elidh Brown	tsiMORAY
Mr Sean Coady	Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services, Health and Social Care Moray
Mr Tony Donaghey	UNISON, Moray Council
Ms Pamela Gowans	Chief Officer, Moray Integration Joint Board
Mrs Linda Harper	Lead Nurse, Moray Integration Joint Board
Mr Steven Lindsay	NHS Grampian Staff Partnership Representative
Ms Jane Mackie	Chief Social Work Officer, Moray Council
Dr Malcolm Metcalfe	Deputy Medical Director, NHS Grampian
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services, Moray Integration Joint Board
Mrs Val Thatcher	Public Partnership Forum Representative
Dr Lewis Walker	Registered Medical Practitioner, Primary Medical Services, Moray Integration Joint Board

Clerk Name: Caroline Howie
Clerk Telephone: 01343 563302
Clerk Email: caroline.howie@moray.gov.uk

MINUTE OF MEETING OF THE INTEGRATION JOINT BOARD

Thursday, 27 June 2019

Inkwell Main, Elgin Youth Café, Francis Place, Elgin, IV30 1LQ

PRESENT

Ms Tracey Abdy, Mr Tony Donaghey, Councillor Tim Eagle, Ms Pam Gowans, Councillor Louise Laing, Ms Jane Mackie, Councillor Shona Morrison, Mr Jonathan Passmore, Mr Sandy Riddell, Councillor Dennis Robertson, Dr Graham Taylor, Mrs Val Thatcher, Dr Lewis Walker
Ms Heidi Tweedie (for Ms Elidh Brown)

APOLOGIES

Mr Ivan Augustus, Ms Elidh Brown, Mr Sean Coady (NHS), Mrs Linda Harper

IN ATTENDANCE

Ms Jeanette Netherwood, Corporate Manager; Ms Maggie Bruce, Audit Scotland; Mr John Campbell, Provider Services Manager; Mr Bruce Woodward, Performance Officer; Ms Lesley Attridge, Service Manager; Mr Adam Coldwells, Chief Officer, Aberdeenshire IJB; Mr Alex Stephen Ms Eilidh MacKechnie, Corporate Communications Officer; and Mrs Caroline Howie, Moray Council as clerk to the Board.

ALSO PRESENT

Councillors Theresa Coull and Sonya Warren

1 Chair of Meeting

The meeting was Chaired by Councillor Shona Morrison.

2 Welcome

The Chair welcomed Councillor Dennis Robertson, Non-Executive Member, NHS Grampian, to his first meeting. She advised Councillor Robertson replaces Mrs Susan Webb.

3 Declaration of Member's Interests

There were no declarations of Members' Interests in respect of any item on the agenda.

Members of the press and public left the meeting at this juncture in order to allow discussion of the confidential item.

4 Towerview Day Service

Under reference to paragraph 14 of the Minute of the meeting dated 30 August 2018 a confidential report by John Campbell, Provider Services Manager, informed the Board of the outcomes from the formal consultation process with staff; and the outcomes from the formal consultation process with service users and families.

Following discussion the Board agreed to the:

i. re-provision of services currently delivered at Towerview;

ii. outcomes of the consultation process being delivered through the Change Management Plan implementation; and

iii. lease of the property being terminated.

The press and public re-entered the meeting following discussion of this item.

5 Minute of Board Meeting dated 28 March 2019

The Minute of the meeting of the Moray Integration Joint Board dated 28 March 2019 was submitted and approved.

6 Action Log of Board Meeting dated 28 March 2019

The Action Log of the meeting of the Moray Integration Joint Board dated 28 March 2019 was discussed and it was noted that all actions due had been completed.

7 Minute of Meeting of Audit, Performance and Risk Committee dated 13 December 2018

The Minute of the meeting of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 13 December 2018 was submitted and noted.

8 Minute of Meeting of Clinical and Care Governance Committee dated 28 February 2019

The Minute of the meeting of the Moray Integration Joint Board Clinical and Care Governance Committee dated 28 February 2019 was submitted and noted.

9 Chief Officers Report

A report by the Chief Officer (CO) provided the Board with an update on key priorities.

The CO advised the Programme Board tasked with exploring opportunities had a range of people in its membership.

She further advised the Keith and East Locality Review may provide an opportunity for a campus approach to health and care for the area; advising Keith was in a good locality for provision of services in Aberdeenshire and Moray.

10 Change of Board Membership

Under reference to paragraph 5 of the Minute of the meeting of the Board dated 28 June 2018 a report by the Chief Officer asked the Board to consider arrangements for a change in Grampian Health Board representation on the Board.

The Chief Officer advised that contrary to information contained in the report it had been decided since writing the report that Mrs Webb would not be in attendance at this meeting as it was not required.

There followed discussion on the appointment of a Chair of the Audit, Performance and Risk Committee and the Chair of the Board advised appointment would be for the next two meetings only as the Chair of the Board was due to change to a NHS Grampian member in October and therefore the position of Committee Chairs would then be taken by Moray Council Members.

Councillor Dennis Robertson advised he was willing to sit as Chair of the Audit, Performance and Risk Committee.

Thereafter the Board agreed to:

i. note the appointment of Councillor Robertson to the Board; and

ii. the appointment of Councillor Robertson as Chair of the Audit, Performance and Risk Committee.

11 Clinical and Care Governance Committee Assurance Report

Under reference to paragraph 5 of the Minute of the meeting of the Board dated 28 June 2018 a report by the Chief Officer (CO) informed the Board of the summary of matters considered and actioned during 2018/19 at the Clinical and Care Governance Committee.

Mr Passmore was of the opinion that the Committee was providing a good evaluation of work being undertaken however he thought it should also look at the quality of services as they undergo change and future reports should provide assurance changes are being made in a safe manner.

The CO undertook to take the comment on board and ensure that where change is being undertaken that this was reflected in future reports to the Committee.

Thereafter the Board agreed to:

i. note the contents of the report; and

ii. the Chief Officer ensuring future reports to the Clinical and Care Governance Committee include assurance that any change is being undertaken in a safe manner.

12 Audit Performance and Risk Committee

Under reference to paragraph 5 of the Minute of the meeting of the Board dated 28 June 2018 a report by the Chief Officer informed the Board of a summary of matters considered and actioned during 2018/19 at the Audit, Performance and Risk Committee.

Following consideration the Boards agreed to note the:

i. content of the report;

ii. External Audit Plan attached as appendix 1 to the report; and

iii. Strategic Risk Register will be reviewed as part of the preparation of the new Strategic Plan and presented to the Board in October 2019.

13 Review of Progress with Integration of Health and Social Care - Self-Evaluation

A report by the Chief Officer (CO) sought endorsement on the draft review of progress with the integration self-evaluation submission to the Ministerial Strategic Group (MSG) for Health and Community Care.

Discussion took place on the scoring used for the evaluation and clarification was sought on whether those scoring themselves as exemplary would be subject to challenge.

The CO advised that scoring on the self-evaluation was not open to challenge but more that it was about what could be learned and how to strengthen the areas where a lower score was deemed appropriate.

The expectation of the exercise being repeated in 12 months was discussed and the Board were of the opinion that further discussion was required and a workshop should be arranged to facilitate discussion prior to completion of another self-assessment.

Thereafter the Board agreed to:

i. approve the draft review of progress with integration of Health and Social Care submitted to the MSG on 14 May 2019, and shown in appendix 1 to the report;

ii. seek an update from the CO on the improvement actions identified within the submission, to be presented to the meeting of the Board on 28 November 2019; and

iii. a workshop being convened to allow discussion prior to a further self-evaluation in May 2020.

14 Revenue Budget Outturn for 2018-19

A report by the Chief Financial Officer informed the Board of the financial outturn for 2018/19 for the core budgets and the impact this outturn will have on the 2019/20 budget.

During discussion the Chief Officer (CO) advised it was her intention to hold quarterly meetings with the Chair, Vice-Chair, Chief Financial Officer, the Chief Executive of Moray Council and the Chief Executive of NHS Grampian to work towards a shift in culture, focussing on outcomes rather than on how the work is carried out.

The CO further advised she currently attends NHS Grampian Board meetings and provides information on what the IJB is doing and it is her intention to attend Moray Council meetings to provide information and the opportunity for Elected Members to seek answers on areas they are unsure of.

Thereafter the Board agreed to:

i. note the unaudited revenue outturn position for the financial year 2018/19;

ii. note the impact of the 2018/19 outturn on the 2019/20 revenue budget; and

iii. approve for issue, the Directions shown in appendices 4 and 5 of the report to NHS Grampian and Moray Council respectively.

15 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 discussion the Board agreed to:

i. note the content of the report;

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

iii. approve the updated Local Code of Corporate Governance (appendix 1 of the report) to continuously support the production of the Annual Governance Statement.

16 Unaudited Annual Accounts

A report by the Chief Financial Officer informed the Board of the unaudited Annual Accounts for the year ended 31 March 2019.

Following discussion the Board agreed to:

i. note the unaudited Annual Accounts prior to their submission to the external auditor, noting that all figures remain subject to audit;

ii. note the Annual Governance Statement contained within the unaudited Annual Accounts;

iii. note the accounting policies applied in the production of the unaudited Annual Accounts, pages 32 to 40 of the accounts (appendix 1 of the report); and

iv. delegate responsibility to the Audit, Performance and Risk Committee for sign off of the Audited Annual Accounts at its meeting on 19 September 2019.

Mr Coldwells and Mr Stephen entered the meeting during discussion of this item.

17 Order of Business

In terms of Standing Order 2.2, the Meeting agreed to vary the order of business as set down on the Agenda and take Item 18 "Hosted Services Governance Arrangements" as the next item of business in order to allow Mr Coldwells and Mr Stephen to vacate the meeting at the earliest opportunity.

18 Hosted Services Governance Arrangements

A report by the Chief Officer informed the Board of the proposed framework for the strategic planning, monitoring and performance management of those services delegated to the three Grampian Integration Joint Boards (IJB) from National Health Service Grampian (NHSG), for both strategic planning and operational management.

During lengthy discussion it was stated that formal decision-making would remain with the IJB and production of a schedule of work for the System-wide Senior Leadership Group (SSLG) would provide the opportunity for the Moray IJB to discuss topics with the Chair and Vice-Chair of the Moray IJB prior to attendance at SSLG meetings.

Consideration was given to the frequency of meetings for the North East Partnership and it was agreed this should be 4 meetings per annum.

Thereafter the Board agreed:

i. to endorse the approach for the monitoring and performance management of delegated services which are hosted by one of the three Grampian IJBs on behalf of the other two IJBs;

ii. that the frequency of meetings for the North East Partnership should be 4 per annum;

iii. to instruct officers to include discussion of this during a development session in September; and

iv. to instruct officers to prepare a draft role and remit for the Partnership.

Mr Coldwells and Mr Stephen left the meeting at this juncture.

19 Health and Social Care Moray Primary Care Improvement Plan Update

A report by Sean Coady, Head of Service, informed the Board of the progress made by Health and Social Care Moray (HSCM) to deliver the implementation of the 2018 General Medical Services (GMS) contract and to provide an update on the plan for 2019/20.

Lengthy discussion took place on the implementation and it was advised that a great deal of work is being undertaken which will highlight risks associated with recruitment of workforce and funding, which can be raised nationally.

The year two plan has been accepted by the Local Medical Committee and public events are planned to ensure the public is kept informed.

Thereafter the Board agreed to:

i. note the revised HSCM Primary Care Improvement plan (PCIP) for 2019/20; and

ii. approve the revised HSCM PCIP as the framework of how the six priority areas detailed in the report will be delivered in Moray.

20 Forres Locality Pathfinder - Interim Progress Report

Under reference to paragraph 11 of the Minute of the meeting dated 29 November 2018 a report by Lesley Attridge, Service Manager, informed the Board of the progression of the redesign of Health and Social Care services in the Forres Locality.

The Chief Officer gave an overview of work undertaken in the last few years, to provide context for newer members of the Board.

There was discussion on whether or not the general public understand what is being done to transform services. Ms Attridge advised meetings are ongoing with the community to ensure their views are being considered when transformation is being undertaken and that consideration of understanding of the public was due to be discussed in July.

Thereafter the Board agreed to note progress on the journey of transforming Health and Social Care services in the Forres Locality based on the information provided within the report.

21 Annual Performance Report 2018/19

A report by the Chief Officer advised the Board of the approach adopted for the production of the Annual Performance Report 2018/19 and confirmed the process prior to publication.

Following consideration the Board agreed:

i. to note the approach taken to produce the 2018/19 Annual Performance

Report; and

ii. the final version to be presented to the Audit, Performance and Risk Committee on 25 July 2019 for final approval prior to publication by 31 July 2019.

22 Items for the Attention of the Public

Under reference to paragraph 10 of the minute of the Moray Integration Joint Board dated 26 October 2017 the Board agreed that the following items be brought to the attention of the public:

i. Unaudited Accounts

ii. Primary Care Contract

iii. Forres Locality Pathfinder

MEETING OF MORAY INTEGRATION JOINT BOARD

THURSDAY 27 JUNE 2019

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Towerview Day Service	Re-provision services from Towerview. Give notice to terminate the lease of the property known as Towerview.	July 2019 July 2019	John Campbell Moray Council Property Services
2.	Clinical and Care Governance Committee Assurance Report	Chief Officer to ensure future reports to Committee include assurance that services undergoing change continue to be delivered in a safe manner.	Ongoing	Pam Gowans
3.	Audit, Performance and Risk Committee	Review Strategic Risk Register and present update to the Board in October.	Oct 2019	Pam Gowans
4.	Review of Progress with Integration of Health and Social Care: Self-Evaluation	Chief Officer to provide an update on the improvement action identified within the submission to the Ministerial Strategic Group to the meeting in November. Workshop to be convened to allow discussion prior to a further self-evaluation.	Nov 2019 May 2020	Pam Gowans Pam Gowans
5.	Revenue Budget Outturn for 2018/19	Issue Directions to NHS Grampian and Moray Council.	July 2019	Pam Gowans
6.	Unaudited Annual Accounts	Audited Annual Accounts to be presented to the Audit, Performance and Risk Committee for sign off in September.	Sept 2019	Tracey Abdy

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
7.	Hosted Services Governance Arrangements	Draft role and remit for the North East Partnership to be drafted and further discussion on the Hosted Services to be held at a development session.	Sept 2019	Pam Gowans
8.	Annual Performance Report 2018/19	Final version of the Annual Performance Report to be presented to the Audit, Performance and Risk Committee in July for final approval prior to publication by 31 July 2019.	July 2019	Jeanette Netherwood
9.	Items for the Attention of the Public	Unaudited Accounts Primary Care Contract Forres Locality Pathfinder	July 2019	Fiona McPherson

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 28 March 2019

Inkwell Main, Elgin Youth Café, Francis Place, Elgin, IV30 1LQ

PRESENT

Ms Tracey Abdy, Councillor Tim Eagle, Ms Pam Gowans, Councillor Louise Laing, Mr Steven Lindsay, Mr Sandy Riddell, Mr Atholl Scott, Mrs Susan Webb

APOLOGIES

Ms Elidh Brown

IN ATTENDANCE

Ms Heidi Tweedie (substituting for Ms Elidh Brown); Ms Maggie Bruce, Senior Audit Manager, Audit Scotland; Ms Jeanette Netherwood, Corporate Manager; Mr Bruce Woodward, Senior Performance Manager and Mrs Caroline Howie, Committee Services Officer, Moray Council, as clerk to the meeting.

1 Chair of Meeting

The meeting was chaired by Mrs Susan Webb.

2 Declaration of Member's Interests

There were no declarations of Members' interests in respect of any item on the agenda.

3 Minute of Meeting dated 13 December 2018

The minute of the meeting of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 13 December 2018 was submitted and approved.

4 Action Log of Meeting dated 13 December 2018

The action log of the Moray Integration Joint Board Audit, Performance and Risk Committee dated 13 December 2018 was submitted and discussed and it was noted that, other than the following, all actions due had been completed:

i. Item 4 - Audit Scotland - Update Report on Health and Social Care Integration - self assessment information yet to be received from the Government, therefore to be presented to the next meeting; and

ii. Item 5 - Payment Verification Assurance Update - not completed, due date moved to next meeting.

5 Quarter 3 (October - December 2018) Performance Report

A report by the Chief Financial Officer updated the Committee on performance as at Quarter 3 (October - December) 2018/19.

The Committee was advised that Delayed Discharges are on the increase, despite ongoing work to reduce this. This had previously been a winter issue but is now an issue all year round.

Discussion took place on the key issues raised, namely Delayed Discharges, Complaints, Sickness Absences, Psychological Therapy Treatment Waiting Times, Smoking Cessation and Alcohol Brief Interventions.

During discussion the Chair requested a report to the next meeting on Delayed Discharges to allow more focus on requirements.

Sickness absence within NHS staff was noted to be consistently red. The Chair requested a report to the meeting in September 2019 as she was of the opinion time would be required to investigate this prior to reporting to Committee.

The Chair stated it would be helpful if the Committee could see further information on the performance reporting developments of Alcohol Brief Interventions and sought a report to the next meeting.

Thereafter the Committee agreed to:

i. note the performance of local indicators for Quarter 3 (October - December 2018) as presented in the summary report at appendix 1 of the report;

ii. seek a report on Delayed Discharges for consideration at the meeting in July 2019;

iii. seek a report on Alcohol Brief Interventions for consideration at the meeting in July 2019; and

iv. seek a report on NHS staff sickness absence for consideration at the meeting in September 2019.

6 Strategic Risk Register - March 2019

A report by the Chief Officer provided an overview of the current strategic risks, along with a summary of action which are in place to mitigate those risks, updated as at March 2019.

During discussion Committee were supportive of the information provided in the report but was of the opinion that timescales required to be revisited and requested a further report, including updated timescales, be provided to the next meeting.

Thereafter the Committee agreed to:

i. note the updated Strategic Risk Register; and

ii. seek a further report, including updated timescales, to the meeting in July 2019.

7 External Audit Plan for the Year Ending 2018-19

A report by the Chief Financial Officer informed the Committee of the Auditor's Annual Plan for 2018/19.

Following discussion the Committee agreed to note the contents of the External Auditor's Annual Plan for 2018/19.

8 Internal Audit Update

A report by the Chief Internal Auditor provided an update on progress towards delivery of the internal audit plan for 2018/19 year and on work being undertaken to inform the 2019/20 programme of internal audit work.

Following discussion the Committee agreed to note the:

i. contents of the update report; and

ii. internal audit reporting protocol as outlined in appendix 1 of the report.

9 NHS Grampian Internal Audit Reports

A report by the Chief Internal Auditor informed the Committee of the outcomes from two recent internal audit reports prepared by PricewaterhouseCoopers, the appointed Internal Auditor for NHS Grampian.

Discussion took place on the content of the report and it was stated it was important to be clear on reporting structures for the varying parts of the system. It was further stated that information in respect of staffing should be presented to this Committee, however patient safety information should be dealt with at the Clinical and Care Governance Committee.

Thereafter the Committee agreed to note the findings and recommendations from the internal audit report.

CHIEF OFFICER'S REPORT TO THE MORAY INTEGRATION JOINT BOARD ON 29 AUGUST 2019

Drug Related Deaths

Following the publication of the Drug Related Deaths in Scotland, the drug death figures for Moray show that there were 17 deaths in 2018 compared to 7 in 2017, 10 in 2016, and 10 in 2015. The profile for those who have died is similar to the wider Scotland profile, i.e. long term poly drug use, with people on average being in their 40's at the time of their deaths. Other important factors include the increased use of benzodiazepines; often bought illicitly and of variable quality.

As part of the work to ensure that services continue to meet the need of Moray, the Moray Alcohol and Drugs Partnership (MADP) are carrying out an audit of how services and organisations work together to reduce drug related harms. The audit is based on the accredited tool produced by the Scottish Drugs Forum – Staying Alive in Scotland. The audit will identify any gaps in services that need to be addressed. Once completed a report with specific recommendations for action will be presented to the MADP.

Moray has undertaken a considerable amount of work, along with increased investment from the Scottish Government, to ensure that services are easily accessible. To this end it is reassuring that Moray is 100% compliant in meeting its waiting time target of getting people into services within three weeks from the initial contact, and it is also 100% compliant in meeting the local target of 72 hours from the initial contact. The numbers of people receiving support has increased from 505 in Quarter 1 2018/19 up to 581 in Q2 2019/20. This ties in with the work undertaken to promote engagement and ease of access into services.

The MADP produces quarterly performance reports which outline in detail how Moray as a whole is performing. The 2019/20 Quarter 1 report will be published before the end of August 2019.

For further information contact Paul Johnson, Moray Alcohol & Drugs Partnership Manager.
paul.johnson@moray.gov.uk

Annual Performance Report 2018/19

Following approval by the special meeting of Audit, Performance and Risk committee on 1 August 2019 the finalised annual performance report was published on the Health and Social Care Moray website on Friday 2 August 2019.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 AUGUST 2019**

SUBJECT: **QUARTER 4 (JANUARY – MARCH 2019) PERFORMANCE REPORT**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1 To update the Moray Integration Joint Board (MIJB) on the performance of the MIJB as at Quarter 4 (January – March) 2018/19.

2. RECOMMENDATION

2.1 It is recommended that the Board consider and note:

i) the performance of local indicators for Quarter 4 (January – March 2019) as presented in the summary report at APPENDIX 1;

ii) the detailed analysis of the local indicators that have been highlighted as requiring further analysis as contained within APPENDIX 2; and

iii) that a review of local indicators is underway and a report with recommendations will be presented to the next Audit, Performance and Risk committee.

3. BACKGROUND

3.1 The purpose of this report is to ensure the MIJB fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in its Strategic Plan. Performance reports are routinely presented to the Audit, Performance and Risk Committee, however as the July 2019 meeting was not quorate, the report is now being presented for consideration by the Board.

3.2 **APPENDIX 1** identifies the The National Core Suite of Integration Indicators which have been developed from national data sources to ensure the measurement approach is consistent across all partnerships in Scotland.

3.3 **APPENDIX 2** identifies local indicators that are linked to the strategic priorities of the MIJB and the functions delegated by NHS Grampian and Moray Council, to allow wider scrutiny by this Board.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 National Indicators have been released for 2018/19. Indicators are presented in **APPENDIX 1**. Indicators NI1 to NI10 are outcome indicators based on questions in the biennial health and care experience survey. There was no survey done in 2017/18 with the next survey due to be run during 2019/20.

4.2 The one indicator where Moray is showing as Red is Delayed Discharge related (NI-19 Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population). A separate report is being presented to the Audit, Performance and Risk Committee on 19 September 2019 in relation to Delayed Discharges.

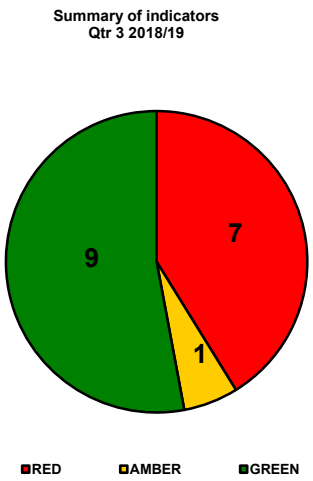
4.3 Indicators NI12, 13, 14, 16 and 20 are currently being reviewed by Information Services Division (ISD) and are likely to change. Therefore the figures in **APPENDIX 1** for these indicators and all the Scottish averages are provisional and will be updated when the final figures are provided by ISD.

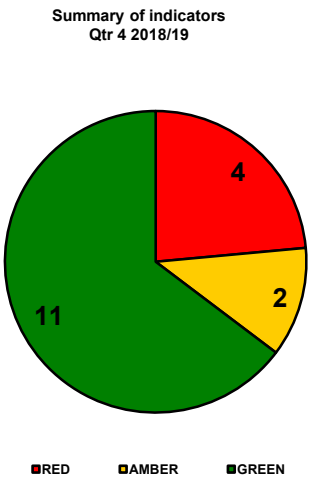
4.4 Local Indicators are assessed on their performance via a common performance monitoring Red, Amber, Green (RAG) traffic light rating system.

RAG scoring based on the following criteria (Where there is no target, previous quarter is used):	
GREEN	If Moray is performing better than target.
AMBER	If Moray is performing worse than target but within 5% tolerance.
RED	If Moray is performing worse than target by more than 5%.
▲ – ▼	Indicating the direction of the current trend.

4.5 The performance information for quarter 4 is attached in **APPENDIX 2.** Moray has 17 local indicators 11 of which are green, 2 amber and 4 indicators showing their status as red.

4.6 Of the 7 red indicators in Q3, 3 are now green and 4 remain red (one of these is L14 which is only updated yearly so no change was expected). There was 1 amber indicator in Q3 which remains amber but is showing an improvement (L09 65+ Emergency Admissions). Of the 9 green indicators in quarter 3, 8 remain green, one is now Amber (L12 – A&E Attendance Rates per 1000 population (All Ages), this is due to the current nature of the measures without targets being measured on previous quarter's performance (See 4.8)).





4.7 Indicators which are RED (not meeting local targets and outwith tolerances) at quarter 4 have been highlighted by the Performance Team with the relevant Service Managers. An investigation into the reasons why the indicator is red has been undertaken and potential remedial actions have been identified, discussed and implemented to improve performance where possible. **APPENDIX 3** provides exception reporting and supplementary information which explains the background to current performance and the management action being undertaken to address the underlying issues.

4.8 Narrative on the low number of Alcohol Brief Interventions (ABIs) has been provided in **APPENDIX 3** and further to that the Grampian Alcohol and Screening Brief Intervention Strategy has been provided as **APPENDIX 4**. The implementation plan for this strategy is currently being worked on with the intention of being published in late 2019.

4.9 A review of local indicators is being undertaken to establish if the indicators submitted to the Audit, Performance and Risk committee remain an appropriate and representative indication of emerging strategic priorities. Review of the targets that have been set and determining if those without require targets or should be presented as information only. Progress and recommendations on this matter will be reported to the next meeting of the Audit, Performance and Risk committee.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

Performance management reporting is a legislative requirement under section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014.

In addition to publishing an Annual Performance Report, the Moray Integration Scheme requires that the MIJB will “monitor the performance of the delivery of integrated services using the Strategic Plan on an ongoing basis” (para 5.2.2 of the Moray Integration Scheme refers).

(b) Policy and Legal

None directly associated with this report.

(c) Financial implications

None directly associated with this report. .

(d) Risk Implications and Mitigation

Appendix 3 highlights some of the difficulties being experienced in staff recruitment and sickness absence and the subsequent impact on service delivery. Further detailed analysis is being undertaken and management are exploring additional approaches and solutions to address this issue.

(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 for the Performance Framework because there will be no impact, as a result of the report, 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:-

- Chief Officer, MIJB
- Caroline Howie, Committee Services Officer
- Service Managers, Health and Social Care Moray
- Corporate Manager

6. CONCLUSION

6.1 This report requests the Board comment on performance of local indicators and actions summarised in the highlight report (APPENDIX 3).

6.2 Progress on the review of Indicators to be presented to the next Audit, Performance and Risk Committee.

Author of Report: Bruce Woodward, Senior Performance Officer
Background Papers: Available on request
Ref:

Moray Core Suite of National Integration Indicators - Annual Performance

Data Source: ISD
Last updated: June 2019

Data for the Core Suite of Integration Indicators, NI - 1 to NI - 23 are populated from national data sources and data is issued nationally. Indicators 1 to 10 are outcome indicators based on survey feedback and are updated bi-annually. Data for National Indicators 11 to 23 are derived from organisational/system data and are updated quarterly. Data for indicators 10, 21, 22 and 23 are not yet available.

	Indicator	Title	Previous score 2015/16	Current score 2017/18	Scotland 2017/18	RAG
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	96%	93%	93%	G ▼
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	74%	83%	81%	G ▲
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	73%	75%	76%	A ▲
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	71%	73%	74%	A ▲
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	79%	80%	80%	G ▲
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	86%	80%	83%	A ▼
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83%	79%	80%	A ▼
	NI - 8	Total combined % carers who feel supported to continue in their caring role	38%	39%	37%	G ▲
	NI - 9	Percentage of adults supported at home who agreed they felt safe	79%	84%	83%	G ▲
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	

	Indicator	Title	Previous score	Current score	Scotland (provisional)	RAG
Data indicators	NI - 11	Premature mortality rate per 100,000 persons *(European age-standardised mortality rate per 100,000 for people aged under 75)*	360 *2016*	372 *2017*	425	G ▲
	NI - 12	Emergency admission rate (per 100,000 population)	9,269 *2017/18*	8,842 *2018/19*	TBC	G ▼
	NI - 13	Emergency bed day rate (per 100,000 population)	96,050 *2017/18*	85,623 *2018/19*	TBC	G ▼
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	84 *2017/18*	75 *2018/19*	TBC	G ▼
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	89% *2017/18*	90% *2018/19*	89%	G ▲
	NI - 16	Falls rate per 1,000 population aged 65+	15 *2017/18*	15 *2018/19*	TBC	G –
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	85% *2017/18*	87% *2018/19*	82%	G ▲
	NI - 18	Percentage of adults with intensive care needs receiving care at home	67% *2016*	65% *2017*	61%	G ▼
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	936 *2017/18*	1,093 *2018/19*	805	R ▲
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22% *2017/18*	19% *2018/19*	TBC	G ▼
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	

RAG scoring based on the following criteria

G	*If Moray is performing the same or better than the Scottish average.*
A	*If Moray is performing worse than the Scottish average but within 5% tolerance.*
R	*If Moray is performing worse than the Scottish average by more than 5%.*
▲ – ▼	*Indicating the direction of the current trend.*

Moray Health and Social Care Partnership: Performance at a Glance Quarter 4 (January to March 2019)
Local Indicators

RAG scoring based on the following criteria (Where there is no target, previous quarter is used)	
G	If Moray is performing better than target
A	If Moray is performing worse than target but within 5% tolerance
R	If Moray is performing worse than target by more than 5%
▲ – ▼	Indicating direction of current trend

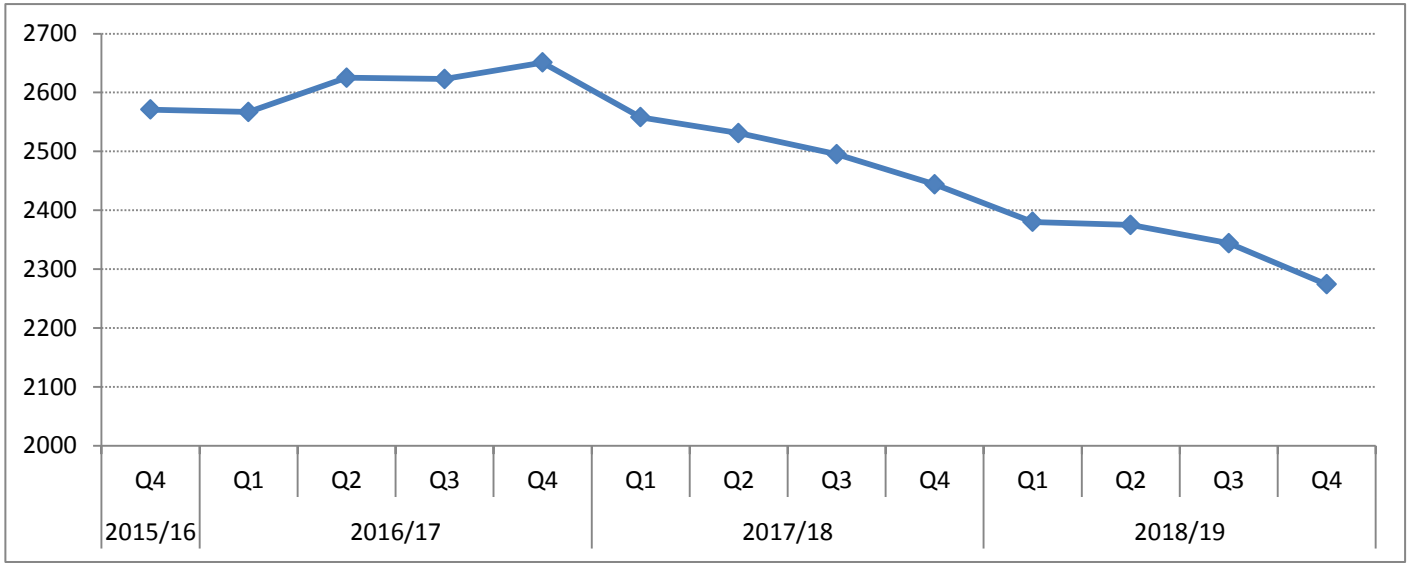
ID.	Indicator Description	Source	Q4 (Jan-Mar 18)	Q1 (Apr-Jun 18)	Q2 (Jul-Sep 18)	Q3 (Oct-Dec 18)	Q4 (Jan-Mar 19)	Target	RAG Status
L07	Rate of emergency occupied bed days for over 65s per 1000 population	NHS	2444	2380	2375	2344	**2274**	2360	G▼
L08	Emergency Admissions rate per 1000 population for over 65s	NHS - PMS	186	191	189	187	**182**	193	G▼
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	NHS - PMS	129	132	130	130	**127**	125	A▼
L10	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	NHS	38	42	45	41	**37**	-	G▼
L11	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	NHS	32	32	39	35	**32**	35	G▼
L12	A&E Attendance rates per 1000 population (All Ages)	NHS	57.6	63.8	62.6	58.0	**59.4**	-	A▲

R	If Moray is performing worse than target by more than 5%
▲ – ▼	Indicating direction of current trend

ID.	Indicator Description	Source	Q4 (Jan-Mar 18)	Q1 (Apr-Jun 18)	Q2 (Jul-Sep 18)	Q3 (Oct-Dec 18)	Q4 (Jan-Mar 19)	Target	RAG Status
L13	A&E Percentage of people seen within 4 hours, within community hospitals	NHS	100% (624)	100% (825)	100.0% (681)	100.0% (564)	**100% (563)**	98%	G -
L14	Percentage of new dementia diagnoses who receive 1 year post-diagnostic support	ISD	Reported Annually		90.7% (2015/16)	66.7% (2016/17)	2017/18 not available yet	70%	R▼
L15	Smoking cessation in 40% most deprived after 12 weeks	NHS	49	30	20	**29**	Q3 is most recent this is always a qtr behind	-	G▲
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	NHS	100.0%	98.0%	100%	100.0%	**100.0%**	90%	G -
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	NHS	95.3%	100%	100%	100.0%	**100.0%**	90%	G -
L18	Number of Alcohol Brief Interventions being delivered (includes ABIs in priority and wider settings where data can be aligned to HSCP)	NHS	-	206	221	166	**125**	259	R▼
L19A	Number of complaints received and % responded to within 20 working days - NHS	NHS	68.4% (19)	50% (8)	54.5% (11)	50.0% (18)	**54.2% (24)**	-	G▲
L19B	Number of complaints received and % responded to within 20 working days - Council	SW	-	-	100% (6)	100% (6)	**100 (3)%**	-	G -
L20	NHS Sickness Absence % of Hours Lost	NHS	5.8%	4.9%	4.6%	4.7%	**3.8%**	4.0%	G▼
L21	Council Sickness Absence (% of Calendar Days Lost)	SW	-	7.9%	8.1%	8.3%	**7.4%**	5.9%	R▼
L41	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	NHS	100.0%	100.0%	100.0%	80.0%	**78.0%**	90%	R▼

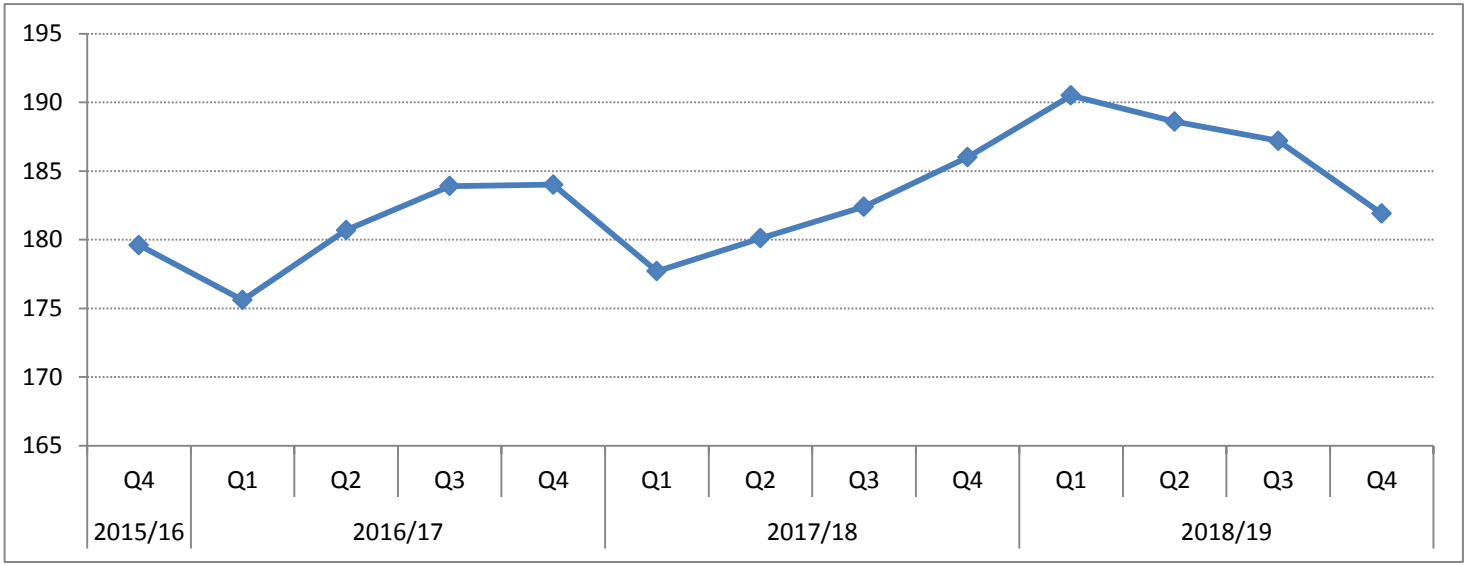
L07 Rate of emergency occupied bed days for over 65s per 1000 population

Financial Year		
2015/16	Q4	2571
2016/17	Q1	2567
	Q2	2625
	Q3	2623
	Q4	2651
2017/18	Q1	2558
	Q2	2531
	Q3	2495
	Q4	2444
2018/19	Q1	2380
	Q2	2375
	Q3	2344
	Q4	2274



L08 Emergency Admissions rate per 1000 population for over 65s

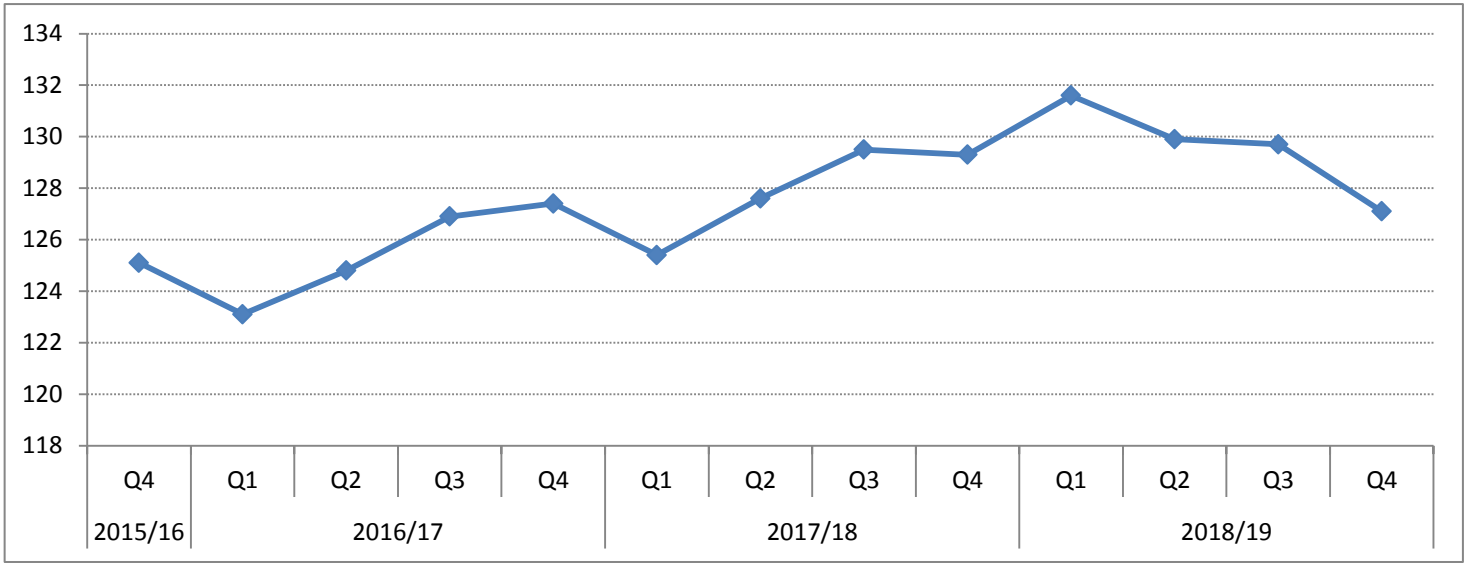
Financial Year		
2015/16	Q4	179.6
2016/17	Q1	175.6
	Q2	180.7
	Q3	183.9
	Q4	184.0
2017/18	Q1	177.7
	Q2	180.1
	Q3	182.4
	Q4	186.0
2018/19	Q1	190.5
	Q2	188.6
	Q3	187.2
	Q4	181.9



L09 Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population

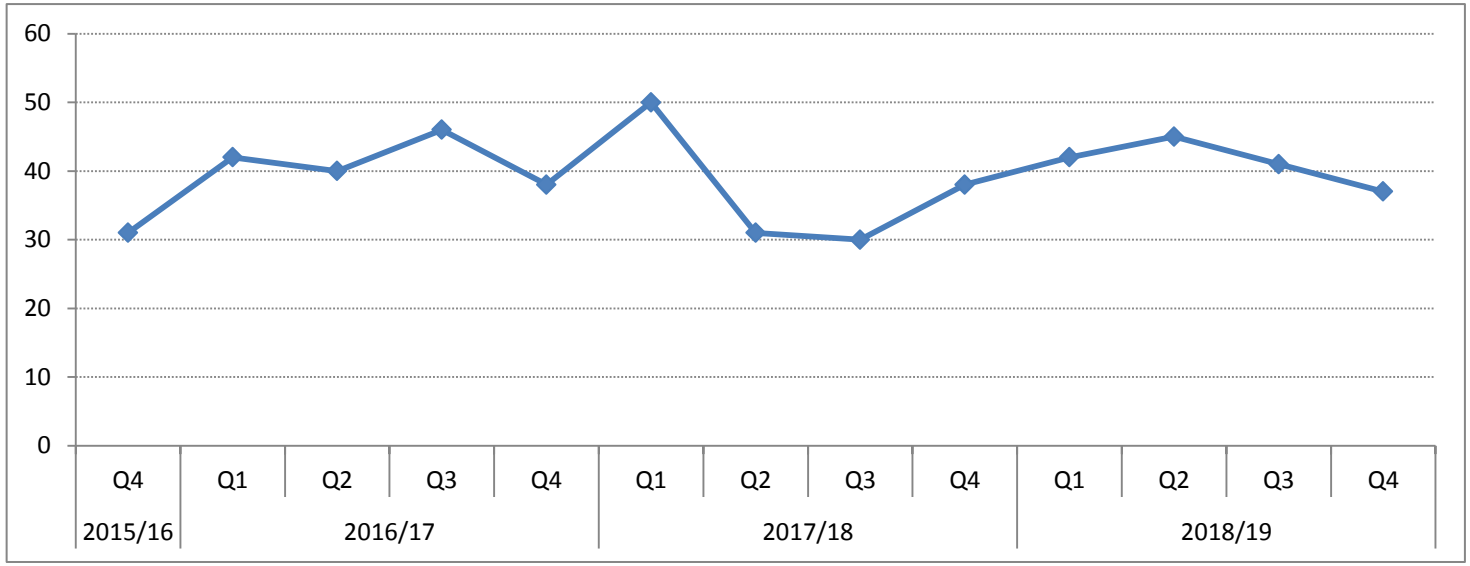
Financial Year

2015/16	Q4	125.1
2016/17	Q1	123.1
	Q2	124.8
	Q3	126.9
	Q4	127.4
2017/18	Q1	125.4
	Q2	127.6
	Q3	129.5
	Q4	129.3
2018/19	Q1	131.6
	Q2	129.9
	Q3	129.7
	Q4	127.1



L10 Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population

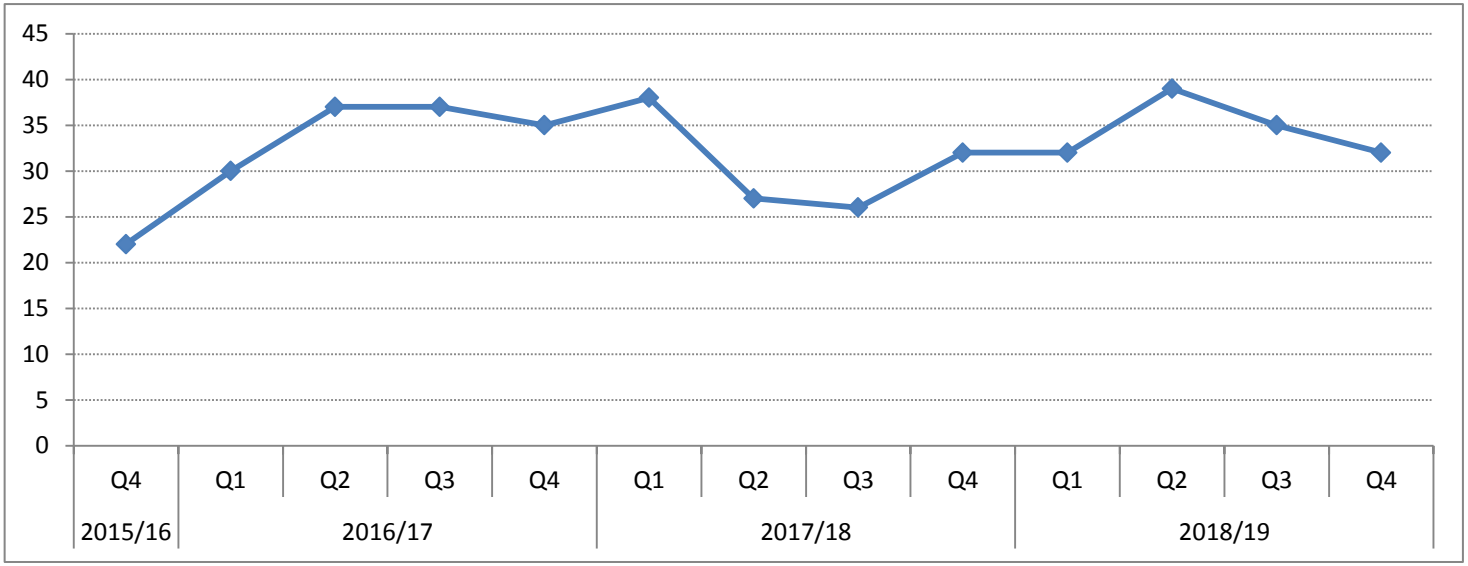
Financial Year		
2015/16	Q4	31
2016/17	Q1	42
	Q2	40
	Q3	46
	Q4	38
2017/18	Q1	50
	Q2	31
	Q3	30
	Q4	38
2018/19	Q1	42
	Q2	45
	Q3	41
	Q4	37



L11 Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)

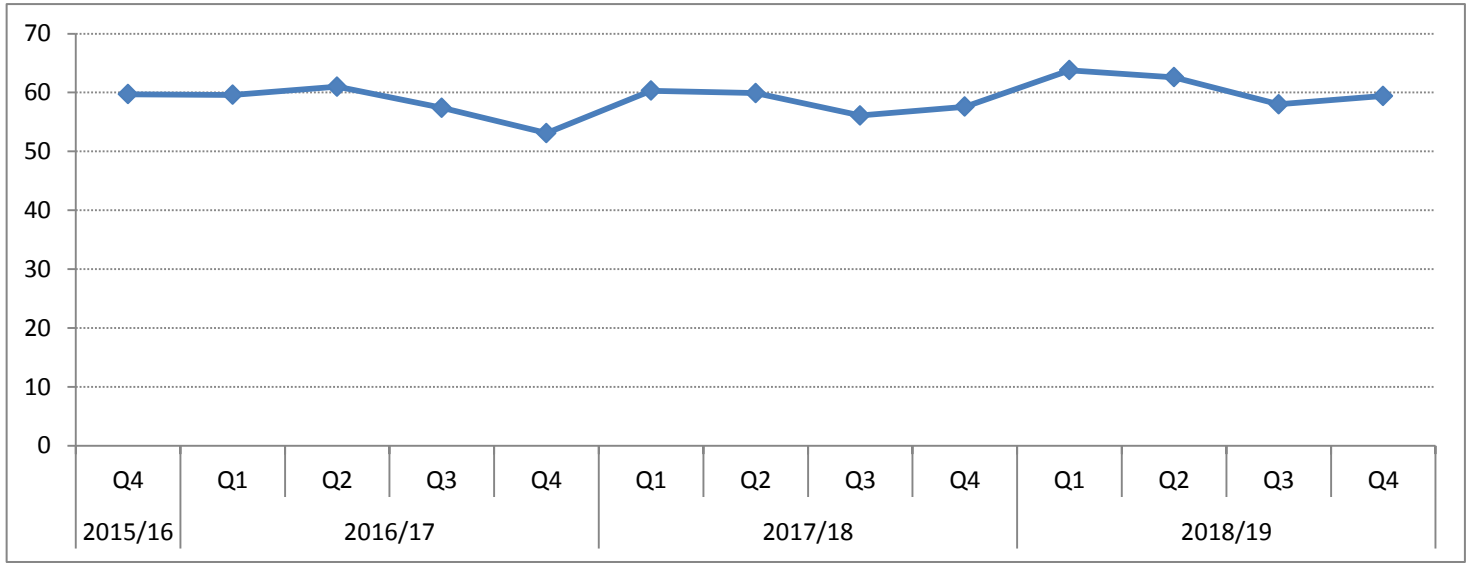
Financial Year

2015/16	Q4	22
2016/17	Q1	30
	Q2	37
	Q3	37
	Q4	35
2017/18	Q1	38
	Q2	27
	Q3	26
	Q4	32
2018/19	Q1	32
	Q2	39
	Q3	35
	Q4	32



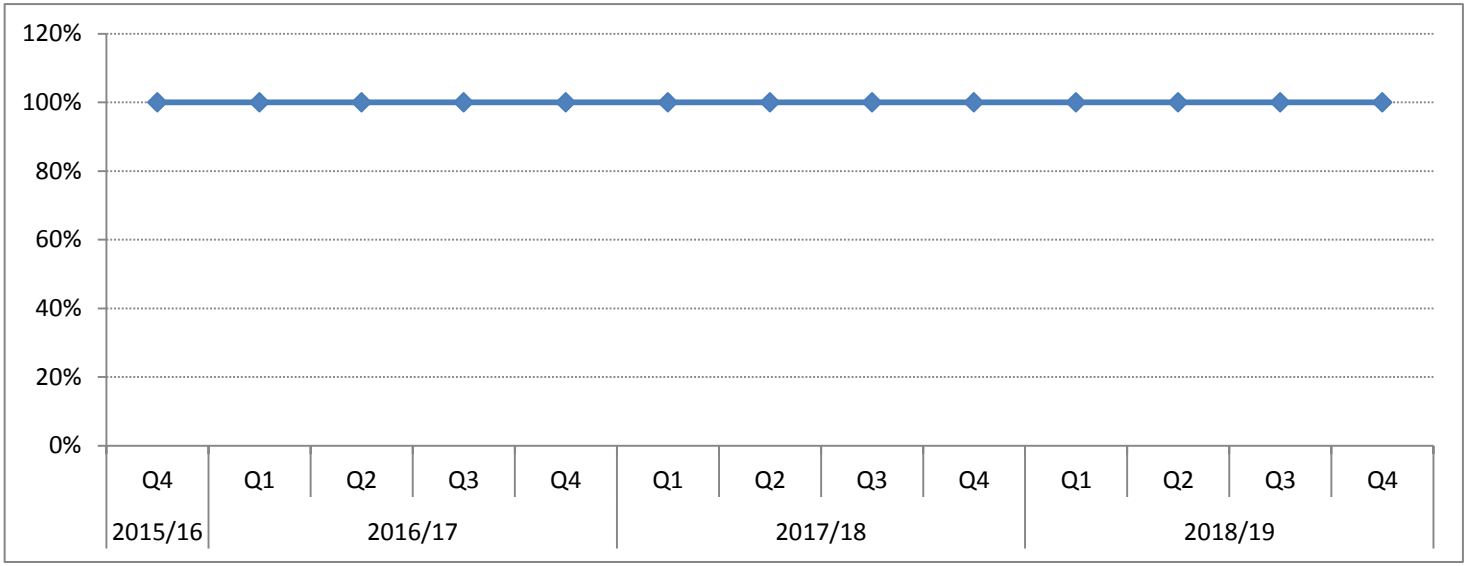
L12 A&E Attendance rates per 1000 population (All Ages)

Financial Year		
2015/16	Q4	59.7
2016/17	Q1	59.6
	Q2	61.0
	Q3	57.4
	Q4	53.1
2017/18	Q1	60.3
	Q2	59.9
	Q3	56.1
	Q4	57.6
2018/19	Q1	63.8
	Q2	62.6
	Q3	58.0
	Q4	59.4



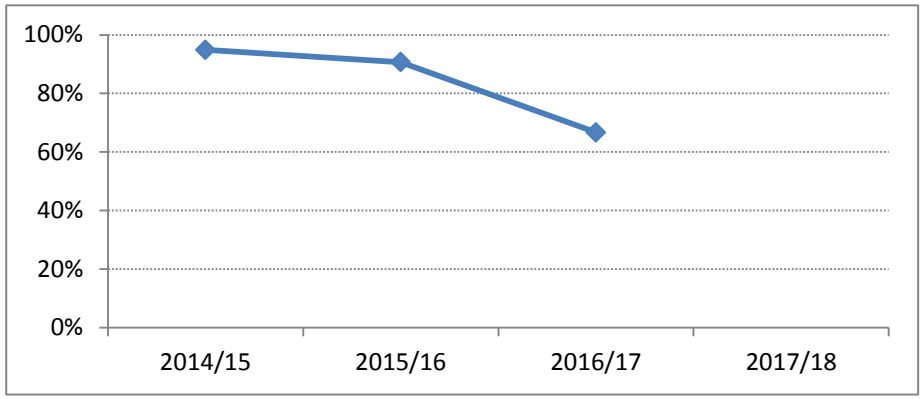
L13 A&E Percentage of people seen within 4 hours, within community hospitals

Financial Year		
2015/16	Q4	100.0%
2016/17	Q1	100.0%
	Q2	100.0%
	Q3	100.0%
	Q4	100.0%
2017/18	Q1	100.0%
	Q2	100.0%
	Q3	100.0%
	Q4	100.0%
2018/19	Q1	100.0%
	Q2	100.0%
	Q3	100.0%
	Q4	100.0%



L14 Percentage of new dementia diagnoses who receive 1 year post-diagnostic support

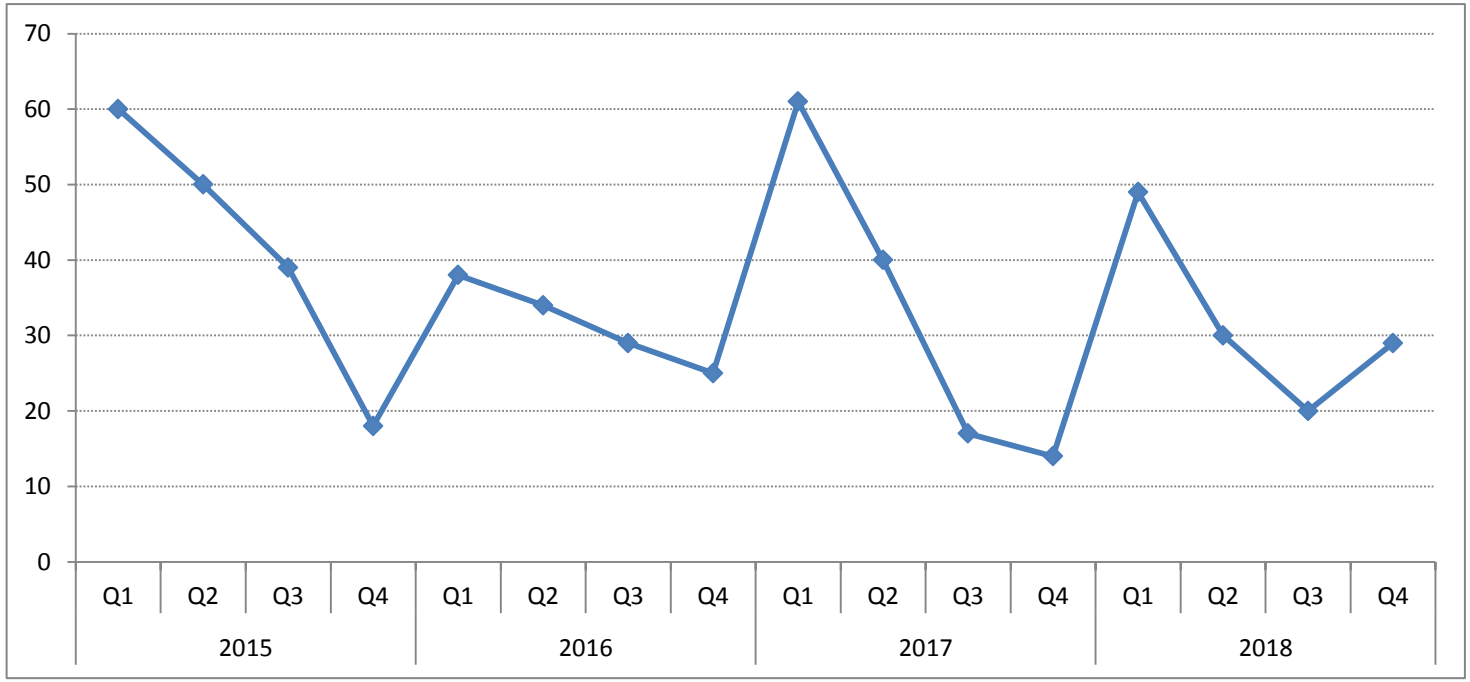
Financial Year	
2014/15	94.9%
2015/16	90.7%
2016/17	66.7%
2017/18	



L15 Smoking cessation in 40% most deprived after 12 weeks

Calendar Year

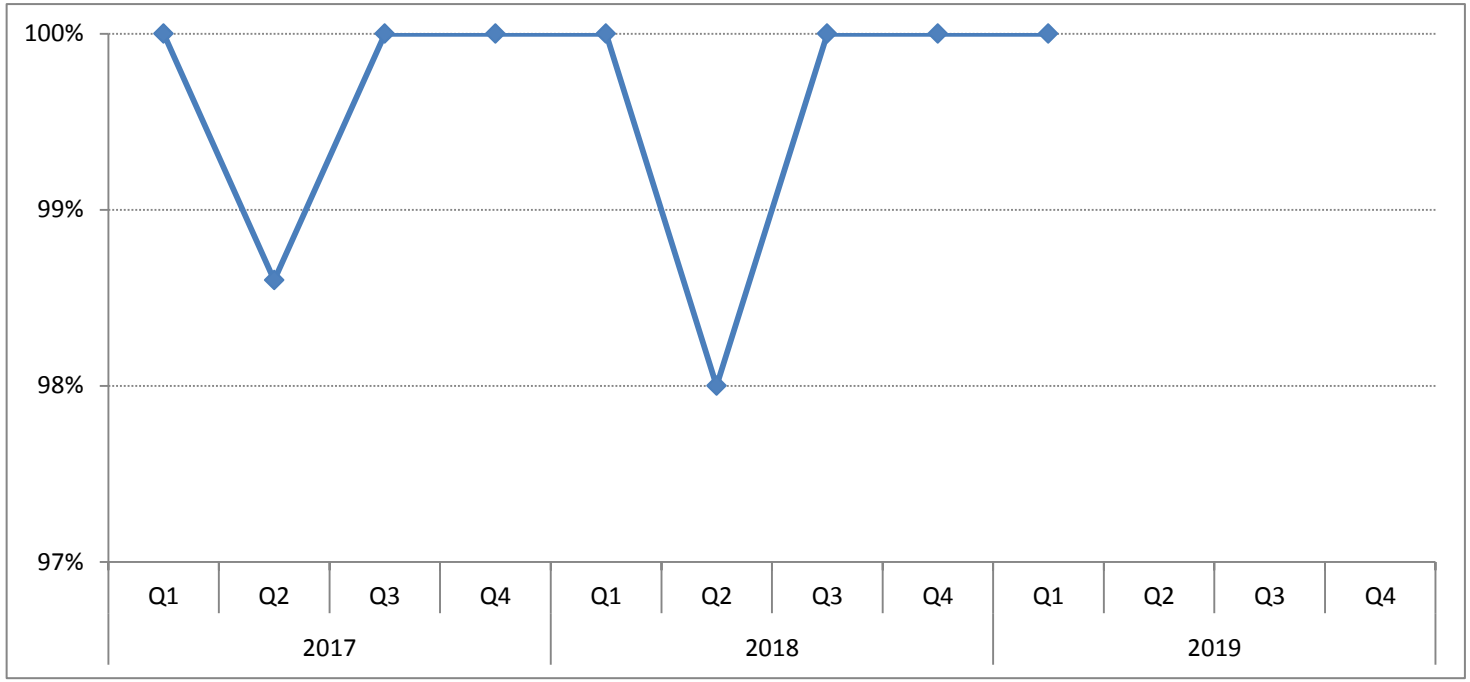
2015	Q1	60
	Q2	50
	Q3	39
	Q4	18
2016	Q1	38
	Q2	34
	Q3	29
	Q4	25
2017	Q1	61
	Q2	40
	Q3	17
	Q4	14
2018	Q1	49
	Q2	30
	Q3	20
	Q4	29
2019	Q1	
	Q2	
	Q3	
	Q4	



L16 Percentage of clients receiving alcohol treatment within 3 weeks of referral

Calendar Year

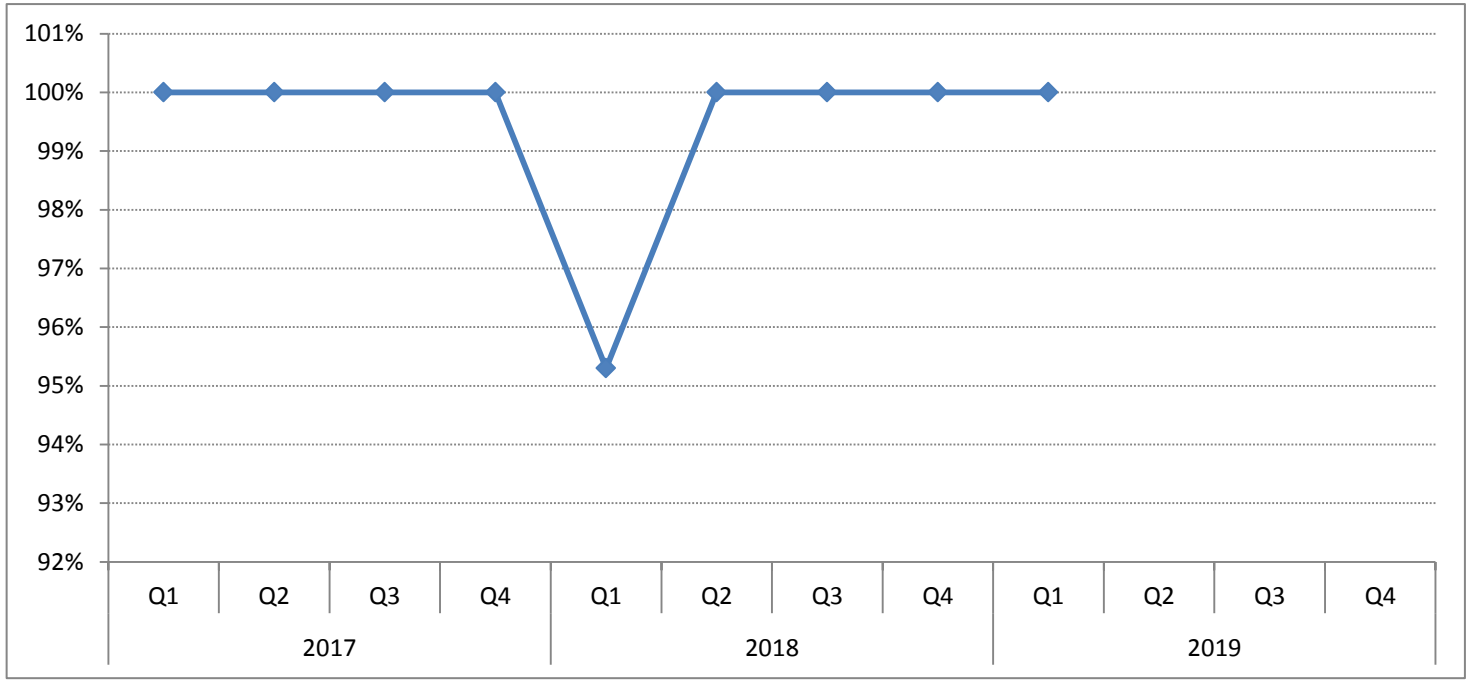
2015	Q1	
	Q2	
	Q3	
	Q4	
2016	Q1	
	Q2	
	Q3	
	Q4	
2017	Q1	100.0%
	Q2	98.6%
	Q3	100.0%
	Q4	100.0%
2018	Q1	100.0%
	Q2	98.0%
	Q3	100.0%
	Q4	100.0%
2019	Q1	100.0%
	Q2	
	Q3	
	Q4	



L17 Percentage of clients receiving drug treatment within 3 weeks of referral

Calendar Year

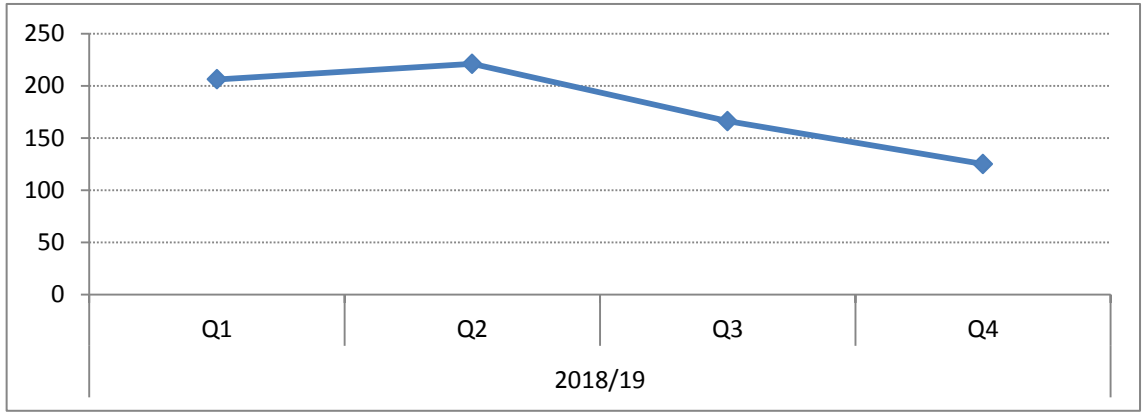
2015	Q1	
	Q2	
	Q3	
	Q4	
2016	Q1	
	Q2	
	Q3	
	Q4	
2017	Q1	100.0%
	Q2	100.0%
	Q3	100.0%
	Q4	100.0%
2018	Q1	95.3%
	Q2	100.0%
	Q3	100.0%
	Q4	100.0%
2019	Q1	100.0%
	Q2	
	Q3	
	Q4	



L18 Number of Alcohol Brief Interventions being delivered (includes ABIs in priority and wider settings where data can be aligned to HSCP)

Financial Year

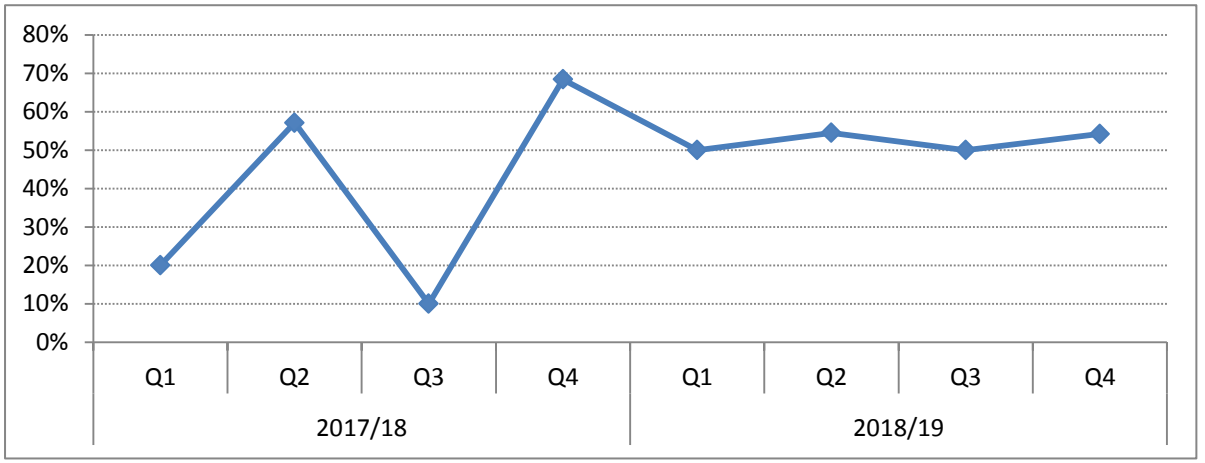
2017/18*	Q1	66
	Q2	59
	Q3	106
	Q4	142
2018/19	Q1	206
	Q2	221
	Q3	166
	Q4	125



* Prior to 2018/19 only ABIs done in GP practices were recorded at partnership level, therefore previous years are not comparable

L19a **Number of complaints received and % responded to within 20 working days - NHS**

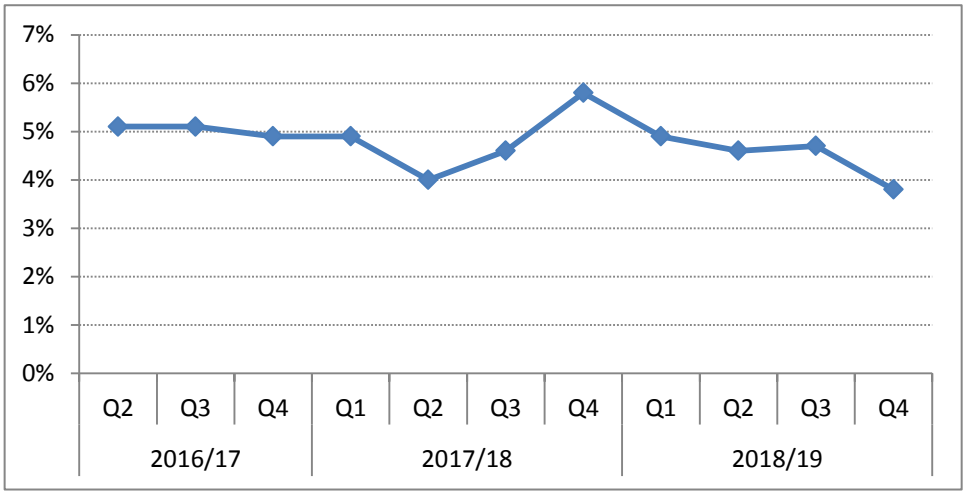
Financial Year		Total number	Done in 20 days	
2017/18	Q1	10	2	20.0%
	Q2	14	8	57.1%
	Q3	10	1	10.0%
	Q4	19	13	68.4%
2018/19	Q1	8	4	50.0%
	Q2	11	6	54.5%
	Q3	18	9	50.0%
	Q4	24	13	54.2%



L20 NHS Sickness Absence % of Hours Lost

Financial Year

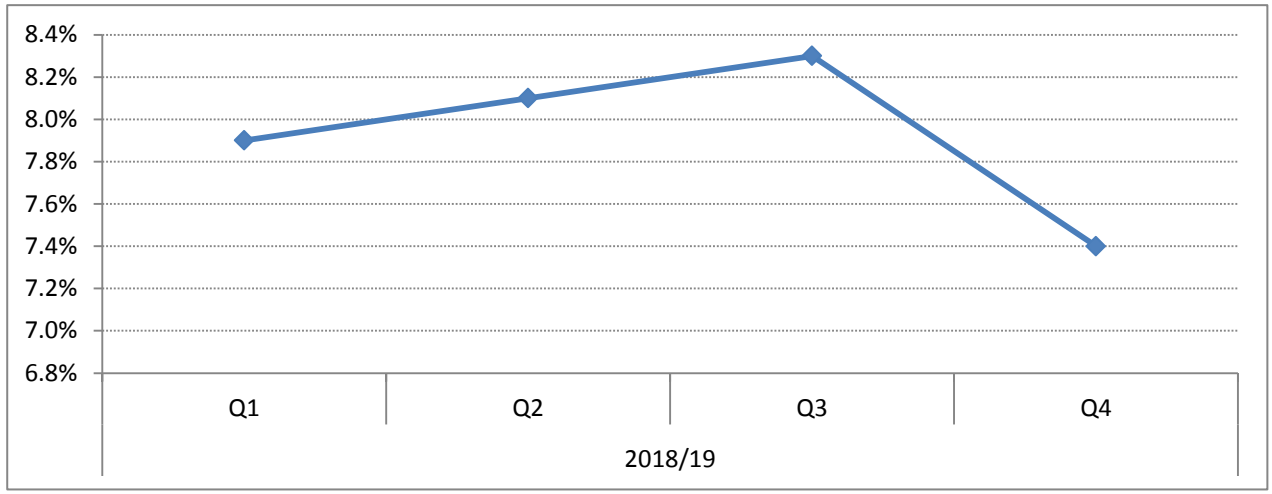
2016/17	Q2	5.1%
	Q3	5.1%
	Q4	4.9%
2017/18	Q1	4.9%
	Q2	4.0%
	Q3	4.6%
	Q4	5.8%
2018/19	Q1	4.9%
	Q2	4.6%
	Q3	4.7%
	Q4	3.8%



L21 Council Sickness Absence (% of Calendar Days Lost)

Financial Year

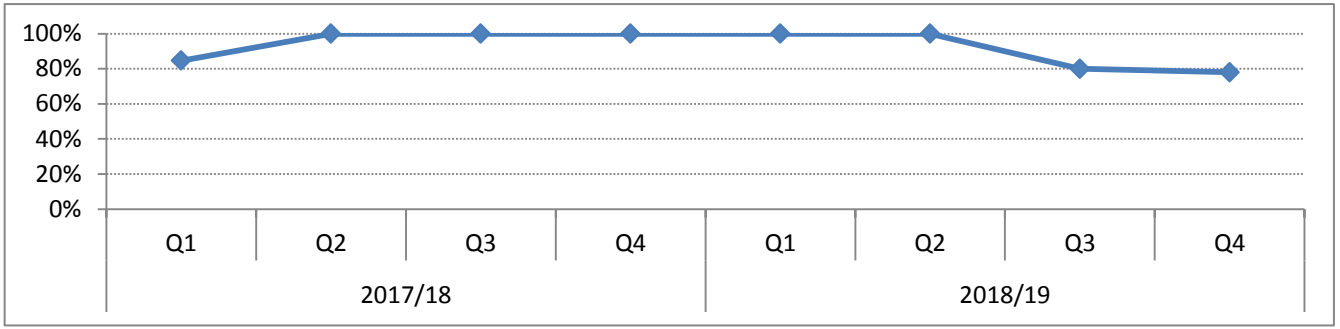
2018/19	Q1	7.9%
	Q2	8.1%
	Q3	8.3%
	Q4	7.4%



L41 Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral (adults only)

Financial Year

2017/18	Q1	84.6%
	Q2	100.0%
	Q3	100.0%
	Q4	100.0%
2018/19	Q1	100.0%
	Q2	100.0%
	Q3	80.0%
	Q4	78.0%



HSCM Q4 PERFORMANCE ANALYSIS

Indicators not Achieving Target in Q4 (RED)

L14 Percentage of new dementia diagnoses who receive 1 year post-diagnostic support

(No update on this measure from Q3, below is the narrative as given in Q3)
Management figures (not yet officially published) show Moray at over 95% for this measure in 2017/18. This is a significant increase on 66.7% in 2016/17 and is higher than the Scottish Average and our neighbours in Aberdeenshire and Highland as well as other comparators (Stirling and Angus). Following publication of this data, more accurate comparison will be possible.

In 2016/17 there was a change in the management of the service from Alzheimers Scotland Post Diagnostic Support (PDS) Link Worker to the Community Mental Health Team who have two Support Workers undertaking PDS on a part time basis and Community Psychiatric Nurses provide services for those who require more complex follow up. Data regarding this service is now collected and monitored monthly. The raw numbers of those who have undergone PDS have risen from 29 in 2016 to 135 in 2018 (currently only calendar year figures are available) which show that the current system is able to provide support within the 12 months for more people.

L18 Number of Alcohol Brief Interventions being delivered *(includes ABIs in priority and wider settings where data can be aligned to HSCPs)*

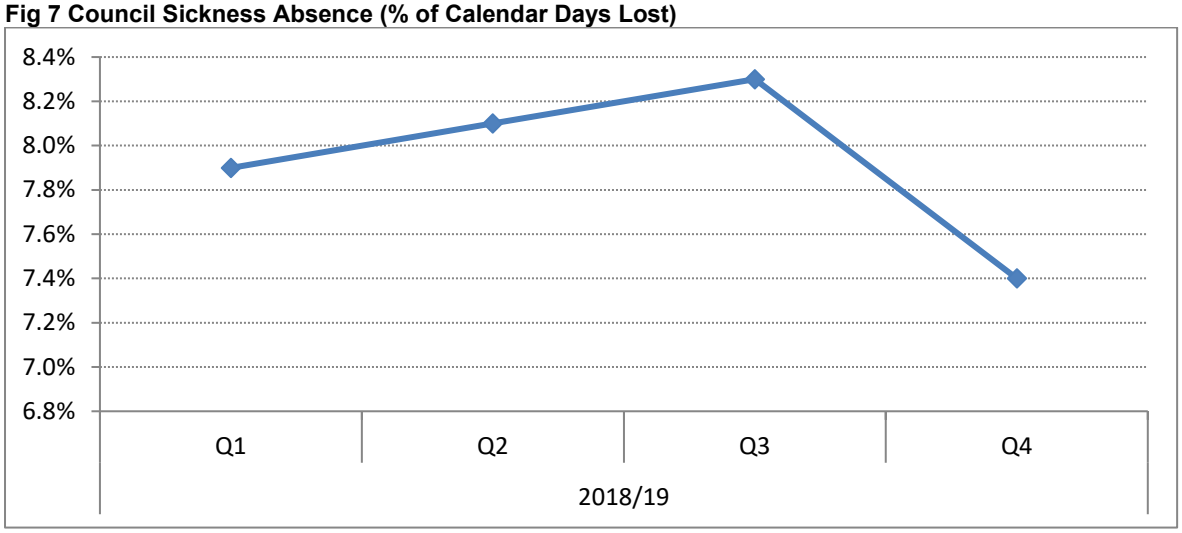
The target for Moray is a very ambitious target. It is, however, also noteworthy that there are some key settings where alcohol screening and brief interventions take place - for example in the emergency department of Dr Gray's Hospital. In DGH, implementation of alcohol screening has been led by the Emergency Department physicians. This has been done because it is in line with best practice recommended by the college of emergency medicine. They have implemented a local protocol and use "drink more than you think scratch cards" to screen for alcohol related attendances. They provide feedback and a leaflet based on the score. Technically this would count as a brief intervention, however these are not counted due to the substantial additional work that it would create and have no plans to put in place a counting scheme as it risks destabilising this clinical practice.

Nevertheless the performance is falling short of the target. In early 2019, a strategy for Alcohol screening and Alcohol brief intervention was taken to the Moray Alcohol and Drug Partnership (ADP) and approved for implementation (Refer to **APPENDIX 4**). The action plan is continues to be developed with ADP partners taking a lead role in implementation. Areas that are being developed include - antenatal settings, integration with self-management approaches (taking a holistic approach to self-management), justice settings etc. A more detailed action plan is being developed and worked up by the ADP and will support the LOIP priority on alcohol.

L21 Council Sickness Absence (% of Calendar Days Lost)

The percentage of days lost in the council contracted staff is recorded as 7.4% which is a reduction from Q3 but still above the council target of 5.9%.

Fig 7 Council Sickness Absence (% of Calendar Days Lost)



Absence management remains a standing item on the agenda of the monthly Provider Services management meeting, specific actions have already been undertaken by the internal homecare services management team which are starting to yield results.

- This has included a 100% staff retention rate at Woodview as the service has expanded to over 100 staff.
- Homecare has seen a reduction in long term sickness due to individuals now receiving 1:1 return to works, where originally telephone interviews were being used.
- Monitoring processes are in place across the whole of Provider Services, as part of a KPI system that has been developed and is focusing on WTE staff absence for each service, several of which have returned 0% absence rates for the last quarter.

Whilst the return to work interviews ensure consistency across the service and compliance with current policies; the process further supports staff to open up about issues that they may need support with and further is supporting teams that are relied on to fill the pressures that long term absence creates.

L41 Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral

Mental Health Services have identified three areas where improvements can be made and below are those areas and actions being undertaken:

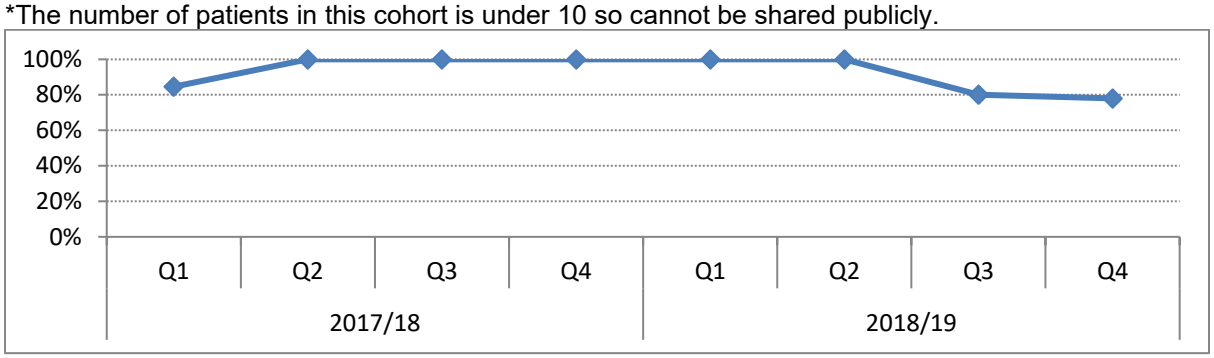
Staff vacancies – the adult mental health psychology team have carried a 1.0 whole time equivalent (wte) clinical psychology vacancy since July 2018. Interviews for this post are taking place on 26 June 2019. Following interview, a 0.48 wte band 6 primary care psychological therapist has been appointed, awaiting confirmation of start date. This post is for 6 months due to availability of funding.

Referrals – referrals into primary care and secondary care are being reviewed and active management of waiting lists is taking place. Psychotherapy referrals

increased again in May 2019 but the team continues to meet the target for patients treated within 18 weeks due to active waiting list management.

Resource allocation – across adult and primary care teams there has been prioritisation of the longest waits rather than patients waiting to be seen in their geographical catchments.

Fig 8: Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral*
*The number of patients in this cohort is under 10 so cannot be shared publicly.



Grampian Alcohol Screening and Brief Intervention Strategy 2018- 2021

Our vision for success is that in 2021

Alcohol screening part of the day-to-day practice of frontline staff and volunteers who work with people who are at risk of experiencing harm from alcohol. People are offered information, advice and support which help them change their behaviour or address the underlying reasons which contribute to high risk alcohol consumption.

The public health system's role in preventing alcohol harm through screening and brief intervention

- The public who make choices about their lives and are affected, informed and influenced by the social, physical, cultural and political environment around them
- The voluntary and community sector – influences people's choices by providing information, services, volunteering opportunities, employment.
- Health and social care workers, primary care – influence people's choices during planned and unplanned contacts, provide information and services. Responsible for prevention and self-management of chronic disease approaches.
- Criminal justice service providers – influence people's choices during contact, provide information, routes into treatment and care
- Industry – particularly in the context of providing employment and efforts to improve employee wellbeing

Grampian Alcohol Screening and Brief Intervention Strategy 2018 - 2021

Tara Shivaji, CPHM, NHSG, Approved by the Grampian ABI strategic Group 13.09.2018

Our health today, why we need to improve

The UK Chief Medical Officer published recommendations on low risk alcohol consumption in 2016. High risk alcohol consumption is associated with an increased risk of physical health, mental health, social and economic impacts in the short medium and long term.

Low risk consumption as no more than 14 units of alcohol spread through a week. People with long term conditions and those on regular medication may be recommended to drink less than 14 units. Pregnant women and those planning a pregnancy are recommended to not drink any alcohol at all.

Source: NHS Grampian, DPH annual report 2017

Alcohol is one of five lifestyle behavioural risk factors which contribute to the majority of the burden of chronic and non-communicable disease. Clustering of lifestyle risk factors is associated with higher risk of premature disease development and mortality[1]. Research within Grampian into the clustering of lifestyle risk factors indicates that these are spread unevenly through the population, increased multiple lifestyle risk factors were observed in men and in people from socioeconomically deprived neighbourhoods.

Alcohol screening

Screening is a process that differentiates people who have, or are at risk of having, a condition from those who do not. In the alcohol screening, the objective is to identify:

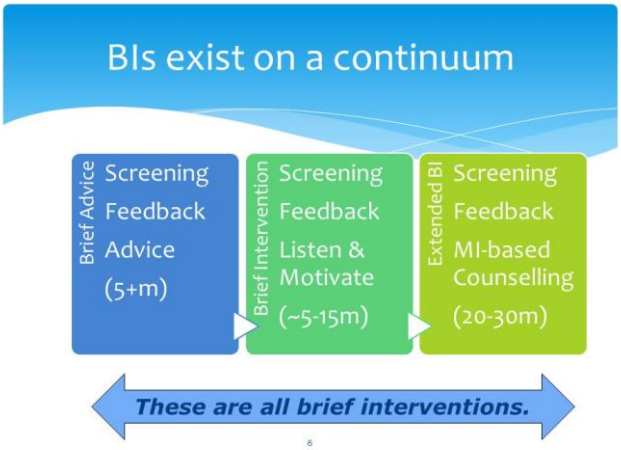
- People whose consumption presents risk of harm to themselves or others
- People who are beginning to experience problems and signs of alcohol dependence.

Alcohol screening should identify both high risk drinking, a pattern of regular excessive or occasional high intensity drinking that increases the risk of alcohol-related harm, and alcohol dependence, or alcoholism. A range of validated screening tools exist which offer professionals and others a systematic way of asking about alcohol.

Alcohol Brief Intervention

There is no formalised definition of an alcohol brief intervention (ABI).It is generally described as:

a short, evidence-based, structured conversation about alcohol consumption with a person that seeks to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and their risk of harm.



Source: Dr Niamh Fitzgerald, http://slideplayer.com/slide/10629505/

Where will the impact of the alcohol screening and brief intervention be seen?

Impact of alcohol screening

Systematic alcohol screening within services and agencies who work directly with people will lead to an improved identification of individuals who are probably alcohol dependent and require additional support. We would expect to see an increase in referrals to alcohol services from partner agencies implementing systematic alcohol screening.

Impact of ABIs

In 2014, NHS Health Scotland recommended ABIs as a prevention best buy[2].

Evidence of effectiveness in primary care

The 2007 Cochrane review by Kaner, individuals who received an ABI consumed an average of four fewer units of alcohol per week one year after the intervention[3]. The evidence base has been challenged by the publication of large pragmatic trials where no or a modest minimal effect was demonstrated[4] suggesting that the efficacy observed in trial environments does not necessarily translate to effectiveness in practice. The pragmatic trials showed that patients in the control group who received screening and usual care had significant reductions in their drinking, suggesting that the active ingredient of ABI programmes might be screening itself rather than the intervention that follows.

Evidence of effectiveness in Emergency Departments and Unscheduled Care Settings

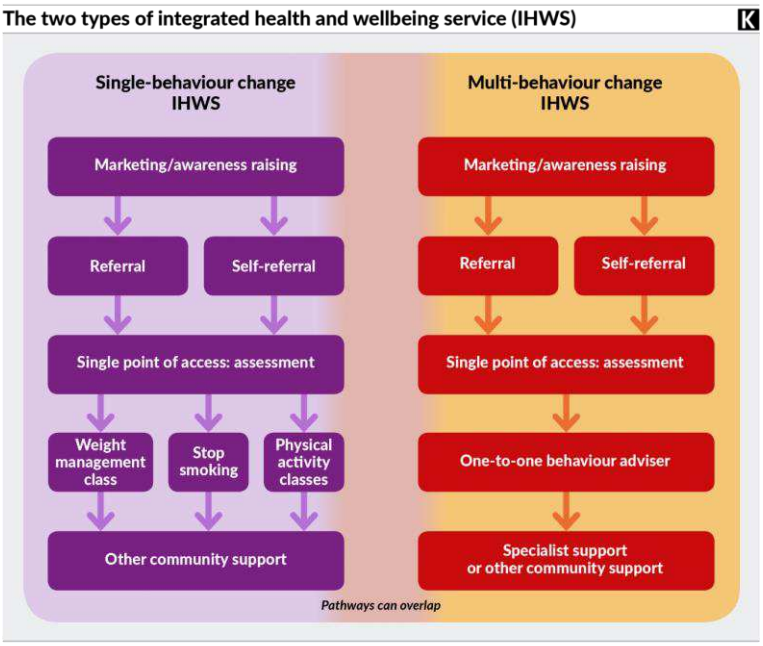
The evidence base for accident and emergency settings is small and includes interventions like personalised mail feedback (rather than structured conversations in the department) which show a small but significant effect associated with reduced consumption at 1 year[5].

Evidence of effectiveness in wider settings

The National Institute for Health and Care Excellence (NICE) recognises the limitations of the evidence base but identifies social care, criminal justice, sexual health and other community or voluntary sectors already engaged with the wider alcohol risk reduction agenda as appropriate settings[6].

Evidence Base on clustered lifestyle risk factors

Clustering has a significant effect on life expectancy and contributes to the inequalities seen. Addressing the clustering of risk factors and, at the same time, addressing their determinants is necessary to reduce inequality and improve population health[7]. Unhealthy behaviours do not respect organisational boundaries, and some of the best partnerships on addressing multiple risk factors occur when local authorities, the NHS and other partners set up formal referral routes between them.



Source: Kings fund (2018)[8]

Intended impacts of ABIs

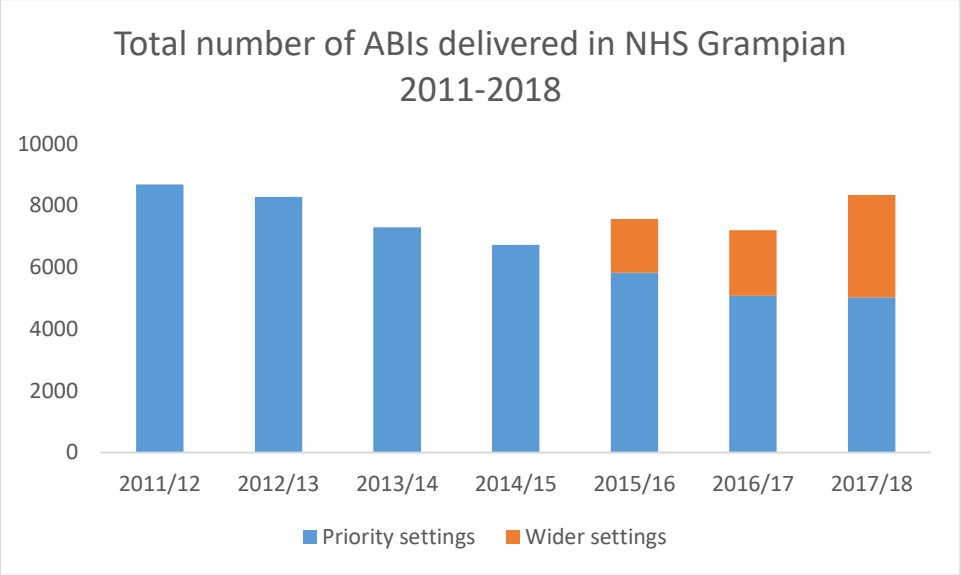
In supporting an individual to reduce their risk of experiencing harm, an ABI is an intervention which contributes to

- Primary prevention (in the prevention of Foetal Alcohol Spectrum Disorder)
- Secondary prevention of the development of health conditions or social impacts associated with high risk alcohol consumption
- Self-management of long term conditions and reduced risk of health complications

Our achievements to date

Scottish Government requirements for ABI delivery are contained within the Local Delivery Plan (LDP) standard (2018/19). NHS Grampian, Aberdeen City, Aberdeenshire and Moray ADP (and by virtue of the partnership link IJBs) are required to continue to embed ABIs into routine practice.

The target number of ABIs allocated to NHS Grampian is 6658. A minimum of 5326 interventions must be delivered in the priority settings of accident and emergency, primary care and antenatal care. The recent growth in ABI numbers is attributable to development of ABI capacity in wider settings.



Source: NHS Grampian, ISD return 2017/18

Most ABIs are delivered in primary care, although there is significant variation between practices which does not directly correspond to variation in need or rates of alcohol related deaths or rates of alcohol related hospital admissions. Primary care is the only setting where practitioners are paid for each ABI recorded as delivered under a locally enhanced service.

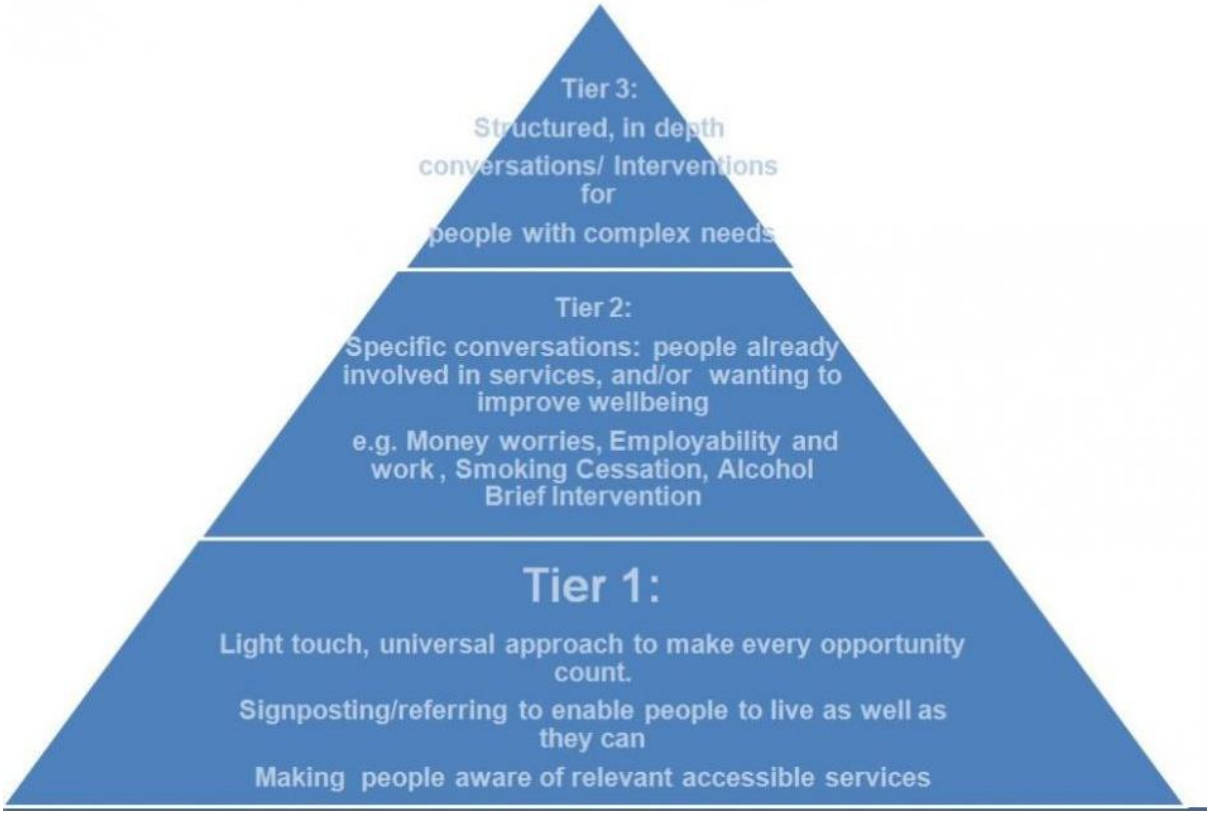
New and emerging opportunities

Making Every Opportunity Count (MEOC)

NHS Grampian has developed an overarching sustainable and inclusive approach for partnership working that makes real our shared commitment to enabling prevention and self-management. The framework (below) maximises opportunities for people, places, systems and services. It acts as a guide to the nature and scope for conversation and action, creating an environment where it is normal to ask about people's wellbeing. Framing the conversation as an opportunity to raise awareness about risk enables the person using services make an informed choice. It puts people first and starts to take account of the clustering of lifestyle risk factors and the associated socio-economic circumstances which shape them. Alcohol screening and brief interventions are an integral part of this approach which has been adopted by a number of partner agencies.

Grampian Alcohol Screening and Brief Intervention Strategy 2018 - 2021

Tara Shivaji, CPHM, NHSG, Approved by the Grampian ABI strategic Group 13.09.2018



Source: NHS Grampian, Making Every Opportunity Count (MEOC)

Alcohol Brief interventions are a tier 2 intervention under the NHS Grampian MEOC approach. Alcohol screening can be delivered at tier one followed up by signposting or referral to a service that offers tier 2 interventions or at tier 2.

Tier 3 interventions are those offered by specialist substance misuse services and our commissioned partner providers (ADA, Turning Point and Arrows). This level of intervention is necessary for individuals with high scores on alcohol screening suggestive of alcohol dependence or other problematic alcohol use. ABIs are not clinically indicated in these individuals.

What the MEOC approach permits is recognition of the referral pathways and signposting needs of our partners involved in screening and brief interventions, not just to specialist services but to other organisations which may be able to provide support with some of the issues underlying high risk alcohol consumption.

Recognition of alcohol as a local priority

Alcohol has been identified as a priority by health and social care partnerships in a number of locality plans (health and social care). The issue of alcohol has also been identified by some community planning partnerships as a local outcome improvement priority (LOIP) and as a key improvement indicator for priority local areas. The relationship between alcohol and criminal justice services and settings has been recognised by some community justice partnerships. This recognition should be supported by public health teams to turn into local

ownership and leadership to continue to develop the alcohol screening and brief interventions program via partnerships. The implications for alcohol screening and brief intervention are that we will work with partners from housing, Police Scotland, Criminal Justice Social Work, HMP Grampian, Care providers and others to embed alcohol screening in appropriate assessment tools. We will look to build on the existing work at locality level of MEOC and look at ways of providing more intense support for those requiring level two or three interventions.

General medical services contract 2017

The general medical services (GMS) contract in 2017 set out the future direction and role of general practitioners and the wider primary care support team. The implication for the Alcohol screening and ABI programme as we go forwards is that alcohol should become part of the self-management agenda, consistent with the approach set out in the NHS Grampian and HSCP Clinical Strategies. We will engage with the wider primary care team to identify the relevance of raising the issue of alcohol within the context of their contact with a patient and look to move away from a GP led model of delivery. To ensure systematic approaches to self management, we will work with House of Care and other self-management initiatives to ensure that alcohol is considered and staff are able to support patients improve their wellbeing through changing their relationship with alcohol.

Implementing Alcohol Screening and brief interventions facilitators and barriers

This information was collected by the Grampian Alcohol Brief Intervention Strategic Group. ABI trainers, existing providers were questioned on a one to one basis about facilitators and barriers to alcohol screening and ABI implementation in practice

Barriers to implementing alcohol screening and brief interventions

- Asking about alcohol seen as invasive, fear of offending patient / client and ultimately compromising trust
- The links between alcohol and patient / client presentation are not clear so an ABI perceived as 'additional' and outside of normal business
- Excessive focus on targets
- Poor recording practice, focused on reporting to meet target. Report does not reflecting the reality of delivery and undermines the confidence of the individual or organisation
- Perception that intervention is time intensive in relation to overall workload and other commitments and pressures
- ABI currently 'process heavy', overly complex, 'standalone' and inflexible, a perception reinforced by the current training model.

Facilitators to implementation

- Regular presentation-led opportunities to link condition or situation directly with alcohol consumption in a way that is flexible and amenable to practitioner's professional judgement
- Separate the screening from the rest of the consultation and ask patients to complete themselves
- Creating a climate where patients/ clients are conditioned to expect to be asked, regularly about lifestyle factors
- When practitioners develop the necessary skills, confidence and practice experience to identify and support clients with broader factors that may affect alcohol consumption (e.g. advising a pregnant woman whose partner is not supportive of her not drinking)
- Support and advice from peers who have more experience of screening and delivery
- Integrating alcohol assessment into standard assessment templates
- Identifying situations where patients and professionals find it acceptable to ask about alcohol
- Using recording to drive improvement, rather than respond to a target

- Clarity about which services patients / clients can be signposted or referred to, when and how.
- Framing the conversation as an opportunity to raise awareness about risk and enable the patient / client to make an informed choice.

How are we going to achieve our vision of embedded and sustainable alcohol screening and brief intervention?

The core themes of our strategy are

Create an environment where it is normal to ask about alcohol

Western medical culture is traditionally focused on disease management and "quick fixes" that "medicalise society's problems" rather than adopting a more biopsychosocial approach. Greater awareness of who is at risk (including family and people around the patient) and embedding assessment into routine assessments can help normalise the alcohol question.

Participatory approaches that engage those delivering ABIs may also be helpful in creating a culture of reflection and an environment where asking about alcohol is the norm.

Higher consumption amongst higher paid staff, reluctance to engage maybe be conscious or subconscious. It is important to raise awareness about these barriers and present alcohol screening and brief intervention as an opportunity for a patient to make an informed decision about their health and wellbeing. It is also important to present messages about the normality of low risk drinking to further reinforce this approach and highlight the abnormality and unacceptability of drinking in a high risk way.

Ask more

It is possible that engaging patients in a discussion about their alcohol use, within the context of the specific professional relationship stimulates behaviour change. Numerous validated screening tools exist such FAST, AUDIT, AUDIT-C, PAT etc. Where possible, a formal screening instrument, validated for that particular context, should be used to ensure a systematic approach and consistency. Ideally this should be embedded into routine assessment tools, where appropriate to do so.

In primary care, health professionals have found it difficult to implement screening questionnaires broadly in routine practice. Getting comfortable with asking a question about alcohol consumption is an important first step in addressing the under-detection of high risk alcohol consumption[9]. This approach would be consistent with a level one light touch conversation in the MEOC framework.

Build trust and acceptability with patients / clients

When embedding alcohol screening and brief intervention in any context where professionals are concerned about compromising the patient/ client relationship, a possible

solution is to initially target presentations where alcohol assessment is widely known to be acceptable to the general public. In primary care, these scenarios include new patient registrations, health assessments / checks, chronic disease assessment and care planning, mental health assessment and care planning[9], medication review.

Build on the assets of the professional team

Many roles are linked to health and wellbeing and there are some existing settings where the team structure and dynamic will change. For example, the 2018 Scottish GP contract describes a broad multidisciplinary team supporting primary care, each having a specific but complimentary role to another. Raising professional's awareness about the impact of alcohol consumption on their specific area or role is necessary to achieve buy in. The roles of team members are particularly relevant to the management of multiple clustered lifestyle risk factors and addressing health inequality. The MEOC framework should act as a guide to the nature of conversation and professional action indicated.

Use recording to drive quality improvement.

Understanding the number of ABIs delivered in the context of a system or organisation can be helpful in driving change. This would allow the organisation to assess, the meaning of the number of ABIs delivered, as a percentage of all eligible presentations[9]. This could provide a more effective stimulus for improvement than centrally allocated targets. Quality improvement methodology such as PDSA and others could be used to drive focused efforts of improvement. To support sustainability, the learning generated from improvement cycles should: inform adaptation and evolution of the ABI programme, it should also be shared with others[10], a role that the ABI leads within HSCPs could take on.

Some organisations find tracking individual performance (the number of ABIs delivered by a specific individual) helpful for stimulating discussion and change. It may be helpful in identifying examples of positive deviance that could serve as peer support or a champion in that setting.

Sustainability

The focus of sustainability in this context include concepts such as: 'sustainable programmes', 'sustainable practice', 'sustainable capacity' and 'sustainable outcomes'. Commitment and support from multiple levels of management within the host and its partner organizations is critical for sustainability[10]. A sustainable initiative is one that is responsive to the needs of the community and **evolves** and adapts as evidence emerges[10], this strategy and associated action plan should be reviewed after 3 years.

Grampian Alcohol Screening and Brief Intervention Strategy 2018 - 2021

Tara Shivaji, CPHM, NHSG, Approved by the Grampian ABI strategic Group 13.09.2018

What are we going to do over the next three years

2018-2019

Seek endorsement of the alcohol screening and brief intervention strategy from management and leadership groups

Undertake tests of change with wider primary care team members, housing services, care providers, emergency department practitioners

Provide one to one support to general practice to make the links between long term condition self-management, alcohol screening and brief intervention.

Provide support to partners developing alcohol screening and brief intervention approaches in their organisations or groups

Increase trainer capacity

2019-2020

Undertake a test of change for embedding systematic alcohol screening within the acute health care sector

Scale up tests of change undertaken in previous years

Provide support to partners developing alcohol screening and brief intervention approaches in their organisations or groups

Embed alcohol screening and brief intervention across criminal justice social work and improve coverage within police custody

Plan evaluation of sustainability of current approach

2020-2021

Conduct evaluation of sustainability

Develop revised strategy

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REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 AUGUST 2019**

SUBJECT: **REVENUE BUDGET MONITORING QUARTER 1 FOR 2019/20**

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 2019 for the MIJB budget.

2. RECOMMENDATIONS

2.1 It is recommended that the MIJB:

i) note the financial position of the Board as at 30 June 2019 is showing an overspend of £837,040;

ii) note the progress against the recovery plan;

iii) 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 2019 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 2019 is shown at **APPENDIX 1.** The figures reflect the position in that the MIJB core services are currently over spent by £790,498. This is summarised in the table below.

	Annual Budget £	Budget to date £	Expenditure to date £	Variance to date £
MIJB Core Service	114,967,355	28,804,230	29,594,728	(790,498)
MIJB Strategic Funds	4,583,900	141,034	187,576	(46,542)
Set Aside Budget	11,765,000			
Total MIJB Expenditure	**131,316,255**	**28,945,264**	**29,782,304**	**(837,040)**

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

4. KEY MATTERS/SIGNIFICANT VARIANCES FOR 2019/20

4.1 Community Hospitals & Services

4.1.1 There are continuing overspends within community hospitals and services for the four localities: Elgin, Buckie, Forres and Keith/Speyside totalling £174,012 to 30 June.

4.1.2 Overspends continue to be realised for the services. The main overspend relates to community hospitals in Buckie £74,719, Forres £67,336 (where the cost is to be reallocated to Community service) and Keith/Speyside £64,123. The overspend in Buckie and Keith are mainly longstanding and relate to staffing. Managers continue to seek to actively manage this. This is reduced by an underspend on administrative and other services £32,166.

4.2 Learning Disabilities

4.2.1 The Learning Disability service is overspent by £102,816. The overspend is primarily due to overspends on the purchase of care for people with complex needs of £121,785 which includes young people transitioning from children's services and people being supported to leave hospital; less client income received as expected of £14,527 and other minor variances totalling £828. This is being offset by underspends on staffing of £34,324, mainly relating to physiotherapy, speech and language and psychology services.

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

4.3 Mental Health

4.3.1 Mental Health services are overspent by £48,673. This includes overspends on senior medical staff costs including locums £33,211, Allied Health Professionals £7,767, supplies and equipment £1,592, and other costs including an efficiency target yet to be achieved £23,586, less income received than expected £2,444 and assessment and care £1,166, which is being reduced by an underspend in nursing £21,093. Services have continued to be delivered where funding has been reduced or withdrawn and management are considering this within the overall redesign of Mental Health services.

4.3.2 This redesign of medical services will result in a reduction in the number of sessions delivered equating to 0.5 whole time equivelant senior medical staff.

4.4 Care Services Provided In-House

4.4.1 This budget is underspent by £71,586. This primarily relates to staffing costs in Care at Home service £97,543, Community Support workers £62,294, which is reduced by a minor overspend in the challenging behaviour unit of £8,727. This is being further reduced by overspends in Day Care of £51,656 (due to a full year saving taken but the decision was not approved by MIJB until 27 June 2019 (paragraph 4 of the draft Minute refers)), less income received than expected £16,216 and other minor variances totalling £11,652.

4.4.2 In-House provided care is being closely monitored in relation to the ongoing changes within the service to ensure budget can be aligned accordingly.

4.5 Older People and Physical Sensory Disability (Assessment & Care)

4.5.1 This budget is overspent by £292,087. This includes an over spend for domiciliary care in the area teams £232,085, less income received than anticipated £39,141, client transport £17,019 and other minor variances of £3,842. 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.

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

4.6 Care Services Provided by External Contractors

4.6.1 This budget is overspent by £69,906. This relates to prior year savings not yet achieved of £36,000, due to the Board approving an extension for exiting grant funded services; increase costs for waking night cover £14,285, increase in OLM Systems Ltd licences £4,867 and other minor overspends totalling £14,754.

4.6.2 The MIJB has requested that information be presented to them by January 2020 to enable a framework to be developed to facilitate prioritisation of the grants made to third sector groups/organisations.

4.6.3 Work is underway to explore alternative models for overnight provision which maintain positive outcomes for service users whilst being more efficient. The work is monitored by the Learning Disability Transformational Change Programme Board. Social Workers are currently consulting with service users and families prior to the commencement of a 12 week pilot and subject to approval by the Board through a separate report to this meeting.

4.7 Other Community Services

4.7.1 This budget is underspent by £75,151. This relates to underspends in Allied Health Professionals (AHP's) £27,345, which includes Speech and Language

Therapy where ongoing difficulties are being experienced in recruitment, Dental £39,233 where underspends exist in Community Dental services arising from staffing, Public Health £15,393 where timing of expenditure within Moray Collective has impacted upon the position to date and Specialist Nursing services £5,778 where there is an ongoing vacancy in the Oaks service. These underspends are offset in part by an overspend in Pharmacy £12,598 which is related to staff costs that are expected to continue.

4.8 Primary Care Prescribing

4.8.1 The primary care prescribing budget is reporting an over spend of £256,675 to June 2019. As actual information is received two months in arrears, this position is only based on one month's actual spend plus an accrual for May and June. The position reflects the continuation of overspend from 2018/19 and is consistent with expectation. Locally, medicines management practices continue to be applied on an ongoing basis to mitigate the impact of external factors as far as possible and to improve efficiency of prescribing both from clinical and financial perspective.

5. STRATEGIC FUNDS

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

- Integrated Care Fund (ICF);
- Delayed Discharge (DD) Funds;
- Additional funding received via NHS Grampian (this may not be fully utilised in the year resulting in a contribution to overall IJB financial position at year end which then needs to be earmarked as a commitment for the future year).
- Provisions for earmarked reserves has been made to fund unutilised allocation for Primary Care Improvement Funds and Action 15 in 2019/ 20, identified budget pressures, new burdens and savings that were expected at the start of the year.

5.2 By the end of the financial year, the Strategic Funds will reduce as the commitments and provisions materialise and the core budgets will increase correspondingly. The 2018/19 outturn position resulted in the MIJB having a deficit of £1,192,677 and a financial recovery plan was put in place, where the Recovery Plan will continue to be monitored and reported through 2019/20.

6. PROGRESS AGAINST THE RECOVERY PLAN

6.1 The financial recovery plan was submitted to the IJB on 29 November 2018, (para 18 of the minute refers) it was acknowledged that service redesign takes time to implement whilst ensuring the wellbeing of the population, as such the high level plan was for recovery over the years 2019/20 to 2021/22.

6.2 The progress against the recovery plan will be reported during the 2019/20 financial year. The following table details progress during the first quarter, however, this is early on in the financial year and more detailed progress will be available for quarter 2:

Theme	Para Ref	Full Year Target	Expected progress at 30 June 2019	Progress against target at 30 June 2019 Exceeded / (Shortfall)
		£	£	£
Mental Health		300,000	75,000	50,000
Care Services Provided In-House	6.3	500,00	125,000	(23,000)
Community Hospitals	6.4	100,000	25,000	(144,000)
Care Services Provided by External Contractors		350,000	87,000	294,000
Prescribing	6.5	200,000	50,000	(13,000)
Accountancy Driven		120,000	30,000	53,000
Total		**1,570,000**	**392,000**	**217,000**
Slippage	6.6	1,500,000		
Total Recovery Plan		**3,070,000**		

6.3 Care Services Provided In-House has fallen marginally short of the target for quarter 1. This continues to be considered in the context of balance of care and provision of service.

6.4 Community Hospitals has not met the target for quarter 1, however there are budget adjustments to be made totalling £276,000. Whilst this doesn't affect the bottom line it does improve the progress against the recovery plan to 30 June by £119,000 so the (£144,000) above would be reduced to (£25,000). The recovery plan option appraisal in relation to future models of care is still being developed.

6.5 Prescribing has not fully met the target for quarter 1 as the position to 30 June includes only one month of actual results. This may improve as the actual position is reported and local medicines management practices continue to be applied.

6.6 Slippage is difficult to gauge at this early stage of the financial year, so no figure is included for the first quarter, but is expected to be achieved during the year.

7. CHANGES TO STAFFING ARRANGEMENTS

7.1 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.

7.2 The staffing arrangements are noted in **APPENDIX 3** as dealt with under delegated powers for the period 1 January to 31 March 2019.

8. UPDATED BUDGET POSITION

8.1 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.

8.2 In addition, the MIJB, for the first time in 2018/19 concluded the financial year in an overspend position following the application of reserves. In line with the Integration Scheme, the funding Partners were called upon to meet this overspend in an agreed proportion. Communication has remained paramount throughout the year so the effects of the MIJB overspend could be built into the financial planning of NHS Grampian and Moray Council. These additional contributions are also show in the table below:

	£'s
Approved Funding 29.3.18	**128,938,000**
Amended directions from NHSG 10.7.19	46,457
Balance of IJB reserves c/fwd. to 19/20	256,863
Budget adjustments M01-M03	
Uplift (medical pay & other)	351,757
Primary Care Directed Enhanced Services	240,366
Public Health Earmarked Funds	211,918
Moray Alliance	40,596
Energy Uplift	30,059
Open University	15,000
Set Aside budget amendment	1,172,000
Improvement grants HRA	100
Other Minor Adjustments	13,137
Revised Funding to Quarter 1	**131,316,255**

8.3 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.

9. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

This report is consistent with the objectives of the Strategic Plan and includes budget information for services included in the MIJB Revenue Budget 2019/20.

(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 2019, an overspend is reported to the Board of £837,040.

The staffing changes detailed in **APPENDIX 3** have already been incorporated in the figures reported.

The movement in the 2019/20 budget as detailed in paragraph 8 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.

The year-end overspend position for 2018/19 gives cause for concern going forward. The general reserves have been depleted in 2018/19. Additional savings continue to be sought and a recovery plan is in place in order to support the 2019/20 budget and beyond. Progress reports will be presented to this Board throughout the year in order to address the serious financial implications the MIJB is facing.

(e) Staffing Implications

There are no direct implications in this report but **APPENDIX 3** summarises staffing decisions that have been implemented through delegated authority within Moray Council and NHS Grampian.

(f) Property

There are no direct implications in this report.

(g) Equalities/Socio Economic Impact

There are no equality implications as there has been no change to policy.

(h) Consultations

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

10. CONCLUSION

10.1 The MIJB Budget to 30 June 2019 has an over spend of £790,498 on core services. Senior Managers will continue to monitor the financial position closely and continue to deliver on the recovery plan.

10.2 The financial position to 30 June 2019 includes the changes to staffing under delegated authority, as detailed in APPENDIX 3.

10.3 The financial position to 30 June 2019 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 2019 - JUNE 2019

	Para Ref	Annual Net Budget £'s 2019-20	Budget (Net) To Date £'s 2019-20	Actual To Date £'s 2019-20	Variance £'s 2019-20
Community Hospitals	4.1	4,671,968	1,179,553	1,353,565	(174,012)
Community Nursing		4,388,866	1,134,515	1,138,462	(3,947)
Learning Disabilities	4.2	6,342,453	1,238,565	1,341,381	(102,816)
Mental Health	4.3	8,099,828	1,999,463	2,048,136	(48,673)
Addictions		1,153,368	290,461	287,467	2,994
Adult Protection & Health Improvement		157,262	32,064	31,607	457
Care Services provided in-house	4.4	16,296,988	3,880,971	3,809,385	71,586
Older People & PSD Services	4.5	16,601,919	3,647,038	3,939,125	(292,087)
Intermediate Care & OT		1,599,214	507,081	509,546	(2,465)
Care Services provided by External Contractors	4.6	8,882,749	3,171,486	3,241,392	(69,906)
Other Community Services	4.7	7,443,453	1,922,518	1,847,367	75,151
Admin & Management		1,554,799	381,120	363,165	17,955
Primary Care Prescribing	4.8	16,398,879	4,074,045	4,330,720	(256,675)
Primary Care Services		15,722,686	3,935,343	3,891,559	43,784
Hosted Services		4,058,555	1,066,464	1,093,393	(26,929)
Out of Area		669,268	141,435	161,313	(19,878)
Improvement Grants		925,100	202,108	207,145	(5,037)
Total Moray IJB Core		**114,967,355**	**28,804,230**	**29,594,728**	**(790,498)**
Other Recurring Strategic Funds in the ledger		1,247,130	79,051	78,257	794
Other non-recurring Strategic Funds in the ledger		138,289	61,983	109,319	(47,336)
Other costs which may be incurred not in the ledger		3,198,481	0	0	0
Total Moray IJB Strategic funds	5.1	**4,583,900**	**141,034**	**187,576**	**(46,542)**
Total Moray IJB (incl. other strategic funds) and other costs not in ledger		**119,551,255**	**28,945,264**	**29,782,304**	**(837,040)**
Set Aside Budget		**11,765,000**	-	-	-
Overall Total Moray IJB		**131,316,255**	**28,945,264**	**29,782,304**	**(837,040)**

Funded By:	
NHS Grampian	88,126,292
Moray Council	42,933,100
NHS Earmarked Reserves	256,863
IJB FUNDING	**131,316,255**

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. IJB Hosted, comprises of a range of services hosted by IJB's but provided on a Grampian wide basis. These include:-

    - GMED out of hours service.
    - Intermediate care of elderly & rehab.
    - Marie Curie Nursing Service – out of hours nursing service for end of life patients
    - Continence Service – provides advice on continence issues and runs continence clinics
    - Sexual Health service
    - Diabetes Development Funding – overseen by the diabetes Network. Also covers the retinal screening service
    - Chronic Oedema Service – provides specialist support to oedema patients
    - Heart Failure Service – provided specialist nursing support to patients suffering from heart failure.
    - HMP Grampian – provision of healthcare to HMP Grampian.

16. Out of Area Placements for a range of needs and conditions in accommodation out with Grampian

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

Other definitions:

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

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

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

APPENDIX 3

Item 8

HEALTH & SOCIAL CARE MORAY

DELEGATED AUTHORITY REPORTS - PERIOD APRIL 19 – JUNE 19

Title of DAR	Summary of Proposal	Post(s)	Permanent/ Temporary	Duration (if Temporary)	Effective Dates	Funding
Systems Integration Project Assistants	Extend 2 x 0.50fte temporary posts to December 2019	2 x 0.50fte grade 6 Systems Integration Assts	Temp	December 19		Vacant Post
Clerical Asst - Commissioning	Make current temporary post permanent	0.50 fte grade 3 Clerical Assistant	Perm	N/A	N/A	G9 post reduction in hours to fund
Change of hours of Storeman in Joint Store	Increase grade 4 Storeman hours from 18.00 to 36.25 using vacant grade 5 post	1.00fte grade 4 Storeman	Perm	N/A	N/A	Deletion G5 vacant Technician /Driver post
Unpaid Leave - Woodview	Care Assistant Grade request unpaid leave 10 weeks	1.00fte grade 4 Care Assistant	Temp	10 weeks	June 19 – Aug 19	Service will incur an additional cost in overtime to backfilling the hours
Delete Information Officer post and recruit OT Assistant	Delete Information Officer post and use budget to create OT Assistant	1.00fte grade 4 Information Officer and 0.50fte Grade 5 OT Asst	Perm	N/A	N/A	Deletion of grade 4 post will release funding to create 0.50 grade 5
Redesign Team Manager MADP	Transfer 0.50fte Team Manager G11 from Addictions to MADP budget where other 0.50fte is funded. Post regrade from 11 to 10	1.00fte grade 11 Team Manager	Perm	N/A	N/A	Funding available in MADP to increase post by 0.5fte due to additional SG funding.
Occupational Therapy post Turner Hospital	Remove 0.50fte grade 9 Occupational Therapist post funded by NHS and matching expenditure as post vacant and service redesign post not required	0.50fte grade 9 Occupational Therapist	Perm	N/A	N/A	Remove matching income (NHS) and expenditure.
Increased hours for	Increase CAH Practioner	CAH Practioner grade 8	Perm	N/A	N/A	Funding vired from core service

Care at Home Practioner	hours 18.13 hours	hours increase				
ILS Winter Pressures	Temporary increase 1.00ft grade 3 Social Care Assistant to June 19	1.00fte grade 3 Social Care Assistant	Temp	6 Mths		Funding from NHS Winter Pressures
Relocation of staff from Keith Resource Centre to Burnie Day Centre	Transfer Care Assistant from KRC to Burnie as LD service now operates from Burnie DS	1 x 21.75 hr Care Assistant	Perm	N/A	N/A	No funding implications
Care at Home Care Officer Development Opportunity	Development roles for grade 3 – 5 acting up to grade 7 for 6 mths to cover long term sickness	2 x 1.00fte Grade 7 Care at Home Officers	Temp	6 mths	April 19 - September 19	Core service to fund both additional acting up and back fill

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:-	£64.7 million, of which £4 million relates to Moray's share for services to be hosted and £17 million relates to primary care prescribing. An additional £11.8 million is set aside for large hospital services.

This direction is effective from 29 August 2019.

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:-	£54.8 million, of which £0.5 million is ring fenced for Housing Revenue Account aids and adaptations.

This direction is effective from 29 August 2019.

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 AUGUST 2019**

SUBJECT: **MEMBERSHIP OF BOARD AND COMMITTEES**

BY: **LEGAL SERVICES MANAGER, MORAY COUNCIL**

1. REASON FOR REPORT

1.1. To inform the Board of changes to Membership due to the requirement for the Chair and Vice-Chair positions on the Board to rotate between NHS Grampian and Moray Council.

2. RECOMMENDATION

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

i) notes the Chair and Vice-Chair are due to rotate on 1 October 2019;

ii) agrees a new Chair for the Audit, Performance and Risk Committee (APR) from the voting membership of the Council; and

iii) notes Mr Roddy Burns, Chief Executive of Moray Council and Professor Amanda Croft, Chief Executive of NHS Grampian will be invited to attend future meetings of the Board in an Ex-Officio capacity.

3. BACKGROUND

3.1. At the meeting of Board on 27 June 2019 (para 10 of the draft minute refers) the requirement to change the Chair to a Health Board member in October was noted.

3.2. As the current Vice-Chair of the Board Mr Jonathan Passmore will take on the role of Chair from 1 October 2019.

3.3. It is for Moray Council to nominate a new Vice-Chair of the Board.

3.4. At a meeting of Moray Council on 13 June 2018 (para 2 of the Minute refers) Councillor Shona Morrison was nominated as the Council representative for Chair/Vice-Chair (dependent on Chair/Vice-Chair rotation with NHS). It is

therefore not necessary for Moray Council to nominate a Vice-Chair on this occasion and the role falls to Councillor Morrison.

3.5. Due to the rotation of Chair/Vice-Chair of the Board there is a requirement to appoint a Council voting member as Chair of the APR to take up post on 1 October 2019. This cannot be the Chair or Vice-Chair of the Board.

3.6. In November 2018, Audit Scotland published their second report on Health and Social Care Integration 'update on progress'. Recommendations were made in relation to improving collaborative leadership and building relationships in recognition of the fact that it would be impossible for Integration Authorities alone to address the issues raised throughout the report. Subsequently and in response to the Audit Scotland report, the Ministerial Strategic Group (MSG) requested that all Integration Authorities completed a self-assessment of the progress being made in relation to the key messages of the report. The MIJB has established good working relationships across the wider partnership, however, to strengthen these further, an invitation is being made to Mr Roddy Burns, Chief Executive of Moray Council and Professor Amanda Croft, Chief Executive of NHS Grampian to attend future meetings of the Board in an Ex-Officio capacity.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The Chair and Vice-Chair of the Board is allocated on a rotational basis every 18 months. The next rotation is due on 1 October 2019.

4.2. The Chair of the APR requires to be appointed from a member of the organisation which does not Chair the Board. As Mr Passmore is the incumbent Chair of the Board, the new Chair of APR must be a Council voting member.

4.3. Councillors Louise Laing and Tim Eagle are the two members who are eligible for appointment of Chair of APR.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

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 rick 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 the report is to inform the Board of changes required to membership of the Board and APR.

(h) Consultations

Consultation on this report has taken place with the Corporate Manager, Moray Health and Social Care and Caroline Howie, Committee Services Officer, Moray Council, who are in agreement with the report where it relates to their area of responsibility.

6. CONCLUSION

6.1. The rotation in Chair and Vice-Chair of the Board at 1 October 2019 should be noted.

6.2. A Chair of APR should be appointed from the Council voting membership of the Board.

Author of Report: Aileen Scott, Legal Services Manager
Background Papers: None
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 AUGUST 2019**

SUBJECT: **DRAFT STRATEGIC PLAN**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1. To request the Board note the approach taken in the development of the Strategic Plan for 2019 to 2029.

2. RECOMMENDATION

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

i) note the approach described in revising the Strategic Plan;

ii) consider and approve on the content of the Draft Strategic Plan attached at APPENDIX 1 for public consultation; and

iii) note the final Strategic Plan will be presented in October for approval.

3. BACKGROUND

3.1. The Public Bodies (Joint Working) (Scotland) Act 2014 requires that all Partnerships prepare a 3 year Strategic Plan that outlines how health and social care services will become more integrated for their area.

3.2. The current Strategic Plan covers the period 2016-2019 and it describes how the integrated partnership will make changes and improvements to develop health and social services for adults.

3.3. Legislation prescribes that the plan be reviewed every three years. Development of this revised plan has been driven forward by the Strategic Planning and Commissioning Group.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The review of the Strategic Plan commenced during 2018 with a number of workshops being hosted by the Strategic Planning and Commissioning Group (SPCG). Workshops invitations included MIJB members, Moray Council Elected members, Third Sector representatives, the wider Strategic Planning Reference Group (members of which were refreshed to ensure all key stakeholders were represented) and Health and Social Care Moray staff.

4.2 The SPCG have provided oversight of the arrangements and monitored progress. In December 2018 there was a presentation of the Joint Strategic Needs Assessment (JSNA) to this group, which highlighted the key health aspects for Moray that require to be considered. This JSNA was subsequently presented and discussed at a development session of the MIJB.

4.3 Glasgow School of Art have supported Health and Social Care Moray Management team and MIJB through a series of development sessions and workshops to identify the vision, principles and themes for the revised Strategic Plan which will be underpinned by the development of the Transformation Plan that sets out how the Strategic Plan will be delivered. The draft Strategic Plan attached at **APPENDIX 1** has been compiled from the output of these events.

4.4 The SPCG have approved the draft Strategic Plan for consideration by the MIJB. Following consideration by Board, approval is sought to commence a 6 week public consultation period. It is intended that the final version of the Moray Strategic Plan will be submitted for approval to the MIJB on 31 October 2019.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

In line with national and locally agreed priorities and the national health and wellbeing outcomes.

(b) Policy and Legal

Legislation prescribes that partnerships Strategic Plans are reviewed every three years.

(c) Financial implications

There are no financial implications arising directly from this report.

(d) Risk Implications and Mitigation

The strategic risk register is in place and monitored regularly with updates reported to Audit, Performance and Risk Committee on a quarterly basis. The Strategic Risk Register will be reviewed and aligned to the Strategic Plan for 2019 to 2029 once it is approved.

(e) Staffing Implications

There are no staffing implications arising directly from this report.

(f) Property

There are no property implications arising directly from this report.

(g) Equalities/Socio Economic Impact

An Equality Impact Assessment is not required as there are no negative impacts on those with protected characteristics as a direct result of this report.

(h) Consultations

Consultation on this report has taken place with the Chief Financial Officer and Heads of Service and their comments have been incorporated in this report.

6. CONCLUSION

6.1. The Board is asked to note the approach described in revising the Strategic Plan and approve the Draft Strategic Plan attached at APPENDIX 1 for public consultation.

Author of Report: Jeanette Netherwood, Corporate Manager
Background Papers: with author
Ref:

Appendix 1

Moray Integration Joint Board

Health & Social Care Moray

Moray Partners in Care

THE STRATEGIC PLAN FOR HEALTH AND CARE IN MORAY OVER THE NEXT 10 YEARS (2019-2029)

Consultation closes 11 October 2019

(Draft document version 0.4)

VERSION CONTROL

Document status:	DRAFT
Version	0.4

DOCUMENT CHANGE HISTORY

Version	Date	Comments
0.1	August 2019	Draft document created by FM
0.2	06.08.19	Revisions from PG
0.3	08.08.19	Revisions from LW
0.4	16.08.19	Revisions from SPCG

What you will find in this document

For more information on the Moray Integration Joint Board and Health & Social Care Moray, or to request this document in large print, other formats and languages, please contact us. You will find the details on page 18.

1. THE HEALTH AND SOCIAL CARE STRATEGY AT A GLANCE

WE ARE PARTNERS IN CARE

OUR VISION: "We come together as equal and valued partners in care to achieve the best health and wellbeing possible for everyone in Moray throughout their lives."

OUR VALUES: Dignity and respect; person-centred; care and compassion; safe, effective and responsive

OUTCOMES: Lives are healthier – People live more independently – Experiences of services are positive – Quality of life is improved – Health inequalities are reduced – Carers are supported – People are safe – The workforce continually improves – Resources are used effectively and efficiently

THEME 1: Taking greater responsibility for our health and wellbeing

THEME 2: Being supported at home or in a homely setting as far as possible

THEME 3: Making choices and taking control over decisions affecting our care and support

TRANSFORMATION (DELIVERY) PLAN supported by enablers:

- Financial Plan
- Performance Framework
- Locality Plans
- Existing strategies
- Housing Contribution
- Organisational Development Plan
- Communication & Engagement Plan

1. WELCOME

To follow.

Jonathan Passmore
Chair
Moray Integration Joint Board

Pam Gowans
Chief Officer
Health & Social Care Moray

2. INTRODUCTION

"We come together as equal and valued partners in care to achieve the best health and wellbeing possible for everyone in Moray throughout their lives."

Health, wellbeing and independent living are important to us all, which is why everyone has a stake in the success of this Strategic Plan.

The Moray Integration Joint Board brings together partners with a shared goal of everyone in Moray being able to live longer, healthier lives as independently as they can at home or in a homely setting.

We have a strong record of accomplishment in joint working to improve outcomes for our citizens. As with all health and social care systems, however, Moray is facing increasing demand for services at the same time as resources - both funding and workforce availability - are under pressure. These challenges will intensify in the coming years as our population grows older and the numbers of residents living with multiple and complex health and care needs rise.

To meet these challenges we have set our sights on transforming the health and care system through the delivery of this Strategic Plan.

We want to see a transformed, sustainable health and care system that manages demand for services in order to safeguard the continued delivery of high-quality care, support and treatment services for those in most need and to get the best value from our limited resources.

Key to this is the strengthening of our partnerships. By working together, we can make the most of the assets and talents of the people, communities and organisations in Moray. We will encourage one another to consider what we can do for ourselves, what we will need support to achieve and the areas of health and wellbeing for which we will depend on services.

Success will see everyone in Moray able to live longer, healthier lives at home or in a homely setting.

3. WHO WE ARE

The Moray Integration Joint Board has responsibility for a range of services in the community and the resources needed to deliver them. These services include:

- Social care services;
- Primary care services including GPs and community nursing;
- Allied health professionals such as occupational therapists, psychologists and physiotherapists;
- Community hospitals;
- Public health;
- Community dental, ophthalmic and pharmaceutical services;
- Unscheduled care services;
- Support for unpaid carers.

The full list of delegated functions can be viewed at the link here.

The Board directs Moray Council and NHS Grampian to deliver on this plan through the staff they employ, seeking them to work together as the Health & Social Care Moray partnership to directly provide or commission services.

4. WHERE WE ARE

A Joint Strategic Needs Assessment was carried out in 2018. This looked at the current and future health and care needs of our local populations. Nine areas were highlighted from the wealth of intelligence compiled.

1. There are continuing inequalities in health status across Moray, with an evident association between level of neighbourhood affluence and morbidity and mortality.
2. The population is predicted to continue ageing, with a growing proportion represented by adults over the age of 65, and growing numbers of adults aged over 80, with implications for increasing morbidity.
3. Significant demand for health and social care services arise from chronic disease and a growing proportion of the population is experiencing more than one condition ("multi-morbidity").
4. There is significant morbidity and mortality due to mental health problems.
5. There is significant morbidity and mortality due to lifestyle exposures such as smoking, alcohol and drug misuse.
6. Moray is characterised as remote and rural, and there are significant access challenges for some in the population to access health services.
7. Care activity is highly demanding of informal carers, and there is evidence of distress in the informal carer population.
8. Moray's military and veteran population constitute a significant group, requiring both general health services and specific services.

The full assessment can be viewed at the link here.

5. THE CHALLENGES WE FACE

As partners in care we face a range of challenges which make the current model of service provision unsustainable. These include:

Increasing demand – demand for health and care is growing at an unsustainable rate as people are living longer and with multiple chronic conditions. While people are living longer, they are spending longer in poor health. This puts a growing challenge on families, communities, public, third sector and independent sector services.

Growing pressure on limited resources – the rise in demand puts pressure on our limited resources at a time of rising costs and restricted budgets. We struggle to recruit and retain sufficient staff in some sectors.

Improving experiences and outcomes – people who use services rightly have increasing expectations of better experiences and outcomes from high quality services and more joined-up ways of working, services and system driven by continuous improvement.

To meet these challenges we will identify what is working well and how we can continue to make improvement. We will also identify what we need to do differently.

This redesign may require us to make some difficult choices about how to allocate our limited resources to achieve better health, better care and better value for the people of Moray.

We are ambitious for transformational change to bring about advances and drive us towards achieving our vision for Moray.

6. DEVELOPING OUR STRATEGIC PLAN

Many partners in care worked to develop this Strategic Plan. They shared their experiences of the challenges facing today's system and ideas for what a better future system could look like.

We found many examples of great practice and good progress that we can build on as well as a range of things we need to do better or differently. We recognise that to move forward we need to:

- Help people understand the need for change and provide opportunities to become involved in defining the change and making it happen
- Strengthen relationships through trust, value and equality to make the best use of our collective assets and resources in throughout Moray
- Embrace new ways of integrated working
- Build on existing good practice and ensure services are safe, effective and sustainable
- Balance what is achievable with what is affordable

In developing the plan, we also reviewed and considered the other elements that influence and impact on our work.

These included how the Moray IJB has delivered on its first strategic plan launched in 2016; financial, service and workforce pressures; national legislation and policy; and direction from the Moray Community Planning Partnership.

We recognise that Moray IJB has a duty to contribute to reducing health inequalities (National Health and Wellbeing Outcome 5). Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. They are a key challenge and have a significant demand on health and social care services.

We will take every opportunity throughout the continuous cycle of planning, implementing and reviewing services and processes required to deliver this Strategic Plan, to take forward actions to address inequalities.

7. WHERE WE WANT TO BE

OUR VISION – **What we are aiming for**

"We come together as equal and valued partners in care to achieve the best health and wellbeing possible for everyone in Moray throughout their lives."

OUR MISSION – **What we are striving for**

We work to deliver the triple aim of the National Health and Social Care Delivery Plan in that we seek to:

- Improve the health and wellbeing of the population (**better health**)
- Improve the quality of care people receive (**better care**)
- Improve the efficiency of health and social care services to ensure we spend public money on services that get good outcomes for people (**better value**)

OUR VALUES – What guides our behaviour

We will demonstrate our values and principles in the way we engage with people and how we behave.

- Dignity and respect
- Care and compassion
- Person-centred
- Safe, effective and responsive

OUR STANDARDS

We work to meet the National Health and Social Care Standards that are:

- People experience high quality care and support that is right for them
- People are fully involved in all decisions about their care and support
- People have confidence in the people who support and care for them
- People have confidence in the organisation providing their care and support
- People experience a high quality environment (if the organisation provides the premises).

8. OUR STRATEGIC THEMES

Building on what we know, we have identified three strategic themes where we will direct effort. As these themes are closely linked, improvements in one area will influence positively on the others.

Areas for activity are highlighted for each. Greater detail on the actions to be undertaken, timescales and performance measures will be set out in the Transformation Plan for the delivery of this strategy.

THEME 1: Taking greater responsibility for our health and wellbeing

We are committed to working with all our partners in care across Moray to support people to live healthier lives for longer.

We will encourage people take charge of their own health and wellbeing and that of their families and communities. We want people to be able to draw on their own personal resources and those of their community not only when they experience health and care challenges but to prevent problems happening.

Personal responsibility - We will support people, including members of the workforce, to take their physical and mental health seriously throughout their lives.

Self-management - We will support people to build their skills and confidence to manage their own long-term health conditions and build resilience, helping them make the most of community connections and community assets.

Information – We will help people to access information to improve their knowledge and signpost them to sources of advice and help to maintain their independence. Staff will make every opportunity count by promoting positive health messages during all interactions.

Early intervention and prevention – We will promote prevention, early intervention and harm reduction programmes, including around mental health and loneliness.

THEME 2: Being supported at home or in a homely setting as far as possible

Good health and wellbeing begins at home and in communities. This is where most people would choose to remain with the right support.

We will develop services in partnership with providers of health and care services and support, including the Third Sector and Independent Care Sector, to deliver better and more joined-up care.

Hospitals will always be required while we explore opportunities for shifting resources to provide more community-based service that are closer to the person.

Multi-Disciplinary Teams – We will enhance locality-based care delivered by health and social care professionals from different disciplines working together as multi-disciplinary teams (MDT) to provide more co-ordinated care to help patients prevent avoidable hospital admissions. These MDTs will expand to include Third Sector partners. They will implement models to identify people at risk of losing their independence, for example those with frailty, and work with them to develop their anticipatory care plans.

Rehabilitation, reablement and recovery – We will continue to work with people to provide them with the services and support they need, in the most appropriate setting and by the most appropriately skilled staff group, to regain and maintain their health, wellbeing and independent living skills.

Housing, adaptations and technology – We will continue to work with housing providers to support people in homes which best meet their care and support needs, such as dementia friendly housing. They will be able to access technology to support independent living.

Crisis support – We will continue to develop rapid responses for people at home who have an urgent care and support need. This will include access to equipment and care at home to prevent avoidable hospital admission where possible and to help people return home from hospital quickly.

THEME 3: Making choices and taking control over decisions affecting our care and support

We are committed to working with people not as passive recipients but as partners in their own care, support and treatment.

We will continue to change our relationship with people who use services, their families and carers so that they are in charge of making informed choices and decisions on what their care and support looks like and how it is delivered so they can live their life and achieve the outcomes that matter to them.

Personalised care and support planning – We will involve people and their families in all processes from assessing their own health and wellbeing needs through to the planning and commissioning of the support to meet their needs. We will build on the implementation of self-directed support (SDS) to support people to identify and achieve their personal outcomes. We will uphold the rights of carers to be involved in the care and support planning of the person they care for or intend to care for.

Realistic Medicine – We will continue to encourage health and care workers to find out what matters to the person so that the care of their condition fits their needs and situation. Through shared decision-making individuals and their families will feel empowered to discuss and understand possible treatment available and the benefits

and risks of these, including the option of doing nothing and what effects this could have.

Long-term conditions – We will explore the opportunities presented by the House of Care programme to help people with long term conditions be more involved in their care and self-management.

Palliative and end of life care – We will support people to exercise their preference in relation to palliative and end of life care in the setting of their choice.

Engagement in services – We will engage with people so they have more say in decisions about local services and more involvement in designing and delivering them.

Market shaping strategies – We will work with current and potential providers to develop a diverse and thriving market place of opportunities and services from which people can choice to access for care and support.

9. OUR ENABLING PLANS

The Strategic Plan for 2019-2029 is the overarching umbrella plan under which many existing programmes of work, client group strategies and delivery plans sit.

These include strategies to improve services and responses for unpaid carers; older people; physical and sensory disabilities; mental health; learning disability; the Moray Alcohol and Drug Partnership.

These are available on the website: http://hscmoray.co.uk/our-strategies-and-plans.html

Delivery of the Strategic Plan will be through the Transformation Plan, supported by a number of enabling plans. These include:

- The Financial Plan - achieving financial sustainability
- The Organisational Development Plan - developing positive organisational culture among the workforce
- Locality Plans – communities working together to identify local needs and local solutions
- Housing Contribution – agreeing the key areas of focus to meet current and future needs
- Communication and Engagement Plan – guiding how we share information, listen to and learn from each other to support

10. THE DIFFERENCE WE WANT TO MAKE

All our plans must deliver on the nine National Health and Wellbeing Outcomes. These are used by the Scottish Government to measure the success of integration by boards across Scotland.

The outcomes we want to achieve	
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 at home or in a homely setting in their community.**
3	**People who use health and social care services have positive experiences of those services, and have their dignity respected.**
4	**Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**
5	**Health and social care services contribute to reducing health inequalities.**
6	**People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.**
7	**People using health and social care services are safe from harm.**
8	**People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**
9	**Resources are used effectively and efficiently in the provision of health and social care services.**

11. MEASURING SUCCESS

Maintaining consistently high standards through a period of transformation is a challenge, but to the people who rely on health and social care services it is vitally important we achieve this.

We will continue to ask people about their experiences of services, listen to what they say and act on it. This will help us learn if outcomes are being met and where improvement should be made.

Performance management arrangements are in place to monitor, scrutinise our effectiveness in delivering the vision and priorities of the Moray IJB and to demonstrate we are achieving the national outcomes and highlight areas for improvement.

Performance information is gathered at service level. Governance and operational performance reports are scrutinised by the Moray IJB that publishes an Annual Performance Report to reflect on activity during each financial year.

12. TELL US WHAT YOU THINK

Health and wellbeing matters to all of us in Moray. We want to involve everyone as partners in care to ensure this Strategic Plan is successful in improving outcomes.

Have we understood what is important to you? Are there any other priorities you want to see included along with the three we are proposing? If yes, what are they?

Do you have any other ideas on how we can best meet the heath and care needs of adults living in Moray, keeping in mind our limited resources and increasing demand for care? What do we need to keep or redesign?

The formal consultation for this draft Strategic Plan opened on 30 August 2019 and closes on 11 October 2019. To ensure we review and manage all the responses consistently please feedback to us using our online survey if possible. This can be accessed at XXXXX.

At the end of the consultation we will publish the responses. Moray Integration Joint Board will review these before the Strategic Plan is finalised and approved for implementation.

If you would like a printed version of the consultation response form, or further information about any aspect of this document, would like it in a different language or format or have any comment to make, please get in touch.

Staying involved

The Moray Integration Joint Board and Health & Social Care Moray are committed to achieving meaningful and sustained engagement with all stakeholders.

If you would like to be added to our Partners in Care involvement database please contact us and we will send you an application form. We will keep you up to date with opportunities to work with us and use your knowledge, skills and lived experience to help achieve positive change.

	**Health & Social Care Moray** **9C Southfield Drive** **Elgin** **IV30 6GR**		**www.hscmoray.co.uk**
	**01343 567187**		**involvement@moray.gov.uk**

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 29 AUGUST 2019**

SUBJECT: **OVERNIGHT RESPONDER SERVICE PILOT**

BY: **CHARLES MCKERRON, INTERIM INTEGRATED SERVICES MANAGER**

1. REASON FOR REPORT

1.1. To inform the Board of concerns raised by family members about risks associated with the pilot for an alternative approach to the provision of overnight care and support for people with a learning disability in Moray and how these risks will be addressed by this pilot project.

2. RECOMMENDATION

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

i) approve the 12 week pilot for an overnight responder service;

ii) note the potential long term benefits; and

iii) note the evaluation of the pilot will be presented to this committee in January 2020

3. BACKGROUND

3.1 There are currently 18 sleepover staff and 8 waking night staff provided every night in Moray for people with learning disabilities.

3.2 Staff presence in a person's home has to be considered sensitively and should only be used where there is a clearly identified need and purpose. People have a right to privacy in their own home and this must be balanced with ensuring the safety and wellbeing of the person.

3.3 The Learning Disability Transformation project has been set up to maximise people's independence while also supporting them to live safely, this is consistent with the progression model which informs all the service provision. The progression model seeks to improve an individual's independence and to

ensure that the right package of care that optimises potential is achieved for the individual.

3.4 The Service has the ability, motivation and creativity to work in partnership with providers to deliver an innovative approach to the provision of overnight support. Providers as partners in care locally are keen to work with the Service on testing out an alternative to the current provision based on looking outwards to other areas and the achievements that have been reached there. Cornerstone successfully operate an overnight responder service in Ayrshire, Lanarkshire and a new project in Glasgow.

3.5 The introduction of the Scottish Living Wage means that the current commissioning of night time support from providers, on behalf of Health and Social Care Moray (HSCM), continues to challenge the provision of care available in relation to the resources available both financially and in relation to workforce supply. The cost of the current delivery of night time care in Moray for people who have a learning disability is £18,561 per week (£965,172 per annum). Elgin carries £564,104 or slightly more than 58% of the total annual cost.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The availability of care staff is an ongoing issue in Moray; this pilot has the potential to free up care staff to work during day time hours, thus enhancing available resource ensuring there is staff intervention when it is absolutely required coupled with other methods that can deliver equal benefit to individuals in a new way of working.

4.2 The pilot is designed to take place in three Elgin based houses that provide overnight care and support to 11 people who have a learning disability. All of the houses are managed by Cornerstone. The overnight support in each of the houses is provided by means of a ‘sleeping’ overnight staff.

4.3 The pilot is designed in two 6 week phases. During phase 1, the sleeping member of staff will remain in-place but any overnight response will be provided by a responder. The sleeping night staff can be used if there is any situation that the responder is not able to deal with safely. During phase 2 and depending on the success of phase 1, for the second 6 weeks of the pilot, the sleeping overnight staff will be removed and the responder service will provide the overnight response.

4.4 The pilot will be continually monitored and if any unforeseen risks arise during any part of the pilot, the sleeping staff can be reinstated if needed. Risks have been considered in consultation with Cornerstone staff who know the service users and telecare sensors have been put in place based on individual need.

4.5 All sensors are linked through the community alarm system to the 24/7 alarm call centre. The call centre will alert the responder service immediately if there are any triggers. The responders have timescales and protocols to work to, to ensure a timely and appropriate response.

4.6 In the unlikely event of fire, the houses are linked to an alarm system, in addition, the call centre will alert the fire services and the responder service. Two of the houses have fire doors and sprinkler systems fitted, in the third house additional smoke alarms, connected to the call centre will be installed as part of the telecare solutions associated with this project.

4.7 During the consultation with parents and guardians, some of the parents/guardians expressed concern about the pilot and the implication for their family member. The parents of two of the people in scope for the pilot are especially concerned about the risk to wellbeing associated with removing the sleep-in staff; the risk of wandering and the risk of fire. The Board is asked to consider these concerns, note the safeguards that have been built into the pilot and the potential benefits of the pilot. See table 4.9 and Paragraph 5 (c).

4.8 Moray Council Adult Social Care Services has developed a Positive Risk Taking Policy, recognising that risk is part of everyday life. This Policy is being reviewed in light of the developing and changing social care landscape.

4.9

Risk	**Mitigating action**
Risk to wellbeing & Risk of wandering	Monitoring of overnight disturbances. Continuation of sleep-in staff for first 6 weeks. Telecare devices providing immediate alert of disturbance. Provision of responder.
Risk from fire	Houses linked to a fire alarm system. Two of the houses have fire doors and sprinkler systems fitted. Additional smoke alarms connected to the call centre being installed in house three.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

This pilot is in line with MIJB's values and principles as set out in the Strategic Commissioning Plan 2016-2019.

(b) Policy and Legal

There will need to be a variation of the contract with Cornerstone to carry out this pilot. The variation will be based on the implementation plan developed jointly with Cornerstone. There are no other contractual issues pertaining to the pilot.

(c) Financial implications

If the pilot is not undertaken the cost of the service during this period will be £23,882.04

Additional expenditure required to carry out the pilot is £1,810.62

Cost of pilot.

Phase 1		
Weeks 1 – 6.	Ongoing overnight costs	£11,941.02
	Responder cost	£ 6,686.82
	Total	£18,627.84
Phase 2		
Weeks 7 – 12.	Responder cost only	£ 6,686.82
	Mileage estimate 10 miles per night	£ 378.00
Total expenditure during pilot.		£25,692.66

Assuming the operational element of the pilot is successful then it is recommended that the responder service is continued during the evaluation phase of the project for the services that are in scope. This will achieve an ongoing cost reduction of £875.70 per week for the three services in scope. The operationalisation of an overnight responder service across all Learning Disability services has the potential to achieve significant ongoing cost reductions.

(d) Risk Implications and Mitigation

Risks have been considered and risk management measures have been put in place reference paragraph 4.9.

(e) Staffing Implications

There are no immediate staffing implications as a result of this report. There is the potential to free up staff to work during day time hours.

(f) Property

There are no property issues as a result of this report.

(g) Equalities/Socio Economic Impact

A full Equalities Impact Assessment has been completed as part of the process and is attached at **APPENDIX 1**.

(h) Consultations

Consultation on this report has taken place with the Chief Officer, Chief Social Work Officer/Head of Adult Services, Commissioning & Performance Manager, Chief Financial Officer, MIJB and Interim Head of Integrated Children's Services, Moray Council, who are in agreement with the report where it relates to their area of responsibility.

6. CONCLUSION

6.1. The concerns expressed by the parents and guardians are understandable because this pilot represents change from a situation that has remained static for many years.

6.2. The pilot has been designed to ensure that the risks to the people have been considered and minimised.

6.3. There are significant potential benefits that can follow on from this pilot. This approach has been tested elsewhere successfully. The pilot will be evaluated to ensure that the learning and benefits can inform the future development of overnight response in Moray.

6.4. An evaluation report with recommendations will be presented to the Board for their consideration. The pilot is planned to run for 12 weeks, the evaluation will take a further 4 weeks, therefore the report will be presented to the January 2020 Board meeting.

Author of Report: Charles McKerron, Acting Service Manager
Background Papers: with author
Ref:

SECTION 1 - DO I NEED AN EIA?

DO I NEED AN EIA? *(see note 1)*

Name of policy/activity: **OVERNIGHT RESPONDER SERVICE PILOT – REPORT TO IJB**
Please choose one of the following: Is this a: • Pilot programme or project? Pilot

Decision Set out the rationale for deciding whether or not to proceed to an Equality Impact Assessment (EIA):- This involves a change to the service provision of people who have a learning disability and as such an EIA is required. **Date of Decision:** 20/08./2019

If undertaking an EIA please continue onto the Section 2. If not, pass this signed form to the Equalities Officer.

SECTION 2: EQUALITY IMPACT ASSESSMENT

General Information

Assessment undertaken by *(please complete as appropriate)*

Director or Head of Service	Jane Mackie, Head of Service
Lead Officer for developing the policy/activity	Charles McKerron, Acting Service Manager LD and Consultant Practitioner.
Other people involved in the screening (this may council staff, partner or others i.e contractor, partner or community)	

Brief description of policy/activity

Describe the policy/activity *(see note 2):*

The pilot is designed to take place in three Elgin based houses that provide overnight care and support to 11 people who have a learning disability. All of the houses are managed by Cornerstone. The overnight support in each of the houses is provided by means of a 'sleeping' overnight staff.

The pilot is designed in two 6 week phases. During phase 1, the sleeping member of staff will remain in-place but any overnight response will be provided by a responder. The sleeping night staff can be used if there is any situation that the responder is not able to deal with safely. During phase 2 and depending on the success of phase 1, for the second 6 weeks of the pilot, the sleeping overnight staff will be removed and the responder service will provide the overnight response.

Who are your main stakeholders? *(see note 3)*

11 people, all of whom have a Learning Disability and who live in the houses identified.
The parents and carers and legal Guardians of the 11 people.
The staff who support the 11 people.

Evidence Base for Assessment *(see note 4)*

Please cite any quantitative and qualitative evidence relating to groups having different needs, experiences or attitudes in relation to this policy/activity. What baseline evidence do you have already for this policy/activity?

Describe briefly the evidence you will draw on to inform this EIA.

There are currently 18 sleepover staff and 8 waking night staff provided every night in Moray for people with learning disabilities. Staff presence in a person's home has to be considered sensitively and should only be used where there is a clearly identified need and purpose. People have a right to privacy in their own home and this must be balanced with ensuring the safety and wellbeing of the person.

The Learning Disability Transformation project has been set up to maximise people's independence while also supporting them to live safely, this is consistent with the progression model which informs all of our service provision. The progression model seeks to improve an individual's independence and to ensure that the right package of care that optimises potential is achieved for the individual.

Our providers as partners in care locally are keen to work with us on testing out an alternative to the current provision based on looking outwards to other areas and the achievements that have been reached there. Cornerstone successfully operate an overnight responder service in Ayrshire, Lanarkshire and a new project in Glasgow.

The introduction of the Scottish Living Wage means that the current commissioning of night time support from providers, on behalf of Health and Social Care Moray (HSCM), continues to challenge the provision of care available in relation to the resources available both financially and in relation to workforce supply.

Engagement and Consultation *(see note 5)*

Thinking about people inside the council, partners and the wider community use the table below to outline any previous engagement or consultation which is relevant to this policy/activity.

Protected Groups	Engagement and consultation
Carers (for elderly, disabled or minors)	1:1 meetings and/or phone conversations with the parents/carers/legal guardians of the people in scope for the pilot to inform them of the proposed pilot and to hear their concerns and discuss the risk minimisation measures that have been put in place.
Staff	
Partners/contractors	Meetings with Cornerstone to design and agree the pilot. Cornerstone have had conversations with their staff.

Procurement and partnerships *(see note 6)*

Is this policy/activity currently or anticipated to be carried out wholly or partly by contractors or other partners? Are they aware of their obligations to address equalities?

Briefly explain:
As noted in section describing activity above, the pilot is designed to take place in three Elgin based houses that provide overnight care and support to 11 people who have a learning disability. All of the houses are managed by Cornerstone and it will be Cornerstone staff who will provide the responders and the management support.

Evidence gaps *(see note 7)*

Are there any significant gaps in the known evidence base, engagement or procurement that would prevent this EIA being completed? If so, you will need to address the gaps before finalising this EIA. Please go to Appendix 1 to assist you in developing a work plan to address the gaps. No identified gaps.

Who is affected and what is the impact? *(see note 8)*

From this evidence or engagement you have already, list how this policy/activity might impact equality and/or the elimination of discrimination for each of the equality groups.

Protected Groups	Positive	Negative
Disability	The 11 people in the pilot will be supported to have greater independence.	The 11 people in the pilot will not have overnight sleep in staff and may feel and be more vulnerable.
Carers (for elderly, disabled or minors)		The parents/ carers/ guardians of the 11 people are likely to feel anxious.
Staff	Staff will be freed up to work during the day.	Staff will lose their overnight allowance.
Partners/contractors	The partner will gain staff who are free to work during the day. The partner will gain income from providing a responder service.	The partners will lose income from providing overnight support.

Summary of Impacts *(see note 9)*

Summarise the impacts of the policy/activity and resulting activities affect different communities and groups.

Does it create positive impacts? Yes

Please explain
The 11 people in the pilot will be supported to have greater independence while also supporting them to live safely, this is consistent with the progression model which informs all of our service provision. The progression model seeks to improve an individual's independence and to ensure that the right package of care is achieved for the individual.

Our providers as partners in care locally are keen to work with us on testing out an alternative to the current provision based on looking outwards to other areas and the achievements that have been reached there. Cornerstone successfully operate an overnight responder service in Ayrshire, Lanarkshire and a new project in Glasgow. Carrying out this pilot will provide learning for the whole system in Moray.

The introduction of the Scottish Living Wage means that the current commissioning of night time support from providers, on behalf of Health and Social Care Moray (HSCM), continues to challenge the provision of care available in relation to the resources available both financially and in relation to workforce supply. The pilot has the potential to achieve efficiencies both financially and in terms of staff resources

Does it create negative disadvantage or inequalities? Yes

Please explain
In part, this depends on your point of view. The pilot is designed to minimise risk and to ensure the safety of the 11 people. Two of the parents/carers/Guardians are especially anxious and have indicated their concerns to elected members of the Council and their elected member of Parliament.

If you have indicated there is a negative impact on any group, is that impact:

Legal? Yes

Please explain
The IJB continues to fulfil its duty of care and will be providing appropriate care and support for the 11 people.

Intended? Yes

Please explain
The IJB continues to fulfil its duty of care and will be providing appropriate care and support for the 11 people. There will be learning from this pilot and this learning can be applied to all of the provision of overnight support.

Mitigating Action *(see note 10)*

Can the impact of the proposed policy/activity be mitigated? Yes

Please explain

The 11 people in the pilot will be supported to have greater independence while also supporting them to live safely. The design of the pilot supports this as does the introduction of telecare equipment.

What practical actions do you recommend to reduce, justify or remove any adverse/negative impact? If more than one action, please list them in the action plan in appendix 2.

The pilot is designed in two 6 week phases. During phase 1, the sleeping member of staff will remain in-place but any overnight response will be provided by a responder. The sleeping night staff can be used if there is any situation that the responder is not able to deal with safely. During phase 2 and depending on the success of phase 1, for the second 6 weeks of the pilot, the sleeping overnight staff will be removed and the responder service will provide the overnight response.
Telecare equipment will be installed in every house, specific to the needs of the residents. All sensors are linked through the community alarm system to the 24/7 alarm call centre. The call centre will alert the responder service immediately if there are any triggers. The responders have time scales and protocols to work to in order to ensure a timely and appropriate response.
In the unlikely event of fire, the houses are linked to an alarm system, in addition, the call centre will alert the fire services and the responder service. Two of the houses have fire doors and sprinkler systems fitted, in the third house additional smoke alarms will be installed connected to the call centre as part of the telecare solutions associated with this project.

Justification *(see note 11)*

From the evidence you have and the impacts identified, what are the key risks (the harm or 'adverse impacts') and opportunities (benefits and opportunities to promote equality) this policy/practice/activity might present?

The key risks are summarised below.

Risk	**Mitigating action**
Risk to wellbeing & Risk of wandering	Monitoring of overnight disturbances. Continuation of sleep in staff for first 6 weeks. Telecare devices providing immediate alert of disturbance. Provision of responder.
Risk from fire	Houses linked to a fire alarm system. Two of the houses have fire doors and sprinkler systems fitted. Additional smoke alarms connected to the call centre being installed in house three.

The pilot seeks to minimise the risks to the individual through a phased approach. The pilot is designed in two 6 week phases. During phase 1, the sleeping member of staff will remain in-place but any overnight response will be provided by a responder. The sleeping night staff can be used if there is any situation that the responder is not able to deal with safely. During phase 2 and depending on the success of phase 1, for the second 6 weeks of the pilot, the sleeping overnight staff will be removed and the responder service will provide the overnight response.

The 11 people in the pilot will be supported to have greater independence while also supporting them to live safely, this is consistent with the progression model which informs all of our service provision. The progression model seeks to improve an individual's independence and to ensure that the right package of care is achieved for the individual.

Keeping in mind the proportionality of any action proposed to mitigate the impact, describe the scale and likelihood of these risks and opportunities

Risk to wellbeing	Possible	Minor	Medium Risk
Risk of wandering	Possible	Moderate	Medium Risk
Risk from fire	Rare	Extreme	Medium Risk

If nothing can be done to reduce the negative impact(s) but the proposed policy/activity must go ahead, what justification is there continue with the change?

The negative impact will be reduced.

SECTION 3 CONCLUDING THE EIA

Concluding the EIA *(see note 1)*

Summarise your findings and give an overview of whether the policy will meet the council's responsibilities in relation to equality and human rights referring to the four possible outcomes.

The pilot has been designed to minimise risk, the project has been designed in two six week phases. In phase 1 the overnight staff will remain in place. Only if phase one is successful will phase two go ahead as currently planned. The care provision will be constantly monitored and additional mitigating actions will be put in place if required.
Telecare equipment will be installed in every house, specific to the needs of the residents. All sensors are linked through the community alarm system to the 24/7 alarm call centre. The call centre will alert the responder service immediately if there are any triggers. The responders have time scales and protocols to work to in order to ensure a timely and appropriate response.
In the unlikely event of fire, the houses are linked to an alarm system, in addition, the call centre will alert the fire services and the responder service. Two of the houses have fire doors and sprinkler systems fitted, in the third house additional smoke alarms will be fitted.

Sign off and authorisation: *see EIA guidance, note 7.*

Service	Learning Disabilities Services
Department	Health and Social Care Moray
Policy/activity subject to EIA	
We have completed the equality impact assessment for this policy/activity.	Name: Charles McKerron Position: Interim Service Manager Date: 20/8/19
Authorisation by head of service or director.	Name: Jane Mackie Position: CSWO/Head of Service Date: 20/8/19
Please return this form to the Equal Opportunities Officer, Chief Executive's Office.	